

**Attachment-Related Fear and Psychotherapy:
Developing Heard and Lake's Theory of Attachment Based Exploratory
Interest Sharing**

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Abstract

This qualitative study uses Stile's theory building method to explore the nature and influence of attachment-related fear within a therapeutic setting. Its starting point is the Theory of Attachment Based Exploratory Interest Sharing; an attachment focused approach to adult psychotherapy developed by Heard, Lake and McCluskey (2009/2012). To critique this approach, the study draws on literature linking attachment theory, complex systems, psychotherapy and shame. Eight case studies were drawn from analysis of transcripts taken from seventeen sessions (fifty hours) of two experiential groups. These groups were the principal focus of two training courses attended by professional caregivers (mostly counsellors and psychotherapists) who met at monthly intervals with a facilitator using McCluskey's approach to group facilitation. Their aim had been to explore their own attachment experiences and apply their learning to personal and professional development. The method of group facilitation places Heard and Lake's (1997; Heard et al., 2009/2012) model of attachment at its core; creating an analogue of the therapeutic encounter in dyadic exchanges between facilitator and each group member. The study aims to develop Heard and Lake's theory so that it reflects findings about the link between attachment-related fear and other critical factors (principally shame, defensive exclusion and attachment styles). Findings: Attunement is a complex two-way process in which the client sometimes adapts to regulate the facilitator; theory can also serve to regulate the group facilitator, obscuring occasions when the 'client' is adapting to the needs of the 'therapist'; attachment-related fear is frequently linked to shame, therefore, regulating fear requires a way to recognise and regulate shame. The study recommends changing the model of facilitation so that attunement within the groups is not dependent on one individual. Although the study begins with Heard and Lake's theory, its findings are relevant to other therapeutic approaches and helping professions.

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Author's Declaration

This thesis is the original work of its author, Patrick Winter. No part of it has been published or previously submitted for an award at this or any other University. All sources are acknowledged as References.

Chapter One: Introduction to the Study

Introduction

This study uses a theory building approach to explore the nature and influence of fear within a specific natural therapeutic setting. It draws on attachment theory to critique a theoretical approach to adult psychotherapy developed by Heard, Lake and McCluskey (2009/2012). Eight case studies were created based on the analysis of over fifty hours of audio-recordings (and transcripts) taken from two experiential groups which met at monthly intervals for training based on the exploration of attachment experiences. The facilitation of these courses was closely guided by a psychotherapeutic approach developed by Heard and colleagues (Heard and Lake, 1997; Heard et al., 2009/2012). The aim of the study is to develop the theory underpinning this approach so that it takes into account findings about the nature of fear, its relationship with other factors (such as shame, selective exclusion and attachment styles) and evidence within the case studies concerning the nature of affect attunement and regulation.

Although the study is of special interest to therapists who are familiar with the body of theory created by Heard and Lake, it deals with issues that are central to effective therapeutic relationships and other forms of professional caregiving. Therefore, it is relevant to a wider audience.

My intention in this chapter is to set the scene for the study. I will do this by briefly defining fear within the remit of the study; by describing the background to my involvement in the project and discussing my personal motivation for embarking on a study of fear. I will identify the aims of the study and set these within the context of wider questions about the meaning of theory within psychotherapy. I outline criticisms of psychotherapy that have been made from a social constructionist perspective before discussing the epistemological approach that informs my understanding of clinical evidence. I then discuss some aspects of the theory building method that has been used and explain why data drawn from training courses, that were not psychotherapy groups, is appropriate for

this study of attachment related-fear within psychotherapy. I close the chapter with an outline of the thesis.

Focus and motivation for the project

Fear as a biological mechanism

This is a theory building study examining how attachment-related fear influences interaction between therapist and client. The theory being developed in the study views psychotherapy as an attachment relationship (Bowlby, 1988; McCluskey et al, 1999); that is, a biologically grounded exchange between someone who seeks care and someone who gives care. The study considers how fear may influence both the recipient of therapy and the therapist.

When beginning the project I had not yet defined the precise focus of my interest in fear and my early work considered fear as a general feature of psychotherapy. The focus on attachment-related fear crystallised gradually as a result of my wrestling with the data. Attachment-related fear is fear that is directly linked to adverse experiences in attachment relationships. Its relevance arises from the fact that fear underpins the relational strategies adopted by insecure people (Mikulincer and Shaver, 2007; Slade, 2008) to protect them from the pain associated with unsatisfying attachment relationships.

The study views fear as a brain system (LeDoux, 1996) whose function is to monitor the environment for indicators of danger and ensure survival of the organism. Its influence is seen in every sphere of life; individual and social. It informs our appraisals of events to ensure that good (life enhancing) events are recognised utilised and conserved whilst potential danger is avoided. However, fear is contagious and can be transmitted between individuals and groups. So while fear may keep us safe it can also infiltrate exploration (Heard and Lake, 2012) and suck the life out of experience. This is because, when fear is activated, play and exploration are inhibited (Ainsworth et al., 1978; Bowlby, 1969; Heard and Lake, 1997; Heard et al., 2012; Winnicott, 1971) and remain in a deactivated state until fear has been regulated in some way (Heard and Lake, 1997; McCluskey, 2005). Because

psychotherapy requires a trusting relationship between therapist and client, and the willingness and capacity for client and therapist to explore the meaning of their experiences, the regulation of fear is central to the therapeutic endeavour (McCluskey, 2005).

Personal background to the study

Serendipity frequently plays a large part in the choice of research subjects (Yin, 2009); this is very true in the case of this project. A practitioner in several caring professions for over thirty years, I have long had an interest in different aspects of counselling and psychotherapy. This interest has coalesced around questions about the meaning of change, the relevance of attachment theory to the therapeutic encounter and the influence of fear on that encounter. My interest in these issues led me to the University of York where Una McCluskey was running training courses that explore the impact of attachment experiences on professional caregivers. In the course of this training I requested that she supervise me in a PhD and it was agreed that I would analyse transcripts and audio recordings arising from courses that had been facilitated by someone using McCluskey's approach to group facilitation.

Although my interest in the subject of fear predates my attendance on the courses, in the process of reading for this study and analysing the data it has dawned on me that my interest is in a particular form of fear. It arises from a belief that I had not previously articulated: for many people fear influences the way they experience the therapeutic relationship; it actively influences the course of counselling relationships and significantly affects outcomes.

The study uses a qualitative approach which recognises that a single event (and seemingly similar experiences) can have very different meanings for different people (Riessman, 1990; Clandinin & Connelly, 2000). The study examines the experience of eight cases drawn from two training courses that have experiential groups at their core. My goal has been to listen with an open mind to the different experiences of people in a situation

analogous to group psychotherapy in order to develop my understanding of attachment-related fear.

Attachment theory, fear and psychotherapy

As said, the study views the therapeutic¹ relationship as an attachment relationship (Bowlby, 1988; McCluskey et al, 1999); that is, the relationship between someone who seeks care and someone who gives care. My focus includes consideration of how fear influences both the recipient of psychotherapy and the psychotherapist.

The attachment perspective is taken because it gives a model for understanding how fear is woven into and influences human relationships from the moment of birth. Thus conceived, fear arises from primitive biology but influences higher biological, psychological, behavioural and social systems. Bowlby's (1980) ideas about the interplay between fear and attachment relationships make fear an important subject for understanding psychotherapy. Fear underpins insecure attachment (Mikulincer and Shaver, 2007; Slade, 2008) and, by influencing attachment related behaviours, has been linked to psychopathology (Bifulco et al., 2002a, 2002b; Dozier, et al., 2008; Slade, 2008; van Ijzendoorn, and Bakermans-Kranenburg, 2008). Yet the role of fear in attachment has been largely neglected in research (Slade, 2008).

Theory Building Research

McLeod argues that, 'In the field of counselling and psychotherapy, virtually all the good ideas (i.e. theoretical developments) have come from practice. There are very few examples of good ideas that have emerged from pure science, laboratory studies' (McLeod, 2010: 160). He cites research (Polkinghorne, 1992) to demonstrate that therapists tend to be pragmatic in their use of theory and view theories as useful 'models and metaphors that "assist in constructing cognitive order" ' (McLeod, 2010: 160). Theory is, therefore,

¹ I use words related to therapy, counselling and psychotherapy interchangeably. Although views may differ about whether these words describe the same activity, the focus of the study applies to every kind of professional caregiving. I refer to the recipients of therapy clients rather than patients.

embraced by therapists in so far as it is deemed helpful in the therapeutic encounter. The purpose of theory building research is to expand the utility of a theory rather than to prove its scientific correctness.

However, because no single theory can account for the complexity of human life, 'theory-building' research (Stiles, 2007) has to be 'permeable' and 'capable of being infused with and changed by new observation' (Brinegar et al., 2006). This means that theory building research tends to rely on case studies that are essentially different to hypothesis testing research. 'Instead of trying to assign a firm confidence level to a particular theoretical tenet, as in hypothesis-testing research, the case study strategy examines multiple tenets of one study' (Brinegar et al., 2006: 165).

When used this way, case studies are used to compare each of many theoretically based statements with one or a few observations. This is achieved by describing the case in theoretical terms.

Each case is different and may address different aspects of the theory. At issue is the correspondence of theory and observation – how well the theory describes the details of the case. Because each detail may be observed only once, the change in confidence in any one theoretical statement may be small.

Stiles, 2006: 123

Stiles and his colleagues (Brinegar et al., 2006) argue that theory is in a constant state of elaboration, revision and development in light of new observations. When a theory cannot account for a new observation the theory has to be changed in order to fit both that new observation and past observations.

The current project is based on eight case studies that have been drawn from courses that were facilitated by someone² using McCluskey's (2008, 2011, 2013; Heard et al., 2012) theoretical approach and run on principals devised by her. The intention is to describe each case using ideas from the theory of human development devised by Heard and Lake

² The anonymity of all course members and their facilitator has been safeguarded in the study.

(1986, 1997; Heard et al., 2009/2012), related ideas about goal-corrected empathic attunement (McCluskey, 2001, 2005), and an emerging therapeutic practice drawing on Heard and Lake's model (Heard et al., 2009; McCluskey, 2005, 2008, 2011, 2013). Attention will be given to occasions when explanations provided by this theory fail to satisfy what is observed in the case and when, as a consequence, the theory can be honed or revised to offer a better explanation. An outline of the theory that is being developed in the study can be found at the start of chapter two.

The role of theory in psychotherapy

McLeod points out that 'theory' has different meanings and can be viewed as a structured set of ideas related to a topic or proposition; a set of social practices within a theory based community; or as a practical guide for action in different situations (McLeod, 2009: 51, Kindle Edition). My principal objective in the study is to increase understanding about attachment-related fear in a way that is relevant to the practice of psychotherapy and other forms of caregiving. The usefulness of theory extends beyond the content of any particular theory (McLeod, 2009). Within psychotherapy, theory may serve as a gyroscope, allowing the therapist to remain balanced in the face of wide ranging distress and other problems. Theory helps the therapist make sense of what the client says; for themselves and for their client. Therefore, a theory may canalise the client's therapeutic experience in line with a specific world view. When the client's own experience or world view clashes with the theory held by the therapist, the utility of that theory may be diminished or nullified. In such instances a theory may impede the communication between therapist and client.

McLeod draws on Argyris and Schön, who distinguish between formally espoused theory about what therapists think they should do in any situation and what counsellors and psychotherapists actually do in sessions. He describes 'implicit theory' which mixes 'intuition, rules-of-thumb and habit, alongside some thought-out principals' (McLeod, 2009: 61) to guide what therapists actually do in sessions. This echoes Claxton's (1997) distinction between implicit and explicit skills learning and, when linked to Bowlby's (1969) ideas about the unconscious nature of attachment styles, suggests that what therapists

think they do is not always the same as what they actually do. If therapy is correctly viewed as an attachment encounter (Bowlby, 1988; McCluskey et al., 1999) it is very likely that what therapists do often reflects their attachment experiences (Dozier et al. 1994; Hardy et al., 1998; McBride et al., 2006; Shapiro, et al., 1999) and the implicit strategies they have developed to minimise relational stress.

The politics of psychotherapy

Postmodernism and social constructionism

Although the study will follow the theory provided by Heard, Lake and McCluskey (Heard and Lake, 1997, Heard et al., 2012; McCluskey, 2005, 2008, 2011, 2013) in drawing on biological and psychological explanations rather than the sociology of human relating, I want nonetheless, at the outset to note challenges posed by postmodern and social constructionist accounts of human experience and the therapeutic encounter.

An initial critique might be based on a social constructionist view of emotion (see for example, Averill, 1982, 1983). Within this perspective emotion is seen to be a product of relationships between individuals which should not be reified as a product of the individual body/mind. Averill's study of anger (1982, 1983) demonstrates this. He points out that the situations in which anger is most commonly experienced are not necessarily those in which an angry response might properly be justified. Instead, anger is more frequently experienced and expressed in relationships in which the expression of anger is safe. He further shows that anger is frequently seen to be functional within these relationships by the person who expresses anger and the recipient of that anger. From this I might conclude that the emotion has to be understood in its relational context and it is inappropriate to look exclusively to psychological accounts for the meaning of emotional expression. However, such a perspective is not incompatible with the approach taken in this study, resting as it does on attachment theory and the concept of interpersonally-regulated behavioural systems (see chapter two). In this theoretical model, emotion is experienced as a means of monitoring progress toward the achievement of the goal of a system (Bowlby, 1969) and expressed as a means of furthering progress toward that goal. Given

that many behavioural systems are interpersonally regulated this model might create a bridge between biology, psychology and sociology.

However, our critique can be developed further by citing Gergen's (2007) argument that psychology is founded on nothing that can be objectively verified because it is dependent on introspection and observation to describe an inner reality that is essentially ineffable. Inner experience is nonverbal and cannot be translated directly into words. Therefore, rather than conveying the reality it purports to represent, language must reflect the multiple discourses that inform it. This includes discourses which inform the subjectivity of the researcher as well as the wider cultural matrix.

The objection is not merely about the fallible nature of claims made by psychology. Hollway and Jefferson quote Foucault as saying, 'subjectivity is the product of positioning in human discourses' (Hollway and Jefferson, 2000a: 136). Therefore, as McLeod argues (2004), the 'narrative resources' available to individuals within a culture are intimately bound up with issues of power and control which shape the stories people tell about themselves in ways they do not understand.

Although psychotherapy is a pursuit that purports to operate by uncovering the client's truth, it usually ignores political realities built into the very fabric of every culture; including the culture of psychotherapy (Gergen, 2007). In the psychotherapeutic process, Gergen argues, 'problems understood in the profane or marketplace language of the culture are translated into the sacred or professional language of mental deficit' (Gergen, 2007: 8). This amounts to a 'colonizing' (Gergen, 2007) of the culture with psychological explanations of human unhappiness that serve the interests of psychological and psychotherapeutic professions. In this process, traditional explanations for personal unhappiness (involving folklore, myth, spirituality, religion, socio-political factors and common sense) are displaced by an individualising 'scientific perspective' that is sometimes less justified than that which it has displaced. And, by these means, the individual may be removed from socially available forms of meaning and community resources.

Gergen explains that 'the language of deficit, in particular, is also a language of moral and political control' (Gergen, 2007: 7). McLeod (2004) appears to agree, saying, 'The tendency of most theories of psychology and psychotherapy to ignore social experience can be interpreted as constituting a form of social control that involves isolating people from collective sources of support and resistance' (McLeod, 2004: 354). Instead, McLeod says, a dependence on the expert therapist is created. 'The person seeking help communicates a feeling of sadness, which is reified as a pathological state (grieving). Through this conversational strategy, the client is positioned as abnormal, and the therapist is positioned as someone who possesses the "authority to assess and prescribe treatment". The therapist is in control of the situation, and it is difficult for the client to resist the call to enter a subjective position and go on to further elaborate a set of symptoms' (McLeod, 2004: 359).

Gergen's target is not the individual health professional who, 'on the whole (he accepts) share a common view about what is unacceptable behaviour. . . . Classifying, studying, and curing illnesses of the mind, no less than the body, is a noble calling' (Gergen, 2007: 8). Rather, his objection relates to blind spots created by the various health professions that individualise the causes of unhappiness and thereby create unseen "collateral damage" and 'infinite infirming' (2007: 8).

The critique has at least four objections to the psychological view of distress:

- It overestimates the value of professional claims to truth.
- By treating the individual's unhappiness as a deficit in the individual (Gergen, 2007), the self is converted into a consumer of treatment.
- Although the commercial nature of treatment (talking therapies and pharmacology) is frequently masked, it gives the therapist a vested interest in the client accepting a particular world view (or story) and continuing in the type of therapy that they offer.
- In the process by which individual unhappiness is privatised, its true source in cultural and political forces, which empower few but damage the masses (Cushman, 1995), remains hidden. By ignoring this perspective the individual is disempowered.

Although I believe the value of this critique is considerable it can, nevertheless, be overstated. It also arises from a culture bound perspective. When arguing for the social control aspect of therapy Gergen says, 'there is nothing intrinsically wrong with prolonged sadness or lethargy; in themselves they are morally and politically neutral. However, to classify these as "mental illness" creates them as undesirable, inferior, and flawed. "Normal" behaviour, in this sense, is simply behaviour that is socially acceptable' (Gergen, 2007: 7-8). This insight reframes the individual's distress but does not address that distress; beyond de-pathologising and de-medicalising problems it offers nothing to help the person experiencing prolonged lethargy and sadness.

It would undoubtedly benefit clients and society alike if therapists and their professional bodies acted on the basis of greater political awareness and employed a critical perspective that included consideration of the subtle ways in which therapy disadvantages clients (Cushman, 1995). It is possible to imagine therapeutic structures that work better to empower clients to recognise their own strengths and authority in the therapeutic encounter and this idea has influenced the creation of several models of therapy (see for example, Rogers, 1951; Egan, 1998). However, the therapist has to respond to the very real distress brought to the consulting room by individual clients. Gergen (2007) argues that his critique necessitates a shift from ontological questions about the nature of self toward pragmatic questions about the route to increased personal empowerment. He (Gergen and Kaye, 1992) advocates a narrative psychotherapy that refuses to privilege the professional perspective over that of the client and makes the client and therapist equal partners in a venture to find meaning in new life-narratives. This is fostered by the inclusion of multiple narratives (McLeod, 2004) of which psychological accounts are one among others.

Although the matrix of much mental anguish may be socio-political, the anguish of each individual is real, and its consequences and ramifications frequently psychological. Therefore, an understanding of individual psychology will always be an important element of psychotherapy. Whilst not all stories are equally valuable, solipsism is disempowering if it removes pragmatic insights that might help an individual in distress.

Cushman (1990) summarises the constructionist position saying, 'Humans do not have a basic, fundamental nature that is transhistorical and transcultural. Humans are incomplete and therefore unable to function adequately unless embedded in a specific cultural matrix' (Cushman, 1990: 601). Whilst the importance of Cushman's observation may be underestimated in much psychotherapeutic literature, its importance can be overstated. The fact that the human self is created in a cultural matrix does not mean that the human is born a blank slate (Pinker, 2003), created and shaped only by culture and other social forces. There is a wealth of research evidence demonstrating that human infants, like other mammals, are in no small part the expression of their genetic heritage; born with instinctive, preprogrammed behavioural systems, such as those identified in attachment theory, that shape the ways in which the individual self develops and is expressed in adult life.

Far from the 'empty self' (Cushman, 1990, 1995), created by social forces to serve the needs of a rapacious consumer society, humans have evolved to experience a range of innate desires that motivate behaviour; and fears related to those desires. For Cushman's empty self to exist there has to be a neurological substrate that generates the feeling of emptiness; a substrate within which all feelings are generated. The empty self may reflect aspects of this substrate that can be manipulated, but it is not simply the product of social forces.

As has already been said, this study is based on the idea that, notwithstanding social forces, behavioural systems underpin much human motivation and are monitored by affect (Bowlby, 1969). Assuagement and disassuagement³ of these systems have a significant role to play (Heard and Lake, 1997; Heard et al., 2012) in individual fulfilment and distress. Whilst social constructionism offers an important perspective, there is a tension between individual and social processes that social constructionism ignores to the detriment of real understanding of human behaviour (Pinker, 2003).

³ I use these terms in the way they are used by Heard and Lake (see for example, 1997: 53) to mean the affective state associated with achieving or not achieving the goal of a behavioural system. For a fuller discussion of assuagement and disassuagement see chapter two.

Therefore, though much has been said in the name of psychological truth that I might, from a different perspective, believe to be of dubious merit, this does not mean that everything psychological is invalid or that nothing meaningful can be known about the human condition at an individual level. The client comes to the therapist in the hope of achieving something that he or she cannot achieve alone. Even if the therapist engenders a relationship of real equality (and this may not be in the gift of the therapist), in order to generate the multiple narratives from which the client's self-narrative is renewed, Gergen's therapist has to bring an expertise and authority that directs the course of the meeting between careseeker and caregiver.

This is not the limit of the expertise that can be offered. The therapist can usefully offer new ideas for inclusion in emergent self-narratives which include insights that would not be available to the non-psychologically trained therapist. The current study is based on a belief that many psychological insights, including those developed within the umbrella of attachment theory, reflect profound truths about what it means to be human and as such can be empowering to the individual regardless of wider power and control issues within the discourses underpinning psychology and psychotherapy.

Epistemology

Naïve realism, subtle realism and critical realism

Speaking reliably about what can be known and how we know what we know is fraught with problems that I could not begin to resolve. Describing difficulties associated with epistemology, Elliott cautions that 'there is no nonshaky ground here' (Elliott, 2008: 42). When describing the stance to be taken in the study I am all too aware of the limits of my expertise in the field of epistemology.

Hammersley (1992) argues that social constructivism presents matters in terms of a false dichotomy between 'naïve realism' and relativism. Hammersley does not accept that relativism is the only alternative to naïve realism and distinguishes between naïve and subtle realism.

The former he identifies with a belief that phenomena we study are independent of us and that we can have direct contact with them and that this contact will provide certain knowledge. In contrast to this he (Hammersley, 1992: 50/51) characterises subtle realism in propositions which I précis here:

- Firstly, he refutes the definition of knowledge as beliefs whose validity is certain. Instead he argues in favour of a definition of truth as beliefs that are *plausible* and *credible* so that we can be reasonably confident about their validity.
- Even though we can never be certain about any claim to knowledge, there are phenomena, independent of our claims about them, which those claims may represent more or less accurately. This means he accepts that true knowledge is true insofar as it corresponds to the observed phenomena and that observations can be made that are independent of the influence and effect of the observer.
- He further argues that the intention of social science is to ‘represent’ reality not ‘reproduce’ it. Therefore, observations are always from a particular ‘point of view’ which will render certain aspects relevant and others irrelevant. Therefore, multiple and contradictory descriptions of a phenomenon can, nevertheless, be valid.

My own view is that understanding the human condition is increased when we view the human being in light of what we know to be reasonable certain. This involves, for example, recognising not just the cultural matrix from which all human thought emerges, but also the biological matrix from which both culture and individual experience spring. Critical realism (Danermark et al., 2002) posits three domains of reality: ‘our experience of events, the events as such (of which we only experience a fraction) and the deep dimension where one finds the generative mechanisms generating events in the world’ (Danermark et al., 2002: 43). Within this perspective, not all explanations are equally valid and it is necessary to be sceptical about the accuracy of our perceptions and the ability of our theories to explain what we see.

Always we are striving to increase understanding of the human condition knowing that any move forward is likely to be superseded in time by new and more accurate observations; and better explanations for our observations. But this fact does not discount the value of

each forward step. Moreover, valuable lessons can be learned even when we find we have entered a *cul-de-sac*.

Epistemology in the context of clinical evidence

When discussing the merit of clinical evidence Erikson (1958) points out that therapists have no choice but to recognise the central place of subjectivity in all their work. Describing the process of his own research he said, 'reporting to you what a patient said to me, how he behaved in doing so and what I, in turn, thought and did – a highly suspect method' (Erikson, 1958: 70). Identifying relevant issues in a client's stories and selecting appropriate modes of treatment are dependent on the subjective rendition of the patient's account of her personal history; her account of the complaint that has brought her to see a therapist; and the therapist's interpretation of those elements. In addition to these factors, as discussed above, can be added the hidden discourses running through the encounter that position each participant in their particular subjectivities. It is hardly surprising therefore that Erikson says, 'It is in such apparent quicksand that we must seek the tracks of clinical evidence' (Erikson, 1958: 70).

In the face of these issues Erikson says, many recognise the scientific justification only in 'auxiliary approaches' (such as neurological and chemical examination), that subject the individual to 'non-clinical observation'; separating out and objectifying some aspects of the person's being. Erikson argues that while this may be useful for identifying elements within a person's experience, it is unlikely to lead to a holistic understanding of the self as brought into the psychotherapeutic encounter. The therapist has to be able to deal with whole persons.

Erikson talks about Freud's "free-floating attention" by which he means the therapist endeavours to keep an open mind in relation to different models and ideas that are sparked by what is said and take into account their own emotional responses and transference/countertransference issues. Translating this into the attachment theory underpinning this study we might present psychotherapy as a deeply human encounter between someone seeking care and someone who offers care. Like the encounter

between mother and infant, it has at its centre, sensitive and attuned guess work as a caregiver interprets the 'vitality affects' (McCluskey, 2005; Stern, 1985) of the careseeker. Whilst misattunement is sometimes inevitable, the therapist seeks to establish a relationship in which repair is possible. Although deeply fallible and imprecise, hopefully a 'good enough' relationship (Winnicott, 1966) is created in which appropriate care can be given and received.

Literature about consciousness further complicates things by suggesting that individuals often don't know what they feel at any given moment. Moreover, what individuals say about the decisions they take frequently amounts to *post hoc* rationalisation for decisions made outside of awareness (see chapter two). Claxton (1997) identifies different ways of knowing and learning and says that most of our decision making is implicit (or unconscious) and that, consequently, often we don't know why we say or do the things we do. All this has a bearing on how I interpret the narratives told by course members in this study and the manner in which they are interpreted by the course facilitator.

Recognising the way similar issues shape the accounts of experience given by research informants, Hollway and Jefferson (2000b) argue from a critical realist position that people don't simply tell the truth but tell a version of the truth that serves their needs. Critically, for Hollway and Jefferson, these needs may include the need to defend themselves. In face of the 'defended subject' Hollway and Jefferson (2000b: 19) advocate a 'narrative interviewing' technique that uses free association to empower the informants to talk about what they think important while they use ideas from Kleinian psychology to interpret what is said.

Although the present study does not share the Kleinian perspective, Hollway and Jefferson rightly describe the problems associated with understanding what informants say. The present study uses a psychodynamic perspective that is based on attachment theory. Within this, Hollway and Jefferson's 'defended subject' becomes the 'insecure subject' and the primary means of defence (discussed in chapter two) include selective exclusion from awareness and the avoidance of pain by deactivating and hyperactivating attachment. Such strategies are likely to motivate and shape the stories that people tell.

Ultimately Erikson draws back from any scientific understanding of the therapeutic encounter by invoking lines from Keats' 'Ode on a Grecian Urn': 'truth is beauty, beauty truth'. In this I think he may have implied that in the successful caregiving exchange the therapist and client 'know' when meaningful care has been given and received. If my interpretation of this is correct, it links most satisfactorily to Bowlby's (1969) ideas about attachment arising from behavioural systems in which relief felt by both parties signals the success of a caregiving exchange; or the achievement of the goals of careseeking and caregiving (Heard and Lake, 1997). Erikson concludes his essay:

The ideological relativity implicit in clinical work may, to some, militate against its scientific value. I could not indicate in this paper what can be gleaned from clinical theory and application. I could only try to give an introduction to the clinician's basic view which asserts that you may learn about the nature of things as you find out what you can do *with* them, but that the true nature of man reveals itself only in the attempt to do something *for* him.

Erikson, 1958: 87 (original emphasis)

The current study takes seriously the idea that scientific certainty is not possible and that, though imperfect, empathic imagination offers the best guide to the value of a proposition.

Reflexivity

Because unmediated observation is impossible the study will be interrupted at times for personal reflections on what is being discussed. The purpose of this is to be transparent when I believe there is a danger that my reading of the data may be influenced by personal material. Elliott (2005) warns against 'unfettered reflexivity' and I accept this. When reporting on my reflexive processes, my opinion is of little importance; what matters is that the reader knows enough about me to understand why I notice what I notice (Hollway and Jefferson, 2000b; Witkin, 2000) and makes an informed judgment about how my personal experience may have influenced my reading of data.

Transparency about reflexive processes is especially important in this study because of my closeness to the subject under investigation. I was a member of one of the training courses from which the data have been drawn (Course A). Therefore I know all of the members of that course and was involved in some of the interaction presented in the case studies. I was also supervised in this project by Una McCluskey, who has collaborated closely with the originators of the theory being developed and developed the group practice that is being studied. We (Una McCluskey and myself), have not always agreed on my interpretation of Heard and Lake's theory or of her own work. Where necessary (and where my awareness allows) I have tried to be transparent about the difficulties that this closeness to the project presents but being subject to the same opacity of self (Butler, 2005) as everyone else it is inevitable that there are gaps in my awareness that are not accounted for in my explicit account.

Riessman, (2008) recommends that qualitative research be written up as a narrative. This further empowers the reader to understand why specific observations have meaning for the researcher. The current study therefore includes information about the processes used and reasons for certain decisions. The intention of including the researcher's voice in these ways is not to persuade the reader but rather to give information against which the value of my perception can be assessed.

Despite my closeness to the theme of the study, it is also likely that differences in personal perspective and theoretical orientation between me and the course facilitator will be reflected in differences in our understanding of what happens in the group sessions. I will therefore report instances when I am aware that this is a factor.

In this exploration of fear within the course sessions I am inspired by the following ideas:

- That human experiencing is multi-layered and complex. People often don't know what they feel and frequently rationalise their behaviour in a manner that is contradicted by the evidence (Claxton, 1997).
- That true understanding of the individual requires empathic attunement; the *best guess* arising from our reading of spoken and unspoken communications, when our understanding is engaged in the service of the other not the self.

- That we should make use of the best science available to us accepting the reality that better explanations will arise in the future.

The data: Exploratory courses for professional caregivers

The study seeks to examine the role of fear in adult psychotherapy using eight case studies. These are drawn from a pool of thirty one members in two separate courses, each of which met at monthly intervals over a nine month period. However, the courses were not psychotherapy groups. Instead they were training courses designed to help professional caregivers explore their attachment experiences using theory devised by Heard and Lake (see chapter two). The contract between group facilitator and group member was for training based on experiential learning. However, I believe that the intention and understanding of the group facilitator and group members was such that the courses are sufficiently analogous to group psychotherapy as to be directly relevant to the focus of the study. The justifications for this belief are numerous.

The courses were facilitated using McCluskey's model of group facilitation (2008, 2013; Heard et al., 2009) and sharing the rationale set out in her training and writing. In these writings it is clear that the facilitator of such courses supports group members in exploration of their experiences in the hope that their joint work will give rise to therapeutic outcomes for course attendees (Heard et al., 2012: 200, see below). Long before she began developing this type of group practice McCluskey identified therapy with exploration saying, 'The goal of psychotherapy can be defined as the exploration of experience in the context of a trusted relationship' (McCluskey, et al., 1999). In a later paper (McCluskey, 2008), reporting on her work in similar groups, McCluskey differentiates her approach to facilitation, then called 'the theory of attachment based interest sharing' (TABIS)⁴ from a model she had previously used in her writing by saying, 'for TABIS, personal development of the self occurs at an intrapersonal and interpersonal level through the experience of an effective relationship with a supportive, exploratory, and empathic caregiver' (McCluskey, 2008:205). Here then, she identified a psychotherapeutic goal for such

⁴ Subsequently renamed by Heard and Lake as the theory of attachment based exploratory interest sharing (TABEIS) (Heard et al., 2009/2012)

groups: 'development of the self'; and within this the role of the facilitator is to be an empathic caregiver.

McCluskey's work in this area is described in a chapter (Heard et al., 2009/2012) entitled 'The structure and composition of exploratory group psychotherapy for professional caregivers'. She earlier summarised her developmental work and training in this area saying, 'we are in the process of constructing a new model of group psychotherapy guided by TABIS' (McCluskey, 2008: 206)

Our hope for this work is that it would lead to a change in the way people understood themselves and that this in turn would help them in their own personal intimate relationships including their interest sharing with peers, and that it would have an effect on how they understood and worked with clients. . . . All through the book we have talked about changes within the self being at the level of an *expansion of the self*. We mean by this that aspects of the self's own history and experience that have previously been excluded from consciousness become known to and accepted by the self in a way that the person can integrate this information and so have more of themselves available for their relationships with other people, their interests, and their participation in life (Heard et al., 2009: 200 – original emphasis).

Because she is explicitly using McCluskey's method these writings suggest that the facilitator of the courses studied in this project will have had a clear psychotherapeutic intent when working in the groups. Therefore, although the contract was training, for the purposes of this study we can assume that the facilitator of the groups⁵ viewed her work as therapeutic and behaved accordingly.

There are clear indicators that this understanding was mirrored in that of most, if not all, of the group members. When asked in interview to say what the groups were, three of the five participants to the study identified them unequivocally as 'group psychotherapy'. A

⁵ Because the training provided in these courses took the form of an experiential group I use the words 'course' and 'group' interchangeably.

fourth group member told me she had come to the groups expecting training but found that it was more like psychotherapy. The fifth participant identified it as 'training'. However, I believe this answer was paradoxical because, when set within that case study, at least as much as anyone else in her group, this participant used the group as a space for undertaking personal therapy. I believe her answer to my question was influenced by particular circumstances that meant that (as will be seen in chapter eight) she had been ashamed of having sought personal care in the group setting⁶.

Although I did not interview anyone from Course A (from which I have drawn three of the cases upon which the study is based), a member of that course said of her experience in the group, 'it feels more toward group therapy' (and the facilitator appeared to agree saying, 'yeah, yeah'). A second group member qualified the idea by distinguishing it from psychodynamic psychotherapy: 'Like group therapy without being locked in the transference'. Nobody contradicted her or offered an alternative description of the groups. It is clear, therefore, that most if not all of the group members in Course A thought of the group sessions as psychotherapeutic.

Nevertheless, despite what participants said to me about their understanding of the groups, they were not psychotherapy groups. I understand from the group facilitator (personal communication, 17/03/14) that during the enrolment procedure each was asked to state their goals for attending and none of the stated goals suggested that they viewed the groups as therapy. This is likely to differentiate their behaviours from people attending formal therapy. Moreover, elements within the courses clearly differentiated them from psychotherapy. For example, the large size of the groups; the use of didactic material wholly determined by the facilitator; monthly sessions; and the inability of the facilitator to help individual group members pursue therapeutic themes across a number of sessions.

⁶ At the time of writing, this person is the only group member to have read her case study. She subsequently agreed with my suggestion that she had called the groups 'training' in interview because she had been ashamed of careseeking in the group and she reported that at the time when she attended the course she had seen it as group therapy.

Yet, while there are differences marking these courses out from group psychotherapy, they are nevertheless sufficiently similar in intent and process to be considered analogous to therapy for the purposes of this study.

Group Process

The encounters focused on in this study all take place in the context of a group. Originally I had anticipated writing a chapter focusing on the influence of group process on the findings. However, in the course of my analysis I decided that the central role of the facilitator in directing dyadic exchanges in the group meant that focussing on interaction between her and group members was sufficient for understanding the most relevant issues. It would no doubt have been useful to include a focus on group dynamics but this was not possible within the space.

This does not mean that group process is irrelevant. The way group members expressed themselves in the groups was situated and particular to a setting. Most group members shared a common professional language and outlook. This is likely to mean that there was pressure in the group to conform to a 'therapeutic' model of group process and to accept the authority of a group facilitator to teach new ideas about the self within a setting that was in many ways therapeutic. Some group members knew each other (or knew of each other) prior to joining the group. Some worked in the same or related agencies. The data suggests that some people felt particular fear and pressure to speak because of the presence of colleagues, peers and superiors. It is perhaps not surprising therefore that one group member spoke about feeling judged by his peers in the group.

A further indicator of the force of group processes is that when a new member in Course A objected to the group 'culture', the three other new members of that course all appear to have recognised something significant in what she said and valued her objections. At the same time, several people who had attended a previous course together sought to make her feel more comfortable with the group culture.

So, although the subject of group process is not dealt with as a focus in its own right, its influence at particular times was significant. However, because the facilitator worked serially in dyads with each of the group members it is possible, and I believe fruitful, to maintain a concentrated focus on interaction between her and individual group members. My decision to exclude wider group processes from the main discussion is revisited in the discussion of findings (chapter fourteen).

Outline of the thesis

The thesis is based around an analysis of transcripts made from audio recordings of two training courses (referred to as Course A and Course B), which ran at different times and in different European cities in the first decade of this century.⁷

The first section of the thesis presents the theory and context of the study. Chapter two sets the scene for the study by outlining the theory that is being developed and setting it within a wider literature. Following this, chapter three describes the method that has been followed in the study including a description of Stiles' theory building approach to case study research (Brinegar et al., 2006; Stiles, 2007; Meystre et al., 2014). Having already outlined the theory underpinning them, in chapter four I give a personal description of the courses based on my own experience as a group member.

In the next section of the thesis I focus on analysing the data. Chapters five to twelve comprise eight case studies drawn from the two groups. The final data chapter examines the role of the facilitator with a specific focus on occasions when fear may have influenced what happened in the interaction. In the final chapter (fourteen) I discuss what the findings mean for the theory.

⁷ The professional community from which participants are drawn is relatively small and may be the same group from which any interest in this study will come. My vagueness on details about the courses being studied is designed to protect the identities of group members.

Conclusion

Although I am using a theory building methodology, my sphere of interest is limited. The analysis of the group transcripts is restricted to what they have to say about attachment-related fear. As part of this I will consider the power of Heard and Lake's theory to explain what happens in the groups and the ways in which their theory informs the mode of group facilitation. The findings are relevant to psychotherapy and wider professional caregiving situations.

The data arises from the messy reality of human relating and as such it is not easy to decipher. Certainty in the findings is not possible and the study appeals to ideas of *plausibility, credibility* (Hammersley, 1992) and *utility* (Erikson, 1958). Ultimately the value of the study depends on whether ideas generated here are useful and empowering for therapists and, through their work, the end users of therapy.

Chapter Two: Literature Review

Introduction

This study examines the role of attachment-related fear as it manifests in the therapeutic relationship. In the process it develops theoretical ideas about the self and psychotherapy. McLeod (2010) advocates beginning this type of case study research with a statement of the theory that is being developed. He also recommends the use of flow diagrams. I have followed both of these recommendations in developing my analytic strategy and begin this chapter with a statement of theory.

The study takes Heard and Lake's 'theory of attachment based exploratory interest sharing' (Heard et al., 2012: 24) as its starting point. This views the therapeutic encounter as biologically grounded in behavioural systems and views the therapist's role as being to support the client in achieving the goals of behavioural systems including careseeking and exploration.

Choice of literature

Because Heard and colleagues (2009/2012) emphasise the role of affect regulation within psychotherapy (particularly the regulation of fear), the first literature I examine, following the statement of theory, concerns the role of affect, affect-attunement and affect-regulation in the mother-infant relationship; which gives rise to the developing sense of self. I follow this by describing the biological model of fear that Heard and Lake take from LeDoux (1996, 2002). Finally in this section on affect I draw from literature on shame to argue that the role of affect in self-experience and self-expression is more complex than Heard and Lake's model allows.

In the next part of the chapter I develop my argument by looking at several key concepts in attachment theory. The most important of these are behavioural systems, information processing (particularly internal models of self and other and defensive exclusion from

awareness) and attachment styles or strategies. Unifying themes in the chapter concern affect within the experience of self and the influence of defensive strategies in shaping perception, memory, affect and behaviour.

Space does not allow me to address the whole of the theory developed by Heard and colleagues (Heard and Lake, 1997; Heard et al., 2009/2012; McCluskey, 1999, 2001, 2005, 2008, 2011, 2013) so I have selected a relatively narrow aspect of it that applies to the goals of interaction between caregiver and careseeker (therapist and client). A central question concerns whether group facilitation (and psychotherapy) conducted in line with Heard and Lake's theory sufficiently recognises the interactive nature of the self or the role of defensive processes in shaping experience and expression of the self (caregiver and careseeker's) at non-conscious levels of relating.

Statement of theory

The theory underpinning this study amounts to a model of the self (Heard et al., 2009: 7), devised by Heard and Lake (1986, 1997) and applied to therapeutic practice (Heard et al., 2009/2012; McCluskey, 2005, 2011, 2013). Referring to their approach as the Theory of Attachment Based Exploratory Interest Sharing, (Heard et al., 2009/2012), and Goal Corrected Exploratory Psychotherapy (McCluskey, 2011, 2013), the authors pick out the central elements of their 'restorative process' (Heard et al., 2009/2012). The main idea is that the experience and expression of selfhood is profoundly influenced by the activation, expression and assuagement (or disassuagement) of innate behavioural systems; and that at the core of the therapeutic encounter is the interplay between careseeking, caregiving and exploration which they (Heard et al., 2012: 19ff.) call, the 'dynamics of attachment'.

Heard et al., (2009/2012) identify seven preprogrammed behavioural systems, which they say work in concert to maintain and restore wellbeing when a threat has been perceived. The systems identified in Heard and Lake's 'restorative process' (1997; Heard et al., 2009/2012) are careseeking, caregiving, the exploratory system (including an interpersonal aspect that Heard and Lake call 'interest sharing with peers') (Heard et al., 2009: 89), the system for defence of the self (comprising a fear system and the attachment system), the

sexual system, the internal (supportive or unsupportive) environment and finally the external (supportive or unsupportive) environment.

Although many systems integral to the experience of selfhood are interpersonally regulated, Heard and Lake point out that the self is experienced as being autonomous. With too little discussion about what this means they talk about an 'autonomous self, embedded within the dynamics of attachment' (Heard et al., 2009: 43ff).

The dynamics of attachment

At the heart of Heard and Lake's theory is an idea, found in Bowlby's (1988) later writing and inspiring wider research (see for example, Dozier and Tyrrell, 1998; McCluskey, 2001; Parish and Eagle, 2003) that psychotherapy is an attachment relationship. Bowlby (1988) suggests that psychotherapy involves the creation of (1) a safe haven for retreat in times of threat and (2) a secure base, from which the world can be explored (see also Collins and Ford, 2011). Echoing Bowlby (1988), McCluskey (2005) highlights two aspects or forms of caregiving in psychotherapy. In the first form, 'offering care and protection' (McCluskey, 2005: 121), the caregiver attunes to the inner experience of the client, offering affect-regulating interventions and accurate empathic feedback (McCluskey, 2005: 13). In the second form, the caregiver supports the careseeker's exploration of pertinent issues. So important is the relationship between careseeking/caregiving and exploration that McCluskey (2005) argues that empathic attunement is goal-corrected and that the value of therapeutic encounters can be judged by whether or not they facilitate exploration (2005: 24).

In caregiving of the first type, the client senses their therapist understands what has been communicated and has 'a feeling sense' of what they are experiencing (McCluskey, 2005, 105). From this they experience being cared for. It is largely in response to the experience of attunement and empathic mirroring that the goal of careseeking is achieved.

Subsequently, the motivation of the careseeker may change from careseeking to exploration (and exploratory interest sharing) and then the task of the therapist becomes

one of supporting their exploration. The goals underlying exploration are wholly different from those of careseeking or caregiving and confusing the two forms of caregiving will result in frustration and distress (McCluskey, 2005: 121).

The caregiving system

Told from the perspective of the caregiver, in satisfactory encounters the caregiver's caregiving system is activated in response to signals interpreted as careseeking and/or the perception of need. Heard and Lake's model suggests that when caregiving is activated the caregiver will be motivated to understand the client and to offer attuned and sensitive care.

The role of affect in motivating caregiving in the mother-infant relationship is well described by George and Solomon (2008).

Mothers express intense feelings of pleasure and satisfaction when they are able to protect and comfort their children; they experience heightened anger, sadness, anxiety, or despair when they are separated from the children, or when their ability to protect and comfort the children is threatened or blocked.

George and Solomon, 2008: 835

So caregiving sometimes has the potential to generate intense feelings. It is normal for secure caregivers to modulate their responses in line with perceived needs of an attached partner, with greater needs being associated with increased caregiving (Collins and Ford, 2010).

In the professional encounter, the caregiver monitors the client's emotive signals, such as posture, vitality affects (McCluskey, 2005; Stern, 1985) and facial expression, to understand their internal state and discern what is needed for the careseeker to achieve the goal of careseeking. Recognising and regulating fear is a key part of affect regulation. When the client achieves the goal of careseeking, the goal of caregiving is also met and both therapist and client may experience relief and satisfaction (Heard and Lake, 1997: 53; Mikulincer and Shaver, 2007).

However, while Heard and Lake's model describes secure caregiving, I am not sure that it pays sufficient attention to the role of insecurity in caregiving. The behavioural systems perspective implies that caregiving, no less than careseeking, is shaped by attachment experiences and influenced by internal models and defensive strategies (Collins and Ford, 2010; Dozier Cue and Barnett, 1994; George and Solomon, 2008; Heard, et al., 2009/2012; 2008; McCluskey, 2005). I will return to this at the end of the chapter.

Regulating fear

McCluskey's (2005, 2011, 2013; Heard et al., 2009) approach to professional caregiving and group facilitation emphasises regulating fear alongside the assuagement of key attachment related behavioural systems. Much that the facilitator does in the training groups from which the data has been drawn is designed to help group members remain 'centred' in their own experience so they do not 'collapse' or freeze in response to the activation of fear and can recover and maintain exploration.

Fear is viewed as a subsystem (alongside careseeking) within Heard and Lake's (Heard et al., 2009/2012) system for defence of the self. Fear can be triggered outside of awareness by fleeting internal and external cues and will activate defensive behaviours (freeze, flight, fight) which may lead to patterns of relating characterised by dominance or submission (Heard and Lake, 1997; Heard et al., 2012). It is therefore important that the therapist recognises when they or their client have become frightened because this will inhibit exploration. The fact that fear may be triggered in milliseconds in non-conscious processes (LeDoux, 1998) within therapist and client presents a serious challenge for empathic attunement.

The exploratory system

In some senses exploration characterises the sense of 'wellbeing' (Heard et al., 2009: 20). In the exploratory state the client is able to play and give rein to their curiosity; is open to experience; can access personal cognitive abilities and curiosity; has a sense of competence; and can collaborate with others. Hence, the second form of caregiving is to

offer 'supportive and companionable relating' (Heard and Lake, 1997: 54) so the client in therapy can achieve the goal of exploration.

The term exploration in this context encompasses a range of activities. It may involve the client being helped to achieve greater self-awareness, self-compassion, appreciation and understanding of what they have experienced and what they have achieved. It may involve just 'being with them' as they mourn a significant loss so that their pain is not excluded from awareness. It might mean helping them to take firmer hold of some thought or feeling at the edge of their awareness (McCluskey, 2011); to regain access to mental content that has been excluded from consciousness (Heard et al., 2009); and symbolise implicit mental content (Gerhardt, 2004) so that it can be more clearly and completely processed.

Thus conceived, therapy may lead to an 'expansion in consciousness of the self':

That all aspects of the self's own history and experience that have previously been excluded from consciousness become known to and accepted by the self in a way that the person can integrate this information and so have more of themselves available for their relationships with other people, their interests and their participation in life.

Heard et al., 2009: 200

However, viewing exploration as a behavioural system implies that it will be subject to defensive strategies that inhibit or exclude an insecure person's readiness for exploration (Heard et al., 2009).

The attachment dynamic described diagrammatically

Dorothy Heard (Heard et al., 2009: 115ff) created a number of diagrams to illustrate the idea of activation and deactivation of some of the systems concerned in the attachment dynamic. Figure 1 presents Heard and Lake's restorative process in relation to a secure caregiver and secure careseeker. Prior to the perception of threat, the individual's exploratory system (including interest sharing with peers) is active. At this point, their fear system and careseeking are quiescent or inactive. In response to a perceived threat, the

exploratory system (and interest sharing) is inhibited as fear and careseeking become active. Fear triggers instant intrapersonal defensive behaviours (freeze, flight and fight) and the activation of the careseeking system.

When behaviours expressive of an activated careseeking system are met by an attuned and empathic caregiver, the careseeker feels truly met and the goal of careseeking is achieved. In such a meeting, fear is regulated and both it and careseeking become quiescent again. As can be seen in the diagram, the exploratory system again becomes the activated system.¹

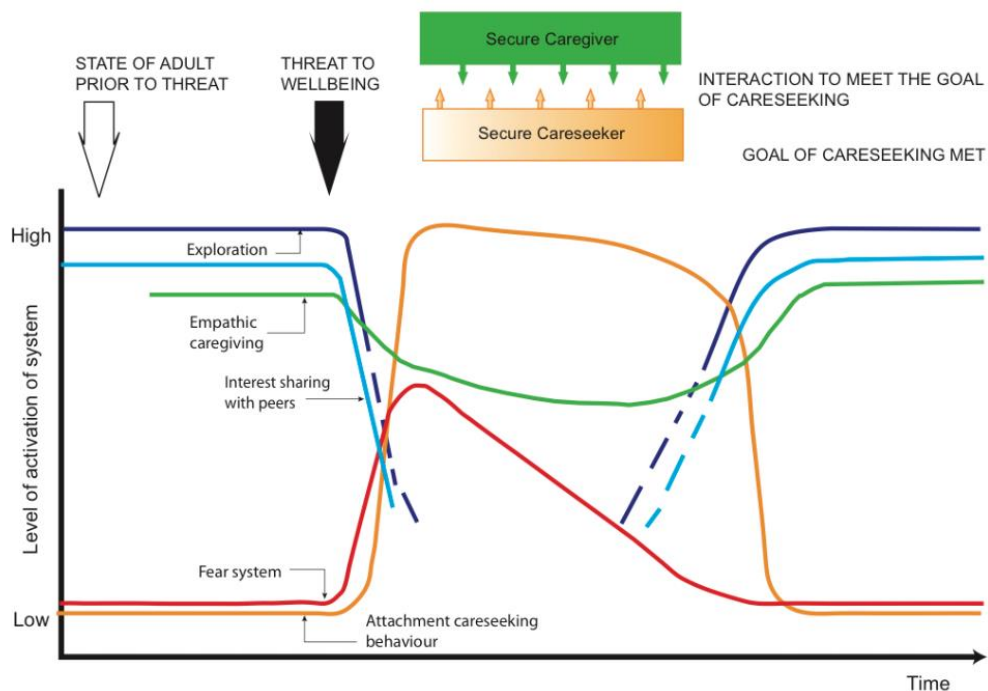
With an active exploratory system, the person is able to bring higher cognitive functions to bear on important issues which, in the context of therapy, promote positive therapeutic outcomes.

Heard and Lake's attachment dynamic builds on Bowlby's (1969) idea of goal-corrected preprogrammed behavioural systems, and the idea that achieving and failing to achieve the goals of behavioural systems² are biologically predetermined and have strikingly divergent consequences. Achieving the goal of careseeking may result in an immediate experience of relief and satisfaction, self-esteem (Bowlby, 1969), a sense of personal and social competence (Heard and Lake, 1997; Lake, 1985), and trust in the care of others (Bowlby, 1969). When incorporated into internal working models (Bowlby, 1969), self-esteem and trust in others form the bedrock of secure attachment. By contrast, the repeated failure to achieve the goal of careseeking (and caregiving) may result in dysregulated fear and distress; and the development of negative internal models of self and/or other.

¹ Because the main focus of the above diagram is on the experience of the careseeker, a significant factor not represented is that exploration and interest sharing are important components of the caregiving system. Throughout the encounter, the secure caregiver retains the capacity for exploration and their curiosity and empathy empower them to attune to the careseeker and offer sensitive care.

² I frequently use their terms *assuagement* and *disassuagement* (Heard and Lake, 1986, 1997).

Figure 1: Securely attached adult responding to a threat to wellbeing



Copyright Heard Lake and McCluskey, 2012³

From this perspective, psychotherapy is governed by biological systems and the caregiver has to be both self-aware and attuned to the inner experience of the careseeker. Supporting exploration when the client is motivated by careseeking (and vice versa), will lead to frustration and dysregulated distress (McCluskey, 2005: 121).

The internal (supportive/unsupportive) system

The internal (supportive/unsupportive) system (Heard et al. 2009/2012), (I prefer to use the phrase 'internal environment', preceded when necessary by the adjective 'supportive' or 'unsupportive'⁴) is the only system in Heard and Lake's model that is not goal corrected. It is activated alongside the attachment system at times of threat and includes different forms of information processing including:

³ Reproduced with the kind permission of Karnac Books Ltd.

⁴ I think this more natural expression (for example, 'unsupportive internal environment'), is the way the system is most frequently spoken of in the courses from which the data has been drawn.

- Bowlby's (1969) internal working models.
- Attributions introjected from early attachment relationships (Heard and Lake, 1997) in which the mirrored reflections from significant others inform the individual's self-image; examples of which might include messages like, 'you are a little angel'; 'you are a good girl and always know what is right'; 'you are hopeless'; 'you never get anything right' etc.
- A wider context that includes maturative ideals and non-maturative idealisation, that is, realistic aspirations which inform the individual's hopes and plans for the future; and unrealistic aspirations, that serve to defend against a negative self-image and the sense of personal incompetence (Heard and Lake, 1997: 116ff).

The internal environment supports the individual at times when they are alone and cannot access someone for support and care (Heard et al., 2009: 138). By drawing on memories of attachment encounters, the person can symbolically access attachment figures and their sense of self-worth; thereby regulating affect and accessing their own competence. However, when the internal environment is unsupportive, negative internal representations of self and other are accessed and the person's fears, anxieties and defensive behaviours are increased (Heard et al., 2009: 138).

Conclusion to the statement of theory

This use of behavioural systems places affect and the regulation of fear at the heart of psychotherapy. The failure to assuage activated systems (such as careseeking and caregiving) triggers negative affects and creates insecurity. In goal-corrected exploratory psychotherapy, the therapist endeavours to be aware of what system is activated in themselves and in their client and seeks to help the client achieve careseeking so they can become exploratory.

Because of the central role given to affect regulation my examination of wider attachment literature will begin by considering the role of affect regulation in the development and experience of self.

Relating the Theory of Attachment Based Exploratory Psychotherapy to a wider literature

The role of affect in the building of a self

Many attachment-focused psychotherapists draw on infant observation and child-development studies to understand fundamental mechanisms that underpin psychotherapy (see for example, Fonagy et al., 2004; Lachmann, 2001; McCluskey, 2005; Mikulincer and Shaver, 2007, 2008; Steele and Steele, 2008; Tronick, 2001). In what follows I pick out just a few elements from this literature that illustrate the relevance of attachment to psychotherapy.

The infant is born with an innate readiness for relationship (Lachmann and Beebe, 1988; Lachmann, 1999; Stern, 1985; Trevarthen, 2001) and the early relationship between mother and infant is mutually regulating at the level of fundamental biological systems (Hofer, 1987). From this mother-infant relationship key mechanisms in the infant's fore-brain are structured (Schorre, 1994, 2003) and these have a lifelong role in regulating affect.

From about two months, pleasure is derived from contingent interaction and the sympathy and shared interest that this communicates (Murray and Trevarthen, 1985; Trevarthen, 2001; Tronick, 1989). In contingent exchanges the mother matches her infant's affective state, confirms the infant's expectancy and so creates what Pally (2001: 79) calls 'equilibrium'. Memory and 'expectancy' (Beebe and Lachmann, 1994; Pally, 2001) are essential elements in this interaction as experience of an event creates the anticipation of repetition. The failure to behave in a contingent manner (thereby frustrating the infant's expectations) generates 'disequilibrium' or distress. Thus memory and expectancy are central components of affect-regulation and dysregulation. Healthy development requires that the mother (or similar figure) recognises and cooperates with the infant's intentions.

'Affect-attunement' (Stern, 1985) is integral to affect regulation. It has been described as 'a form of selective and cross-modal imitation' that creates a 'path to sharing inner feeling states' (Stern, 2004: 84). Through cross-modal imitation (perhaps matching facial

expression, vocalisation and hand movements in a manner that matches the infant's vitality and rhythm), the mother comes to share her infant's affective state. By taking her lead from the infant, understanding and cooperating with his or her intentions and goals (Beebe and Lachmann, 1988), sometimes up- and down-regulating the infant's excitation by attuning and purposefully misattuning (Stern, 1985) to his or her affective state, the parent helps him or her regulate and sustain the vitality necessary for successful play/exploration and achievement (Grossmann and Grossmann, 1991).

In this process of matching affect and mirroring her understanding of the infant's internal state, the mother helps her infant understand him or herself. In the longer term this helps the infant to symbolise (Gerhardt, 2004; Vas Dias, 2000) his or her experience and helps shape the infant's developing sense of self (Reddy, 2003).

Unintentional failures of the mother to fulfil her infant's expectancies for affect-matching create 'disequilibrium' (Pally, 2001: 9) or distress. Non-contingent 'perturbation' experiences trigger protest, despair and self-soothing behaviours in the infant (Murray and Trevarthen, 1985; Tronick, 1989). Therefore, healthy development requires accurate mirroring from an attuned and empathic partner.

The secure mother is open and attunes to whatever her infant wants to communicate. She can mirror her understanding back to the infant. However, when her defences cause the mother to exclude from awareness what she sees in her infant, she cannot attune to her infant's internal world (Cassidy, 2001) and is not a faithful mirror. Her edited mirroring fosters the development of biases and gaps in the infant's awareness and sense of self. In this way 'many children are educated out of knowing what their feelings are' (Ginnott, quoted by Cassidy, 2001, p.121; see also Vas Dias, 2000).

Hence it can be seen that 'dialectical process' (Lachmann, 2001) is integral to the infant's sense of self. At a neurological level, 'processes involving self-regulation, the creation of meaning, and interpersonal communication involve overlapping neural circuits' (Siegel, 2003: 18) between mother and infant. The mirroring other is internalised and security (or insecurity) is woven into the warp and woof of the infant self. Schore says that 'by the

middle of the second year, when the average infant has a vocabulary of only fifteen words, their behaviour is predicated on an understanding of their own mental states and those of others' (Schore, 2003: 22). Schore concludes that, '[t]he core of the self is . . . nonverbal and unconscious, and it lies in patterns of affect regulation'. Affect regulation and attachment theory are therefore directly relevant to the core of clinical practice (Schore and Schore, 2008).

Fear as seen within Heard and Lake's model

A key idea influencing the study is that fear has a major role in therapeutic relationships. A primary trigger for careseeking (Bowlby, 1969), fear also triggers defensive strategies (Mikulincer and Shaver, 2007; Slade, 2008). Therefore regulating fear is one of the principal functions of the attachment-focused therapist (Heard et al., 2009; McCluskey, 2005, 2009, 2013). Heard and Lake's (Heard et al., 2009/2012) final presentation of their model incorporates LeDoux's (1996) concept of the fear system. This divides into two systems (Jacobs and Nadel, 1985; LeDoux, 1996) which are described in terms of their different functions.

The faster fear system

The faster fear system is evolutionarily primitive and centred on the amygdala. It has links to wide-ranging brain systems (LeDoux, 1996). Constantly monitoring the external environment and memory systems for signs of danger it triggers instantaneous physiological and behavioural responses: activating the sympathetic nervous system (flight or fight), and the parasympathetic nervous system (freeze and shock); preparing the individual for battle and injury (LeDoux, 2007; Bracha, 2004; Bracha, et al., 2004).

Mature at the time of birth, the faster system alerts infants to danger long before they have language-based cognitive and memory systems with which to process it. It operates in milliseconds and is particularly sensitive to subliminal relational cues in the periphery of our visual field (LeDoux, 2000). It makes sense, therefore, that fear is a primary trigger for careseeking (Bowlby, 1980). Moreover, the totality of the infants dependence on others

means that the quality of care received in times of threat profoundly influences the developing self; setting baseline levels of neuropeptides (cortisol, oxytocin and serotonin) influencing the individual's lifelong ability to tolerate stress and anxiety (Cozolino, 2002; Gerhardt, 2004) and readiness to seek care from others.

Emotional systems in the brain operate independently of consciousness (LeDoux, 1996; Nathanson, 1992; Tomkins, 1962) so when we speak of fear we are not just speaking about a felt emotion. LeDoux talks about the 'emotional unconscious' (1996: 55ff) and quotes Kihlstrom to argue that our understanding of fear (and other affective/cognitive) processes *cannot* be dependent on subjective experience: 'In fact, it is widely recognized that *most cognitive processes occur unconsciously, with only the end products reaching awareness, and then only sometimes*' (LeDoux, 2000: p.156 – emphasises added). This means that unconscious affect can trigger motor responses that are expressed in a body-to-body level of interpersonal communication (Pally, 2001) outside of the awareness of either party to an encounter.

The slower fear system

The slower fear system involves cognitive and explicit memory systems in the neocortex. In older children and adults, when immediate defences have been initiated (LeDoux, 1996; Jacobs and Nadel, 1985); it enables perspective taking and other language based tools, to self-regulate, devise complex defensive strategies and to learn from experience (Cozolino, 2002).

Within Heard and Lake's attachment dynamic, the faster fear system instantaneously triggers primitive defences (freeze, flight, fight) and activates the careseeking system. The slower fear system informs the individual's exploration; allowing a review of events and drawing lessons for the future.

Pride and shame in the developing infant

Whilst fear is a key component in Heard and Lake's (1997; Heard et al., 2009/2012) model and the practice that comes from it (Heard et al., 2009/2012; McCluskey, 2005, 2008, 2011, 2013), Heard and colleagues have much less to say about shame. It is discussed in this chapter because I believe it plays an important role in the therapeutic relationship that is frequently hidden or disguised.

Pride and shame are basic emotions (Ekman, 1999) contributing to the 'innate human moral condition' (Trevarthen, 2001: 95). As such they are integral to the infant's developing sense of self. When something new is achieved and a parent mirrors the infant's pride, this pride is amplified and supported. The infant's excitation is up-regulated and he or she is motivated for further achievement.

Shame is similarly integral to the infant's socialisation. Studies of social referencing (Emde, et al., 1991; Klinnert et al., 1986) show how the infant uses the adult's facial expressions to inform them what is safe and unsafe. A theoretical role has been suggested (Gerhard, 2004; Pally, 2001) for shame as the infant learns what is acceptable and unacceptable. Shame is triggered by disapproving or rejecting looks which cause abrupt interruptions in positive exploratory behaviour (Pally, 2001) and activation of the autonomic nervous system (Gerhardt, 2004: 26); producing 'a sudden lurch from sympathetic arousal to parasympathetic arousal, creating the effects we experience as shame – a sudden drop in blood pressure and shallow breathing' (Gerhard, 2005: 49). In adults, shame is experienced as 'a particularly intense and often incapacitating, negative emotion involving feelings of inferiority, powerlessness and self-consciousness, along with the desire to conceal deficiencies' (Andrews, Mingyi and Valentine, 2002: 29).

Though it may be a necessary element in an infant's socialisation, recovery from shame and dispersal of the cortisol it generates (Gerhardt, 2004) are crucial to the infant's wellbeing. This recovery depends on affect-regulation by an attuned mother. Ekman (1999: 47) argues that the signalling function of facial expression underpinned the evolution of emotion. So shame serves as a signal that the mother is needed to regulate her infant's distress (Pally,

2001). If the mother fails to repair the shame-filled-moment by offering reassuring looks, the infant is left in a dysregulated state that can cause lasting harm. Citing Schore, Pally argues that, 'if the shame state persists, parasympathetic changes become permanently encoded and result in a maladaptive excessive shame response' (Pally, 2001: 80). Thus, informing internal representations, shame can become incorporated into the infant's sense of self.

Reflecting the interpersonal roots of shame from a psychoanalytic perspective, Wurmser says it operates at a conscious and unconscious level and is created by a 'discrepancy between expectancy and realisation',

. . . the polarity, the tension, between how I want to be seen and how I am. . . The higher the self-expectation and the greater the demand for perfection, the likelier and the greater the discrepancy, and the harsher the need for self-chastizement by self-ridicule, self-scorn and by symbolic or real disappearance and self-effacement.

Wurmser, 1987: 76

Wurmser coined the term 'absolute shame' which Ayers uses to describe the persecuting nature of an internalised critic:

Absolute shame requires no audience, but occurs through the observations made by a staring critical internal eye that objectifies and poisons the other parts of self being scrutinised. The shaming other exists within although it does get projected and populates the world with staring eyes that magnify and distort one's self-image, and from which one fanatically seeks to escape. One pictures oneself in the eyes of the other through a scrupulous study of facial expressions, and is turned to stone by her gaze.

Ayers, 2003: 11

It is understandable therefore that shame (Ayers, 2001; Pally, 2001) can be profoundly problematic for self-development. However, the above descriptions focus on shame as something that triggers self-loathing, self-persecution and hiding. It is not surprising that shame is empirically linked to depression (Andrews, 1995; Andrews, Mingyi and Valentine, 2002).

Although described here as global experience, recent studies suggest there is merit in not viewing shame as a single entity. Different categories of shame (characterological, behavioural and bodily) have proven useful in investigating links between shame-proneness, childhood abuse and depression (Andrews, 1995; Andrews, Mingyi and Valentine, 2002). Shame is also linked theoretically (Gilbert, 1998; Wurmser, 1987) and empirically (Hejdenberg and Andrews, 2011; Tangney and Dearing, 2002) to anger. Anger may serve a life-long function in defending against the pain generated by shame (Gilbert, 1998), by deflecting blame (Hejdenberg and Andrews, 2011) onto the sources of criticism. Thus the experience of shame may be displaced by anger and aggression.

An important study (Farmer and Andrews, 2009) found lower levels of shame-proneness in young male offenders than in male undergraduates. Discussing this, the study's authors quote Mesquita and Ellsworth to argue that 'infrequency [of emotions] is a sign of their significance rather than their insignificance' (Farmer and Andrews, 2009: 59). They suggest that in their young offender sample, shame underpins a defensive strategy which, by valorising masculinity and aggression, prevents the experience of shame coming into conscious awareness.

So it is that shame can be an invisible affect that motivates both hiding and aggression. And it seems that shame linked aggression can be directed towards the self or another.

Behavioural systems and the self

Innate behavioural systems

Heard and Lake structure their model of the self on an extension of Bowlby's (1969) 'behavioural systems'. These are sometimes referred to as motivational systems (Lichtenberg, 1995, Lichtenberg et al., 2011; Stern, 2004; Panksepp, 2002) and were used by Bowlby to describe instinctive behaviours (like careseeking), that require no learning. The activation of a system focuses perception, cognition and affect toward achieving the

goals of that system. Thus, perception, affect and cognition are integral to, and inseparable from the operation of behavioural systems.

Six of the systems identified by Heard and Lake (1997; Heard et al., 2009/2012) are goal corrected. The system they call the 'internal (supportive or unsupportive) environment' is not goal corrected but comprises information processing integral to the other systems (I will return to this below).

Goal-corrected behavioural systems originate in rudimentary actions which coalesce and integrate more complex behaviours into their "mature form" (George and Solomon, 2008: 838). This development is influenced by environmental shaping (Bowlby, 1969) and the integration of associated memory systems (Heard and Lake's 'internal environment'). Bowlby was clear that,

Instinctive behaviour is not inherited: what is inherited is a potential to develop a certain sort of system . . . both the nature and the forms of which differ according to the particular environment in which the development takes place.

Bowlby, 1969/1997: 45

The attachment system is triggered automatically by internal and external cues in a process that may not be conscious. Instead of an 'internal environment' Mikulincer and Shaver (2007) speak about the 'preconscious activation' of attachment. By this they mean that, when the attachment system is activated, memory, cognition and affect systems are activated outside of awareness, triggering enhanced access to some attachment related memories, thoughts and affects, while inhibiting others. In this process, internal working models of self and other (Bowlby, 1969) and selective exclusion from awareness (Bowlby, 1980), give shape to the individual's in-the-moment perception, cognition, affect and behaviour.

Heard and Lake's (Heard et al., 2009/2012) 'internal environment' is therefore inseparable from the systems which it is said to influence. Moreover, from this perspective, Heard et al.'s (2009/2012) description of seven behavioural systems that maintain and restore

wellbeing, assumes the integration of secure relationship histories in which security has been internalised.

Chaos and the self-organisation principle

Although Heard and Lake focus mostly on systems as if they were properties of the individual self (though interpersonally regulated), other theorists talk about systems being ontologically interpersonal, and comprising more than one self. Lichtenberg and colleagues define motivational systems as ‘complex self-organizing systems of emergent and cocreated affects, intentions and goals’ (Lichtenberg, Lachmann, and Fosshage, 2011: xiii). This prioritises the emergent quality of relationship and suggests that, while empathic-attunement may be a goal of careseeking behaviours, it is not a simple response to a preprogrammed biological imperative. ‘Motives are not simply givens; they emerge and are cocreated and constructed in the developing individual, embedded in a web of relationships with other individuals’ (Lichtenberg, Lachmann, and Fosshage, 2011: xiii). While experience may create expectancy that has positive affective tone, for some people, experience develops expectancy that has negative affective tone.

Making plain the interpersonal nature of self, Siegel says, ‘The mind, beyond subjective experience and beyond conscious and non-conscious information processing, can be seen as a self-organizing, emergent process of a complex system. And that system is both within us and between us and others’. He adds that complex systems are ‘non-linear with the potential for small inputs to have ‘large and unpredictable results’; they are open to be influenced by things outside of themselves; and they are capable of ‘chaos’ (their functioning is sometimes erratic and unpredictable) (Siegel, 2014: 1). So while Heard and colleagues’ systems focused model of psychotherapy links careseeking with positive outcomes in an orderly fashion, this link cannot be taken for granted. The presence of a caregiver may elicit careseeking as McCluskey (2005) claims, but it might also elicit a defensive response.

Internal working models

Attachment theory suggests that, from early in life, experiences of careseeking and caregiving are recorded in implicit memory systems as 'internal working models' of self and other (Bowlby, 1973). These have been described as,

conscious and/or unconscious rules for the organization of information relevant to attachment and for *obtaining or limiting* access to information, that is, to information regarding attachment-related experience, feelings and ideations.

Main, Kaplan and Cassidy, 1985: 67 (emphasis added)

Internal models edit and shape the individual's perception, awareness, affect, cognition and behaviour (Bowlby, 1980, 1988). Their role is to facilitate rapid decision making and protect the individual from pain and disruption which might arise from awareness of facts that threaten close relationships (Bowlby, 1980, 1988). Good levels of care will be reflected in positive models of self and other and will support careseeking behaviours in times of need (Bartholomew and Horowitz, 1991; Mikulincer and Shaver, 2007). Unsatisfactory careseeking and caregiving exchanges are encoded in unsupportive internal working models of self and/or other (Bowlby, 1973/1998: 236) which can trigger defensive behaviours when attachment is activated.

Consciousness and defensive self-awareness

Bowlby (1980) assembles a lengthy argument that conscious awareness is edited at different levels of information processing. He argued that experiments using dichotic listening (Moray, 1959; Norman, 1969) and inattention blindness (Simon and Chabris, 1999) demonstrate that information processing, involving memory and perception, operates unconsciously, allowing into awareness only that which is 'salient or necessary' to the person's 'context and goals' (Bowlby, 1980). Bowlby (1980) cited hypnosis as demonstrating that the conscious ego is far from the sole source of executive decision making for the individual. He argued that conscious control can be assigned by the 'executive ego' to 'subordinate systems' so that the person can function without being consciously aware of what is being processed or how they are behaving.

The idea of a conscious and controlling self is further undermined by experiments (using functional Magnetic Resonance Imaging) which demonstrate that, even when a person believes they are consciously deciding to take an action, their decision is in fact taken at an unconscious level some milliseconds beforehand (Kahneman, 1999). This supports an argument that consciousness, and the self that experiences consciousness, may be illusions arising from non-conscious processes (Blackmore, 2004). It also reinforces Kihlstrom's assertion (LeDoux, 2002: 156) about cognitive processes being referred to consciousness 'only sometimes and after the event'.

Perceptual blocking and selective exclusion from awareness can mean that cognitive and affective information does not enter memory or is forgotten (temporarily or permanently). Thus, attachment related memories can be altered and/or eliminated if they threaten attachment relationships (Bowlby, 1980, 1988).

Bowlby described three major types of defensive exclusion which are theoretically linked to insecure attachment strategies (Bowlby, 1980: Chapter four; George and Solomon, 2008):

- *Deactivation*, whereby information (percepts and memory) that would trigger the activation of a system is suppressed or excluded from awareness.
- *Cognitive disconnection*, whereby information pertaining to a system, such as careseeking (Bowlby, 1980) or caregiving (George and Solomon, 2008), is fragmented and separated from its source. In this form of exclusion, events and their associated affects are separated from their cause and are 'neither fully remembered nor fully excluded' (George and Solomon, 2008: 845), but are perceived or remembered selectively in a manner that supports the hyperactivation of a system.
- *Segregated systems*, whereby painful and threatening memories and their associated affects are blocked from consciousness and held but not processed in a parallel system that is segregated from the conscious state (Bowlby, 1980/1998: 59). When they break into awareness, these segregated systems can flood the individual with unprocessed memories and affects linked to traumatic events (George and

Solomon, 2008: 847) causing ‘lapses of reasoning’ and ‘temporary alterations in consciousness’ (Hesse, 1999); resulting in behaviour that is disorganised/disorientated (Main and Solomon, 1990; Lyons-Ruth and Jacobvitz, 2008).

Selective exclusion is relevant to Stern’s (2004) exploration of the present moment in psychotherapy. He cites a process first outlined by Edelman (1998) in which ‘presently ongoing experiences act as triggers to select and assemble fragments from the past that, when integrated, help us to recognize what is happening now in the present’ (Stern, 2004: 198). Awareness without memory or reflexivity is fleeting and ephemeral. Only when percepts trigger memory systems and reflexivity, is a ‘present moment’ created and consciously known (Stern, 2004) in Edelman’s (1998) ‘remembered present’. The person’s experience of a present moment is inevitably shaped by defensive exclusion.

Something similar is described by Nathanson (1992: 306/7) from the perspective of affect and script theory (Tomkins, 1962). When percepts and memory are edited by defensive exclusion the individual’s consciousness is partial. Nathanson says scripts operate like Bowlby’s internal working models to separate the individual from real, in-the-moment, experience:

Since many of these scripts contain rules for the handling of powerful affective experiences, we develop affective responses to the scripts themselves. So complex and pervasive are the habits and skills of script formation that we adults come to live more within these personal scripts for the modulation and detoxification of affect than in a world of innate affect.

Nathanson, 1992: 310

In telling words that anticipate Damasio’s (1999) theory of consciousness, Nathanson says, ‘It is affect that makes things matter’ (1992: 305).⁵ When we are conscious, we are

⁵ In a manner wholly consistent with the larger argument of this chapter, Nathanson (and Tomkins) sees affect in terms of biological systems that are bound up with motivation. ‘Affect makes us care about things in different ways. The reason emotion is so important to thinking beings is that affect controls or acts upon the way we use thought. . . . Whenever we are said to be *motivated*, it is because an affect has made us so, and we are motivated in the direction and form characteristic of that affect. Whatever is important to us is made so by affect. Affect is the engine that drives us’ (Nathanson, 1992: 59 – original emphasis).

consciousness of something; consciousness is focused toward some goal and this usually involves the activation of a motivation. Consciousness (or self-awareness) is, therefore, a meeting-point between perception (triggering event), memory (edited biography), and expectancy.

Subject to the unconscious influence of internal models and defensive exclusion, the insecurely attached person is unable to experience a present moment that is not defensively created.

Attachment styles

Although Heard, Lake and McCluskey do not emphasise attachment styles within their work, and there are few explicit references to attachment styles in the training groups from which the study data is drawn, this theory has informed Heard, Lake and McCluskey's thinking. This can be seen, for example, in their discussion of the system for defence of the self (Heard et al., 2009: Chapter four) and descriptions of patterns of insecure caregiving and careseeking (Heard et al., 2009: 134ff; McCluskey, 2005: 219ff).

In what follows I pick out a few ideas from research into attachment styles to show how my understanding of Heard and Lake's restorative process has been influenced by the Adult Attachment Interview (AAI) (Hesse, 1999), Bartholomew's (Bartholomew and Horowitz, 1991) model linking attachment style with internal models of self and other, and a behavioural systems model of attachment devised by Mikulincer and Shaver (2007, 2008). There are significant differences in how these measures work and what they purport to assess but space constraints do not allow me to discuss what these differences mean in any depth.

Adult Attachment Styles

The earliest attachment classifications (*secure, anxious/ambivalent and avoidant*) arise from observation of infant behaviour in response to mildly threatening events, including separation and reunion with a parent (usually their mother) in the Strange Situation test

(Ainsworth et al., 1978). Following reunion, secure infant's look to their mother for comfort and are soothed by their contact with her. Anxious/ambivalent infants mix urgent demands for care/reassurance with angry protest; and they are less easily soothed by her care. Avoidant infants tend to respond to separation and reunion by immersing themselves in a distracting activity, such as focusing on play with toys.

A fourth attachment category, *Disorganised/disoriented* (Main and Solomon, 1990) was created to classify infants who respond to threat with seemingly contradictory and confusing behaviours. Drawing on ethology, it was suggested that these infants were simultaneously motivated by contradictory system (Lyons-Ruth and Jacobvitz, 2008) to seek proximity and to withdraw (Main, 1979). These infants were thought to lack any organised strategy for dealing with the stress of separation (Main and Solomon, 1990).

Research was soon extended to explore attachment behaviours in adults. This tended to be conducted in either of two ways: using self-report measures that were then popular in social psychology and using narrative methods based on interviews that derive from developmental psychology (Diener and Monroe, 2011; Bartholomew and Shaver, 1998). This has resulted in a range of attachment measures drawing on different ways of conceptualising and operationalising the relevant factors (Bartholomew and Shaver, 1998). The analysis of data in this thesis is strongly influenced by the fourfold classification originating in the Adult Attachment Interview and so I will focus on this rather than self-report measures. The discussion will be supplemented from other strands as required.

The Adult Attachment Interview (AAI) focuses attention on how percepts, cognitions, affects and memories are processed and stored, and how they are excluded from awareness and forgotten. Its purpose is to ascertain the interviewee's 'state of mind' (Hesse, 1999) in relation to attachment by examining 'how relationships are mentally represented, remembered, and described' (George and Solomon 2008: 834). Organised on psychodynamic principles (Bartholomew and Shaver, 1998) the AAI protocol involves asking questions about early childhood relationships and allowing interviewees a relatively free reign in how they respond. Discourse analysis, focusing on mode of speech as much

as content, is then applied to interview transcripts in order to discern patterns of behaviour about which the interviewee may be largely unaware.⁶

From this method three adult attachment styles have been identified that corresponding to the three organised infant categories:⁷

- Free and autonomous with respect to attachment (elsewhere called secure).
- Enmeshed and preoccupied with attachment.
- Dismissing of attachment.

A fourth category is theoretically and empirically linked to the infant *disorganised/disorientated* classification:

- Unresolved/disorganised

This category is thought to reflect fear without resolution (Main and Solomon, 1990) and is used to classify people who can appear disorientated and confused when discussing unresolved trauma or loss (Hesse, 1999).

Attachment style and internal representations

A theoretical link between attachment classifications and internal models of self and other is clearly expressed by Bartholomew and Horowitz (1991). They suggest, for example, that secure attachment reflects positive models of self and other while fearful attachment, (a category defined by Bartholomew and Horowitz), reflects negative internal models of self and other. In contrast to this, Mikulincer and Shaver argue that the link between internal representations and attachment strategies is neither direct nor automatic. Instead they say (Mikulincer and Shaver, 2007) that attachment strategies reflect the role of avoidance

⁶ The Adult Attachment Interview makes use of Grice's (1975) principles of cooperative, rational discourse (Hesse, 1999). These are distilled into four maxims:

- Quality: be truthful and have evidence for what you say;
- Quantity: be succinct and yet complete;
- Relation: be relevant to the topic at hand;
- Manner: be clear and orderly (Quoted in Hesse, 1999: 404).

⁷ Each of these categories has been divided into subcategories that are not used in this study. Detail of these subdivisions can be found in Hesse, 2008. There is insufficient need or space to include the Adult Attachment Interviews '*unclassifiable*' category in this discussion.

and anxiety; and the tendency to deactivate and/or hyperactivate attachment when an attachment figure (physical or symbolic) cannot be relied on.

Seen from this perspective, the anxious or preoccupied individual's positive model of others is strategic and masks more negative views. Reviewing many studies, Mikulincer and Shaver conclude that anxiously attached people 'tend to be jealous, distrustful, easily angered, and sometimes violent' (Mikulincer and Shaver, 2007: 98); qualities which are at odds with positive internal models of others. Similarly, they say the avoidant person's positive self-regard masks or denies negative self-beliefs. Mikulincer and Shaver identify the significance of their argument by saying,

Keeping internal working models conceptually distinct from measures of attachment related emotions and behavior allows us to retain the complexity of Bowlby's (1969/1982) discussions of working models, which he thought could exist at different levels of consciousness and be in conflict across these different levels.

Mikulincer and Shaver, 2007: 98

Behaviours descriptive of organised attachment styles

Diagrams which I have created to analyse the study data were strongly influenced by the literature on attachment strategies. I now present pen-sketches of attachment classifications drawn from this literature. My presentation includes unresolved differences arising from differences in how attachment styles are conceptualised (Bartholomew and Shaver, 1998; Bifulco et al., 2002a; Mikulincer and Shaver, 2007). These pen-sketches refer to careseeking. I will address caregiving in a later section of the chapter.

Secure attachment

Those secure in attachment 'have internalised self-worth and enjoy intimacy in close relationships' (Bartholomew and Shaver, 1998: 31). Valuing attachment relationships, they are able to function in an autonomous manner and trust that others will give care when needed. They show warmth and 'balance-of-control' in friendships, and romantic relationships (Bartholomew and Horowitz, 1991).

The discourse of secure individuals about early attachment experience is coherent and subtle with descriptions of a parent's positive and negative qualities being supported by evidence. Accounts of parental failings are often implicitly forgiving (Hesse, 1999: 401). Secure people conform to Grice's maxims for cooperative discourse and are neither unnecessarily prolix nor terse (Hesse, 1999).

Enmeshed and preoccupied with attachment

In Bartholomew's model (Bartholomew and Horowitz, 1991), those classified as enmeshed/preoccupied are thought to have a negative internal model of self and positive model of others. In Mikulincer and Shaver's (2007) model, they score high on a measure of anxiety and low in avoidance.

Sometimes controlling in close relationships (Bartholomew and Horowitz, 1991), preoccupied individuals increase their sense of vulnerability (Mikulincer and Shaver, 2007). They 'anxiously seek to gain acceptance and validation from others, seeming to persist in the belief that they could attain safety, or security, if they could only get others to respond properly toward them' (Bartholomew and Shaver, 1998: 31). In interview they can appear highly expressive, angry, incoherent, preoccupied and overwhelmed by particular relationships or traumatic experiences (Bartholomew and Horowitz, 1991) and their talk may appear exaggerated, unconvincing or lacking objectivity (Mikulincer and Shaver, 2007). Cognitive disconnection (Bowlby, 1980; George and Solomon, 2008) allows the preoccupied careseeker to divert attention from other subjects and impose their will over that of a caregiver (Hesse, 1999).

Enmeshed/preoccupied individuals tend to breach Grice's maxim of relation (relevance), manner (coherence), and quantity (by speaking at greater length than their subject warrants).

Dismissing of attachment

Thought by Bartholomew (Bartholomew and Horowitz, 1991) to reflect a positive internal model of self and negative view of others, she describes this attachment style as the polar opposite of the enmeshed/preoccupied group (Bartholomew and Horowitz, 1991). Mikulincer and Shaver (2007) say people who score high on avoidance decrease their sense of vulnerability, suppress any tendency to express need, and try to be self-reliant. In my flow diagram for this group (chapter five) I lean on Mikulincer and Shaver's model more than Bartholomew's internal representations.

Dismissing attachment histories tend to be presented in positive terms that are not supported by evidence and may be contradicted by details within their accounts (Hesse, 1999). Negative expectations of attachment relationships motivate these individuals to avoid intimacy and downplaying the value of close relationships (Main, 1995) in order to bolster their sense of self-worth (Bartholomew and Shaver, 1998: 31). Avoidant attachment may be marked by apparent self-confidence, self-reliance, devaluing attachment relationships, low capacity to careseek or use others as a secure base and lack of emotional expressiveness (Bartholomew and Horowitz, 1991: 229). In therapy, clients who are dismissing present themselves as invulnerable and tend to push the caregiver away (Dozier, et al., 1994). However, these strategic devices can break down under stress (Mikulincer, Dolev and Shaver, 2004).

Because thought is organised so that attachment can remain deactivated (Hesse, 1999) avoidant discussions of attachment history lack detail, are internally inconsistent, incoherent and terse (Hesse, 1999: 397).

Fearful attachment and the unresolved/disorganised classification

Bartholomew's 'fearful' classification is not recognised in the Adult Attachment Interview just as the 'unresolved/disorganised' category does not appear in Bartholomew's model. In my flow diagrams I follow Mikulincer and Shaver (2007: 30) in combining these classifications. This does not do justice to the thinking that informs the different traditions

that give rise to these classifications. Nuanced discussion of these categories can be found elsewhere (see for example, Bartholomew and Shaver, 1998; Mikulincer and Shaver, 2007).

Bartholomew and Horowitz (1991) suggest that behaviour of fearfully attached individuals reflects negative internal models of self and others and these result in low self-confidence and mistrust of caregivers (Bartholomew and Horowitz, 1991). Scoring highly on both avoidance and anxiety (Mikulincer and Shaver, 2007) these individuals are caught in a dilemma in which, 'highly dependent on the acceptance of others for self-affirmation [their] negative expectations of others generates anxiety or fear, [so] they avoid intimacy in order to avert the pain of loss and rejection' (Bartholomew and Shaver, 1998: 31).

The classification, *unresolved/disorganised* is unique in the AAI because it is assigned alongside an organised classification (Levy, et al., 2011). *Unresolved/disorganised* people can become disorganised and disorientated during discussions of potentially traumatic events (such as loss or abuse). Their discourse includes lapses of reasoning suggestive of 'temporary alterations in consciousness or working memory [which] are believed to represent either interference from normally dissociated memory or belief systems, or unusual absorption involving memories triggered by the discussion of traumatic events (Hesse, 1999: 405). George and Solomon (2008) suggest this presentation is consistent with interference from what Bowlby (1980) called a 'segregated system'.

An additional avoidant style: angry dismissive

Although my analysis of the data was based on a fourfold classification drawing on the above descriptions, an additional attachment style used by Bifulco and colleagues (Bifulco et al., 2002a, 2002b) has proven useful in exploring links between attachment style and depression. Bifulco and colleagues subdivide the dismissing category into 'withdrawn-dismissive' (which conforms to the earlier pen-sketch of dismissing attachment) and 'angry-dismissive'. This classification describes people with high hostility to attachment figures they perceive to be unavailable or unsupportive (Bifulco et al., 2002a). Although it is not represented in my diagrams and did not inform my analysis of data, this classification may

enrich discussion of the findings and would, I believe, be useful if the study were to be extended to other therapeutic settings.

New diagrams depicting Heard and Lake's restorative process

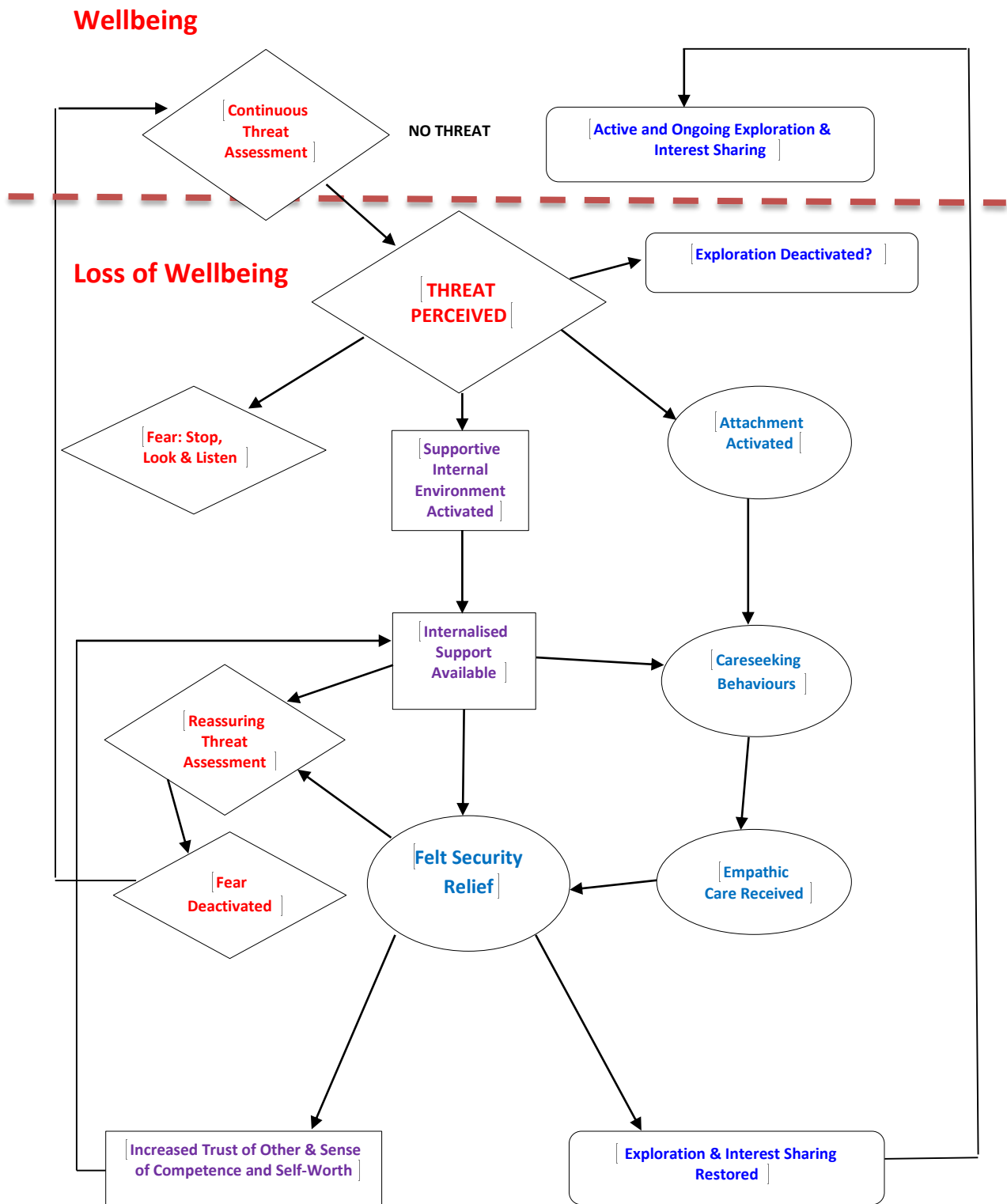
My attempt to present Heard and Lake's attachment dynamic in diagrams took its inspiration from Mikulincer and Shaver's behavioural systems focused model of attachment (which is described in Appendix 2). Rather than replicating their three modules in one diagram, I chose to draw one diagram for each of the three AAI organised attachment strategy. The first of my diagrams is intended to represent the key features in Heard et al.'s (2009) restorative process working in an optimal manner to maintain and restore wellbeing. In addition to fear, careseeking/caregiving and exploration, the diagram includes information processing in the form of Heard and Lake's supportive internal environment.

My flow diagrams were drawn to understand the behaviour of careseekers rather than caregivers. Interesting questions would be raised by diagrams describing secure and insecure caregivers, but that is work for the future.

Figure 2 is read from top to bottom (overleaf). Key events are as follows:

- Exploration (and interest sharing) are deactivated when a threat is perceived.
- Fear, careseeking and the supportive internal environment are activated.
- The internal environment enables access to the individual's sense of competence and activates cognitions and affects that support and motivate careseeking.
- Careseeking is met with empathic-attunement by a (internal or external) competent caregiver.
- The goal of careseeking is achieved (satisfaction and relief felt).
- Exploration again becomes the activated system (and if required may be used to better understand the problem situation).
- Like Mikulincer and Shaver's 'broaden-and-build' cycle of attachment security, arrows link the satisfaction/relief resulting from careseeking back into the internal environment.

Figure 2: THE RESTORATIVE SYSTEM (OPTIMAL FUNCTIONING)



Flow Diagram 1. The restorative process (optimal functioning) (FLOW DIAGRAM1).

The Diagram shows the fear system interacting with three of Heard and Lake’s seven attachment related systems as they work to restore wellbeing. Diamond = Fear; Oval = Attachment (Complementary systems for Careseeking and Caregiving); Rectangle = Supportive Internal Environment; Rounded rectangle = Exploration and Interest Sharing with Peers.]

Although not depicted as such in the diagram, Heard and Lake would wholly agree with Mikulincer and Shaver that the caregiver could be a physical presence or an internalised attachment figure. Therefore, fear, distress or need will only lead to careseeking from an external caregiver when a caregiver is available and/or when the need for care exceeds inner resources. The more secure the person, the more internal resources are available to support them.

The diagram represents a secure careseeker (interacting with a secure caregiver). The internal environment (Heard and Lake, 1997; Heard et al., 2009), or preconscious activation of internal representations (Mikulincer and Shaver, 2007), supports attachment behaviours. Because the processes depicted don't include Bowlby's defensive exclusion from awareness, the careseeker could be expected to speak in a coherent and balanced manner about both positive and negative aspects of their experience (Holmes, 1998). They will also be able to say something about what is happening in their internal environment; about thoughts and feelings that support or hinder careseeking and contribute to their sense of personal competence. The personal history they recount will seem realistic, authentic, coherent and complete (Hesse, 1999; Holmes, 1998).

The restorative process with insecure careseekers

In chapters five and eight (pages 120 and 175) I present two further diagrams to depict the same processes as they might manifest with insecure (avoidant and preoccupied) careseekers. In these diagrams I describe the same systems but now the placement of the symbols is intended to represent the role of selective exclusion from awareness. These new diagrams are essentially unbalanced with symbols placed on the right side of the page to represent processes that are most easily accessible to the individuals consciousness (and most visible to the caregiver) while those on the left are selectively excluded from awareness. In each case I have placed symbols for the internal environment in order to show the role of information processing in either deactivating or hyperactivating attachment. The diagrams are described in introductions to the case studies.

Research on careseeking, caregiving and attachment style

Responses to the offer of care

The justification for a study of the influence of fear within psychotherapy is that fear underpins insecure attachment strategies (Mikulincer and Shaver, 2007; Slade, 2008). Most users of psychotherapy are insecure (Dozier et al., 2008) and so struggle to see a therapist as a secure base (Slade, et al., 2008). Research demonstrates that insecure attachment influences careseeking and caregiving behaviours.

For example, Dozier et al. (2001) report that avoidant people reject attachment figures in times of stress. Florian et al., (1995) found that avoidant people become confused when offered emotional support and that anxiously attached individuals become more emotional when offered practical support. In their discussion of this finding Mikulincer and Shaver (2007) suggest that the offer of emotional support challenges the isolating defence while practical support challenges the hyperactivating defence.

In another study (Carpenter and Kirkpatrick, 1996; see also, Feeney & Kirkpatrick, 1996) biometrics (heart rate and blood pressure) were measured in subjects placed in an artificially stressful situation. The results suggest that the presence of romantic partners ('a kind of attachment figure') leads to a slight reduction of stress in securely attached subjects and increased stress for insecure subjects. Mikulincer and Shaver (2007: 199) say this may indicate fear of criticism (that is, fear of being shamed).

It may be that the activation of careseeking in these subjects evokes preconscious memories of unassuaged/unsatisfactory careseeking (Mikulincer and Shaver, 2007) and internal models linked to personal incompetence (Lake, 1985) and shame. Activation of negative internal models supports the adoption of a defensive strategy. If this is correct, the offer of care may itself trigger fear and/or shame.

Studies describing complex responses to the offer of care have profound implications for affect regulating interventions, caregiving and exploration as described by Heard and

colleagues. The therapist's care and the invitation to move from careseeking into exploration may both threaten to expose a shame-filled self (Wurmser, 1987) and so motivate hiding or aggression.

Caregiving, defensive strategies and the therapeutic alliance

A key function of therapy is to create a 'secure base' for the client's exploration (Bowlby, 1988). Yet attachment theory 'would predict that the predilection to care is as vulnerable to distortion in the insecure therapist as it is in the insecure patient' (Slade, 2008: 768). In what follows I very briefly recount some of what research reveals about how the caregiving system is influenced by internal models and defensive strategies (Collins and Ford, 2010; Solomon and George, 2008).

Slade (2008) says that insecure therapists are likely to respond to their client's defensive strategies rather than the underlying need. This means they become entangled in the overt demands of preoccupied clients and are unduly cognitive with avoidant clients. She also says that insecure therapists may try too hard to be liked, creating an early therapeutic alliance which is not sustained (Sauer et al., 2003) and fails to provide a secure base. Similar findings linking quality of therapeutic alliance with therapist and client attachment styles is reported by Tyrell et al. (1999). Attachment styles and therapeutic alliance are associated with therapeutic outcomes (Sauer et al., 2010). Because of this link I present a few brief findings relevant to different organised caregiving styles.

Secure caregiving

Collins and Ford (2010) report that secure people have more effective caregiving styles and modulate their response in tune with the level of need expressed by attachment partners. Secure therapists attune to underlying need rather than the careseeker's hyperactivating or avoidant presentation (Slade, 2008). They offer care that 'complements' (rather than complies with) the careseeker's defensive strategies (Dozier, Cue and Barnett, 1994). When required, secure caregivers can offer care in ways that challenge their own comfort (Dozier, Cue and Barnett, 1994: 798) rather than reflecting their own needs.

Enmeshed/preoccupied caregivers

George and Solomon (2008) link preoccupied/enmeshed caregiving with Bowlby's (1980) 'cognitive disconnection'. They argue that this prevents the preoccupied caregiver from accurately perceiving the careseeker's distress. Emphasising the need for closeness these people offer an intense form of care (Collins and Ford, 2010; Dozier, Cue and Barnett, 1994) that meets their own needs rather than those of the careseeker. In intimate relationships they can react negatively to their partner's distress, sometimes causing them to become more self-focused and to feel angry and frustrated (Ford et al., 2010).

This reported link between insecure caregiving and anger may throw light on a study by Strathearn et al., (2009). Using functional Magnetic Resonance Imaging (fMRI) they found that different brain regions are activated when secure and insecure mother's view pictures of their own infant in a state of distress. For secure mothers the pictures of their upset child activates brain regions associated with attachment (care/love). By contrast, brain regions activated in insecure mothers are associated with the mother herself feeling bad (pain/distress). I suspect the researchers were seeing the neural consequences of preconscious activation (Mikulincer and Shaver, 2007) of affect linked to the caregiving system. If a mother has repeatedly failed to achieve the goal of caregiving, painful internal working models of self (incompetence/shame) and other (demanding/never satisfied) will become linked with signals of distress from her infant; triggering pain. It is easy to imagine that in insecure caregivers this pain triggers frustration and defensive anger (Collins and Ford, 2010; Solomon and George, 2008).

Avoidant caregivers

The deactivating strategy influences avoidant caregivers to act in a manner consistent with internal models that downplay the importance of attachment (George and Solomon, 2006: 845). This gives rise to a parental style of caregiving that Solomon and George (1996) call "distanced protection". In a study of caregiving in intimate relationships (Collins and Ford, 2010), avoidant caregivers show patterns of 'relative neglect' in which less support is offered. In Dozier, et al. (1994: 798), dismissing case managers (untrained professional

caregivers), were seen to intervene non-intensively regardless of their client's characteristics.

In Ford et al.'s study (unpublished manuscript cited in Collins and Ford, 2010) insecure caregivers in intimate relationships also react negatively to their partner's distress. The study found that as their partners become more upset, avoidant caregivers become tense and angry (Collins and Ford, 2010). This finding may reflect an angry-dismissive attachment category (Bifulco et al., 2002a, 2002b) and both may also relate to Strathearn et al.'s (2009) findings.

The influence of segregated systems (Bowlby, 1980) on caregiving can be very profound (George and Solomon, 2008) but are less relevant to this study. We might conclude that, while careseeking may activate a caregiving response in an attachment figure (Heard et al., 2009/2012), it may also trigger paradoxical and unhelpful behaviours (Collins and Ford, 2011; Ford, et al., 2010; George and Solomon, 2008; Strathearn et al., 2009) reflecting the caregiver's attachment strategies and internal models of self/other.

Conclusion

I began this chapter by describing the theory that is being developed in the study. This posited an 'autonomous self . . . embedded in the dynamics of attachment' that is expressed in the activation, assuagement (or disassuagement) of behavioural systems. I also described how Heard and colleagues translate these ideas into a model for psychotherapy that focuses on the dynamic relationship between careseeking, caregiving and exploration.

The wider literature raises a number of questions about what Heard and Lake's model means. The autonomy of the self is challenged, for example, by Siegel's description of the mind as 'a self-organizing, emergent process of a complex system . . . that is both within us and between us and others' (Siegel, 2014: 1). It is challenged too by the idea that perception (and so the experience of self and other) is edited in non-conscious processes so that the expression of self is profoundly shaped by defensive strategies operating

outside of awareness. If it is true that ‘most cognitive processes occur unconsciously, with only the end processes reaching awareness and then only sometimes’, (Kihlstrom quoted in LeDoux, 2000: p.156) we might expect much that happens in psychotherapy to reflect a body-to-body level of interaction (Pally, 2001) with decision making and other behaviour being post-rationalised (Kahneman, 1999). This suggests that awareness of defensive processes which operate outside of awareness in both therapist and client, has to take centre stage in any discussion of psychotherapy.

In light of this literature Heard and Lake’s idea of ‘innate preprogrammed systems’ poses a number of questions.

- Are the seven systems of Heard and Lake’s restorative process inherited and fixed in their form and pre-programming.
- Are they ‘linear systems’ (Lichtenberg et al., 2011) that motivate different individuals, who have had different personal histories, in much the same way?
- Or are they complex systems created in relationship experiences (from rudimentary components) so that they express relationship history in very diverse ways?
- Can fear be regulated by a therapist, and if so, how is shame regulated?
- How is the therapist influenced by internal models linked to the caregiving system and does the activation of their caregiving create expectancies for them that want to be met in contingent responses from a careseeker?

The last question is particularly challenging for Heard and Lake’s theory. When a therapist is working with someone for whom the activation of attachment (careseeking and caregiving) activates preconscious expectancies of being shamed, this will trigger defensive behaviours which will not meet the therapist’s expectancies in the encounter; perhaps triggering the therapist to experience (consciously or unconsciously) shame, frustration or anger.

From this reading of literature I believe Heard and Lake’s description of the attachment dynamic has too little to say about how the therapist (secure or insecure) might meet the insecure careseeker in a manner that adjusts to their particular defensive strategies. While Heard and her colleagues describe a range of insecure patterns of careseeker/caregiver

behaviours (Heard et al., 2009: 134ff; McCluskey, 2005: 219ff), and propose defensive strategies that may underpin them (Heard et al., 2009: chapter 4), they say too little about selective exclusion from awareness (in the therapy dyad) and how interventions based on their ideas might need adjusting to address this.

Chapter Three: Method

Introduction

In the last chapter I identified a body of theory that is being developed in the study. This theory posits a range of different motivational systems which work to enhance survival and wellbeing. It arises from Heard and Lakes' (1986; 1997; Heard et al., 2009) view of human development and ideas about the role of empathic attunement within psychotherapy (McCluskey, 2005). A central idea within attachment theory is that experience of self and other reflect relationship history and the consequent, ease or difficulty with which an individual engages in careseeking and caregiving. Incorporating LeDoux's (1996) concept of the 'fear system' into their model of human development, Heard and Lake (Heard et al., 2009) point to the vital role of fear within every individual. The importance of attuning to and regulating affect is highlighted in McCluskey's (Heard et al., 2009; McCluskey, 2005, 2008, 2009, 2011) examination of the therapeutic encounter. The present study examines data arising from training courses facilitated by someone using Heard, Lake and McCluskey's ideas. The intention is to see if and how aspects of the theory might need to be developed in respect of attachment-related fear.

In this chapter I will outline the justification and focus for the study before moving on to discuss the design and related practical, theoretical and ethical issues concerned in safeguarding the integrity of the study and the wellbeing of participants.

Justification and focus for the study

Justification for Research

Although fear is widely recognised as being integral to attachment behaviours (Mikulincer and Shaver, 2007) its role has been neglected within attachment research (Slade, 2008). My searches failed to find literature focused directly on the influence of fear in psychotherapy. Research linking attachment and psychotherapy predominantly uses the concepts of internal representations and attachment styles (Dozier et al., 1994; Florian et

al., 1995; Fonagy et al., 2004; Hardy et al., 1998; Mallinckrodt et al., 2005), to explain the behaviour of individuals in stressful situations. Attachment based therapy tends to focus on the influence of internal representations and attachment strategies on narrative coherence in therapeutic outcomes (Holmes, 1998; Slade, 2008). McCluskey's work examining the role of attunement in psychotherapy (McCluskey, Roger and Nash, 1997), and developing her concept of 'goal-corrected empathic attunement' (McCluskey, 2001; McCluskey, Hooper and Bingley Millar, 1999) moves the focus of concern toward the role of attunement and empathic mirroring to help clients achieve the goals of behavioural systems, especially, careseeking and exploration (McCluskey, 2005, 2008, 2011, 2013; Heard et al., 2012). She describes 'the process of affect attunement and regulation as a fundamental element of assuaging care-seeking' and called this process 'goal corrected empathic attunement' (GCEA) (McCluskey, 2013: 149). When this is set within a wider view that includes Heard and Lake's (1986, 1997) concept of the restorative process a new approach to psychotherapy is proposed. By incorporating LeDoux's (1996) fear system into their conceptualisation of the self (Heard et al., 2009/2012), this approach places fear, and the regulation of fear, at the heart of the therapeutic encounter.

The present study examines transcripts of training courses in which members of experiential groups were helped to explore their attachment experiences. The study focuses on how fear influences the interaction in the groups with the view that, by inference, this will help understanding of the role of fear in other caregiving and therapeutic encounters. It describes what happens when attachment-related fear is activated; the strategies used by different people to mitigate their fear; and the impact of this on caregiving and exploration within the therapeutic encounter. The study develops Heard and Lake's (1986, 1997) ideas about assuagement and disassuagement of behavioural systems by suggesting that shame (and the fear of shame) arising from failed careseeking experiences shapes the way people respond in careseeking/caregiving encounters.

The salience of the project arises from the idea that for some people the activation of careseeking and the offer of care activates fear. This idea underpins descriptions of disorganised/disoriented attachment (Main and Solomon, 1986; Hesse and Main, 2000;

Hesse and Main, 2006) and can be seen in the paradoxical responses of insecure people to offers of care and support (Florian, et al., 1995; Mallinckrodt, Porter and Kivlighan, 2005). This is normally discussed in terms that highlight internal working models and the attachment strategies to which they give rise.

McCluskey (2001, 2005, 2011; 2013; Heard et al., 2012) emphasises the need for therapists to be aware of which system is activated at any moment for themselves and their client. The role of the therapist is to support the client in achieving the goals of careseeking and exploration. Working in this way involves monitoring for signs of fear in their client and in themselves and regulating this emotion. She stresses the difficulty in this task saying, ‘. . . I think the major developmental work for all of us—taking a life time—is to regulate our own fear system so that we can remain truly explorative care-givers when called upon to be so in our personal and professional relationships’ (McCluskey, 2013: 148). Subsequently she alludes to the impact of the arousal of fear in the therapist on their ability give effective care.

In this paper I want to focus on the enormous consequences for adults, particularly for adult care-givers, of having their own affect unregulated and their own care-seeking system unassuaged. Apart from the consequences for adult care-givers in their own lives, this lack of assuagement and an inability to notice or regulate their own arousal levels has a huge effect on whether care-givers can provide effective exploratory care for their clients. Clients can threaten the well-being of therapists. We do not often talk about this fact. When this happens, the therapist’s own fear system is likely to be triggered, as is their attachment system, expressed through care-seeking.

McCluskey 2013: 149

The study examines data from a natural setting to examine the difficulties McCluskey here describes.

Aims of Research

As discussed in chapter one, the aim of the project is to use transcripts of exploratory groups to increase understanding about how attachment-related fear influences caregiving/careseeking exchanges.

The courses are studied as a natural setting in which an experiential course facilitator interacts with multiple course members. The courses met at monthly intervals in sessions that lasted for three hours. Each course had nine sessions. The role of the facilitator of these courses is to be an attuned and empathic caregiver (McCluskey, 2008: 205) so that they can support course members in their personal exploration of attachment experiences. The study is concerned with how well Heard, Lake and McCluskey's ideas describe the interaction between facilitator and course members so that it can be developed where necessary to increase the utility of the theory.

Questions

The central research question, as represented in the study title is, 'How does attachment-related fear influence psychotherapy?' Supplementary questions that informed the study are as follows:

1. Do Heard and Lake's (1997; Heard et al., 2012) ideas about the attachment dynamic and behavioural systems support empathic and attuned course facilitation (and therapy)?
2. How does fear manifest in the group setting?
3. How are caregiving/careseeking in the groups influenced by attachment styles?
4. Does the theory underpinning the groups enable the facilitator to regulate fear in the groups and offer 'fear free caregiving'?
5. What is the relationship between fear and shame and how does shame influence psychotherapy?
6. What is the role of negative affect (anger and/or hate) in psychotherapy?
7. Does exploration indicate working alliance?
8. What do these groups tell us about viewing psychotherapy as exploration?

Design

Design overview

The study is an embedded case study (Yin, 2009) which brings together ideas drawn from narrative inquiry (Clandinin and Connelly, 2000; Elliot, 2005; Riessman, 2008) and theory building case study (Stiles, 2007; McLeod, 2010). Eight cases were selected from thirty members of two courses of exploratory groups (the nature of which is described in chapters one and four) in order to access a range of contrasting experiences as recommended in wide ranging qualitative methodologies (Riessman, 2008; Strauss and Corbin 1998; Yin 2009).

Because the project was a PhD study its process has reflected the development of my knowledge and confidence. I had undertaken a good deal of work on the course transcripts whilst learning about possible approaches. This meant that I became very familiar with the transcripts in the period before settling on a method. I read and re-read them, listening to the audio recordings a number of times to ensure accuracy of attribution and the meaning of the texts. This process of reading and re-reading (and where necessary checking transcripts against the audio recordings) continued throughout the study.

In the early period, prior to deciding on a method for the study, I undertook experimental coding using qualitative data analysis software (QSR NVivo 9). While this increased my familiarity with the course transcripts and helped me identify important themes for the study, I soon abandoned it as a method because the ever growing number of codes and classifications seemed to fragment understanding of each person and increased my distance from individual speakers. Nevertheless, the initial coding identified important themes, including differences between how much individuals spoke in the groups, their levels of emotional expressiveness (including the expression of fear and distress), and the role of self-reliance and defensive caregiving in the narratives related. All of this underscores the importance to the study of attachment theory and attachment styles.

The decision to use Stiles' Theory Building method (Brinegar, 2006; Stiles, 2007; McLeod, 2010) was taken relatively late in the project. This decision reflects the integral nature of Heard, Lake and McCluskey's (Heard and Lake, 1986, 1997; Heard et al., 2012; McCluskey, 2005, 2008, 2011, 2013) ideas about the self in psychotherapy. Incorporating the theory building method anchored the study and, through McLeod's suggestion to use a theory statement and flow diagrams, gave rise to the final structure of the thesis.

Narrative analysis

Whilst Stiles' theory building approach informs the structure and rationale for the project, insights from thematic and narrative analysis informed the process of analysing the data. Narrative inquiry uses literary theory to examine the manner in which people present their stories so as to understand the complex and 'rich multiplicity of meanings' embedded within them (Huber, Murphy and Clandinin, 2003). It is based on the idea that stories are related for a purpose and include 'perceptions, conclusions and feelings' that convey the 'narrator's interpretation' and information about what makes the story salient for them (Poindexter, 2002). Its focus is on 'how and why events are storied, not simply the content to which language refers' (Riessman and Quinney, 2005: 394). Narrative inquiry has been used to differentiate unique meanings in seemingly similar events (Riessman, 1989) and recognises the uniqueness (Cooper, 2009) of each informant. Because narrative analysis is able to encompass the 'embodied' nature of self (Clandinin and Connelly, 2000) and the culturally positioned nature of self-expression (Hollway and Jefferson, 2000) it is a good fit with the theory and aims underpinning the study.

There is no single approach to narrative inquiry (Elliott, 2005) and I have followed the example of others (Poindexter, 2004; Riessman, 2008; Clandinin and Connelly, 2000) by selecting ideas from a range of different theorists, (for example, Gee and Green, 1998; Hollway and Jefferson, Labov and Waletzky, 1967; Mishler, 1986) when presenting my work on session transcripts. The study seeks to be faithful in giving 'voice' (Riessman, 2008), to the course members, so that their unique contributions can be heard in and through the analysis. At the same time it recognises a need 'to assist in the production of (the

informant's voice' (Hollway and Jefferson, 2000, p.56). These ideas reflect the complexity of the task at hand.

In the first place, stories are not neutral and do not represent objective reality. Rather, they are situated in place and time and are told to fulfil a purpose or meet a need in the story teller. We have no direct access to the experience of others (Danermark et al., 2002; Riessman, 2008) and are wholly dependent on what they say. Yet, as Craib (2000) points out, stories are told for all sorts of reasons, including to cajole and persuade. It has been said that stories are told backwards and work toward a known conclusion (Freeman, 1993). As such, they may be told to reveal or hide; to inform or mislead. Even when told to give access to the storyteller's self they are culturally positioned and subject to the storyteller's theories about self which include blind-spots and biases which inform the storyteller's self-awareness. In short, storytellers are subject to the same fallible self-awareness as we are (we are all story tellers).

Hollway and Jefferson (2000) make a very similar point saying that we should not automatically accept the veracity of what we are told. Our understanding requires interpretations to be made in the light of both sides of what Giddens, (1993) calls a 'double hermeneutic'. So, whilst we might want to hear from, and give voice to, those who might otherwise go unheard (Riessman, 2008), our reports are dependent on accurate interpretation. They are subject to the fallibility and defended subjectivity (Hollway and Jefferson, 2000) of both participant and researcher.

Other factors affecting the complexity of narrative study results from the need to translate oral narratives into text. Presenting a transcript is an interpretive process (Mishler, 1991) in which, 'there are only choices, no faithful copies' (Myerhoff, quoted in Poindexter, 2002). From the outset, therefore, decisions have to be made which affect how a text is read and what meanings will come from it. Although the transcriber seeks to remain faithful to the speaker's intentions, this inevitably requires interpretation at every point. Riessman points out that 'the same stretch of talk can be transcribed very differently, depending on the investigator's theoretical perspective, methodological orientation, and substantive interest' (Riessman, 2008, p.29).

Therefore, narratives, no more than any other phenomenon, can be taken to present truth/reality in a manner that is at all straightforward. But as has been argued in chapter one, all scientific data have to be interpreted in line with the three domains of reality posited by critical realism: 'our experience of events, the events as such (of which we only experience a fraction) and the deep dimension where one finds the generative mechanisms generating events in the world' (Danermark et al., 2002: 43). In the study I present the text in idea units (Gee and Green, 1998) and stanzas (Poindexter, 2004) in order to get as close as possible to the thinking of group members at every moment of an exchange whilst using ideas drawn from psychodynamic-attachment theory to question the exchange. In this way I attempt to reach behind words used in the course sessions and test the ability of Heard and Lake's model of the self to account for the mechanisms that give rise to therapeutic experience.

Theory building case study research

In keeping with what is said above (and in chapter one) about the limitations of what can be directly known, the spirit of the project is captured in the following quote:

Theory-building research begins with a current understanding, which is considered as permeable, that is, capable of being infused with and changed by new observations. [. . .] The theory is not considered a rigid treatise to be voted up or down in light of supporting or disconfirming evidence. Rather, theory is a flexible (permeable) account that was constructed as a way of understanding previous observations and now must be elaborated, extended, qualified, and modified to encompass the observations at hand.

Brinegar et al., 2006: 165

Thus the project is not a definitive or final episode but part of an ongoing striving toward an ever developing understanding of self within psychotherapy. In all likelihood, this striving will last as long as our species survives. In addition, Brinegar and colleagues differentiate the theory building approach from hypothesis testing in the following terms:

Theory-building case studies emphasize broad attention to the rich case material at hand—not just one or a few variables. Instead of trying to assign a firm confidence

level to a particular theoretical tenet, as in hypothesis-testing research, the case study strategy examines multiple tenets in one study. . .

Brinegar et al., 2006: 165

Thus the theory testing approach fits the data set used in this study as well as the goal of developing a particular theoretical description.

Stiles (2007: 125) describes the theory building approach in terms of eight sequential steps:

1. Develop a theoretical starting point
2. Selection of case
3. Construction of rich case record
4. Immersion in the case
5. Applying the theory to the case
6. Identifying gaps in the theory: applying the case to the theory
7. Refining the theory
8. Testing the revised version of the theory against further cases

Because the theory-building method was adopted relatively late in the project the sequence has not been followed rigidly. Steps 1-4 were largely complete before my decision to use this method. Nevertheless, my understanding of the theoretical starting point and immersion in the data were enhanced and advanced by production of a statement of theory and flow diagrams as suggested by McLeod (2010). The study has also benefitted by the conscious use of steps 5 and 6, that is, analysing the cases in light of the theory (chapters five to twelve) and then reversing this process and 'turning the observations back on the theory' (Stiles 2007, p. 125) and analysing the theory in terms of the cases (chapter thirteen: examining case presentations in terms of the process of course facilitation). Because the study involves examining eight case studies and the role of the facilitator, step eight was not followed sequentially but informs the back and forth comparisons made between multiple case presentations.

The later stages and discussion were informed by the following questions as suggested by McLeod (2010: 165):

- Does the theory do justice to the complexity of the case?
- What are the segments or aspects of the case around which the theory has nothing to say?
- At what points did I feel frustrated or confused when I was using the theory to code or analyse the case?

Operationalising the method

Prior to the inception of this study, data was generated in the form of audio recordings and transcriptions of many exploratory courses of the type described in chapter four. Each of these courses met with a facilitator for three hour sessions on nine occasions scheduled at monthly intervals. As a member of one of these courses (having also attended other forms of training in similar experiential groups), I was unwittingly preparing for this study long before formally embarking on it.

My involvement in the study began with a period studying literature about fear, attachment theory, psychotherapy, and research methods. This process was ongoing as the project evolved.

Selecting the study Data: transcribed recording of course sessions

Prior to reading for the project I had volunteered to check the accuracy of transcripts that had been produced by a professional transcriber for Course A. This happened because I had attended that group and knew the voices of all of the group members. When I began the study, it made sense to build on my familiarity with these transcripts and so Course A was included in the study. I judged that any problems arising from my familiarity with the group would be outweighed by potential benefits (later in this chapter I discuss issues raised by this insider role for my research).

The second course (Course B), met in a different city a few years after the first. It was chosen to introduce a greater diversity within the fieldwork data, and thus facilitate a more rigorous test of the explanatory propositions. These differences included the fact that, while I knew everyone in Course A, none of the members of Course B were known to me. Another difference was that two thirds of the members (10 out of 15) of Course A were repeating an earlier course experience; they were familiar with most of the ideas underpinning the course and shared much that could be called a group culture. By contrast, all but one of the members of Course B were attending a course for the first time.

At the time of selection, Course B was the most recent course series for which there was a near-complete set of audio recordings and transcripts¹. This selection of courses gave me a pool of 30 potential participants and 55.5 hours of recording (which had been transcribed). Individuals in the two groups appear to reflect a range of behaviours and attitudes that attachment theory suggests may be relevant to the focus of the study. I familiarised myself with the transcripts of all sessions of both courses. I did this by repeatedly listening to the audio recordings and checking the accuracy of the transcripts.²

McLeod's (2010) idea to use flow diagrams and a statement of theory were both important in shaping the manner in which the study was operationalised. The diagrams were used to represent Heard and Lake's view of the attachment dynamic from which predictions could be made regarding what might be seen in the transcripts. In creating my flow diagrams I drew on Mikulincer and Shaver's (2007) attachment model (see Appendix 2). It immediately became apparent that more than one diagram was necessary to describe behaviour seen in the groups. In turn this pointed to the necessity of linking Heard and Lake's ideas with literature about attachment styles. This secondary literature has become a significant platform from which Heard and Lake's ideas have been critiqued.

¹ I was initially unsure about using an incomplete set of recordings (for technical reasons there is a half hour missing from session seven and it had not been possible to record any of the final session). However, preparatory work on Course A showed me that, as the project was a qualitative study and not focused on therapeutic outcomes, there was more than enough data for each participant in the available record. Because I had planned to interview participants from this group, I also reasoned that any known gaps could be filled by questions in interview.

² The primary data consists of audio recordings and transcriptions of two training courses collected by my PhD supervisor as part of an ongoing research project into 'attachment, affect attunement and regulation'.

Selecting participants

It would have been possible to select participants for my study from a large number of similar courses which have run in four different countries in Western Europe over approximately nine years. However, practical considerations caused me to narrow my choice.

The first consideration was that creating accurate transcripts requires listening to each session several times. Ensuring correct attribution of speech to a definite speaker is difficult when working solely from audio recordings. It necessitates learning to recognise the voices of all members of a course and listening to each session a number of times. More difficult sections have to be heard a number of times more. This is only practical with a small number of courses.

Moreover, making sense of individual narratives requires knowledge of the speaker's wider life story (Huber, Murphy and Clandinin, 2003). When life stories are told in therapy and in the courses, it tends not to be in a single telling but in multiple contributions over many sessions. In their narratives people frequently refer back to what they have said in previous sessions and anticipate what they will say in the future (Erikson, 1958); so to understand a single event in the groups it is necessary to know what happened throughout a whole course. It is therefore necessary to select a small number of courses. Therefore, participants for the study were chosen from just two courses.

A problem limiting the number of potential participants was that there were three course members whose voices I was unable to differentiate sufficiently to guarantee accurate attribution of their speech (the professional transcriber had had the same problem). Therefore, they were excluded from the pool of participants. I judged that if I started with a new set of transcripts there was a strong likelihood that I would encounter the same problem; this is a limiting factor when working with audio recordings rather than video.

Because of my familiarity with members of Course A, I decided that the major focus for the study would be on Course B. This made sense for a second reason. By the time of selecting course participants, Course A had faded into history. When I tried to recruit people from Course A, I found that three people whom I had selected were no longer available (having failed to respond to an email inviting them to participate). Two people who were contacted expressed anxiety that the passage of time meant they would be poor informants. Because of their anxiety I decided against interviewing anyone from this course.

However, the availability of potential participants in Course B was further reduced because, when I was preparing to invite participants, I discovered that three course members had missed the enrolment session (immediately before the start of session one) and had not been asked to sign consent forms. Prior to this I had wrongly believed that all course members had signed consent forms and this error only became known to me after I had spent many months amending transcripts and conducting my initial analysis. Whilst this lack of consent eliminated a further three course members from the selection process (meaning that the initial pool of potential participants from Course B had reduced from sixteen to ten), I nevertheless judged there to be sufficiently wide ranging potential participants available in the remaining group. It had always been my intention to write a maximum of five or six case studies from this course.

When the inclusion of Course B was proposed by my PhD supervisor it was thought particularly suitable because she believed an unusually large percentage of the membership admitted to being fearful about participating in the course and that there was a higher than normal level of fear in the course as a whole. This group therefore represents a 'critical case' (Shaw and Holland, 2014) on the basis that such cases 'may be used to test a proposition and if the proposition does not hold up for that case then it is likely that it does not hold up for others' (Shaw and Holland, 2014: 87).

Holstein and Gubrium (1995) dig deeper into notions of qualitative sampling, exploring the prospect of sampling meanings during an interview, rather than sampling at participant level. Hence the 'sampling frame' is meanings. 'The idea is

not so much to capture a representative segment of the population as it is to continuously solicit and analyse representative horizons of meaning' (p.74).

Shaw and Holland, 2014: 88

Course B was therefore included not because it was typical or representative but because it was thought likely to illuminate to the main theme of the study.

Individual participants were selected on the basis of the quantitative observation, found in my initial coding, that course members differed markedly in the amount they spoke in sessions. These differences appear to be present in both groups and are largely consistent between sessions (see Appendix 1). The study's 'theoretical sampling' (Wengraf, 2001: 99), reflects a hypothesised association between fear (anxiety), attachment styles and volume of speech. Choosing three points on the quantity of speech continuum was intended to include people with different attachment styles. Following ethical approval for the study, invitations were sent to two potential participants from Course B who had the highest word counts; two who had the lowest word counts and two who most nearly represent the mid-range³. In the event, of the six people invited to participate in the study five consented. The selection of three cases from Course A was made using the same method.

First phase narrative analysis

Following the selection of cases my analysis of course transcripts focused on the input from the five people who consented to be interviewed and three people from Course A (selected using the same word count criterion) who were to be included in the study⁴ but not interviewed. The purpose of this analysis was to let individuals speak through the data (Riessman, 2008) so that I could identify the most significant events in the course for each of them. This early analysis recognised the fact that narratives were told in a very particular course setting in which a specific theory was being taught. When interpreting the

³ Because this category was affected by the problem that I could not distinguish between voices of three participants I had to choose people who were spread over the mid-range.

⁴ Inclusion of these cases complies with consent given to the course facilitator for audio recordings and transcripts being used in research by her and her colleagues.

narratives I attempted to understand both conscious and unconscious processes behind what people said. I was also mindful of the need to keep an open mind so that my analysis did not affect my ability to meet with each person in their own terms (Cooper, 2009) in the transcripts and interviews.

For every case study the primary data is the course transcripts. Interviews were used to check-out findings from analysis of the group transcripts. As the work built to include all the different participants, comparisons were made to evaluate the different ways fear manifested in the group; comparing what emerged from narratives given by the same person at different times and in different contexts; and between inputs from different course members.

Semi-structured interviews

My initial analysis of course transcripts was used to inform the creation of an interview schedule (see Appendix, 6) for semi-structured interviews. Although the schedule is detailed and reads like a script for the interviewer, it was created in order to help me think through the issues about which I was curious and to assist my memory when in meetings with the participants. However, the intention was to use this schedule with a light touch to produce what Yin (2003: KL2194⁵) calls, 'guided conversations'. Prior to meeting respondents, I road-tested some of the questions with two peers (colleagues in counselling and psychotherapy). This helped me focus the questions and hone the interview schedule.

In the event I found the detailed nature of the schedule distracting so I used it only as a prompt; pausing to refer to it at intervals in the interviews so that I covered all the intended ground. I scheduled the interviews at intervals over three days so that I could listen to some of them before going on to the next person (Strauss and Corbin, 1998). I was therefore able to adjust my interview style slightly in light of experience.

⁵ KL refers to 'Kindle location'. This is used when a book has been accessed in a kindle edition for which page numbers have not been made available.

Recognising that the same questions will have different meanings for different people (Mishler, 1986) I saw my role as being to help respondents recount their experience in their own terms (Cooper, 2009) and in a manner that allowed narratives to unfold with minimal interference (Hollway and Jefferson, 2000). My approach in each interview was informed by my experience as a humanistic counsellor. I was happy to help informants in producing their own voice.

However, recognising the situated nature of self (Riessman, 2008), I was not trying to meet a reified other and each interview was seen by me as a meeting between two people. Unlike those who advocate free association (for example, Hollway and Jefferson, 2000) I was not a blank screen. My interventions were aimed at helping people express whatever they wanted to say, clarifying ambiguities and testing the perimeters of what they were saying. My interventions were also informed by the idea that access to cognitive material is state dependent (Mikulincer and Shaver, 2007) and that it is important to recognise there are gaps in what people know at any one time. Sometimes, therefore, I used counselling skills to help them access different aspects of their experience.

Although very much present as a person and an active partner in the interviews, my ideal, as far as possible, was to eavesdrop on a facilitated discussion between the informant and him or herself about subjects that I had chosen. Informants were invited to contact me with any additional thoughts or reflections that came to them after the interviews.

Hollway and Jefferson (2000) recommend that where possible arrangements be made for people to be seen twice so that participants can be more relaxed in a second meeting. For practical reason (I was living in Canada at the time of the interviews and so visited Europe specifically to meet participants), wherever possible and sufficient, one interview was desirable. I judged that, because I was familiar with the courses being studied and with the professional milieu from which participants were drawn, with most if not all participants, it was realistic to get what I needed in one extended interview. Nevertheless, I arranged my diary so that I could see one or two people a second time if necessary. I also discussed with participants the possibility of telephone contact. In the event, no one was seen more than once and only one person wanted telephone contact.

Care was taken in the creation of my interview schedule to invite all shades of experience from respondents: positive and negative. I was explicit in telling participants that I had no interest in how they responded and that it was important to me only that they say whatever they really felt and thought. I also assured informants (in an information leaflet sent with my invitation to participate and in interview) that the content of my interviews would not be shared with the facilitator of their groups and that, like the case studies, their comments would be anonymised. When anonymity was not realistic (for example, in the case of the only male informant or when dealing with a specific and prominent event) I discussed the implications of disclosure with informants and gained specific consent for their material to be used.

Gullone (2000) points out that some studies of fear have been distorted by emotion triggered by the researchers' questions. For example, respondents might react emotionally to the fearful nature of a situation described within a question when they have never in fact experienced this fear prior to being questioned. Information given to participants prior to interview described the project in general terms indicating that it was focused on 'the role of 'affect' in the processes of psychotherapy'. Care was taken not to lead participants in their definition of affect, or to suggest, for example, that informants had experienced fear in the groups; or that their experiences of fear conformed to any particular idea or theory. Ethical approval was given on the understanding that informants were informed of the focus on fear at the end of each of the interviews.

An additional risk in this project may have been that research interviews would be confused with counselling sessions (Wainwright, 2010) because both parties were more used to this type of encounter; and each might see the other as a caregiver (eliciting careseeking; McCluskey, 2005). This risk was perhaps elevated because of the counselling related approach used by me and the fact that interviews sometimes raised sensitive and distressing issues. There was a need, therefore, for me to constantly hold explicit awareness about the difference between the two types of meeting and to guard against straying from one to the other. It was sometimes necessary to check in with myself and

respondents during the interviews to ensure that we were both clear about what was happening.

My professional experience also means that I was sensitive to the potential for distress and ways of ensuring that interviewees maintain control over what they chose to share and withhold. In every interview, informants were explicitly invited to keep themselves safe and only to share what they were comfortable sharing. I repeated this during the interview whenever I thought it might be helpful or necessary to protect the speaker. Concern was also shown for the fact that some people shared sensitive and painful experiences; I ensured that they were not left in a state of distress and that, if necessary, they had an available source of help and support. They were also invited to email or phone me if they wanted to talk about anything that had been stirred up in interview. At the same time, as said above, I was alert to the danger of being pulled into, or choosing to stray (consciously/unconsciously), from the role of researcher into that of a caregiver.

A non-judgemental attitude guided the interviews. I have tried to ensure that any observations made, in the interviews or in my subsequent analysis, are both tentative and sensitively delivered, in a manner that I hope would promote exploration and does not assume special knowledge or authority on my behalf as the researcher (Hollway and Jefferson, 2000).

I was also conscious that my empathic responsiveness in the interviews may have helped respondents further an exploratory process begun in the courses. Therefore, there is a chance that the interviews benefited some respondents (Hollway and Jefferson, 2000). I did not want to eliminate this because it was one way in which informants could get something in return for their participation.

Transcription and analysis of interviews

The interviews were transcribed by me and subjected to similar analysis to that used on the course transcripts. All informants chose to see copies of the transcribed interviews (for which they had been invited to correct any errors).

Reporting findings

Throughout the study my intention has been to heed Cooper's advice that '*each and every situation or context is unique and particular, and must be understood – 'apprehended' in its own terms*' (Cooper, 2009: 440, original emphasis). This supplements Erikson's (1958) idea that 'the true nature of man reveals itself only in the attempt to do something *for* him.' (Erikson, 1958: 87, original emphasis). The integrity of the study's findings is safeguarded only insofar as they reflect Stiles' idea that the purpose of the theory building method is to stand back from the theory and assess as objectively as possible the explanatory capacity of the theory in relation to specific observations and to adjust it where necessary to give a better explanation.

Because objective reality is unattainable I have tried to be transparent about the processes by which my findings have been attained. Elliott (2005) suggests that reports of narrative studies be made in narrative terms so that the reader can see the reflexive processes and differentiate between input from the researcher and that of informants. Quoting Hinchman and Hinchman (2001), she says that 'narrative approaches to knowledge', like narratives themselves, 'are always firmly rooted in time and place' (2005, KL2627). Presenting research accounts as narratives, therefore, 'serves to underline the fact that we are writing as situated, positioned authors with a specific perspective' (Richardson, quoted in Elliott, 2005, KL2628). The current report, therefore, seeks to tell the story of the research; allowing readers, 'as far as it is possible, to see, hear, and feel as the fieldworker saw, heard and felt [and so] to braid the knower with the known.' (Van Maanen, quoted in Elliott, 2005: KL2611).

Reflexivity

The concept of reflexivity alerts us to the fact that both we and our informants are changed by the process of research (Jones and Alony, 2011). Qualitative researchers have to bear in mind how research processes influence the behaviour of respondents, for example, causing them to give what they think the researcher wants (Jones and Alony, 2011). In

interviews I tried to elicit narratives that stayed within the meaning-frame of interviewees (Hollway and Jefferson, 2000) and, as said above, I was explicit in inviting all shades of experience. I have relied on transparency in my report to ensure that the integrity of the study is evident to the reader.

Some of the risks involved in understanding narratives may be illustrated by an experience I had when listening to one of the sessions in this study. The most vivid memory I have from my attendance at the first group series (Course A) was of an episode in which I had felt criticised by another course member. Although this memory was vivid, hearing the recording allowed me to see that my recollection was far from perfect. Most notably, I had remembered being verbally abused by the other course member. But this did not happen. Rather, whilst expressing strong displeasure at a phrase I used, she was clear that her objection reflected sensitivities that belonged to her. She had taken care to separate her feelings about the phrase I used from criticism of me as a person; but I did not hear this at the time or recall it later. As a result of reflection it has become clear to me that my *in-the-moment experience* of the event, and my subsequent *memory* of it, were both shaped by sensitivities that I took into the meeting and the emotional significance the encounter had in terms of my personal history.

The distorting influence of cognitive and emotional history became apparent when working with this event only because I had the opportunity to compare my recollection with the content of the recording. Any such distortion, for example, coming from my relationships with others in the study, from bias caused by my theoretical preferences, or from my personal defences, are difficult to detect in the research and require vigilance, careful reflection and transparency so that the reader can make their own judgement.

A further point can be made about narrative inquiry. If, following the group, I had given an account of this incident to an inquiring researcher, my account would have reflected the imperfections in my perception and recollection, as well as the shape I chose to give my narrative so that the researcher took from it the meaning I intended (Riessman, 2009). In Goffman's (1959) terms, the story would have been 'performed' to achieve a desired outcome. This last point highlights Gusdorf's idea that a story 'confers a meaning on the

event which, when it actually occurred, no doubt had several meanings or perhaps none' (quoted in Freeman, 1993, p.31). Therefore, we should not treat people's narratives as if they contain transparent truths about their lives (Hollway and Jefferson, 2000). Instead, in our interaction with data, we must wrestle with 'ambiguous representations' and sometimes very difficult interpretation (Riessman, 2008) of what Hollway and Jefferson (2000, p.19) call the 'defended subject'.

The above story illustrates the very human difficulties involved in Giddens's (1993) double hermeneutic. Such dynamics are potentially present in every level of a research project. We and our informants may react emotionally toward each other and other triggers arising from data or discussion. The more closely we and our informants are drawn together, the greater the likelihood that emotional triggers will be activated (Cooper, 2009). At levels that may be outside of our awareness, these may subtly (and sometimes grossly, as illustrated above), affect how we hear our informants and what they choose to reveal to us. It is for this reason that some researchers (see for example, Cooper, 2009; Hollway and Jefferson, 2000; Smith, 2007) advocate the active use of psychodynamic concepts to sensitise researchers to the role of unconscious motivations, transference, projective identification and splitting, as we wrestle to understanding what we and our informants bring to the research encounter. Understanding my part in the story related above would be deepened by exploring it in psychodynamic terms.

A different approach is described in Witkin's (2000) who echoes some of Cooper's insights when recommending a 'theory of noticing'. He begins his article by quoting Laing:

The range of what we think and do is limited by what we fail to notice. And because we fail to notice that we fail to notice, there is little we can do to change; until we notice how failing to notice shapes our thoughts and deeds.

(Witkin, 2000: 103)

As seen in chapter two, failing to notice may be integral to our personal defences (Bowlby, 1980, 1987). Witkin argues that noticing is relational and contextual; limited by culture, experience and language. Saying what we notice is risky because it 'creates it', drawing other people's attention to it so that they notice it (seeing what we see and possibly 'misinterpreting as we misinterpret'). On the other hand he says, 'If we want to know

what our clients notice and what we fail to notice, we need to create relational spaces where divergent noticing can be safely expressed' (Witkin, 2000: 103).

Therefore, to limit damage caused by what we do not know or notice we have to have a weathered eye on reflexive processes and empower our informants to withstand our noticing and speak about what they notice. Whilst remaining focused on the meaning of the data and avoiding what Elliott (2005) calls 'unfettered reflexivity', I employed a questioning attitude in relation to my perceptions; asking questions suggested by Hollway and Jefferson (2000, p.55):

- What do we notice?
- Why do we notice what we notice?
- How can we interpret what we notice?
- How can we know that our interpretation is the right one?

Problems specific to the practice near nature of the research

Having trained with Una McCluskey for a number of years I am steeped in the theory underpinning the courses. I have described above how the theory building method has been used to maintain balance in the study. Because theory is viewed as permeable the researcher is positively motivated to develop it. I consciously resisted feeling loyalty to any of the ideas (or the originators of ideas) in the theory; striving instead to improve on the observations that can be made and our understanding of the fit between those observations and ideas used to describe them. There is a need not to be naïve about the dangers associated with 'confirmatory bias' (Baron et al., 1988) or that the research questions might be shaped by self-fulfilling prophecies (Snyder and Swan, 1978). However, while real, the dangers should not be exaggerated (Campbell, 1975). The study actively looks for 'counterexpectational reality' (McCracken, 1988: 36) and other evidence that the theory may be wrong or in need of development. Ultimately, as has been said, I cannot know the validity of any conclusions reached in the study but by being transparent about the process it may be possible to produce knowledge with a greater utility for therapists and those they serve.

Wengraf (2001), points to benefits that may come from a researcher's nearness to a study. He quotes Maxwell as saying, 'recognizing your personal ties to the study you want to conduct can provide you with a valuable source of insight, theory and data about the phenomenon you are studying: experiential knowledge' (Wengraf, 2001: 76/7). It is my belief that notwithstanding potential difficulties, the present study has been enhanced by my closeness to it.

In line with the ESRC framework (see below), participants were informed about my past course attendance and about supervision arrangement for the study. An information leaflet (see Appendix 4) also set out procedures that were in place to ensure my independence and impartiality and specific arrangements to safeguard confidentiality of participants within the supervisory process.

Ethical issues

Ethical framework

My early work on the course transcripts was based on consent given to the course facilitator at the time of registration. This allowed for the course sessions to be recorded, transcribed and used by the facilitator and colleagues for research. However, this consent did not extend to my research project and new ethical approval and participant consent had to be sought.

In the preparation of my application for ethical approval and general planning for the project I was guided by the Economic and Social Research Council (ESRC, 2010) *Framework for Research Ethics*. This identifies six key principles which served to guide the project:

1. Research should be designed, reviewed and undertaken to ensure integrity, quality and transparency.
2. Research staff and participants must normally be informed fully about the purpose, methods and intended possible uses of the research, what their participation in the research entails and what risks, if any, are involved.
3. The confidentiality of information supplied by research participants and the

anonymity of respondents must be respected.

4. Research participants must take part voluntarily, free from any coercion.
5. Harm to research participants must be avoided in all instances.
6. The independence of research must be clear, and any conflicts of interest or partiality must be explicit. (ESRC, 2010, p.3)

Formal ethical consent for the project was applied for from the University of York, Humanities and Social Science Ethics Committee (HSSEC) and approval gained (in May 2012). All conditions for this approval were complied with. From ESRC principles were followed but for want of space I will conclude this chapter by picking out a few elements of the framework beginning with informed consent and confidentiality.

Informed consent

In all my contact with informants I stressed the voluntary nature of participation. The information leaflet sent with my initial invitation to participants outlined the purpose of the research (see Appendix 4). In interview informants were reminded that they could withdraw consent at any time before the report had been finalised in line with Silverman's (2010) concept of 'process consent'. Consent forms are included in the appendices (Appendix 2 and 3).

Data protection and confidentiality

Confidentiality has been maintained at every stage of this project. The course data was sent to me on password-protected, encrypted data discs. First names were originally included in these transcripts so that I could check their accuracy against the recordings. Subsequently, I amended the transcripts so that they were wholly anonymised using a coding system known only to me. My field notes used the same coding system. Copies of the audio files used for transcription purposes were deleted from my computer. Interviews were digitally recorded (on a Sony ICD Recorder), then immediately transferred to a password protected file on my computer. At that point they were deleted from the recorder.

The original encrypted data disc is stored in a locked fire-safe at my home. Copies of the transcripts on my computer are encrypted and password protected. In compliance with ethical approval, five years after submission of the thesis, the data disc will be destroyed and all copies of transcripts and interview recordings will be erased from my computer.

Confidentiality is a bigger issue in narrative inquiry than in quantitative or survey research. Even if names and other details are changed, the nature of stories means that it is possible that some participants would be identifiable by members of their families (Elliott, 2005). I therefore gave realistic information about the nature of the research and possible dissemination of study findings to participants in the information leaflet (again, see Appendix 4) and discussed these issues in interviews. Following the interviews, participants were invited to see and amend any errors in the transcripts before they were used in my report. However, they have not been invited to see the completed case studies as they appear in the final report because I judged that this may have inhibited my ability to think freely. One course member asked for this prior to giving final consent. The reason for not offering to share the case studies is that, even if very accurate and compassionate, my interpretations are situated and so present the truth only as seen by me; they may not relate a reality that the course member would recognise or find useful and they may activate unhelpful defences (Hollway and Jefferson, 2000). Participants were offered a summary of the findings and may seek out the final report at York University Library or read extractions from it in papers that may be published subsequently.

Because of the need to safeguard informants' identities from the course facilitator (see above), participants were recruited using secretarial staff involved in administering the original courses. This allowed me to make contact with potential participants without their identities being disclosed to me before they gave consent and allowed their names to be kept from both of my PhD supervisors. I was only ever given details of people who had given consent to participate in the study.

Risks specific to qualitative/narrative research

The point has been made that additional care is owing to respondents in qualitative research and narrative inquiry because there exist particular risks (Hollway and Jefferson, 2000) arising from the fact that the data often contains information that is detailed and highly personal. This creates potential vulnerability that goes beyond the issue of confidentiality. For this reason I have tried to ensure that I am the only identified participant in the study. Because the world of professional care is relatively small I have withheld information about the location and timing of the courses being studied. I have also changed a few culturally specific words used by the participants if these words included clues to personal identities. This has been extremely rare and at all times I have tried to be absolutely faithful to the meaning of the words used by informants.

Elliott talks of risk arising from the role of narratives in the maintenance of identity and wellbeing. 'Narratives are constitutive of self' (Elliott, 2005: KL2213) and care must be taken to accord them the appropriate respect. Elliott goes on to say that narrative research may lead people to explore aspects of self that they have not explored before and so there is a risk if interpretations made by the researcher are given privileged status (Hollway and Jefferson, 2000). I believe that my experience as a counsellor enabled me, at interview stage, to help respondents relate their experiences in their own terms, in a manner that privileged their perspective over mine. However, as one of the premises of the study is that unconscious processes are active in shaping interaction, it is necessary to be modest about how well I might have achieved this. I have tried to be transparent in the report about any occasions when I may have influenced informants.

Funding arrangements

The project was conducted as a PhD. study and was privately funded. All costs were met by the researcher.

External Validity

It is anticipated that the focus of this research, examining as it does the in-the-moment operation of fear, will be of particular interest to therapists working from an attachment and psychodynamic perspective. However, the focus on how fear affects careseeking/caregiving means that it is relevant to all modalities of counselling and psychotherapy. Indeed it will be relevant to workers in a wide range of caring professions including education (and researchers working in those fields).

Conclusion

In this chapter I have set out the arrangement by which the aims of the study have been operationalized and integrity safeguarded. Within this I have tried to convey the idea that the ways in which informants were heard in the study is subtle and nuanced but that the guiding principal is that empathic insight was focused on creating knowledge that is beneficial and at the service of the users of therapy. Theory, though of great importance because without it we can see nothing, is necessarily tentative and malleable. The primary value underpinning the study concerns the development of theory so that it better serves the needs of people who have recourse to counselling and psychotherapy.

Chapter Four: Introducing exploratory courses of the type from which the data are derived

Introduction

In this chapter I give a brief and personal introduction to the courses from which the study's data were derived. The theory underpinning this type of course is described in chapter two and the theorist's perspective can be read in writings of Heard, Lake and McCluskey (Heard and Lake, 1985, 1987; Heard et al., 2012, McCluskey, 2008, 2011, 2013). As far as I am aware, no one has given a personal account from the perspective of a course member. I have, therefore, written this chapter from my perspective as a former participant in several of these courses¹. I have undertaken a range of training experiences in this model and have chosen to write a personal account here because, as far as possible, I want to be centred (see below) in my own experience and to write the truth as I see it. If successful I will present McCluskey's ideas with relatively few references to her writings (which are more formally presented in chapter two). However, unless explicitly stated, none of the ideas in this chapter are my own; they originate in the written and spoken words of Una McCluskey, Dorothy Heard and Brian Lake. While the chapter does not set out to give a scholarly account of their theory I have tried to be faithful to the ideas underpinning the courses as I have experienced them.

McCluskey's written accounts of her exploratory courses are useful for understanding the breadth of theory (drawn from psychodynamic psychotherapy, attachment theory, infant observation, child development and systems centred therapy) that has informed her research (McCluskey, Roger and Nash, 1997, McCluskey, Hooper and Bingley Miller, 1999; McCluskey, 2001, 2005) and practice (McCluskey, 2008, 2009, 2011, 2013). Limitations on space and time mean that I will draw on elements of this embedded theory only when necessary for explaining an event that is described. It is important to note that McCluskey has been developing and teaching her approach to course facilitation for a number of years and so some of the practices used by the facilitator in the courses being studied may be

¹ The courses from which the data has been drawn were facilitated in accordance with Heard, Lake and McCluskey's ideas.

dated. In recent contact with facilitators using this approach I have been struck by what may be a more relaxed style than may sometimes be seen in the courses being studied. In some respects, therefore, as in all theory development, the courses analysed in this study represent moments in time.

Personal experience of the courses

I began reading about attachment theory after qualifying as a counsellor (in 2001) as a way of deepening my understanding of the counselling relationship. Some years later I joined a nine-month course run by Una McCluskey at the University of York on the recommendation of a colleague. I attended similar courses in the three subsequent years. Because I moved house twice in this period I attended three complete courses in three European cities. I have also attended conferences and other forms of training focused on the same theory of group facilitation. It was during this period that I began to work on this study.

Composition of the courses

The courses being studied were advertised to professional caregivers primarily as a course that would 'explore the dynamics of attachment in adult life'. The advertisements in professional journals described the courses as offering professional caregivers the opportunity to explore the dynamics of attachment in their own lives'.

The courses being studied had fifteen (Course A) and sixteen (Course B) members working with the same female facilitator. Some people had joined the courses after seeing the advertisements while others had attended workshops and introductory training events in professional settings prior to attending the extended courses. Some group members had learned about the courses by word of mouth from people who had attended similar courses.

The courses were run on the basis of three-hour sessions that took place at monthly intervals over a nine month period. The three-hour sessions were structured with a fixed

timetable and most of the time was given over to experiential learning. This involves people telling stories about their lives and exploring their thoughts, feelings and experiences in conversation (principally though not exclusively) with the course facilitator. There was a fifteen minute tea break half an hour before the end of the experiential element of the session. The theme of each session was set in advance to reflect the seven biologically preprogrammed behavioural systems identified by Heard and Lake (1997, Heard et al., 2012) as being involved in the restoration and maintenance of survival with wellbeing (see below). The discussion that follows is structured using the structure of these course sessions. Although I am writing about events in the past, much of the discussion and description that follows will be in the present tense. I have chosen this as a device to allow me to be more fully present in the discussion. However, it must not be assumed that this has any bearing on when the courses studied took place.

Session structure

Each session in a nine month course follows a set pattern. This includes the following headings (timings are only approximate):

1. Invitation to get centred
2. Feedback from the previous session (20 Minutes)
3. Teaching input - a general introduction to the theme of the session (20 Minutes)
4. Experiential learning (1 hour: 30 minutes)
5. First period of reflection on surprises and learning; satisfactions and dissatisfactions (5 minutes)
6. Application of learning to professional work (25 Minutes)
7. Second period of reflection on surprises and Learning; satisfactions and dissatisfactions (5 Minutes)

My discussion of the different components of course sessions will follow this structure beginning with a description of the facilitator's invitation for group members to get centred in their experience.

1. Invitation to 'get centred'

Not actually a separate part of the session structure every session begins with an invitation for group members to get 'centred' in their body; to take their full space in their chair and place in the group. Using a tone and pace of speaking that sets a relaxed but focused atmosphere the facilitator invites people to sit up in their chairs (which are selected to be comfortable but upright so that one is not tempted to slouch or collapse in response to emotion as one might be in the kind of low chair often used for counselling). The facilitator encourages group members to let go of any tension in their bodies and to plant oneself firmly on one's 'sitting bones' with both feet comfortably on the floor.

As a group member I hear this invitation as a call to relax in my body and mind whilst maintaining as much awareness as possible; to bring into awareness all of what is happening in my body-mind in the present moment. It sets the scene for a session in which we are encouraged to tune into and value our experience and to allow this experience to be who we really are in the present moment. It is clear from much of the data that course members (and in this I am sure they are representative of normal experience) have become used to having their own experiences discounted and devalued; and as a consequence they tend to 'skip over' or discount these experiences themselves. The facilitator's invitation to become centred is therefore an invitation to make contact with one's self.

People who have experienced poor caregiving in the past may find that shame and fear are triggered by the presence of a caregiver. Because of the pervasive nature of fear and shame for some people, the facilitator's invitation to bring one's own experience into the group, an invitation to make space for all that one is at any moment in time, may not be fully heard by all group members. Affect regulating interventions are an important part of course facilitation because individuals lose their experience when they 'collapse' within themselves as a consequence of unregulated fear or distress. The invitation to become centred is, therefore, an invitation to enter a state of subjectivity: to have, and be aware of, all of your emotion inside yourself without collapsing under it. In more recent group

sessions I have heard a facilitator invite people to be compassionate with themselves in a manner that is supportive and companionable.²

The affect-regulating component means that the invitation to centre is also intersubjective; to be present with one's whole experience in relation with the facilitator and with others in the group. To have your feelings within yourself is one thing; to bring them into relationship with an attuned and empathic other (or others) is another experience. So the invitation to centre is both an invitation to subjectivity and to intersubjectivity. Both are necessary for healing and growth (Heard et al., 2012). Infant observation and child development literature attest to the need of infants to withdraw from interaction for periods in order to regulate their emotion and integrate what they have learned (Heard and Lake, 1997). McCluskey's (2001, 2005) study of 'goal-corrected empathic attunement', suggests that empathically attuned mirroring is essential both for the acquisition of self-knowledge and maintenance of the vitality required for play and exploration; in infants and adults. When she senses tension or distress in the speaker or wider group the facilitator will ask people to let their tension go. This might be done to help the speaker regulate their tension and so to remain exploratory. But it is also done to prevent other group members from mirroring fear or distress and so exacerbating any tension felt by the speaker.

The invitation to become centred in one's own experience is linked to a second invitation; sometimes direct but often indirect: an invitation to be 'curious' about one's experience. The work of the group is exploratory and people benefit most when they can explore their experience with a curious and open mind; ready to hear and extend the breadth of their self-experience to include previously excluded material.

Although not explicitly stated at the start of the first session (when it would be lost in the myriad of things that are being said to new course members) an important aspect of the invitation to get centred is an invitation to be centred *in one's own experience* rather than

² This might be an instance of me being open to hear something that has been said many times before without me hearing it.

the experience of other group members. By this I mean that, in the facilitator, the group has one caregiver who will take care of everybody as they explore their own issues. Whilst they might be compassionate and supportive of each other, caregiving is not the responsibility of any other group member.

This highlights a key difference between groups run along the lines of these exploratory training courses and common forms of group therapy that I have experienced. In a lot of group psychotherapy the philosophy underpinning the group is that care comes from every member of the group. It might even be said that there are as many therapists working in a group as there are group members (Yalom, 1995). In such a group the pattern of interaction is evenly spread between members and therapist. A number of group members might be engaged in empathising and giving care to one group member until the focus changes and another group member seeks help from within the group. The role of the therapist in such a group is less central and serves to ensure that the whole group works constructively to meet the needs of those who choose to bring issues.

In the experiential groups that form the core of the training courses being studied the pattern of interaction is very different. Only the facilitator is present in the role of empathic caregiver (McCluskey, 2013) and then only some of the time. The work of the group is exploratory and group facilitation aims to regulate affect and achieve the goal of caregiving (when careseeking has been the active system in the group member) in order to help a group member maintain an exploratory frame of mind in which they can access their full cognitive and affective self while retaining their competence.

Course members are not there to give care to other course members and may be halted if their caregiving becomes activated so that they do not interfere with or derail another person's exploration. From my own experience I know that while this is sometimes difficult to maintain, it is very liberating. If my role is to be centred in myself and to trust the facilitator to look after other group members then I am freed to have my own experience and to respond to that without worrying about how my experience will affect anyone else. Open to my experience I can choose when to explore it in the group. Without this freedom I might fear that my expressions and exploration may anger other course members. Only

if everyone knows that this is the case can I say something without it being taken as a comment on what has been brought to the group by previous speakers. If negative emotion is triggered in a course member by what someone else has said the facilitator makes clear that each party should speak only to her; and that the anger, fear or disgust being expressed has nothing to do with the earlier speaker but has been triggered by elements in the new speaker's own history.

The beginning of the first session does not typically include the personal introductions or contracting that typically precede the start of group therapy sessions. Instead the course facilitator gives a brief explanation that in early sessions it would help if course members say their first name before speaking so that everyone present can quickly learn and use each other's names. Other information about individuals is not invited unless necessary to understand a particular story. The facilitator explains that this is designed to avoid establishing a hierarchy that might inhibit free exploration. In all of the sessions that I have attended I have found this idea of avoiding hierarchy useful and I would follow this practice if facilitating a comparable course.

However, from meetings with a few of the participants I have become aware of drawbacks to this practice. Professionals attending the courses from any locality are likely to be part of a professional network and bring with them awareness of a hierarchy that is present in the courses but may or may not be known to the facilitator. This raises questions about the extent to which group members are encouraged to be vulnerable in the presence of colleagues with whom they have ongoing professional relationships.

The message that everyone in the course is equally valued and respected is crucial but several people told me that they had felt inhibited by the presence of group members who worked for the same or similar organisations and might judge them. This seems to have been a particularly concern for quieter course members and I am not sure if fear of exposure in the presence of peers (or superiors) triggered inhibition or if their quietness reflected a more general inhibition. One of the more vocal course members also mentioned the lack of contracting about confidentiality in the context of a discussion about feeling exposed and ashamed for having sought care in the course at a time when she was

particularly vulnerable. Although I am informed by the facilitator that contracting issues, including confidentiality, are addressed in consent forms signed at the start of the first session these comments may suggest a lack of understanding on the part of some course members.³

2. Feedback on the interval since the previous session

In all but the very first session (which begins with teaching input) this part of the session is designated for course members to bring reflections or stories about events linked to the last session. This might include reflection that has taken place since the previous session. Sometimes it includes stories of event that have occurred in the meanwhile which illustrate something that was talked about in the previous session. There is no fixed time for this but typically I think it lasts approximately 20 minutes. Although the facilitator sometimes states that this is for brief feedback rather than deep experiential work, it does not always work out this way. I think it offers the opportunity for people to solidify or deepen their learning from the previous session. Sometimes it is an opportunity for course members to deal with their reactions to events from the previous session.

Not everyone speaks in this part of the session and I think it significant that one of the participants in this study, a quieter group member, never spoke in the feedback session. In her case I think silence indicated lack of comfort in speaking but it might also indicate that she did not think about the course between sessions. Another of the participants in the same course told me that he dealt with his fear of the group by excluding from his memory everything that had happened in the session so when he returned he typically had little if any recall of what had happened in the previous session. But there are normally several people who want to speak in this part of the session and recount events linked to an earlier discussion or develop ideas first discussed in the previous meeting.

³ Misunderstandings or ambiguities about the purpose of the courses (see chapter one) can be seen in what is said by group members in some of the case studies. I believe these are also reflected in the writing of Una McCluskey (See for example, Heard et al., 2009/2012) where similar courses are described both as training and as group psychotherapy for professional caregivers.

3. Teaching input

Each of the first seven sessions is given over to exploration of one of the seven systems identified by Heard and Lake in the following order:

- Session one - Careseeking
- Session two - Caregiving
- Session three - Exploratory interest sharing
- Session four - Affectionate sexuality
- Session five - Defence of the self
- Session six - Internal (supportive or unsupportive) environment
- Session seven - External (supportive or unsupportive) environment

The eighth session is used to explore how the systems work as a unified whole to maintain survival with wellbeing. The final session is used to consolidate all the learning and complete any unfinished business (including saying good bye and closing the course).

In the teaching input for every session it is normally made clear that each of the individual systems works as part of a greater whole. The teaching input typically fills a block of time during which the facilitator explains how the system to be focused on in that session functions within the 'restorative process' described by Heard and Lake (Heard et al., 2009: 6). Some of the theory is explained but a large part of what the facilitator does at this time sets the scene for subsequent exploration by course members of their own experience and what the theme might mean to them. In the text that follows (Illustration 1) I have included a section taken from one of the transcripts to serve as an example of how the teaching was conveyed. The example given was from session two of Course B and followed seamlessly from the feedback section of the meeting.

The extract is relatively brief. It was not unusual for teaching inputs to be longer than this. The input is not rehearsed in advance and in the courses that I have attended the facilitator spoke spontaneously in whatever manner seemed right for that day. In reality the teaching input and every other part of the session is the product of human relating and it is

sometimes apparent that the facilitator was thinking on her feet and reacting to whatever was happening in the room. In the real life setting of a group the teaching comes across more naturally than it does as dry text on a page. Because it is not subjected to close analysis this extract from the group transcript has been altered little from the initial draft transcript.

Illustration 1: Example of teaching input to the course:

Facilitator: So caregiving, caregiving, an instinctive system, we are preprogrammed to have it, that's what we are looking at today. And, we're going to look at what we know about our own caregiving and if possible to get as much information about our own caregiving as we can in the context of other people exploring what they know about it. When it first kicked in; what do we know? Do we remember it getting activated in response to a younger sibling, a wounded or hurt animal, er, bullying in the playground, er seeing a parent upset or crying for the first time? I mean the first time you saw them . . . er, what was the context? What got you going? And you know, you became aware of distress in you, you wanted to do something about something or other; that is the activation of caregiving. The system actually kicks in and you remain distressed or in a situation of arousal until you can do something about it.

Now as a small child you might not have been able to be coherent enough to inform an adult, to help you get what you needed to fix whatever it was you saw, you know; that alerted this in the first place. So, you will either have had this experience of being effective as a caregiver, when it kicked in, or ineffective; therefore left in a situation of distress. So we're talking about when you don't reach the goal, the system is fired, care seeking or caregiving on its way to the goal; if reaching the goal is blocked, the person is in emotional and physiological distress. So, it may be that this all happened, you are unable to do anything very effective about it, you were crying and distressed, nobody

could make any sense of what was going on in you; you weren't able to do it either. So, we just begin to look at the arousal of caregiving, what triggered it and if we don't know

much about the early stuff (and some of us will but some of us won't), to start wherever we are now. What arouses it now?

The thing about caregiving, caregiving can also be infiltrated by fear, we want to discriminate that inside ourselves; that when our caregiving was aroused was our fear also aroused? The situation that elicited caregiving might have also frightened us, do you know.

Also if we were unable to be very effective we might have got frightened or the person or animal that we were trying to do something about, might have been very frightened. And we might have attuned to that and picked that up ourselves; so in all sorts of ways fear could have got muddled up.

So when we're doing our work if we can get the memory and get the experience as much as possible and begin to disentangle some of the elements in it we might help ourselves. What else do I want to say about it? The fear system; Yes, effective caregiving requires that the exploratory part of the self remains absolutely active and attentive, and is the same in all, that one is exploring what is going on outside with the person you are giving care to and figuring out what it is they need and open to negative feedback; open to positive and negative feedback, in relation to your efforts, and adjusting accordingly so some of the stuff that people are bringing in today like sometimes the caregiver I go to gives me too much care - they are not actually checking back, they are not actually being an exploratory caregiver; do you know. So whatever else is going on it is not exploratory because, if it was, they would be picking up some negative feedback, so we've got to remain really open for that. And then the whole thing, the whole interaction is goal-corrected; when you as the caregiver has figured out what is wrong over there, put it in place, the other person is satisfied; the care seeker and you are relieved; and go back to what you were doing before this whole episode kicked in.

But if you weren't able to be effective, and you didn't get relief the chances are those levels of distress are still around somewhere. And they keep getting re-enacted; you keep getting pulled by certain things. Remaining exploratory in your caregiving self. And the other thing about a caregiver is, or caregiving is, a vital aspect of caregiving is helping the care seeker

to be in touch with their peers; putting the care seeker in touch with their peer group; from which they can then go on exploring and developing. And that I think is important also at every level of life but particularly parental to child's level. But it's an important part of care giving.

So if that is enough, plenty of talk we need to open up the time to get down to business, just in our usual... Getting a bit chilly now... will you close the window - But like everything else what we're doing is regulating our environment and in all care seeking, all caregiving a major aspect of it is emotional regulation. So in the way that we work (which is at the edge of the unknown), not knowing what we're going to do today until we begin to start doing it. And if we can remain curious we will keep the fear down and keep our curiosity active and our availability as open as possible to whatever may happen. So can anyone come in, have we got some curiosity to explore caregiving in the room? Well then go for it.

4. Experiential Session

The main body of the session is given over to experiential learning. As seen in the extract above, the closing remarks of the teaching input include an invitation for people in the group to engage their curiosity in exploration of their own experience in relation to the system being focused on in the session. This normally takes at approximately one-and-a-half hours of the three hour session and is where much of the personal work is engaged in by course members. Most of the material discussed in the case studies comes from this part of the session. The aim of the experiential session is to facilitate exploration of individual life experiences in relation to the seven behavioural systems. The facilitator helps the group member explore their experiences in terms that bring into conscious awareness information that is frequently excluded from awareness about what system was active in motivating their behaviour and what their goals had been when they acted.

A key idea underpinning this method of group facilitation is attunement to the group member who is working at any time (whilst also being attuned to the rest of the group).

The facilitator actively tries to understand what behavioural system is activated for the group member in the present moment and help the person achieve the goal of the activated system. When necessary an affect regulating intervention may be used to regulate fear or demonstrate empathic attunement so that active careseeking, when met, can give way to exploration; and the person's whole self and attention can be deployed in exploration of important and difficult issues. In this way the person can face difficult issues with their whole competence.

Often exploration involves recalling past experiences and bringing them into relationship in the group; some of which will be emotionally difficult. Sometimes it means just noticing what one is feeling and working to understand the causes of this emotion.

A guiding principal for the course facilitator is that she offers 'fear free caregiving' (McCluskey, 2013). This does not mean that the facilitator denies her own very natural responses but rather that she uses awareness of her own processes to guide her behaviour in the group. On these occasions she monitors her responses and offers what Fonagy et al. (2004: 9) have called 'marked mirroring'. This means that she is watchful that her own response (and those of others in the group) do not mirror back to the person vitality affects that are frightening or discouraging.

From the case studies it is apparent that many other group members who listen quietly to the individual speaking in the moment are working privately in relation to their own issues. They may become tense as they react to what they hear and so the facilitator works to regulate affect, for herself, for the individual working at that moment and for the wider group. In affect-regulating interventions she works to ensure that her own verbal and non-verbal reactions (and the reactions of other group members) do not interfere with or derail the individual's exploration.

In affect regulating interventions the facilitator typically says something like, 'keep the tension down', or 'make a lot of space' in order to help people resist the very natural (often automatic) response of physically tensing and defending against emotionally difficult material. In her reactions we frequently hear the facilitator of the groups in this study

matching and maintaining the vitality of the speaker with paralinguistic encouragements ('uh hu', 'mm, hmm', 'yeah' etc.) and offering paraphrases that mirror back to the person what has been said. This allows the individual to hear themselves as well as demonstrating that the facilitator is listening and is interested in what is being said. When done well this operates in the manner of cross-modal attunement without breaking the rhythm of the individual's work much like the various signals a parent gives to encourage and support the play of their toddler (Grossman and Grossman, 1991).

In addition to mirroring and encouragements to continue, the facilitator uses interventions that up-regulate more hesitant speakers, helping them not discount or excluding their own experience; again amplifying the importance of what they are saying. At other times she down-regulates and offers containment for the speaker's affect if they appear to lose detail because they have become overwhelmed by affect or carried away by emotional expression. This approach reflects a belief that '... the therapist who can catch the underlying emotion and surface it, or who can bring in the emotions of surprise or curiosity, is more effective than one who responds with the same affect that is being expressed by the patient. This also links with the work of ... researchers [who] stress the need to raise arousal levels on some occasions and lower them on others' (McCluskey 2005: 27).

At various times in a session the facilitator may draw links between what group members have said at different times and the ways in which what they have said might resonate with material brought by other group members. Underpinning all of the individual work of group members is the idea that this takes place in a group and that bringing one's distress into relationship with the facilitator and with the wider group is integral to the process.

This use of subjectivity and intersubjectivity is nuanced. It is reflected in the way individual work is linked to the work of subgroups and the wider group as the facilitator interacts with each group member individually. Individuals are not left to feel exposed or isolated in the group and if no one else offers a 'resonance' or 'join', the facilitator will suggest a link with the speaker from her own experience saying something like, 'we know very well what that is like'. This and other aspects of group process often seem to normalise experiences that have become a focus for shame.

In early sessions particularly, the facilitator is mindful not to allow group members to talk for too long. This recognises the need for balance in the group and that it is not helpful for one person either to dominate a session or to feel exposed before sufficient trust has been established. An important function of facilitation is to establish an atmosphere of supportive empathy in which group members can feel safe to explore their own experience and to learn from the experience of others.

Usually contributions to the group are begun by group members choosing to speak but the facilitator will sometimes invite specific people to join a discussion. This might be because she recognises a link between what has been said by different speakers or she believes someone has been particularly affected by what has happened. She will also sometimes check out with quieter group members whether they want to speak. This last point recognises that it is not always easy for group members to bring themselves into the group.

As said above, the facilitator will sometimes invite a group member to look slowly around the group getting eye contact with every person in turn. I suspect this is done at times when the facilitator judges that other group members have been involved in supporting the exploration of the individual. This practice underlines the connections between the individual and the wider group. I suspect that eye contact for some individuals may be useful to counter individual history in which eye contact has triggered profound shame (Ayers, 2003). It also makes clear the intersubjective nature of work done in the group. Whether this practice sometimes accords with or overrides the wishes of individual group members is a question for which I do not have an answer.

Intersubjectivity and subjectivity both play an important part in the development of self (Heard and Lake, 1997) and if the facilitator gets it right people will come into relationship with her, work on something significant and then withdraw and (consciously or unconsciously) process what has happened.

Because intersubjectivity involves the facilitator attuning to vitality affects and guessing what is happening for the other individual, there will always be accidental misattunements

(as opposed to ‘purposeful misattunements’ which are used to up-regulate and down-regulate an individual’s affect, Stern, 1985; Heard, et al. 2012). Therefore, an important skill involves recognising when ‘rupture’ has occurred in the relationship: times when the facilitator gets it wrong, misses the intent of the speaker in some way and perhaps activates shame, fear, withdrawal or anger. Perfect attunement is an impossible ideal and so the ability to facilitate satisfying repairs to the relationship is crucial to every attachment relationship (McCluskey, 2005; Hughes, 2006).

5. Review of session: Surprises, Learning, Satisfactions and Dissatisfactions (1)

At the end of the experiential session a few minutes is scheduled for people to review their experience of the session. This is time to reflect on how they have been in the group; what they have learned and whether they are satisfied with things that have happened. If they have not been satisfied, it is time to consider what they might want to be different in future sessions.

6. Application to work

After reviewing their work in the experiential session the agenda moves to exploring ways in which things that have been learned in the teaching input and experiential session might be applied to the group members’ work as professional caregivers. Typically this lasts for about twenty five minutes and involves case discussion directly linked to the theoretical and experiential learning. The tenor of this part of the session is different to the experiential session because people are typically not exploring their own experience but reflect on the experience of their clients.

7. Final review of learning: Surprises, Learning, Satisfaction and Dissatisfaction (2)

The session closes with a few minutes of further reflection on what people have learned from the session including the application to work section.

Conclusion

In this chapter I have attempted to give a personal and largely uncritical impression of the thinking behind the method of group facilitation that McCluskey has developed and taught in the last ten years. At the same time, I have sought to show the structure of the groups from which the data has been drawn with the intention that the case studies at the core of the study can be seen within the theoretical and practical context of the groups. From this sketch it can be seen that behavioural systems, the regulation of fear and elimination of shame are all important elements in the facilitation of this type of exploratory group. It is also clear that the rationale for this work links to important insights from mother/infant observation, child development and attachment theory.

In this presentation I have also shown that the style of facilitation used in this type of training course differs from the typical therapist's role in group psychotherapy. Although designed as training courses to teach about attachment and facilitate personal exploration, the goals of the groups are ambiguous and have much in common with the goals of psychotherapy. Although the data arises from train groups offered to professional caregivers, similar methods have been used therapeutically with more general populations.

The invitation to become centred in one's own experience (body and mind) is integral to every part of the session and is repeated at several points in a session. In this way the individual is helped to maintain contact with the entirety of their in-the-moment experience, the strength to seek care and the openness to make use of what is said and experienced. Attunement and affect regulating interventions are intended to help people maintain a centred position. They form part of a wider strategy in which lessons drawn from infant observation studies are applied in order to reduce fear in the individual careseeker; helping them meet the goals of careseeking and exploration.

The current research is influenced by the idea that individual experiences of subjectivity and intersubjectivity are affected by prior experiences of attachment related fear and shame. Because each individual's personal work is supported by a wider group the

opportunity exists for shame-reducing connections to be made with a wide group of supportive peers. However, the extent to which this works in practice is one of the aspects to be studied in this research.

This chapter closes the introduction to the ideas underpinning the study. The eight chapters that follow each present a different case drawn from membership of the two courses being studied.

Chapter Five: Quieter Group Members (I)

Case Study One - Helena

Introduction to the first three case studies

This chapter begins the process of step five of Stiles method: applying the theory to the cases (Stiles, 2007; McLeod, 2010), as outlined in chapter three. This and the next two chapters examine the assumptions underpinning flow diagram two (see below). A problem with discussion of this flow diagram is that, because it describes people who spoke least in the groups, there is less recorded evidence to support or refute the diagram. For different reasons it was not possible to include the quietest person from each group in this study. In Course A this was Lucy.¹ She said too little in the group to allow full discussion and it has not been possible to interview her. The quietest person in Course B was Katie and I excluded her from participation because she had known the facilitator socially prior to attending the course.

I have therefore chosen to study three people who are relatively quiet in their respective groups and yet provide sufficient evidence with which to assess the accuracy of the flow diagram. In the case of Helena (from Course A) this is because her first input to session three described her reaction to events in session two thereby giving two types of evidence concerning her experience in the group. The second and third case studies are based on two people from Course B whom I have interviewed. The group transcripts are supplemented with interview data for Rebecca and Stephanie.

Sub-optimal functioning of the restorative process – Flow diagrams 2 and 3

The three flow diagrams created for this study reflect my reading in attachment theory; particularly literature focused on attachment styles and Mikulincer and Shaver's systems focused model of attachment (see Appendix 2). In my diagrams I describe what I saw in

¹ All names in the study have been changed to safeguard the anonymity of group members.

preliminary interaction with the data. However, by including the system Heard and Lake call the internal (supportive or unsupportive) environment a more complex picture emerges than is seen in diagrams produced by Heard (Heard et al., 2009: 108ff). Flow diagrams two and three (chapter eight) are influenced by descriptions of 'avoidant' and 'preoccupied' attachment strategies respectively (see chapter two).

Hate within the internal environment

During my early contact with the data I became interested in a hypothesised link between attachment behaviours and hate. In what follows I describe ideas that are very tentative but which were active in shaping my analysis of the data. My conceptualisation of hate is distinct from an attachment focus on anger (Bifulco, 2002a, 2002b; Bowlby, 1973/1988; George and Solomon, 2008). The extent to which this description of hate is useful is discussed in chapter fourteen.

In part, my interest derives from Suttie's (1935) description of hate as a response to the failed appeal to love. This early text links hate directly with failed careseeking. My interest also reflects Winnicott's (1949) 'Hate in the countertransference', and the idea that hate is a normal (though frequently latent or unconscious) component of attachment-type relationships. When put alongside Mikulincer and Shaver's (2007) ideas about preconscious activation of systems, I suggest that hate plays a significant role in shaping the perceptions, affects, cognitions and behaviour of insecure careseekers and caregivers.

Within Heard and Lake's conceptualisation of self, the failure to achieve the goal of careseeking leaves the individual in a dysregulated state and depletes their self-esteem. It makes sense that disassuagement would trigger powerful negative feelings. Suttie describes hate as, 'a standing reproach to the hated person [which] owes all its meaning to a demand for love'. He describes hate as

a development or intensification of separation-anxiety which in turn is roused by a threat against love. It is the maximal ultimate appeal in the child's power – the

most difficult for the adult to ignore. Its purpose is . . . the preservation of the self from the isolation which is death, and the restoration of a love relationship.

Suttie, 1935: 31

It may be that hate underpins the protest seen from infants in the Strange Situation (Ainsworth et al., 1978) and perturbation studies (Murray and Trevarthen, 1985) and serves the biological functions of 'overcoming such obstacles as there may be to reunion' and to 'discourage the loved person from going away again' (Bowlby, 1973/1998: 286).

At a different level of abstraction this may be linked to Panksepp's (1998) concept of the 'rage circuit'. Panksepp argues that this is a neural circuit which is activated so that people (and other organisms) experience rage when frustrated in their pursuit of the goal of a system. As such it expresses the 'hot displeasure' of anger (Bowlby, 1973/1998: 288) and is clearly strongly felt. The expression of anger can have profound impact on attachment relationships and has been identified as a significant factor linking attachment styles and psychopathology (Bifulco et al., 2002a, 2002b). In these sentences hate and anger may be synonyms; but this loses something of the intensity that I believe was intended by Suttie and Winnicott. Whilst hate may be experienced as 'extreme dislike' and 'intent to bear malice' (Oxford English Dictionary, 1971) it can be 'latent' and 'unconscious' (Winnicott, 1949).

As conceived within the study, hate is not a consciously experienced feeling, though it may predispose someone to anger and break into consciousness with profound intensity. From chapter two it will be remembered that negative affects can trigger defensive strategies that work to exclude feeling from awareness. Bowlby's (1974, 1988) writings on selective exclusion suggest that this will be particularly so when the excluded feelings might otherwise threaten attachment relationships. The 'infrequency [of emotions] is a sign of their significance rather than their insignificance' (Mesquita and Ellsworth, quoted by Farmer and Andrews, 2009: 59). I suspect that many people act on the promptings of hate while feeling little or nothing.

The inclusion of hate in the flow diagrams reflects an attempt to understand and represent the difference between attachment strategies that deactivate attachment and those that

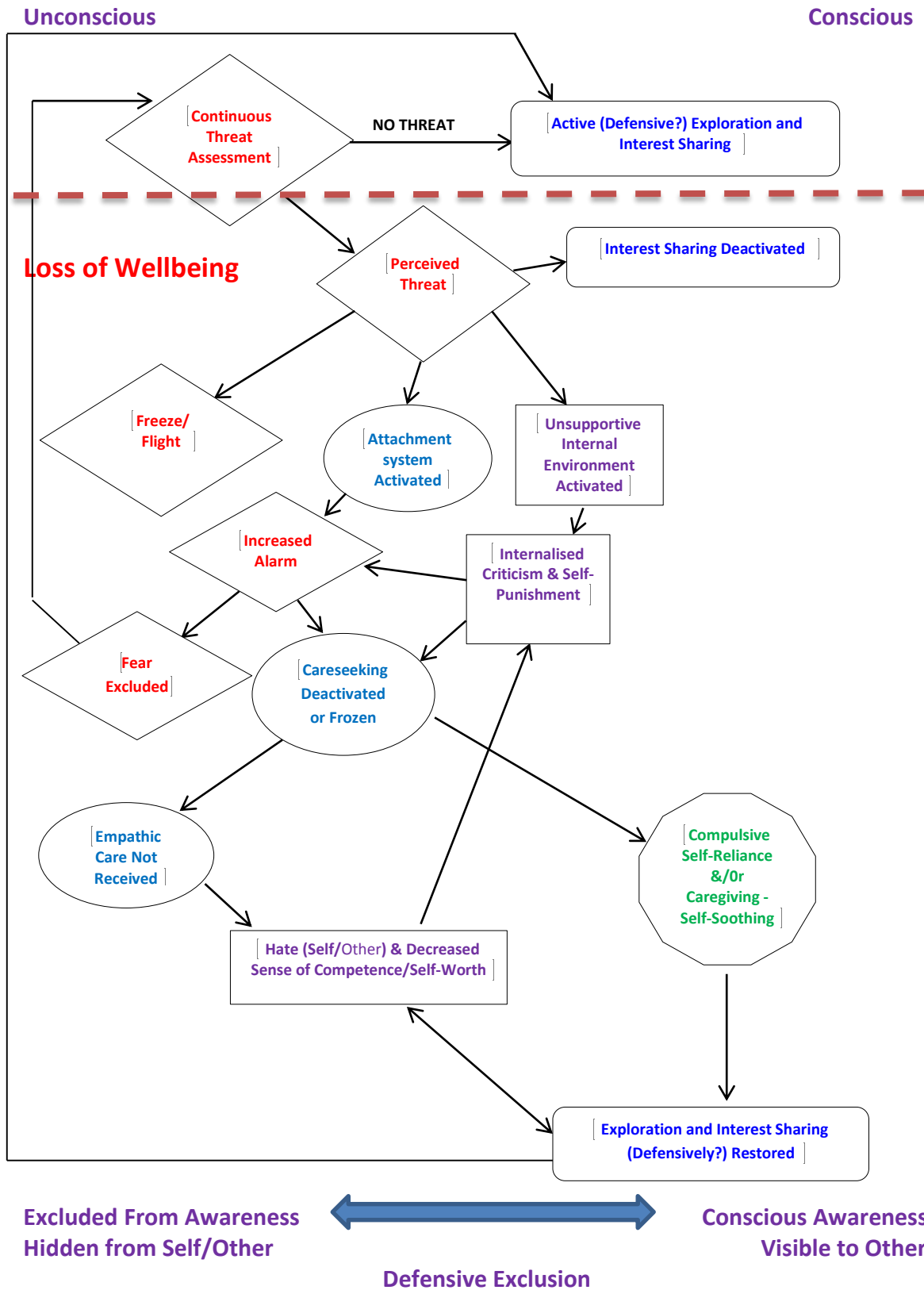
hyperactivate attachment (Mikulincer and Shaver, 2007, 2008). As a part of what is selectively excluded in 'cognitive disconnection' or 'segregated systems' (Bowlby, 1980; George and Solomon, 2008), hate might link hurt, anger, shame and attachment strategies.

I suggest that hate as a non-conscious motivator may result when feelings linked to an unreliable, negligent or abusive caregiver are excluded from awareness but encoded in implicit memory as part of an internal model of self and/or other. As such, it is possible to conceive of hate as underpinning the hyperactivation of attachment. In these circumstances hate may motivate the preoccupied person; ensuring, for example, that they exclude a caregiver's perspective from awareness and prioritise their own exaggerated distress and neediness (Mikulincer and Shaver, 2007). Here the target of hate is external to the self.

The link between shame and anger is well known (Hejdenberg and Andrews, 2011; Nathanson, 1992; Tangney and Dearing, 2002). But shame induced anger may be directed externally or internally (Nathanson, 1992; Wurmser, 1987). Where experience teaches the careseeker that protest is futile I suggest that hate may be more directly linked to shame and become directed against the self. Wurmser (see chapter two) sees shame as (conscious and unconscious) affect, triggering 'self-chastisement, self-ridicule, self-scorn and . . . self-effacement' (Wurmser, 1987: 76). Ayers talks about 'self-loathing' and 'a hateful vision of ourselves' (Ayers, 2003: 11/12). I suggest that when informing internal models of self, self-directed hate will give access to cognitions and affect that emphasises the unworthiness of self and the risks associated with careseeking. In this way it motivates self-reliance and the deactivation of attachment.

The flow diagram in this chapter (and that in chapter eight) suggests that hate is the consequence of rage being encoded in implicit memory, woven into internal models of self and other and then projected into the future as fear of disassuagement (which might include fear of being shamed). Used in this specific sense, I suggest that hate is an unconscious mechanism within internal representations of self and other. In the diagrams

CARESEEKING CONSTRAINED BY AN UNSUPPORTIVE INTERNAL ENVIRONMENT



Flow Diagram 2. New shape (bottom right) represents something akin to Winnicott's 'False Self'.

therefore, hate (directed against self or other) is depicted as being integral to the internal environment which shapes the individual's responses to events.

The restorative process with insecure careseekers

Here and in chapter eight I present new diagrams to depict Heard and Lake's restorative process as it might manifest in the case of insecure careseekers. In these diagrams I depict the same systems as in flow diagram one (page, 63) but my placement of the symbols on the page is intended to represent the role of selective exclusion from awareness. In contrast to flow diagram one the new diagrams are essentially unbalanced, with symbols placed on the right side of the page representing processes that are most easily accessible to consciousness (and most visible to the caregiver) while those on the left are selectively excluded from awareness. In flow diagram two, symbols representing the internal environment have been placed to show the role of information processing in deactivating attachment.

Reading flow diagram two

In order to orient to the diagrams of suboptimal functioning of the restorative process, it is helpful to draw attention to the two-way arrow at the bottom of the page. This represents the distorting role of defensive exclusion from awareness (Bowlby, 1980, 1988) as described in chapter two. It is envisaged that individuals depicted in flow diagrams two and three are more consciously aware of things on the right-hand side of the page. This is also likely to have an impact on how they present to others so that the caregiver interacting with such individuals is going to have easy access only to those elements on the right side of the page. Something similar has long been recognised in attachment theory and underpins the Adult Attachment Interview (Hesse, 1999).

Predictions from flow diagram two

On the basis of this diagram one might predict that the people thus described would have in common to some degree the following characteristics:

- A tendency to speak less than average.
- Less expressiveness resulting in fewer signals of distress/fear.
- Self-reliance and reluctance to seek care.
- Evident unsupportive internal environment.
- Self-directed hate greater than other-directed hate.
- Indications of defensive or compulsive caregiving.
- Evidence of greater levels of confusion or blankness concerning feelings.
- Attunement to others in the group in a manner that demonstrates external rather than internal contingency.

Selection of the cases in chapters five six and seven was made on the basis of their lower word count (and a hypothesis that this reflected fear and self-reliance) and not because they had been assessed as exemplifying the profile of the diagram.² As will be seen below, all three cases contribute to theory development by providing examples of 'counterexpectational reality' (McCracken, 1988: 36) or factors that do not fit neatly my presentation of theory. For example, Helena expressed far more fear than would have been predicted using the diagram and, when speaking in the groups, Rebecca and Stephanie showed little evidence of an unsupportive internal environment.

Group process

The examination undertaken in this and two subsequent chapters focuses almost exclusively on input from individual cases. It sometimes excludes consideration of the important role played by the facilitator and other group members. This is not meant to deny the idea that self is socially constructed in narrative performance (Elliott, 2005) and situated in profoundly influential group processes. The partial separation of individuals from group process has been made in these chapters for practical reasons; space requires that limits be imposed on the analysis. The role of the facilitator is examined in chapter

² Indeed, case selection was made before my flow diagrams had been drawn.

thirteen and comments on group process will be made when necessary to understand specific incidents; but it is otherwise excluded from the study.³

Case Study One: Helena

Introduction

As the second least vocal member of Course A (which I attended) the choice of Helena for inclusion in the study reflects a hypothesised link between how much a person speaks and the active influence of fear. In session three Helena spoke at some length about a strong and painful reaction following the previous session. This means that there are two types of evidence. Firstly, there is a record of what happened in session two when she discussed emotionally difficult events. Secondly, there is her reaction to having spoken, as related in the subsequent session.

A psychotherapist/counsellor Helena was the eldest of four children. Her mother suffered from postnatal depression so her grandmother took over caring for her at some time in her childhood. At the time of the group she was in her early forties, married with three daughters. She described her childhood home as 'a very stable, loving house, [where] there was no chaos.' Helena was attending the groups for the first time following a recommendation from two of her colleagues. They had attended previous courses and also attended this course.

In the first session Helena said a lot about fear; about not feeling safe and having a tendency to be frozen or withdrawn. Indeed, in that session she did not appear to get beyond fear to explore anything else. Given the infectious nature of fear it is relevant that before she spoke in session one, the facilitator had made numerous references to fear. Moreover, Helena's two work colleagues and several other group members had expressed high levels of fear which they attributed to being in the first meeting of a new group. It is

³ Disadvantages resulting from this decision are discussed in chapter fourteen.

possible that their expressions of fear, coupled with the pressure to speak, meant that Helena experienced and expressed more fear than was normal for her.

At the end of session one, using language that she is likely to have picked up from the group culture, Helena said she was curious and excited by the opportunity to explore the emotions involved in careseeking and caregiving. She said it had been good to be reminded of the fear clients experience at the start of therapy. From what she said in the session it is clear that she was very frightened at the start of the group series but in this contribution, at least, instead of seeking care for herself, she chose to reframe her fear in terms of the good her awareness of fear could do for her clients. This may suggest that her careseeking was suppressed and that fear triggered caring for others, what might be called 'defensive caregiving' (McCluskey, 2013).

In session two Helena explored something that had great emotional meaning for her. However, she subsequently reported that following this session she experienced 'rage' about things that had happened during the session. She reported this reaction in session three. I think it helpful to have this reaction in mind when reading her input to session two so my analysis begins by looking at her reported reaction.

Feedback to Session Three⁴

In her first contribution to session three Helena said:

301⁵ 'I was left, with something from the last day, er . . .

302 probably a rage is the best way to describe it.

303 And it's not with me and

⁴ When I decided on a method for setting out the transcripts for analysis I chose to set out the group members' words in stanzas but not the words spoken by the facilitator – because the latter are not analysed as closely in the case studies (this is reversed in chapter thirteen). This undermines (and preceded my awareness of the importance of) the focus on interaction. If I were starting again I would not do this – but that would have implications and without this way of truncating my analysis it may not have been possible to have as many case studies.

⁵ When text is quoted from the group transcripts, the first digit in the line number identifies the session from which it is taken. When presenting text from interviews the line number begins with *. Line numbers are somewhat arbitrary because most of the text has not been analysed in this detail or rendered into stanzas.

304 now I'm in another place of fear,
305 so it is hard to get into how it was.

306 I thought about it the entire month. (F: Right)
307 And I think it's around, you know,
308 first I came I was late, I got the wrong . . .
309 Then the second time I came I said something that wasn't appropriate, you know?

310 It's interesting what you said today about interpreting
311 and not putting the emphasis on your own interpretation
312 rather than the words that were said.

313 Because I heard the words you said which were,
314 'You might not know', (F: Mmmm, mmm)
315 or, you know what I mean (F: mmm. mmm).
316 I heard those.

317 And so my rational place was able to say
318 'That is what was said; you're not being given out to.' (F: Yeah)

319 But the other place was, you know,
320 I did my,
321 I felt exposed, I suppose,
322 which is a very vulnerable place for anybody,
323 you know. (F: Yeah)

324 Erm, I did a piece of work that I didn't expect to do,
325 and er, that's a pattern I know:
326 exposure, vulnerability, give out, rage. (F: Yes)

327 Right (F: Yes) so I can see that in my head now
328 but it has triggered erm an anger that scares me.

329 I have an anger, you know (F: Umm, Hmmm, make a lot of space)

330 And usually gets diluted with tears.

331 So I don't go to the anger because I can't bear the tears.

332 But my fear is that the anger is going to take over now,

333 not just because of this,

334 but that I am stirring things up.

Clearly Helena had a complex and powerful reaction to the previous session. She said she had thought about it for the entire month and was left feeling 'rage.' But, back in the group situation, she was not feeling rage. Instead, she was in 'another place of fear'.

The themes within her reaction are likely to be significant. She began by saying that she was late for the first session having 'got the wrong . . .' (308). This sentence is incomplete but I think she might have gone on to say that she got the wrong time. In the audio recording of session one it seems that some people, including Helena, had thought the start time was half an hour later than the group actually started. It appears that she was left with feelings about being late to the session which, in this feedback at least, are turned against herself (though, because others had made the same mistake, she may also imply veiled criticism of the facilitator). She then recalled that in the second session she had said something inappropriate (309-318) and, it appears, despite rationalising that it was not so (317-318), she had felt rebuked by the facilitator.

Below I will examine the exchanges that gave rise to this discomfort. She communicates the idea that, having explored emotionally significant events (concerning a bereavement) she left the session feeling exposed, vulnerable, given out to (318) and rage (326). Despite rationalising that she was not being 'given out to' she nevertheless continued to feel angry. Helena's feedback about feeling exposed and criticised suggests that her anger was a reaction to feeling shame (or shamed) in the group.

It seems that anger was difficult for Helena and was normally lost in tears (330). She also talked about being frightened of crying (see below, 209-219). The final line quoted above

also suggests that she may have believed there was a danger that stirring up anger in the group would tap into a reservoir of anger that she feared might have come to dominate the group (332-334). This may imply that her defensive strategies were, in part at least, designed to suppress anger (and the experience of shame); and that her defences were threatened by her attendance of the group.

Narrative and other input to Session Two

I will now examine the events in session two which gave rise to this reaction. Before Helena spoke there were several contributions from other group members with which she may have resonated. Vanessa told a story about being the eldest child in a large family and having to shoulder too much responsibility from a very young age. Martha spoke about experiencing a strong physiological-emotional reaction in the session that had been triggered by the memory of being sexually abused as an eight-year-old and trying, not wholly successfully, to protect her sister from the same abuser. Martha then went on to mention briefly the fact that one of her younger brothers had died in an accident which, though nothing to do with her, caused her to feel as if she had failed to protect him. Following this, another group member, Lucy, talked about being overlooked in a chaotic childhood-family home that had been dominated by her father's work as a medical doctor and physical and mental illness suffered by other members of her family. The last person to speak before Helena was Irene. She spoke about being at her mother's bedside at the age of five and failing to understand what happened when her mother died. So the session had been emotionally charged before Helena chose to say the following:

201 I think my biggest thing is listening to . . .

202 because I identified with a lot of what was said today. (F: Yeah)

203 When Martha was speaking,

204 and I was very teary (F: Yeah)

205 and there was a lot of mention of grandmothers.

206 And as much as I wanted to say something

207 it's the fear of the tears
208 which I probably have identified for the first time.

209 And it is not the fear of what I might say (F: Yeah)
210 it's the fear of the tears. (F: Yeah)
211 That, that's the intolerable piece (F: Right) you know.

212 [F: And Helena, do you know tears were allowed in your childhood?]

213 My sense is, is 'Grow up or [indistinct],'
214 you know [indistinct]
215 and again I'm the eldest so there was a lot of
216 'You should know better' and
217 'Cop yourself on [indistinct].'
218 These kind of phrases.
219 And I think neither of my parents would be very good at crying.

220 So it's not the words, it is what would go before it;
221 that is absolutely intolerable, you know.

222 I thought I was going to have a heart attack and then,
223 you know, Irene was speaking;
224 because it was around my grandmother, erm.

225 And I visited her the night before she died,
226 and they took her oxygen tank
227 and she died of emphysema.
228 And I didn't stand up for her.

229 [F: What do you mean they took her oxygen?]
230 They only had one on the ward.

231 [F: And they took her tank away from her?]

232 Yeah, yeah. And they said 'we're just borrowing this now OK' and er,

234 [F: Yeah. Just if you can, Helena, just let the tears come. Take a big breath. Please help Helena, would you all please, by letting your own tension go. And if you can let the tears go just keep on telling us what happened that night.]

235 So I left her,

236 and they said they would bring it back.

237 But they didn't.

238 That's not why she died

239 but I think that's why she died. (F: Yeah)

240 So she was the person who loved me the most in the world.

241 [F: She was the person who loved you the most in the world. Yeah. So just make space for yourself and let, have your tears. They are your own emotion. And to have one's emotions is good. And you don't need to hurry it up, you don't need to hurry it up and get it over with. What you know is that your grandmother loved you.]

242 [Sigh]

243 [F: And you were nearly having a heart attack you told us. And you were getting a pain in your chest - Are you OK? - Which would have been the tension of presumably keeping all the emotion in. And er, what was coming up for you was the image of your grandmother the night she died, was it?]

244 Yeah. And as well, two things was:

245 her expression that she loved me, and that,

246 the fighting people's battles all my life,

247 and I didn't fight hers [Crying] (F: Yeah) that night.

248 [F: And what do you think of that, what emotion, what are you making of that?]

249 I feel such a failure, which is I think [indistinct] (F: Uh Hmmm)

[10 second pause with what sounds like her trying to control her breathing]

250 The pain's gone.

251 [F: Pain is gone?]

252 Yeah

253 [F: And again Helena, if you can also, as you take your own breath, also just look at who is in here and how they've been looking at you, that one is in human company, and we all feel more connected with each other as we catch each other's eyes. And the other thing we need to kind of open up for ourselves is feeling a failure in these kind of situations. When a particular aspect of the self is active, like one's affectionate-connecting-self, one's loving self, to the other person; may not be your militant advocacy active self that is likely to be around that, so what kind of stresses are we putting ourselves under. Anyone else?]

The facilitator here appears attuned and empathic, offering exploration in which empathy is highly active. Voice is inherent to what the facilitator says. Hearing Helena's distress and the self-punishing internal environment the facilitator allied herself with kinder voices expressed in Helena's story. She helped her regulate her distress and encouraged her not to make harsh judgements against herself by offering a systems-centred explanation for what happened. The facilitator then ended Helena's input by inviting other group members to speak.

Later in session two, during the first 'Surprises and Learning' section of the meeting (which followed immediately after the end of the experiential session) Helena commented on what had happened when she was speaking:

258 I was surprised by the depth of feeling (F: In yourself Helena?) Uhm,

259 so quickly,

260 but I'm exhausted;

261 but there is a lot of relief.

262 [F: 'Relief. So just notice what the feelings are. There's relief; and see if exhaustion describes it. Because when we bring in big words like that we bring in other emotions. Just notice what happens to yourself. We may be tired, we may feel relief, just notice; track it. Good surprise, neutral surprise, that it went so deep, or bad?]

263 I know it is good but I,

264 I'm still very surprised without a judgment on that.

265 Do you know what I mean?

266 In my head I think it is good.

267 [F: We have to see whether it is or not. Great! Anyone else?]

In this reflection Helena may have indicated that speaking had been a significant event that left her feeling exhaustion and relief. There is no indication here that she felt vulnerable or exposed at this point, although 'exhausted' suggests that talking had been stressful. Alternatively, it might not be that talking was stressful but that she had experienced something new: feeling that she was being heard. It appears that she had wanted to impress on the facilitator that, although very hard, it was 'good' for her to speak in this way. Yet, while she may have been stressed by the experience, I suspect that later, when thinking about what had happened (translating core experience into explicit language) Helena was able to experience shame that had been excluded from awareness or her memory of the incident was infiltrated by shame.

Twice the facilitator urged Helena to just notice and track what she was feeling and to hold back from making any judgement about her feelings. Helena may have felt conflicted because she repeats that 'it is good' whilst saying she is surprised but [echoing the facilitator] not making 'a judgement about that'. I think the purpose behind the facilitator's suggestion is that Helena should remain exploratory and truly open to all shades of her experience so that she did not edit any part of that experience out of awareness. I will refer back to this exchange presently.

Approximately half an hour later, in the applications to work section of the session, Helena contributed to a discussion initiated by Martha. Martha had told a story in which she was distressed and felt she had 'failed' because a client had terminated therapy unexpectedly. The facilitator invited other group members to react to Martha's story and several people made observations and suggestions. Eventually Helena joined this to ask:

270 'What happens to you Martha when your caregiving is rejected?'

At this point the facilitator interjected:

271 [F: 'Uh uh, I'm going to stop this because the thing is that in here we don't actually move in to fix people. It is about creating an organisation and a context so Martha or whoever else can just get the information they need to carry on doing their own exploring.']

I think this may be the moment that Helena was referring to in her subsequent feedback (session 3) when she talked about having said something inappropriate (309) though her words link with the earlier input. I suspect one difference between Helena and the facilitator is a matter of motivating system and that the facilitator had formed the view that Helena (and other speakers before her), was caregiving and so may have diverted rather than supported Martha's exploration.

Helena's final input to session two comes at the very end of the session. She spoke after Annette who said she felt supported in the session. Helena said,

272 'I think I want to say something similar about working [indistinct] today.

223 Not knowing,

274 feeling a couple of people

275 but not really knowing anybody

276 and to say it was very supportive, thank you.'

In this final contribution to session two Helena gave no indication that she was distressed or angry.

Discussion of Helena's input to sessions 2 and 3

Using Heard and Lake's model of the self, my interpretation of these events is as follows: Having observed other people successfully seeking care in the group situation Helena heard echoes that resonated with her own experience. It may be that exposure to these stories allowed Helena to access aspects of self that might otherwise have been excluded from awareness; and that this gave access to careseeking cognitions in a manner that may not have been typical of her. In particular, she was reminded about trauma associated with the death of her grandmother. Although she does not ask for care, I suspect that her impulse to speak arose from careseeking triggered by what she heard in the group. Attachment theory, as described in chapter two, suggests that, for some people, activation of careseeking will lead to the activation of fear. From the start of Helena's input to the session it seems that there was a tussle going on between her motivation to speak (careseeking) and fear that she would cry (205-211). When prompted she recalled her parents being critical in response to childhood tears and it may be that crying in itself made her feel vulnerable and exposed. Frightened to cry she was hesitant to speak about emotional matters (206). This supports the depiction in flow diagram two of the role of an internal environment that keeps her careseeking in check; triggering memories linking careseeking to further distress. When drawing the flow diagram I anticipated that a critical internal environment would suppress the experience of painful emotion. In light of what Helena says in session three it may be that the experience of emotion is merely deferred until after an exchange.

Helena spoke only after listening quietly to others even though she had experienced powerful somatic reactions to what was said (222). If the group process had broken down normally avoidant defences, then what happened in her exchange with the facilitator may have been new. If I am right to suggest that she was careseeking in this exchange, it is interesting that she expresses herself in terms that suggest she had been exploring. For example, she talked about new learning having occurred (she was frightened of crying; 206-208) and she heard different voices within her narrative (e.g. 238/9). She may sometimes have disguising careseeking as exploration.

Voices within the narrative

The idea that narrators switch between different voices, reflecting different aspects of their experience and their multiple roles, identities and experiences is one way of clarifying tensions within narratives. This idea is highlighted elsewhere in qualitative research (Holstein & Gubrium, 1995; Gonçalves et al., 2011; Huber, Murphy and Clandinin, 2003), has been used in attachment and narrative based psychotherapy (Holmes, 2000; Brinegar et al., 2006) and some forms of humanistic psychotherapy (Elliott and Greenberg, 2007) as both a therapeutic tool and outcomes measure.

Although Heard, Lake and McCluskey do not use the idea of voice in their writings (neither do they draw on the idea of narrative), I believe the concept of a multiplicity of voices is consistent with the idea of a self as arising from a multiplicity of interpersonally regulated behavioural systems which each have separate goals. These systems shape and are shaped by experiences and it makes sense that they would give rise to different voices being expressed at different times. Indeed, the idea that self arises from a multiplicity of behavioural systems is not so very far from the idea of the self comprising a multiplicity of voices (Brinegar, et al., 2006; Elliott and Greenberg, 2007).

Therefore, I have sometimes used the idea of a multiplicity of voices as a means of clarifying and analysing what can be heard in the data. Being sensitive to the different voices of a group member highlights potentially interesting information about systems; and possible differences in motivating systems active in the group members and group facilitator.

In Helena's story it is possible to hear several voices. The first voice is of someone who expressed love by caregiving. Her pain is reflected in such phrases as 'the person who loved me the most in the world' (240). The second voice focuses not on loss but on how she had let her grandmother down; failing to fight her grandmother's battle and so contributing to her death (235-239). In this account her grief was derailed by the vicious self-attribution, 'I feel such a failure' (249) as her story is commentated on by an actively critical internal voice. There is a tussle between the voice that accuses her of causing the death of her grandmother by failing to fight her battle and the voice that knows this is not so (238/39).

Finally there maybe the voice of a woman seeking care by sharing her distress with a caregiver (caregivers) in the group and the voice of someone who appears to be learning new things. In the following session she speaks as someone who recalled having felt exposed and vulnerable.

I suspect that recounting the above narrative was a significant event for Helena precisely because it was a very rich experience in which she experienced close attention and mirroring by the facilitator. Hopkins (1991) draws on Winnicott to say that the infant's experience of being held is an experience of being loved. Therefore the earliest anxiety is of being insecurely held. In various papers Winnicott suggests that by communicating deep understanding of the individual's inner experience the therapist symbolically holds the client and conveys a type of love. These ideas support the idea that being heard in the group was an intense and powerful experience for Helena. However, I think she felt 'dropped' when her question to Martha was interrupted in an abrupt manner by the facilitator. If correct, it may be this that activated her subsequent 'rage' and underpins her feeling vulnerable and exposed. It is significant that she did not explicitly link this to shame.

However, I suspect that the intensity of the experience for Helena and her subsequent vulnerability reflect a history of attachment distress. Lacking confidence in her role as careseeker she perhaps disguised her careseeking as exploration when recounting her initial story. In doing so she may have been adjusting to what she saw in the facilitator.

So when, in the following session, Helena talked about feeling vulnerable and exposed, I think this was not simply because she expressed distress in a manner that was careseeking. It may be that shame had been triggered; either when the facilitator insisted on not rushing to judgement about whether talking had been good, or when she interrupted Helena's question to Martha. Whichever it was, a month later Helena talked about having got it wrong, being given out to and feeling rage. It is also significant that, except in veiled terms, she did not direct her rage at the facilitator.

Evidence supporting a behavioural systems interpretation of the narrative

The evidence supporting a behavioural systems description of this narrative event can be summarised as follows:

- That Helena spoke when there was internal pressure on her to keep silent (and avoid the risk of tears) may indicate the activation of careseeking.
- The idea that the activation of her careseeking activated fear is suggested by the fact that she has had a strong internal reaction before speaking (222), felt exhausted after speaking and later still experienced 'rage'. This is especially true if the rage was linked to being 'dropped' by the facilitator when she rejected her feedback or interrupted her question to Martha. In either case, what I am calling fear seems to be linked to shame.
- The activation of a critical internal environment is indicated by her fear of crying and recollection of criticism from her parents (207-211, 217); her tendency to blame herself for what happened, both in the original narrative ('I didn't stand up for her', 'I didn't fight her [battle]', 'I feel such a failure') and when giving feedback a month later ('I got the wrong [time]' and 'I said something inappropriate').

The stress associated with talking suggests that it was not every day that Helena shared in such depth with others (at least in a group setting). Her feedback in session two included the information that she felt 'a lot of relief' (261) after speaking which may be an indicator that the goal of careseeking was achieved in this encounter. It might also reflect language learned in the first session about achieving the goal of careseeking. In any event, her repeated insistence that it was 'good' might suggest that the relief was somehow precarious or, perhaps, that she heard the facilitator's invitation to remain open (262) as rejecting her feedback.

In session three she said there was a pattern for her to feel 'exposure, vulnerability, give out, rage' (322-326) and this may imply that this level of intimacy felt dangerous.

Defensive caregiving

A link between insecure attachment and 'compulsive caregiving' was first hypothesised by Bowlby (1969); is developed by Heard and Lake (1987; Heard et al., 2012) and is taken further by McCluskey (2013). One of the learned strategies for managing distress identified by Heard et al., (2009: chapter 4) is for the individual to give care to others. So it may be that caregiving (including 'fighting other people's battles') has been important to Helena's survival and a source of self-esteem. Confessing that she had failed to fight for her grandmother (246) is likely to be a major self-disclosure. It may also be that when she was beside her grandmother's bed, she defended against the pain of imminent loss by focusing on giving care to her grandmother. When this failed (as it must) she was left with a strengthened self-punishing internal environment (inner voice) berating her for her failure.

Systems dynamic in feedback to session three

I have suggested that Helena found it difficult to seek care in the group setting; she was rendered momentarily speechless by her distress and later reported feeling both relief and exhaustion. It is possible that her feedback in the surprises and learning part of the session(258-266) was motivated by a defensive desire to give something to the facilitator as a way of managing discomfort of some kind (rather than either careseeking or exploration). This interpretation is suggested by the insistent quality of her feedback: 'there is a lot of relief' (261) and 'I know it is good' (263) and 'In my head I think it is good.' She is keen that the facilitator should know that their earlier exchange had been positive. If it was unusual for Helena to act in the role of careseeker, she may have been frightened in that role and was motivated by defensive caregiving to give something in return to the facilitator.

However, if this interpretation is correct, there may have been a mismatch between Helena's desire to give positive feedback to the facilitator and the facilitator's encouragement for her to keep an open mind. The intensity of feeling associated with her narrative is self-evident and I suspect that when relating her story careseeking had been activated. But her careseeking was infiltrated by fear and was defensive. I suspect that

remembering the self-destructive judgements that Helena made when telling her story, the facilitator was attuned to parts of Helena's experience that were being actively suppressed or denied by her words 'very good' and 'relief.' Hence the repeated suggestion that Helena might stay open to the possibility that her experience was not wholly positive (262 & 276). But by seeming to reject Helena's care the facilitator may have rejected Helena's frightened self and blocked her attempts at self-regulation.

If this reading is valid, any discomfort caused by the facilitator rejecting her care will have been compounded the next time Helena spoke. On the face of it, Helena's question to Martha (270) may be exploratory or caregiving but I think the facilitator sensed that the group had shifted from helping Martha explore into trying to fix her problem. Speaking a month later, Helena's recollection was mediated by a critical internal environment (309) yet her reported rage (the target of which was not made explicit) might suggest that self was not the only recipient of her blame for what happened. I think it possible that this intervention by the facilitator was experienced by Helena as a rebuke and undid any intimacy that Helena had experienced earlier in the session, triggering (conscious or unconscious) shame and then rage. Although she reported rage rather than shame, I think it not far-fetched to see her rage as a reaction to feeling shamed; and that shame is an ever-present potential within Helena's internal environment that motivates her defensive strategies.

Conclusion

In this opening case study I have tried to show how a systems based model of the self can be used to describe one group member's experience in the group. The case study offers evidence that Heard and Lake's model of the self can throw light on interaction between careseeker and caregiver. In doing so it has highlighted questions about the purpose of the therapeutic meeting and the relationship between careseeking and exploration.

I think it significant that it is not always clear which system is actively motivating Helena's speech. Whilst she never asked for help and sometimes appears to use the language of exploration, I suspect that careseeking was a dominant motivational system for much of

the time; and that this was always infiltrated by fear. Careseeking may have been triggered for Helena by the presence of a caregiver and the example of other careseekers in the group; all of which served to activate distressing memories, erode avoidant defences and activate fear.

The presence of fear (fear of tears, fear of anger and fear of feeling exposed and vulnerable) pervades Helena's input to the group. I suspect the 'rage' that Helena spoke of is evidence of her fear reaction rather than a specific 'rage circuit'. In session two Helena sought proximity, affirmation and some kind of holding relationship with the facilitator but underlying fear meant that her careseeking was always fragile. Moreover, as she describes it, Helena's fear appears to be powerfully linked to shame.

Chapter Six: Quieter Course Members (II)

Case Study Two: Rebecca

Introduction

In this second case study I continue my exploration of the experiences of quieter course members. Rebecca was a clinical psychologist in her early thirties at the time of the group. She was then living in shared rented accommodation and described herself as single (having never been married) with no children. When I met her she informed me that since the group she had bought her own home where she lived alone. Born second of four children, in interview, she said her family background was 'very secure'.

Rebecca is the person who initiated least discussion in Course B (though she has the second lowest word count). She never gave feedback at the start of a session and approximately a third of her input was spoken after the experiential session had ended, in the section that focuses on applying Heard and Lake's theory to client work. Moreover, rather than in pursuit of her own agenda, a significant proportion of her input was spoken in response to other group members who were exploring issues. She does not seem to have been seeking care in these contributions and may either have been exploring similarities in her own experience or (which I think more likely) supporting the original speaker.

In interview Rebecca said she had worked hard in sessions and gained a lot even though she did not appear to seek care. A possible exception to this came in the application to work section of session one when she expressed vulnerability in relation to her work with a particular client with whom she felt she had failed. Apart from that incident Rebecca did not express fear or distress in any obvious manner and probably shared least in the group about her own experience.

Evidence from the group sessions

There was no obvious crisis for Rebecca in any of the sessions so there is evenness in the record of her input to the groups. The first time she spoke in session one followed input from several people who identified themselves as 'self-reliant'. She responded to Hannah, a group member who had expressed surprise at hearing others speak about feeling entitled to care. Hannah had said that she didn't have permission to seek care. Rebecca responded that her tendency had been to be self-reliant but added that,

102 'I have given myself permission over the last few years.

103 I'm better now able to careseek than I used to be,

104 and it's much more satisfying'.

Several things strike me as significant about Rebecca's initial contribution to the group. Firstly, she identifies with Hannah's problem but, as applying to herself, located it in the past; she spoke as someone who had overcome reticence about careseeking. Secondly, as a response to Hannah's statement of a problem it may have been exploration; designed to offer a different perspective. Hannah had been disquieted when making the comparison between her own lack of entitlement to care and the clear entitlement expressed by others. Rebecca spoke about giving herself permission and by implication she reframed the problem and offered a solution to Hannah. Thirdly, Rebecca's response implies that she had not always felt entitlement and previously lacked permission to seek care.

Entitlement and permission to seek care were not things bestowed on Rebecca by early experience but are dependent on an act of will. Therefore, though she described early home life as secure, somehow it seems to have failed to endow her with a key element of security. This may indicate a fault-line in her awareness or blind-spot of the type used to identify insecure attachment in the Adult Attachment Interview (Main, Kaplan and Cassidy, 1985) indicating selective exclusion and internal representations.

Anxiety and security

Rebecca's presentation of a secure family in childhood was in some ways puzzling. In session four she said, 'I suppose similar to some other people, I would have had a very . . . grown up with very loving parents who've been very affectionate with each other and still are, so that was very healthy to see'. (In interview she repeated this and said her childhood was very secure.) But, as seen above, until giving herself permission to careseek, she did not have a sense of entitlement. Again, in session four she spoke about pain caused to her when her mother repeatedly warned her severely, 'Don't you dare darken this door pregnant'. She said this had caused her to feel ashamed because her mother had not had the same conversations with her older sister, '. . . what was my mum thinking of me to be constantly having this conversation?'

In the following session Rebecca reported that she was prone to anxiety:

501 'I suppose what to do with the fear system and anxiety
502 I suppose that's just something that, that I do continuously work on.
503 That kind of, you know, a tendency to be a worrier as well, [F: mm hmm]
504 and ruminate about things, on the inside'.

505 [F: Like Vera was talking about.]

Rebecca then said that contrary to appearances she was a worrier. She didn't like being this way and described it as 'habitual' and a 'waste of good energy'. Again placing this in the past she said that this was something that she had been working on for a long time and that it was getting easier. She continued;

508 . . . I think it's easier when your attachment system, you know,
509 I've noticed that connection;
510 that when I'm feeling more secure,
511 it's definitely much more manageable.

512 But it's when your attachment system is activated

513 and when you're not feeling so secure,
514 that's when it gets its energy;
515 and when it's not so easy for you to then,
516 for me to bring it down, you know.

517 It's much easier to bring down when I'm feeling OK
518 and when I'm feeling, yeah, things are OK. [F: yeah]
519 And I have people to go to; then it's manageable.
520 It's when, when you're not feeling so secure, [F: yeah]
521 that's when it takes on, it's, you know . . .
522 And it's not so easy to be logical about it I think.

523 [F: Well we've reached the end of the exploration time, and just to say to you Hannah, you know, what you brought in, and what you're saying now, is again what the kind of work that we were doing with Sarah . . . (continued to address Hannah).]

In the group (and interview) Rebecca was normally coherent and eloquent so it is noteworthy that these sentences are not easy to follow. It seems she was saying that her anxiety was somehow linked to security in attachment. When she was feeling secure her anxiety was more manageable. When attachment was activated and she was not feeling secure then her tendencies to worry and ruminate became less manageable (512-516). It was when she was not feeling secure that her fear was unmanageable.

However, Rebecca did not explain what she meant by 'attachment system is activated', 'feeling secure' and 'not feeling secure'. Lines 518/19 seem paradoxical: 'when I'm feeling, yeah, things are OK and I have people to go to, then it's manageable'. She may have meant that the more insecure she felt the harder it was for her to seek support and that when she most needed care she was least able to seek it. In any event it appears that the processes described in these lines were intrapersonal and perhaps lonely. Though she had people to go to, it seems she felt they were most available when she was feeling most secure. So despite what she had said to Hannah about giving herself permission to careseek, the

impression given is of someone who acts as her own caregiver and takes care of herself without an external caregiver.

An interesting aspect of this input is that, though it may have been one of the most significant things she shared with the facilitator in Course B, she got little back in terms of attunement. Having twice acknowledged what Rebecca said with the word 'yeah' (5016/20) the facilitator made no comment and immediately moved on by pointing out that it was time to move into the surprises and learning stage of the session. This is the only time Rebecca spoke in the session and the fact that she was less coherent than normal might indicate that she was conflicted, and perhaps, at some level, motivated by careseeking. However, her input did not lead to activation of caregiving in the facilitator. I don't think this was just because the facilitator's focus was on management of the group's time boundary because there are numerous examples when the facilitator dealt more flexibly with boundaries. Rather, I am inclined to think that Rebecca was working in secret and, despite the words used, hid any careseeking intent. Without being present it is not possible to say what she was communicating nonverbally. This may be evidence that the activation of careseeking in its turn activated fear and gave rise to incoherent and mixed messages.

In session six Rebecca talked about her relationship with her father. She said this had become difficult because, throughout her childhood, he had been easily overwhelmed and his fears dominated life for her and her siblings. She said he constantly gave them the message that the world was a scary place in which every activity was risky and something dangerous might happen at any moment. As she grew up she says she came to feel, 'very resentful with him for creating this anxious disposition'. For a number of years her anger and resentment about this prevented them getting on but she reported that this had improved,

641 and now I've worked on that.

642 And now I can catch myself when I'm moving into anger.

643 when he moves into hysteria [F: yes]
644 I start to move into anger.
645 But now, when I drew those connections,
646 when I realized what was actually going on between me and him . . . [F: yeah]

647 For a long time we, you know,
648 it did impact on our relationship,
649 we didn't get along really.

650 But once I was able to look underneath
651 and realise what was my anger about [F: mm hmm]
652 and why was I being so disparaging of him, disrespectful really.

653 Now I'm more empathic, with his anxiety,
654 I mean I have to work on that, and catch myself from moving into anger,
655 because it brings my anxiety, my fear system gets activated.

656 [F: So Rebecca, with this new insight, and again what you're bringing is a self, observing a self, isn't it, and you're saying you had more empathy for him. Have you any evidence so far of the effectiveness of your empathy; the effect it's having on him?]

657 I'm not so sure it's having a . . .

658 I suppose the only way I can see a positive effect is, [F: Uh hnn]
659 we're closer now.
660 Like we seem to have bridged that difficult gap that we had in our relationship,
661 without really ever talking about it.

662 We've moved forward and we're closer,
663 and we can sit in the same room together
664 and get along and not be sparking over small things.

665 [F: Well that is huge. [. . .]

In this input Rebecca was joining a discussion that other group members had begun and again spoke as if talking about the past rather than presenting a current issue. She began by saying that this was not an attribution but was about how she had been affected by her father's fear.

In light of her statements in the previous session about security and the management of fear (501-522) it is significant that the solution to a problem once more came from private actions taken by Rebecca. The change she described in her relationship with her father came from her looking at her own behaviour, recognising that she had been disparaging or disrespectful and changing her attitude so that she was more understanding about her father's fear. He appears to have been passive and excluded from this process of change while she suppressed her anger as a means of self-regulating (654/655). When subsequently invited by the facilitator to identify the effect of her empathy she says that they were now closer and able to be in the same room with each other and not spark over small things.

Behavioural systems

This narrative can be retold using Heard and Lake's behavioural systems: Rebecca began by telling the group she was prone to anxiety and it is likely that, in childhood, she had been dysregulated and disorganised by her father's exaggerated fearfulness. Unable to regulate her own fear she became angry and her fear system activated behaviours characterised by dominance and submission (Heard and Lake, 1997). She said this changed when she reflected on what had been happening, stopped fighting and instead actively tried to empathise with his anxiety. In this empathy it seems she was regulating her own fear (anger). However, though this was partially successful, Rebecca was careful not to overstate her success; 'closer' (659) seems to mean that they could be in the same room without sparking off each other. It may be that the reported change reflects the substitution of one defensive strategy with another; a move from fear (dominance/submission) to defensive caregiving. In the Adult Attachment Interview,

parental fear is linked to disorganised/disorientated attachment in children. It may be that Rebecca has imposed order by adopting a strategy that involved pulling back from her father in anger. (In chapter thirteen this input is discussed in terms of group facilitation).

Caregiving

At the beginning of this case study I pointed out that one third of Rebecca's contribution to the group came in the section of the meeting in which the focus was about how personal learning in the group could be applied to client work. My reading of this is that caregiving was an important element within Rebecca's self/identity. She showed vulnerability in this part of session one when she described how one young client had caused her to feel 'very rejected, and very rejected, very punished, invalidated and kind of helpless'. In interview she spoke about being easily drawn into giving care to others. In session two of the group she related a story about caregiving in childhood.

201 I suppose my earliest memory of caregiving
202 would have been when I was about eight.

203 My mum had to go into hospital to have my younger brother,
204 so she was . . .
205 My one older and one younger sibling,
206 and she was away for my birthday, so . . .
207 And that was kind of a hard time.

208 But when she came back from hospital
209 my brother was very sick for the best part of 12 months.
210 [F: Your new brother?] The new brother, yeah.

211 And he just seemed to cry pretty much all the time.
212 Apart from maybe an hour in the day;
213 the rest of the time it seems like he just cried.

214 It was just very harsh, shrill voice,
215 and I just remember, I mean, I didn't feel responsible for helping,
216 but I do remember just that sense of helplessness in the house.
217 That everybody was at the end of their wits,
218 and nobody knew what to do.

219 And everybody was trying desperately to help him
220 and soothe him and comfort him, rock him and do everything they could;
221 and nothing seemed to be working.

222 [F: Yeah, and that sense for you, because it's where it left you, all the attention
would have been out there on him, but where did that leave you Rebecca?]

223 It just was . . . just felt very stressed and helpless,
224 I remember feeling very helpless.
225 And could see how stressed and tired my mum was.

226 And I, myself and my other two siblings tried very hard
227 to help him in the little ways that we could,
228 but we knew it wasn't, it wasn't really that helpful.

229 So that was hard to feel then
230 you couldn't help your mum who was very distressed, exhausted.

Here Rebecca offers an example from her childhood of experiencing dysregulated emotion and showing care for others rather than receiving care. In her description of life in that period it is clear that there was a lot of distress in the home: 'everybody was at the end of their wits and nobody knew what to do' (217/18). They all tried everything they could think of but nothing worked (219-221). Unable to assuage his distress, her brother's cries for help were remembered as a 'very harsh, shrill voice' (214). It is easy to imagine that Rebecca's parents were frightened and less available to their older children as they tried to care for the young baby. It is telling that she answered the facilitator's empathic

question (222) about what it all meant to her by coupling her own distress with mention of her mother's exhaustion (223-230). Rebecca appears to have tried hard to help her mother (and brother) and it is easy to imagine that in this period of intense need, being 'good' was coupled with giving care.

Throughout the story there is an implicit link between dysregulation and the problem of unassuaged caregiving. Everyone in the house was frustrated because they could not help assuage the distress felt by her brother and mother. It is also likely that during this period, when her brother's illness caused such distress in the home, Rebecca's own careseeking was unassuaged and that this reinforced Rebecca's propensity for self-reliance with a need not to make demands on her parents. Read in light of the above story about her father's fear (not told in the group until four sessions later), it might be that his fearfulness triggered unconscious memories of this period when caregiving (and the family's fear) could not be assuaged.

This story may illustrate what McCluskey (2013) says about the link between defensive caregiving and the activation of fear. As a child Rebecca was not able to regulate her brother or mother's distress; and her own distress and fear were being overlooked because of the fear generated by her brother. It seems likely that she learned to offer care in this period as a means of regulating her own distress and bolstering self-esteem in the absence of an attuned caregiver. The habitual nature of this may be seen when she responded to empathic mirroring from the facilitator by passing it on to her mother (222/225).

Internal environment

As said above, Rebecca appeared most vulnerable in the group on an occasion in session one when she described feeling inadequate because she thought she had failed a client. When we met she described the groups as 'therapy groups for health professionals' and she said she saw others seeking care and using the group to address deep personal issues. But she could not think of any instance when she had sought care for herself in the group. Although she had known that caregiving came naturally to her she said she was surprised to discover how difficult it was for her to careseek. Nevertheless, despite being

considerably quieter than the average, she said she worked very hard in sessions, adding that 'most of my work was going internally'.

Remembering that she had described herself as having overcome a tendency toward self-reliance, I asked where this came from but Rebecca gave no answer. This may be the wrong question. It is possible that, although she did not overtly seek care in the groups (and probably came closer to giving help to others) she was not demonstrating self-reliance but the inhibiting influence of fear. In interview she talked about the fear associated with speaking in the group:

*001¹ '... every month I went back I would be filled [laugh] with anxiety before I got there.

*002 What's going to come up?

*003 What's what's the topic for the day?

*004 What's going to come up?

*005 How am I going to bring myself in?

*006 What am I . . .

*007 It was that; the bringing myself in and and and scrambling in my head

*008 What'll I say . . .

*009 And that sense of almost being in the class room, around, got to think of the answer.

This appears to express fear that what she might say would not be acceptable to the group. Although she referenced the 'class room' she subsequently said that at school she was able to participate confidently and had experienced none of the difficulty she experienced in the group. This may be about feeling competent at school where the work had not usually been intimate.

One explanation she gave for her reluctance to speak in group sessions was that it comprised fellow professionals with whom she would subsequently need to interact on a professional basis. She said that she would feel too vulnerable if she had disclosed intimate

¹ An asterisk indicates the text is taken from the interview transcript rather than a group session.

material with them in the group. Why this was more of an issue for Rebecca than it was for many other group members was not discussed. However, it raises important issues that I may have been slow to grasp. The groups were advertised as training yet they clearly have a strong therapeutic character which encourages (and may put pressure on) group members to make themselves vulnerable in the presence of colleagues (and possibly, superiors). Ambiguities in the nature of the courses may influence the behaviour of some group members in ways that cannot be known.

In interview Rebecca described herself as 'more of a background person at times maybe. I'm wary. [. . .] I'm cautious [. . .] I suppose in forming relationships. You know, I can be wary and cautious and sussing people out before I put myself . . .'

Describing the fear that she experienced she said,

*201 I didn't realise that I was going to find it so anxiety provoking

*202 and that actually bringing myself into the group would be quite a challenge.

*203 And that I would be counting 'Oh God, it's coming to me again, [small laugh].

*204 I need to think of something, what am I going to say?'

*205 And I would get quite anxious.

*206 And I would find it so difficult to bring myself in.

*207 And it's not that I wasn't working – I was working myself,

*208 I was attending, I was processing. [P: Right]

*209 But I did find it hard to share [P: Right]. Yes I did.

It seems that speaking was enough to make her feel vulnerable and exposed. In a separate part of the interview she said, "I think it became difficult to think clearly when it was coming to my turn to bring myself in. That's when I'd be, 'I can't even think of an example . . . she's going to look for something specific and I can't think of anything specific'". This sounds as if her thinking processes were inhibited by fear.

Paradoxically, though she said relatively little in the groups, in interview, she expressed resentment about some people who spoke a lot in the group. At the same time she said that she knew that these feelings were to do with her own experiences and that those people had not really been 'demanding'. I asked her what it would feel like to have the attention of the group for fifteen or twenty minutes and she reacted strongly saying,

- *301 Oh I wouldn't be able for that at all – no [. .]
- *302 as somebody who is hogging the floor,
- *303 who is preoccupied with myself,
- *304 who's self-indulgent or . . .
- *305 I, I couldn't bear the thought of a room full of people thinking,
- *306 'Oh here she goes again'.

Her responses suggest that a part of her feels that seeking attention in the group setting is self-indulgent and inappropriate. However, this was not directed explicitly at any named individuals and may originate in attitudes introjected about herself and the inappropriateness for her of seeking care in a group (or family) setting. I asked if she felt the same in one-to-one counselling and she said it was easier, more intimate, safer and more private. Perhaps tellingly she added 'Oh I'm not saying it's not difficult; but not the same level'. So whilst she intimated that one-to-one counselling is not easy, her strong language ('hogging the floor' 'preoccupied with myself', 'self-indulgent') suggest that careseeking, in the group setting at least, triggered fear of criticism. This may be supported by what she said about school not being difficult in the way the group was.

Speaking about the impact of the groups on her she said, 'when I'd leave the group I'd feel absolutely exhausted. Exhausted. I'd be just fit for nothing that evening.' She said this reflected nervous energy and the effort of processing all that was happening in the group. She also said it was because she was very sensitive to others and absorbed their distress.

Unsupportive internal environment

Although Rebecca did not describe the criticism of her internal environment directly she reported that this had been a considerable problem for her and that she was trying not to 'beat myself up' for being inadequate as a daughter, niece, friend and psychologist. As she described her relationships it was clear that she felt a strong sense of expectation that she be 'good'. She talked about a tendency to measure herself against other people's standards. 'Good' therefore had a wide range of meanings but a major part of this involved caregiving to others. She said that more recently she was learning that she did not have to respond to every cry for help and could take time off from being a caregiver.

Rebecca also told me that she had been frightened that she may become vulnerable in the group. 'I might get upset and I don't want to get upset and I don't want to feel not regulated in myself and . . . the exposed really'. It seems from this that she had no trust that a caregiver would help her to regulate her feelings if she became distressed. It may also mean that, for Rebecca, becoming distressed was somehow associated with shame.

In interview Rebecca alluded to an incident in which a group member became angry and walked out of the session. She said the thing that would hold her back from behaving in a similar manner was fear of hurting someone's feelings. She said she wouldn't have the 'gumption' ('confidence' or 'guts') to play it out in public but would have worked it all out in her head. This is wholly consistent with her behaviour in the group.

Exposure and vulnerability in the group

Looking at her input as a whole I am struck that the occasion in group when Rebecca appeared most vulnerable occurred in the applications to work section of the first session. She engaged in a relatively lengthy discussion that involved numerous exchanges with the facilitator and other group members to address her work with an adolescent boy with whom she felt herself to be struggling. She described more feelings in relation to this casework than at any other time in any session. In view of what she said in interview about feeling vulnerable in front of her peers it may be that she left that first session feeling over

exposed. At no time did she ever give feedback to the group so I can only speculate about the impact that this first session had on her in subsequent sessions. Her word count in subsequent sessions never matched the total of her first session. In five sessions for which I have transcripts² (2, 3, 5, 7 & 8) she spoke only once and on three of those occasions only when invited specifically.

In chapter thirteen I speculate about whether something in her presentation meant that Rebecca was unable to activate caregiving in the facilitator or whether the facilitator was at some level attuned to the discomfort that Rebecca felt when required to speak in sessions. It appears that she never became comfortable about speaking in the groups. When I met her in interview she was very helpful and perhaps solicitous of my needs. I subsequently wondered if caregiving to me (and indirectly to the facilitator) influenced some of what she said about the groups.

Conclusion

Rebecca confirms much that is suggested by flow diagram two. Again there is evidence that activation of careseeking was linked to shame and the activation of fear. Indeed, her relative silence in the group may be evidence of the operation of shame. Moreover, her internal environment appears to undermine careseeking by linking careseeking with attention seeking. Consequently, her default position seems to have been to self-regulate by excluding her distress and need for care and actively giving care to others. That this is a way of life for Rebecca may explain why her strongest experience of vulnerability appears to have come in discussion of failed professional caregiving in session one and was never repeated. The process of selective exclusion may explain her surprise to discover how difficult it was for her to ask for care in the group.

It is interesting that Rebecca gave hints of a shadow side or limit to her empathic caregiving. When talking about people who spoke most in the group, despite what appears to be a strong internal pull to the contrary, she seems to equate their behaviour with

² Session nine was not recorded

demandingness and self-indulgence (*301-306). It is easy to imagine that this reflects either introjects from frightened and harassed parents or a child's attempts to understand why there was little care for her in the home. I am also struck by her description of her brother's cry as 'a very harsh, shrill voice'. It is possible that this reflects remembered pain arising from unregulated distress or even unassuaged caregiving; suggesting a possible link with Strathearn et al.'s (2009) findings about brain mechanisms activated when insecure mother's see their infant in a state of distress (see chapter two).

Although neither anger nor hate were directly expressed by Rebecca in the group, it is clear that negative emotions are within her repertoire. She spoke of having to work at controlling her anger toward her father. In the context of the group she gave no hint of negative feelings in relation to more vocal group members. It seems likely that she either masked or did not access these negative feelings when in the group situation.

Finally, I am struck by the fact that Rebecca appears to have revealed more about her internal world in a one-to-one research interview than she did in eight sessions of a group focused on exploring attachment relationships. This may be because she was less frightened in a one-to-one research interview and/or that she wanted to help me achieve my goals.

Chapter Seven: Quieter Course Members (III)

Case Study Three: Stephanie

Introduction

When she attended Course B, Stephanie was part of a team offering professional care to people with mental health problems. She was in her early forties and was married with two young children. She informed me that the groups were recommended by a colleague. She first attended a two day introductory workshop run in her department. She was unequivocal in describing the groups as 'a therapy group for health professionals'. Course B was the first series that she attended. She had attended two subsequent courses before I met her.

I had originally excluded Stephanie from consideration in this chapter because the group transcripts offered insufficient evidence about her experiences in the group. Nevertheless, as the third least vocal member of Course B (her word count is slightly higher than Rebecca's) I chose to meet with her in interview and it was quickly apparent that she had much to say that was relevant to my study. This case study is largely based on one input from session six and what she told me directly.

During our interview Stephanie said that a major part of her original motivation to attend the groups had been to deal with sexual abuse she suffered in childhood. However, she did not share this information with Course B. It was not until she attended a second course that she felt able to speak about it. When she did so, she said she was helped by the example of another group member who spoke about similar experiences.

Presentation in Course B

In interview Stephanie said she felt she was very quiet in the first course and that this reflected her 'cautious' personality and 'slowness to trust others'. She said she had not

had therapy before attending the group and initially found the group a strange and difficult experience. Her difficulty was exacerbated by the fact that she knew at least three people in the group (one of whom had been a friend and colleague) and anticipated meeting them in professional meetings in the future. Because no mention was made of confidentiality at the start of the group,¹ Stephanie said that it took a long while for her to trust that this was a safe forum in which to reveal personal and intimate aspects of her experience. This again raises questions about the management of the groups but it is clear that Stephanie came to the first course, on the recommendation of a colleague, specifically because she thought it was therapy.

Like Rebecca, Stephanie was clear that her relative quietness in the group should not be taken to mean that she was less deeply engaged in it: ‘. . . I got a lot, I was doing a lot of work inside but not as much out in the group’. Also like Rebecca she described powerful emotional reactions to the group sessions; sometimes she ‘dreaded’ attending and sometimes she would leave feeling ‘drained’. But, having achieved a lot in private, she also said she came out of sessions feeling ‘energised’, ‘happy’ and ‘free’. Stephanie said that the issue of trust concerned protecting herself from becoming vulnerable.

Childhood experiences and perception

In session six of the group Stephanie picked up on a phrase used by another group member who had said that her mother just wasn’t emotionally available. Stephanie began her next input by linking what Katie had said to a recent dilemma when choosing a mother’s-day card:

602 I’m thinking of my mum, and how detached at times I think she is;

603 but it’s not something that I would have noticed as a child,

604 [. . .] as a child I would, I mean

605 I can think of lots of happy memories,

¹ I understand from the facilitator that confidentiality was dealt with fully in consent forms signed by group members immediately prior to the first group session.

606 and I can think of her just whistling and singing,
607 and that was kind of her way.
608 And she was great, the house was always warm, everything . . .
609 There was all of that.

610 But it's like there was no real major conversations going on; or talking.
611 And there was no opportunity really to talk, how you are,
612 and it's the same today.

She then said that she felt anger and frustration in relation to her mother and had recently faced a dilemma selecting a very neutral Mother's Day card that was neither hypocritical nor hurtful.

623 And for me at the moment I see mum,
624 I mean she has a great life, she's a lot of interests, [F: mm]
625 now she's developing her interests.

626 But I think she's losing out on,
627 [. . .] the most important interest she should have,
628 is her family and her grandchildren; [F: mm]
629 but she's not there and it's very frustrating.

630 But I wouldn't have seen it as a child. [F: yeah]
631 I'd have thought she was there,
632 but whatever has happened she's not there now.

The facilitator then asked her what emotions she was covering over with the word 'frustration'.

634 I suppose it's sadness really, and disappointment,
635 that I can't have this:
636 I thought, a lovely, fairly lovely family,

637 but there is a particular thing that isn't very lovely.

638 Mother was OK,

639 but in the last few years I don't have that feeling now.

640 It kind of feels all coming apart'. [Sounding close to tears].

641 [F: Yeah, that it's all coming apart, because of this lack of connection.]

642 Lack of connection.

643 Now there is a particular issue that I think has kind of come to the fore,

644 and that has really damaged everything,

645 But I get frustrated that that one issue,

646 that more than that person who caused that issue,

647 and it has affected everything.

648 And it's like the family is gone; the extinct family in many ways. [Crying]

649 [The facilitator mirrored back the pain in what Stephanie had said and invited her to say more about the 'issue'.]

650 [Text omitted that adds nothing new; she did not talk about the issue.]

656 I'm seeing all Mum's flaws now,

657 whereas up to now I'd have defended her,

658 defended her, she was good, [F: yeah]

659 she did her best and all of this.

660 But now I'm really angry with her, [F: yeah]

661 and she frustrates me,

662 day in day out at the minute

The facilitator responded by following Stephanie's focus on the anger she feels about her mother. Stephanie contrasted positive memories of childhood: her mother 'humming and singing' and the 'house always warm', with another reality in which she described an absence of real connection between her and her mother (originally the facilitator's words) and the absence of talk about how she was really feeling (610/611) and the presence of a 'particular issue' that 'has really damaged everything' (643/644).

When Stephanie first described the problem it was in terms of her own children; her mother was missing out on the chance of a relationship with them. She summarised the problem as, 'she's not there and it's very frustrating'. When asked to say what 'frustrating' meant to her she spoke about sadness and disappointment that she can't have 'a lovely [. . .] family' (636). In a possible reference to her abuse she then talked about a 'particular issue' that had 'come to the fore' and was causing the extinction of the family (644-648).

Selective exclusion from awareness

At key points in this input Stephanie repeated the idea that when she was a child she would not have noticed the problems that were then making her angry (603/4; 630). 'I'd have thought she was there (631) and 'I'd have defended her, she was good, she did her best' (657-59). It appears that her first recognition of the problem arose not because of anything directly experienced in her own relationship with her mother, but from the absence of interest shown by her mother in her (Stephanie's) own children. She illustrated this in a separate story when she reported that her mother had not bothered to phone after seeing Stephanie's eldest child performing on the television. Here, and in interview it was apparent that Stephanie's intense care for her children provided a lens through which she had reevaluated her mother's behavior toward her and her siblings.

Viewed through this lens it had become clear to her that her mother had never felt the intensity of care (love) that Stephanie experienced in relation to her children. When she had been a child she slept in the same bed as her four sisters; they were just 'the girls' and were not seen as individuals with separate personalities and needs. She told me this lack of individuation in her mother's attitudes toward her daughters continues into the present.

Internal environment and careseeking

Perceived unavailability of her mother had meant that Stephanie and her siblings were required to look after themselves and as a child she said she got most care from an older sister. In session two of the group Stephanie said she found careseeking difficult and that her husband was the only person she expected to consistently offer her care. In session five she spoke about occasions when, because she was upset with her husband for some reason, she found it difficult either to seek care from him, or to say what was wrong. On those occasions, she said, her 'fear system would come up' and she was unable to talk to him and would brush off his concern by saying, 'I'm fine', even though 'everything was telling him I'm not fine'. She reported that he had come to understand that 'I'm fine' is code for, 'I need care but I can't talk to you'.

Asked in interview if Course B had been a place where she could seek care Stephanie said that she 'absolutely' knew that it was possible to ask for help; she saw other group members doing so and receiving positive responses; but she did not recall any occasion when she had done so.² She said that it takes time for her 'to trust [. . .] that it's the right care or that the person is genuine'. She also talked about a general lack of confidence, unrelated to the group, that her requests for care would be heard:

- *401 Maybe there is a thing,
- *402 if I ask for . . .
- *403 maybe I'm not so sure I will get heard,
- *404 or get the answer,
- *405 or get the result even, if I ask for myself [. .]

- *507 Maybe I've much more conviction
- *508 when I'm advocating for somebody else
- *509 that I really see this . . .
- *510 Or how they've been hard done by.

² In the period between her attending Course B and my meeting with her, Rebecca attended two further courses. Although she tried to answer my questions solely in relation to Course B it is likely that her answers were influenced by awareness gained in the subsequent two courses.

*511 So maybe I'm more forceful or . . .

*512 I dunno . . .

From this extract it seems that she lacks confidence that other people will hear her if she asks for care. More than this, it seems that she does not see things as clearly in relation to her own need as when she is caring for others. So she can assert herself in relation to other people's needs in a way she cannot in relation to herself. This suggests a strong distorting influence exerted by an unsupportive internal environment.

Working privately in the group

Stephanie spoke clearly about benefitting from hearing other people speak and I suspect that, like Rebecca, she controlled things so that she received care in the group at a more private level. In part this was achieved because hearing the experiences of others normalised her imperfect personal history.

*101 . . . you see people in the groups and you know they all have their positions,

*102 and, do you know, everybody has their stuff,

*103 and it's that that it wasn't just me, everybody has it. [. . .]

*104 . . . It's really normalising, yeah.

*105 And that there's no such thing as the perfect upbringing.

*106 And very few people have it I'd say have . . .

*107 Without having some problems or some difficulties.

*108 That became very evident in those groups.

For Stephanie it appeared to have been a significant insight that, no matter how impressive their professional roles and how 'together' other group members appeared on the surface, everyone had real personal history which included trauma and other difficulties; and that this did not reflect badly on them. Again this suggests an unsupportive internal environment as I suspect that, though she knew all this at an intellectual and professional level, in her first group series at least, personal issues were (consciously or unconsciously)

viewed as imperfections in the self and so her personal history triggered shame and inhibited her participation in the group.

Caregiving

In interview Stephanie said that caregiving came more easily to her than careseeking. She saw caregiving as the major function of her professional role. However, in session two she spoke of being exhausted with caregiving and said, 'I feel I've done too much caregiving at the minute; I feel a bit overloaded with it'. She then became upset and reported that, because of the effort she expended at work, her children got 'the rag end' of her energy. My reading of her distress was that at the moment of speaking she felt she was not giving enough to her children.

Caregiving and selective exclusion

Using something a colleague and friend in the group had said in session one, Stephanie contrasted their different experiences by pointing out that Louise had expressed surprise when she looked back and found that things weren't as bad as she had thought. By contrast Stephanie said she had tried to present things as if they were fine and happy but had to admit 'it wasn't all happy'. When saying this to the group, the facilitator responded with affect regulating interventions suggesting that Stephanie may have been signalling distress (see chapter thirteen).

When set beside what is said above about Stephanie re-evaluating her history through a lens provided by her experiences as a mother, this event suggests that she had selectively excluded some negative aspects of her early experience. Moreover, the suggestion that she tried to present things as if they were all right may suggest that, in part at least, this exclusion was achieved with effort or as an act of will. In what she said about defending her mother and protecting her from criticism (657-659) it is possible that the early relationship between Stephanie and her mother had become inverted with Stephanie caregiving to her mother. However, a key element of this caregiving involved turning a blind eye to things that were not right in their relationship; namely, her mother's limited

ability to show interest in her and the fact that, as part of this, she had failed to protect Stephanie from serious harm.

Unsupportive internal environment

As has already been seen above, evidence of a critical internal environment was plentiful in my interview with Stephanie. For example, sometimes she was punitively self-critical about her unreadiness to self-disclose in the group. For example, failing to disclose the fact that she had been sexually abused as a child was a personal failure compounded by her professional role. Although she knew at an intellectual (and professional) level why this had been difficult for her, when she attended Course B it is apparent that, at an emotional level, she had few internal resources from which to draw support. I suspect that, because she had not addressed this issue prior to attending Course B, it existed as raw and unsymbolised trauma and shame.

In interview she spoke about a tendency to beat herself up and give herself a hard time saying that this was especially true when she felt vulnerable.

*201 I was probably the greatest critic myself;

*202 why I hadn't done something about it sooner. [P yeah]

*203 And I suppose I kind of . . .

*204 It was maybe more about myself really,

*205 more so than others in the room. [P Right].

*206 But there was a sense of needing others in the room not to go down the route I went down.

In this extract from her interview with me I think Stephanie's self-criticism was linked to a sense of personal vulnerability; the fear that, if they had known about her, other people in the group might have gone 'down the same route', and so, would have judged her harshly. A professional consideration may have influenced how she felt if she believed she had a professional duty to report the abuse/abuser as a matter of protecting others. I believe

that it was necessary for her first to witness other people sharing intimate and painful revelations, and to see the response they received, before she could disclose the source of her own troubles to the group. I spoke above about her having insufficient inner resources to help her deal with her pain. Outside of the relationship with her husband, she appears not to expect attuned or empathic understanding and so she finds it difficult to trust that she will not be judged harshly for all her self-designated failings.

Private nature of group participation

Late in our meeting I asked Stephanie what had been the most significant event to have occurred in the nine sessions of Course B and she replied that it had been her decision, taken in private, to seek one-to-one counselling and to return for a further group series. It appears that the major benefit that Stephanie reaped from her first course was the opportunity to hear from and feel a connection with other group members whilst being allowed to work in private. The openness of other group member's about painful experiences, particularly about childhood experiences, was 'normalising' for Stephanie and gave her the courage to talk about her own pain. But this did not happen until she came back to the second group series when the example of others talking about similar experiences seems to have moderated the shame associated with her history.

Conclusion to Stephanie's case study

Many of the observations made in respect of Stephanie echo what has been said in relation to Rebecca and Helena and the chapter will close with discussion and comparison of the three case studies in this section using the statement of theory and second flow diagram.

When writing about Stephanie I have been struck by the link between issues arising from her personal history and her sense of vulnerability. From childhood she appears to have carried shame for the abuse she suffered and she feared that, the more people knew about her, the more likely they would be to judge her as harshly as she judged herself. Here is confirmation of the power of shame to motivate hiding.

There is also evidence that, in this first course at least, it was difficult for Stephanie to ask for care. Caregiving came easily to her; she trusted her judgement concerning the needs of others and had the confidence to advocate on their behalf. It is especially noteworthy, therefore, that she did not trust her judgment in relation to her own need for care. This may have been influenced by the fact that the issue she most needed care to address, as a child and in the group, was profoundly associated with shame.

Discussion of the three case studies using predictions from the statement of theory

Though containing counterexpectational elements the three cases discussed in this section offer interesting evidence, much of which conforms to flow diagram 2. To aid discussion of the findings I have reproduced flow diagram two (overleaf) and structure the discussion with headings drawn from the predictions made at the start of chapter five. In light of my analysis of these case studies I have amended flow diagram two by including the word 'shame' in the box representing the content of the unsupportive internal environment.

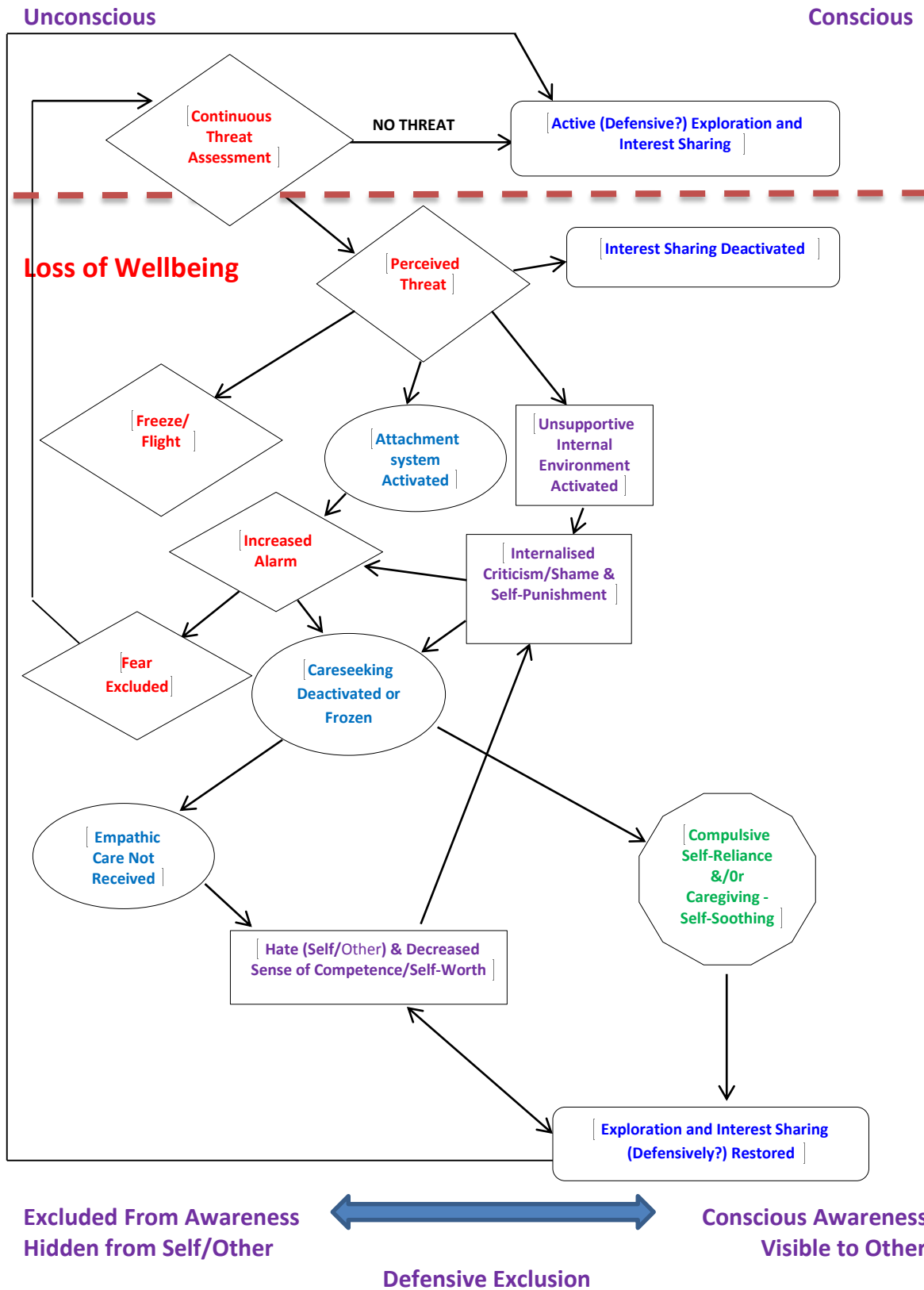
Quantity of speech

These cases were selected on the basis of word count. Interview evidence from Rebecca and Stephanie suggests that both worked alone (exhibiting self-reliance) in the groups rather than seeking care from the facilitator. Rebecca most clearly expressed a link between speaking and fear but in all three cases speech appears to be associated with risk of exposure (shame).

Expressions of fear and distress

Helena expressed more fear than would have been predicted using the diagram but I think this may reflect the wider group process. Course A included two of her colleagues, both of whom joined with other established members early in session one in expressing high levels of fear. In view of what she shared in the group it seems likely that group processes undermined her normally avoidant defences. There is ample evidence that Helena did not find it easy to speak in the group, she was surprised by the depth of her feelings in session two and connected more fully with some feelings (rage) only when she had retreated from the situation.

CARESEEKING CONSTRAINED BY AN UNSUPPORTIVE INTERNAL ENVIRONMENT



Flow Diagram 2. New shape (bottom right) represents something akin to Winnicott's 'False Self'.

Rebecca and Stephanie more obviously conformed to flow diagram two because neither expressed fear or immediate distress in their group; yet in interview both described high levels of fear about group sessions. In the group this fear appears to have manifested as silence and, for Rebecca at least, expressions of self-reliance, competence and caregiving.

The fear described by these cases suggests that activation of careseeking was probably associated with activation of fear. In information processing terms this might mean that when careseeking was activated, preconscious memories, affects and cognitions were triggered which undermined careseeking. Words used suggest that careseeking appears to be associated with negative experiences such as being exposed, vulnerable, crying, and being judged adversely. The fear of exposure suggests that careseeking for these people has become associated, at a conscious or unconscious level, with the activation of shame.

Interview data suggest that Rebecca and Stephanie both worked privately in the group. This may support the idea that their internal environments inhibited the expression of fear (and careseeking) as depicted in flow diagram two. However, it seems that, while they gave little indication in the group, Rebecca and Stephanie experienced powerful feelings that they kept private. Although this is not what I anticipated when drawing the diagram, it perhaps concurs with studies that measure biometric responses of avoidant individuals (see chapter two).

Careseeking

In view of the above sentence it is not surprising that all three of these cases appear to have had difficulty with careseeking. Although Helena sought and received care in session two, this was a very intense experience which subsequently became associated with rage. It is likely that her rage was a reaction to shame.

It may be that Rebecca came closest to careseeking in the applications to work section of session one (when she spoke of failing and feeling rejected by a client). This was not repeated in subsequent sessions, perhaps because it caused her to feel unbearably vulnerable. When interviewed, Rebecca and Stephanie both described the groups as

therapy yet neither sought care for themselves in any way that was clear or obvious. In the case of Stephanie this is noteworthy because she had attended with a definite aim to obtain therapeutic help with a specific issue.

In the three cases examined thus far, I believe an argument can be made that careseeking was activated by the presence of a caregiver and the example (and stories) of other group members; but activation of careseeking triggered the simultaneous activation of fear (and perhaps shame). It may be more helpful to invoke Mikulincer and Shaver's (2007) idea of preconscious activation of memories, cognitions and affects that deactivate careseeking. So for these group members, the activation of careseeking (a request for care), was a largely private process in which any careseeking intent was deactivated and may have been disguised as something else (such as exploration).

Unsupportive internal environment

Helena, Rebecca and Stephanie might all be said to evidence negative internal models of self and other. They might therefore be thought to fit more clearly into Bartholomew's fearful attachment group. Here perhaps is a consequence of adopting a four category model that combines different research traditions. The people in this group of case studies do not appear disorganised/disoriented in their presentation and so I have classed them as withdrawn. Nevertheless, while they emphasise self-reliance and appear to deactivate attachment in times of threat, they appear not to downplay the importance of close relationships.

Flow diagram two depicts a self that is held in check by an unsupportive internal environment. It seems likely that for all three of these cases, an unsupportive internal environment inhibited careseeking. I have suggested that Helena sought care in her group because avoidant defences were eroded by group process. She subsequently felt very vulnerable and exposed. For Rebecca, careseeking was associated with attention-seeking and self-indulgence while Stephanie appears to be confused and frightened in relation to her need for care. In all three cases there is evidence that the activation of careseeking triggered shame.

Other-directed hate and self-directed hate

The evidence for other-directed hate of any kind in these case studies is sparse. Helena experienced feeling vulnerable (shame) in response to exchanges with the facilitator and this subsequently triggered 'rage' or intense anger (probably directed at the facilitator). I suspect this was defensive anger triggered by shame. I don't think it is hate as defined in the study. The only other possible evidence for other-directed hate may be seen in negative attitudes expressed in interview by Rebecca about more vocal group members. But these attitudes were not apparent in the group and were not directed at any named individuals. Helena and Rebecca both spoke in the group about anger that they felt outside of the group setting which was directed at other people. It is possible that these people have difficulty expressing their anger toward others. It is also possible that they felt constrained in the group but were better able to express anger in their relationships outside of the group. The data provides insufficient evidence about this.

More convincing, perhaps, is evidence that self-directed hate infiltrates the internal environment of each of these cases with critical judgments that undermine their ability to seek care. I suspect that, for each of these people, self-directed hate is part of a braking system, within their internal environment, which is activated at times when they are distressed and works to inhibit careseeking. In keeping with the flow diagram, it appears that careseeking was constrained (being pushed over to the left side of the page) and held in check by an unsupportive internal environment. As it appears in these chapters, self-directed hate appears to be profoundly shame-linked; perhaps the preconscious activation of memories involving criticism and rejection that have been incorporated into models of self and other.

Defensive caregiving

All three participants offer evidence of defensive caregiving as a means of dealing with threats to wellbeing. For Helena, being good was associated with giving care to others and fighting their battles. Rebecca seemed most active when concerned with the needs of others and became distressed in the group when reflecting on a case in which she felt she

had failed. Stephanie talked about being worn out by caregiving and distressed at having insufficient energy to give her children what they needed from her. It seems that, in each of these cases, caregiving was easily expressed, as if it was bound up with self-esteem or personal identity. This confirms the depiction within the flow diagram.

Selective exclusion

In all three cases there is evidence of the role of defensive exclusion as a strategy for managing fear and deactivating attachment. For example, Helena gave no hint of rage during session two and, in session three, could only access it as a memory. Rebecca's account of a secure childhood home appears to mask various fault-lines in her awareness while Stephanie's impression of her mother changed only when she saw her through the eyes of her children.

A pattern in many, if not all, of the case studies is that people benefitted from hearing other people relate their experiences. In the case of Helena, this process may have eroded avoidant defences allowing her to access memories, affect and cognitions that might otherwise have been excluded. Something similar may account for Rebecca allowing herself to become vulnerable in the first session (and perhaps strengthening her defences thereafter).

Confusion and incoherence

There was little if any clear evidence that people in these case studies felt blank or confused in the group. Although speaking in the group seems to have been difficult for Helena, there is no evidence of her being confused or incoherent.

In interview Stephanie was clear that the group was somewhere in which it was possible for her to think clearly. Rebecca talked about becoming confused when it was her turn to speak but this seems to have been a specific response to her fear of speaking in the group. Both Stephanie and Rebecca valued the work they did in private. When left alone, it seems

the groups provided a place where they could hear others speak about topics that stimulated their own reflections.

Conclusion

The findings from these three cases go some way toward confirming the behavioural systems account of the self as represented in flow diagram two. In particular they attest to the general shape of the flow diagram in which selective exclusion operates to deactivate careseeking and reveal only more acceptable or safe aspects of the self. Although these cases tend to be reticent in their expressiveness, it is clear that while appearing to give little away to the group facilitator and other members of the group, a lot was happening for them at the level of both cognition and affect.

The flow diagram depicts these cases as being careful not to expose themselves to adverse judgment; and deactivating careseeking seems to be part of this. It seems clear that there is more happening for this group than they show to others. The diagram suggests that work with this type of client requires looking beyond their presentation, hearing and recognising the self-punishing nature of their internal environment and patiently regulating both fear and shame (now added to the flow diagram) so that they learn to trust that self-exposure and careseeking will not be punished.

The findings from these case studies and those in the next five chapters will be discussed in chapter fourteen.

Chapter Eight: More vociferous Group Members (I)

Introduction

This and the next chapter examine two cases representing people with high word counts. My early attempts to understand this group are expressed in a third new flow diagram. Sarah and Alison were included in the study because both were the second most vocal members¹ of their respective groups and they were influential when I was creating the flow diagrams. They were not in the same group and as far as I know do not know each other. Both are psychotherapists/counsellors.

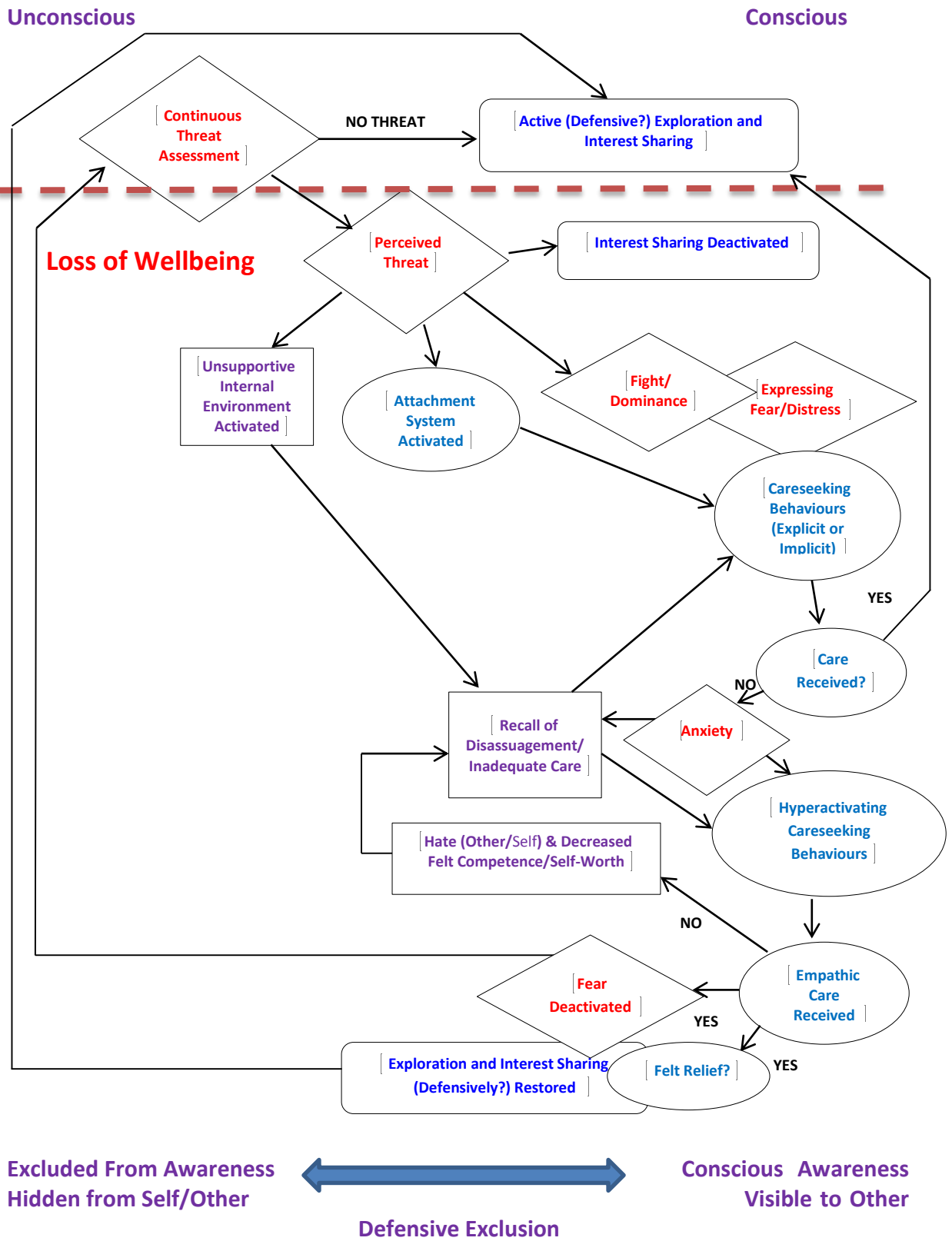
Predictions based on flow diagram 3 (below)

Because we have now moved to consider people who appear to behave in a different way in the groups, this chapter will begin with a new flow diagram. The diagrams were influenced by Mikulincer and Shaver's (2007) descriptions of preoccupied attachment and the idea that selective exclusion operates in a way that allows for the hyperactivation of attachment. The diagram tries to describe people who have in common to some degree the following characteristics:

- Likely to speak more than most in the group.
- More readily express emotion (distress and fear).
- More likely to seek care in the group.
- Emphasis on internal contingency (what is happening inside them) rather than what is happening in the group; a tendency to redirect the focus of the group to issues that concern them in the moment.
- Selectively exclude issues that would inhibit careseeking.
- Likely to be less troubled by an internal environment that inhibits careseeking.
- Other-directed hate stronger than self-directed hate.

¹ The most vocal person in each group was unavailable to participate.

CARESEEKING HYPERACTIVATED BY FEAR OF DISASSUAGEMENT



Flow Diagram 3. Restorative process in which careseeking is hyperactivated by fear of disassuagement.

In flow diagrams two and three I have omitted the word 'wellbeing' which appears at the top of flow diagram one to depict the individual's state prior to the perception of a threat. This omission is intended to represent Heard and Lake's idea that, for insecure individuals, exploration may be defensive or non-existent.

Case Study 4: Sarah

Introduction

At the time she attended Course B, Sarah was a woman in her early fifties working as a counsellor/psychotherapist with a client group of predominantly young adults. Brought up as a middle child (an older sibling had died at birth), she was married with young children living at home. In interview she said that she had joined the groups for professional development (CPD). Like all but one of the members of Course B, Sarah was attending her first group series.

As with all of the case studies, I selected extracts for analysis having first familiarised myself with all of the transcripts. In this case study I have chosen extracts that I believe typify Sarah's contributions to her group. All of her narratives were taken from the transcript of session six (Course B) because they deal with issues that were important to her over the nine month period.

Sarah missed the third session because she had suffered a bereavement when her mother-in-law died unexpectedly. She reports that their relationship had been very close. In interview she told me that in sessions after this bereavement she was in a fragile emotional state that altered her behaviour in the group. Her word count increased following this event.

The first story to be examined was told in the feedback at the start of session six (which precedes the experiential group). It recounted an event that took place after the previous meeting. Later she reflected on her general experience of careseeking which she related to experiences in childhood.

Context created by previous narratives

In her first input to session one Sarah identified with group members who described themselves as self-reliant and said she was more likely to try to sort out problems herself than ask for help. She also said she preferred to 'invite' rather than ask for care. Late in that session she expressed surprise at realising that, for her, careseeking was associated with fear. She linked this to an incident some years before when she was rejected by one of her siblings. She subsequently spoke of other occasions when she had been hurt or failed by significant attachment figures. In session four she said that from her infancy her mother sometimes responded to signs of her distress in a manner that was unempathic and shaming.

However, her reflections in that session were impacted by grief because her husband's mother had died in the previous month. Sarah described her relationship with her mother-in-law as uniquely close and loving. Speaking at this very sensitive time Sarah talked about how her distress was mixed with anger because her husband had refused to honour a small bequest that her mother-in-law had intended for her. In the following session (s. 5) Sarah talked about her husband repeatedly failing to support her at times when one of his siblings had treated her in a domineering and hostile manner. Repeating a conclusion reached in session one she began that story by saying, 'What triggers my fear system [. . .] is fear of rejection, or being blamed or made to feel like the bad person [. . .] when I feel rejected [I] feel blamed'.

Narrative about seeking reassurance from her husband

Sarah's feedback in session six began by linking her story to the previous session saying, 'I found it helpful, to understand things in a certain way' (6001). This linked her input to a previous story in which she spoke of feeling unsupported by her husband when persecuted by one of his siblings.

The context of the new story was known to other group members from earlier sessions. The death of her husband's mother meant that her father-in-law was in need of ongoing

care from the wider family. At the start of her story Sarah said she felt a rising frustration that no one else was doing anything to address this need for care. She, therefore, decided to email her husband's siblings to organise ongoing care but was conscious of dangers involved in doing so.

6020 I struggled a lot with knowing
6021 whether I was operating out of a fear system kind of anger;
6022 sort of frustration or annoyance or anger.
6023 And that I was going to put something in the email
6024 that was going to get sort of a defensive reaction.

6025 I spent ages looking at the wording
6026 and seeing, 'Now, well where am I now?
6027 Am I over here careseeking?
6028 Am I in a mature adult position', is how I would describe . . .

6029 which is a reasonable position to ask for what you need for yourself.
6030 'Or am I over here demanding?'

6031 And I found that I had very, a very low capacity to differentiate which I was doing.
6032 And I, what I realised was that I need external reassurance,
6033 in order to be able to stand sort of secure in my adult position.
6034 My careseeking, caregiving kind of mature position;
6035 I couldn't know that I was there on my own.

6036 I needed, and still do need,
6037 which is . . . pisses me off, you know,
6038 somebody else to say
6039 'Yeah, that sounds good, that sounds normal.' You know.

6040 And that pisses me off,
6041 because I feel I need to be able to establish for myself [F: OK] what that is.

The facilitator made an affect regulating intervention saying, 'If you can let the tension go' (6042) and asked, 'Do you have a sense that you could in time begin to know when you're defensive and when you're not; from the inside?' Sarah responded by saying, 'The scary answer is no' (6043). The facilitator worked to reduce Sarah's fear.

6045 I'm actually feeling very frustrated about it,
6046 because, I think I was still over . . .
6047 I needed reassurance that my email was OK.

6048 And two [of his family members] emailed me back
6049 saying, 'Thanks, sorry', kind of thing.

6050 My husband, when I said, 'did you read my email,'
6051 looking for reassurance [said] 'Yeah.'
6052 And I said, 'Well what did you think?'

6053 He said, 'Well, you wrote your email. [F: yeah]
6054 And you decided to write it and you wrote it
6055 and it's fine.'

6056 So I thought, 'What!'

6057 But I actually just totally detached from him and let them off to bed.
6058 And I stayed up watching television.

6059 And I don't understand that.
6060 I'm so cross with myself that I needed it from him. [F: Yeah]
6061 And I'm very cross with him
6062 and don't understand.

6063 I mean maybe he, you know . . .

6064 If he was my therapist I'd understand it because he'd be saying
6065 'Well now what does it say about you that you need me to reassure you?'
6066 But he isn't.

6067 [Catherine: That really annoying way that therapists do].

6068 But at least I wouldn't feel that the therapist had a hidden agenda
6069 in sort of keeping me on some kind of a hook or something.
6070 God forgive me, you know, he probably doesn't . . .

6071 [F: . . .] At this point the facilitator offered an affect regulating intervention but was interrupted by a group member arriving late for the session. The facilitator welcomed the latecomer and gave a summary of what the group were doing. She then reminded Sarah that her story had been told in part of the session designed for brief feedback rather than substantial experiential work. She invited her to bring the story back into the experiential session because she was talking about things that were important to a wider section of the group.

Purpose in relating the story

In this story it is noteworthy that through much of the action Sarah says she acted alone. This may reflect what she had said in session one about being self-reliant. In her story it appears that she alone saw the need to act in order to give care to her father-in-law. She also appears to have been alone when she decided that forward planning was required, when she struggled to understand her motivation and when she composed a carefully worded email. Only after the email was sent did she share what she had done with her husband and ask for his view.

Telling this story in the feedback part of the session means that Sarah had taken the earliest opportunity to share the events with the group. This may suggest that she was holding a level of distress that she wanted to share with a sympathetic audience and so indicate that

careseeking was, at that moment, activated by the presence of potential caregivers. Early in session four, the first session after her mother-in-law's death, she had told another group member, Catherine (who, outside of the group, was her clinical supervisor), that before arriving at the group she had had a fantasy that she would break down in the group and that Catherine would give her care. Here then is a simple statement that she came to the group hoping to receive care. However, it is perhaps telling that her fantasy involved receiving care because of a breakdown rather than because she asked for care. This might be consistent with a strategy of acting out careseeking (or acting out her need) rather than requesting care.

In interview Sarah described her emotional state during this period as 'fragile' so we might assume that receiving care was especially important. Although she did not explicitly ask for care from the group it is reasonable to assume that her story was a means of eliciting understanding and as such it expressed active careseeking. The implicit nature of this careseeking may explain why she requested her husband's opinion, 'Well what did you think?' (6052), when what she really wanted was his reassurance. On that occasion the implicit careseeking within her question was unassuaged and she became angry.

Affect, disassuagement and the internal environment

Emotion is a central feature of many of Sarah's stories and was emphasised over detail. Her first story in the first group meeting lacked all detail except that she had learned something before the group that caused her to feel 'collapsed'. She expressed distress but gave no information at all about the cause or nature of her distress. Other stories lacked details so, for example, we don't know how or why she had experienced rejection in family relationships but do know about the distress it caused her.

Though stories told in session six did not lack detail, they emphasised emotion (and her distress) over action. It is worth noting in passing how this contrasts strongly with most of the stories told by quieter people who tend to hide their feelings. The above story began with Sarah feeling concern for her father-in-law and a rising level of frustration (6011/12) because no one in her husband's family had responded to the situation. She 'felt' a need

to ask for forward planning (6016) but feared that her email might provoke a defensive response (6026/7). She struggled to understand the feelings underpinning her motivation and whether it originated in fear or anger (6022-6025).

Sarah's struggle seems to reflect an unsupportive or persecuting internal environment. Though heard only indirectly I believe it may be possible to discern in her story an internalised voice which told her that it was wrong to seek care; and that careseeking was 'demanding' (6028-6030). However, this internalised voice seems to be heard outside of awareness and was never directly articulated by Sarah. Nevertheless, insecurity about 'careseeking'/'demanding' was the trigger for Sarah's realisation that she needed external reassurance in order to stand firm in an 'adult position' (6032/33). Although Sarah's story demonstrated self-reliance to the extent that she says she acted alone, it is likely that this was based on fear of being rejected as a nuisance. It does not reflect deactivation of attachment. When she eventually sought reassurance from her husband her request was masked, 'Well, what do you think?' (6052); and she did not, explicitly talk about her insecurities or ask for reassurance and care.

Sarah's story concluded with her feeling angry about her husband's failure to give reassurance (6056; 6061/2; 6068/9). However, in a manner that does not comply with flow diagram 3 her anger is initially self-directed (6060). While this may indicate that a normally implicit self-persecuting internal voice had become more explicit, even in this expression, her anger is principally about her husband.

When she first talked about the anger she felt toward her husband she did not say why she was cross with him but closed her sentence, 'and I don't understand' (6061/62). It may be that this issue was closed down because it was too threatening. Soon after this, she suggested that he had 'a hidden agenda in sort of keeping me on some kind of a hook or something' (6068). However, she again silenced herself saying, 'God forgive me . . . he probably doesn't'.

This suggestion of a hidden agenda may reveal a defence mechanism by which pain was converted into an angry accusation. The sense of her accusation was that he withheld care

from her because of some hidden agenda. This charge was made at a particular moment in time and does not reflect the fullness of her feelings. Elsewhere Sarah spoke very warmly about her husband whom she described in generous terms. It is not surprising that Sarah hit out at a principal attachment figure at a time when she was in touch with acute distress. When careseeking is deeply aroused the reaction to disassuagement can be intense. In chapter five I referred to Panksepp's (1998) hypothesis of a 'rage circuit'. It is noteworthy that many of the elements of Sarah's story reflect negative feelings (externally directed frustration and anger) and evidence of conflict in her attachment relationships. These difficulties may be accentuated for Sarah by a connection between careseeking and shame which I will discuss below. It seems clear however, that Sarah's internal models of others appear to be more negative than Bartholomew's attachment model might lead us to expect.

Caregiving within the story

Sarah appeared to focus on her careseeking within the story (6027, 6030, 6032, 6034) but, while this is telling, I think she could just as easily have said it was about caregiving. It begins with concern for her father-in-law and by attempting to ensure that his needs were met she would also have been addressing the needs of everyone in her husband's family. However, the caregiving system is subject to attachment style and internal models and it is possible that her hyperactivating style clashed with more dismissing attachment styles of those surrounding her. This may explain why she feels misunderstood and why, in close relationships, she sometimes achieves the opposite of what she seeks (see below). Whichever is the activated system, it is perhaps noteworthy that negative internal models appear to be activated in which caregivers in the family cannot be relied on and have to be sparked into action.

In session two Sarah told two stories about caregiving as a child. In one of these she described a very tender moment between her and her mother when, as a six-year-old, she responded to her mother's tears with understanding and care. She also talked about offering practical care to her father (cleaning his filthy boots) at the same age but he failed to acknowledge her efforts. It may be that such instances represent a child's attempt to

regulate her own distress by giving care to her parents. If, as described in other stories told by Sarah, the child's needs are not met with empathic understanding and care, then the child might learn to care defensively for others as a means of regulating her own care. This may account for a pattern of compulsive or defensive caregiving in professional caregivers (Bowlby, 1980; Herman, 1992; McCluskey, 2013).

It may be that her confusion about whether she was careseeking or demanding (6025-6030) reflected her real experience as a child in which careseeking had been dismissed as 'demanding'. It may also be that, having developed a hyperactivating attachment style in some of her relationships, Sarah was experienced by some family members as demanding. Sarah talked about childhood experiences in which her real distress was sometimes mocked by her mother (see below). It is possible, therefore, that if her caregiving originated in her own distress or need for care then this story about addressing her father-in-law's long term care needs tapped into a deep well of fear and distress. If, as McCluskey (2013) suggests, defensive caregiving arises from fear rather than empathy, then in addressing her father-in-law's need for care Sarah was in reality regulating her own fear and distress. Fear is frequently associated with anger. This might account for the breakdown of communication between her and her husband. She did not ask directly for care and he seems not to have recognised or participated in her caregiving to his father. Instead he went to bed leaving her feeling hurt and angry.

The internal environment and childhood experience

In the teaching component of session six the facilitator talked about the impact of growing up in a culture where children were not allowed to question their parents (even if they experienced neglect or abuse). She said that children internalise parental criticism in the form of critical attributions. The facilitator also spoke about the tendency for some people to idealise their parents.

Reflecting on childhood relationships Sarah said, '... I didn't have anything from my father' but added that she had always thought, 'Wasn't I lucky to have such a fantastic mother'. She therefore described having felt 'shock' and 'surprise' in the preceding months during

which she had come to question her beliefs about her mother. Earlier in the session Sarah listened as another group member expressed anger about her own mother's inability to respond to her in an empathic manner. This resonated with Sarah who said that she had recently watched her mother interacting with her (Sarah's) nephews and nieces in an uncaring and impatient manner and thought, 'God, was she like that with us? How come I never saw it?' This triggered the 'realisation' that her mother had shown similar impatience toward Sarah and her siblings when they were children.

6204 And when I'm looking for, for some little memory
6205 or some little clip, [F: mm]
6206 I'm getting a real strong sense of her absolute disparagement
6207 of my emotions or my upset, [F: Yeah] or my, my pain. [F: Yeah]

6208 Of trying to express to her,
6209 as my main person that I would have gone to for careseeking,
6210 a huge level of distress or pain.

6211 And of her . . . and of anger as well [F: mm hmm];
6212 defiance and anger and frustration and all that.

6213 Whatever else was going on for me, and not getting heard, but getting . . .
6214 there's a very powerful destructive, 'disparagement' is the word.

6215 But it's not a strong enough word,
6216 because it was an annihilation
6217 kind of experience; of being closed down or not being, val . . . whatever.

Although Sarah later said that her mother didn't treat her badly all the time, she is clear that rejection of her emotional expression had been a significant part of her experience and that she had long since stopped seeking care from her mother. She spoke of being 'put down' and mocked by her mother when she was distressed and said, 'It would be her

tone of voice and her; you know, absolute dismissal of, mocking, mockery of anything to do with feelings'.² Shortly after this she addressed a question to the facilitator:

6252 And I'm kind of a little confused. I wanted to ask you,
6253 is that what you were talking about later on when you said
6254 'it's OK to need validation'?³

6055 [F: Absolutely, one needs validation.]

6256 Yeah, so in other words it's not wrong to say about you
6257 if you need validation from someone else?
6258 It's normal and OK to need some validation.

6281 [F: One needs validation,]

Sarah's insecurity on this point may explain her inability to ask her husband in a direct manner for the reassurance she wanted about her email. In this extract it is noteworthy that Sarah was surprised by what appears to have been a new realisation.

Careseeking and demanding

When starting to speak she appears to have poor recall of the detail from childhood (6204/5) and says the new view of her mother came in part from seeing her mother interacting with her mother's grandchildren (this does not explicitly include Sarah's own children) and realising, 'God, she must have been like that with us'. This echoes her statement in the introduction to the first story that attending the group had helped her to see events in a new way.

² The point made above in relation to her relationships with her husband also applies to what Sarah said about her mother; this account is not the whole truth. In interview she spoke very warmly about her childhood relationship with her mother whom she recognized had been under immense stress throughout her childhood which sometimes affected her ability to respond to Sarah and her siblings.

³ This refers to another element in the teaching input, when the facilitator said, 'when we discover something and we have our discovery validated, that kind of nails it . . . affirms us, and we need the validation'.

Sarah talked in passing about a 'huge level of pain and distress' (6210) in childhood, the nature of which was not specified as she focused on the experience of careseeking from her mother. Not surprisingly she said the disparagement and mockery was 'powerful' and 'destructive' (6214) and an 'annihilation experience' (6238). She talked about being 'closed down' by it (6239) and about closing herself down as a defence. This may imply that she excluded distress from awareness but her stories suggest that, if so, this was not wholly successful. It is likely that these interactions created a link between careseeking, feeling rejected and intense shame.

There appears to be considerable ambiguity in the line about 'defiance and anger and frustration' (6211/12). The sentence is broken and might mean that either Sarah or her mother had been defiant and angry. It is possible to imagine that each felt frustrated in these encounters because careseeking/caregiving was not assuaged for either party and both probably experienced some measure of distress and anger. If so this may have fed back into their relationship in a destructive cycle so that, in line with the findings in Strathearn et al. (2009), rather than activating caregiving, Sarah's expressions of distress, caused her mother to feel personally bad.

Anger in attachment relationships

In session one Sarah had spoken about being surprised to realise that fear prevents her from careseeking. She also said that, with one or two exceptions (including her husband), all her relationships provoked fear. Asked by the facilitator if her fear manifested in 'fight or flight', Sarah said her normal response was fight. Elsewhere she spoke of a propensity to become angry in her dealings with others and joked that she could give some of her anger to a group member who was less capable of expressing anger directly. Given the history that she later described it is possible to imagine that activation of careseeking would (consciously or unconsciously) trigger a fear of disassuagement and of being shamed.

I have suggested that Sarah had an unsupportive internal environment containing the implicit message that careseeking is 'demanding' and is therefore bad. Yet, like all people she needed attuned mirroring even though seeking it may have triggered shame. I think it likely that Sarah adopted an implicit mode of careseeking that allowed her to exclude her careseeking motivation from awareness whilst she acted out her need. If careseeking and fight are kept outside of awareness but are neither deactivated nor regulated, they may manifest in controlling behaviours and emphatic focus on her distress. This might account for Sarah's reported mystification in session six about when people challenged what she had thought were reasonable requests:

6402 . . . I produce the thing that I fear the most:

6405 I expect to be fought back with, you know.

6406 I expect people to challenge my reasonable request [. . .]

It may also be linked to her confusion about careseeking and demanding. It will be remembered that in session one Sarah said she was frightened to careseek. I am reminded of another group member, Antonio, saying that he did not careseek but placed himself in the vicinity of a caregiver in the hope that care would be given (see chapter 10). This may be the way to understand Sarah's stories in the group: by telling stories about failed careseeking she placed her distress in the vicinity of a caregiver (caregivers). Earlier I suggested that Sarah's stories emphasised emotion over action. This appears to be because her stories were the channel through which she created emotional proximity with caregivers in the implicit hope of an empathic and healing response. But I think Sarah sometimes goes further than Antonio by acting out her neediness in a way that holds potentially reluctant caregivers to task. This may link to the numerous indications of conflict in her closest relationships.

Intersubjectivity

This raises important questions about Sarah's experience of intersubjectivity. In order to deny that careseeking/caregiving was taking place she may have filtered her perception to

exclude content that was threatening. If true, this may mean that she never felt fully met and her careseeking was never fully assuaged.

In her final session (s.8) Sarah came closer than in any other session to asking directly for care. She engaged in a detailed exploration of her experience as the only family member present when her mother-in-law had died. In the transcripts this appears to be different to all that had preceded it because she seemed much clearer about what she wanted from the facilitator and allowed the facilitator to help her give a detailed account of what happened and what it meant to her.

Interview

My interview with Sarah took place more than two years after the group terminated. Sarah was the only group member I interviewed who identified the group as a place of training rather than therapy. This may reflect an ambiguity in the enrolment process but I think it also reflects difficulty Sarah may have with explicit careseeking. Sarah told me that she was in a fragile emotional state following her bereavement and that this had distorted how she behaved in the group. There is evidence to support this because she is considerably more vocal in most subsequent sessions. However, since meeting her, I have wondered if the idea of scrutiny by an observer from outside the group triggered fear that she would be criticised for careseeking in the group.

Sarah spoke critically about the facilitator in interview and expressed reservations about what happened in the group. One such criticism was that the facilitator had failed to contain Sarah or redirect her to external sources of care rather than letting her careseek in the group. In an extended quote it is possible to see that her recall contained a high measure of implied self-criticism:

*101 Well what she did was she took time then and I remember feeling,

*102 'Oh God, you're doing it again, you're a powerful person and now you're taking over'.

*103 And I'm so careful not to do that, usually.

- *104 I try not to take more time and I wait for other people.
- *105 Actually I count to ten and sit there and wait for other people.
- *106 And if nobody says anything then I'll speak just to make sure I don't overpower,
- *107 do you know what I mean? [P: Right]
- *107 So when somebody seems to indicate even in a sort of a sideways remark
- *108 that there is something like that going on then
- *109 I always feel, "Oh God, I shouldn't be doing this", erm,
- *110 but that doesn't stop me.

In this quotation there appears to be a conflict between her urge to seek care and fear of being 'demanding' and 'taking over'. Elsewhere in the interview she spoke about 'spilling over' in the group. About the exchange in session eight she said, 'nothing like that intensity of spilling my guts had ever happened to me before'. This reinforces my belief that a critical internal voice, more explicit here (and in *102) than elsewhere, influenced Sarah's feelings about careseeking; telling her that sharing her feelings and desiring care was not appropriate. At the same time the activation of careseeking is powerful and will not be stopped (*110). Although Sarah did nothing inappropriate in the group I believe her memory has been infiltrated by shame and self-punishment.

Sarah expressed ambivalence about what happened in the final session saying, 'She did one thing for me that was hugely valuable, and she didn't do it willingly if I recall correctly'. This related to the start of her work with the facilitator in the final session. Although she was clear that she had benefitted from this exchange, in interview she indicated that she did not believe the facilitator was truly interested in her and agreed only reluctantly to her request to look again at her loss saying, 'We're going to have to do this aren't we.' She also said she had come to feel that the facilitator was primarily using the group for her research though she indicated that this thought had been triggered by my invitation for her to participate in my research. It is possible that my invitation did not give rise to this thought *ex nihilo* but rather gave her access to doubts or thoughts that she had excluded from

awareness during her encounters in the group.⁴ It is likely that, having been invited to participate in the study, she associated me with the facilitator.

During our meeting it was agreed that I would listen to the final session with Sarah's criticisms in mind. I found no evidence to support her memory of the session though I do not doubt the sincerity of her belief. The facilitator said nothing that would account for the words Sarah remembered and appeared to respond to Sarah's distress with genuine care and sensitivity. Other group members also joined in the work and, I suspect, were helped by what Sarah had shared to address similar pain in their own experience. It is therefore my view that Sarah's memory of this event had become infiltrated by shame caused by a voice within her internal environment that says she is bad to 'demand' care (for alternative thoughts on this incident, see chapter thirteen).⁵

Sarah's suggestions about the motivation of the facilitator reminded me of the earlier suggestion that her husband had a hidden agenda for withholding care. It is possible therefore that it reflects her defensive reaction to a very painful link between careseeking, shame and the fear of being judged. There can be few meaningful relationships that any of us have that do not involve less welcome aspects or doubts that we exclude from awareness but gain access to at times when our various desires are disappointed.

Conclusion

While there is much that fits the predictions made in accordance with flow diagram three, there is also a large measure that I had not expected before writing the case study. Whilst careseeking is not deactivated in times of distress as we have seen it in earlier case studies, indeed it sometimes appears to be hyperactivated, asking for care is more difficult and complex for Sarah than might be expected from the diagram. Need appears to be largely acted out rather than care being asked for. Moreover, the fact that careseeking/caregiving is taking place might be excluded from awareness. It may be recalled that Sarah's fantasy

⁴ I will return to this issue and my interpretations in chapter fourteen.

⁵ In line with an agreement made in our session I subsequently created a document with all the content of her dialogue with the facilitator in session eight so that Sarah could read the exchange in full.

was of receiving care after breaking down and not because she asked for care. The reason for the implicit nature of Sarah's careseeking seems to be that careseeking triggered shame.

Although the diagrams predicted that Sarah would readily express fear in the groups, she does not appear to directly express or experience fear in this setting. When she talked about fear it was in telling stories about situations in her personal life. In the group situation it appears that her careseeking was activated by the distressing content of narratives rather than the experience of fear. Moreover, for Sarah it is likely that fear was most frequently expressed as fight. I think it possible that the immediate experience of fear was excluded from awareness to prevent it impeding fight.

Another difference from the diagram is the measure to which her hate is self-directed as well as other-directed. The diagram suggests that people conforming to this diagram would project hate onto the potentially unreliable caregiver. Whilst this can be seen in the form of anger and conflict, there is also evidence that Sarah's internal environment contains negative introjects that are perhaps experienced as a profound self-hate (shame). Both sides of this might reflect the link between anger and shame.

The evidence suggesting that Sarah self-regulates distress by means of defensive caregiving is also counter to the expectations created by the diagram. Such differences from the diagram show that attachment related feelings are more nuanced than the diagrams portray. The findings are consistent with attachment literature in which preoccupation with attachment has always been associated with ambivalence. We might also view it as evidence of conflicts between different layers of consciousness (Mikulincer and Shaver, 2007).

From her evidence I suspect that the reason shame and an unsupportive internal environment do not deactivate careseeking for Sarah in the way they might have for people presented in earlier chapters is because of the role of rage; and the dominance of other-directed hate over self-directed hate. Indeed, careseeking may in fact be hyperactivated by this mechanism allowing her to emphasise her own needs while excluding from awareness the wishes of a caregiver. The cost of this strategy may be that intersubjectivity

is inhibited by the need not to see the caregiver as they really are; creating the potential for resentment, misunderstanding and conflict in attachment relationships.

Chapter Nine: More Vociferous Course Members (II)

Case study five: Alison

Introduction

Alison was the second most vocal person in Course A. At the time she attended the course she was a psychotherapist in private practice. She was in her late fifties, was married and had two grown up children. Alison and most members of Course A had also attended the same group together during the previous year.

Most of the material examined for Alison is taken from session six. However, I begin discussion of Alison's input by looking at her first contribution to session one. It is perhaps not a coincidence that for both Sarah and Alison I have drawn extensively on session six. The teaching input for this session (see chapter four) focuses on the system Heard and Lake have called the internal (supportive/unsupportive) system (Heard and Lake, 1997; Heard et al., 2012). This system includes factors like internal working models of self and other, attributions and the influence of messages introjected in childhood on current attitudes towards self. This is one of two sessions that focus on the link between past experience and current strategies for self-defence and is important for any discussion of attachment-related fear. Where necessary I have augmented the discussion with quotations from other sessions.

Reflections on the experience of careseeking

Alison began her first input to session one by identifying a resonance between herself and three of the previous speakers (all of whom she knew from the previous year's group). She appears to have used this resonance to shape her own reflections. Unlike these speakers Alison did not tell a story but talked about her experience in non-narrative terms without reference to specific times or events.

She began by asking the previous speaker for permission to enter the discussion. This is typical of Alison and may suggest sensitivity to other people in the group. However, this was not unique to Alison and may reflect a previously established culture in Course A.

101 Well I feel I can resonate with both of you,
102 probably with Vanessa and everybody else.
103 I wonder is it alright to come in Annette?

104 [Annette: Yeah. Absolutely, sure]

105 I think about care seeking, you know,
106 I've come to a place in my life like
107 I recognise that I care gave to get care.

108 And I realise that I start to feel that place:
109 I don't know how to get care,
110 I just don't know how to do it.

111 Like, I don't want it from caregiving.
112 I don't want it from caregiving.

113 And it's like I know some people who I'm close to
114 but still they can't just be with me.
115 And that would give me care;
116 if they could just be with me.

117 And I'm finding it really lonely. [F: Yeah]
118 Really lonely. [F: Right]

119 Because I can't be with people
120 because they always seem to want something [F: From You?]
121 or ring up and they have this problem; or meet for a walk

122 and it turns out to be for some other reason.

123 I am absolutely amazed at how hard it is for me [p] just to get that.

124 I think it was easier when I wasn't aware, like if the caregiving . . .

125 I wasn't aware that I was getting something back,

126 it was easier.

127 And now I'm aware of that.

128 And I don't want to do that.

129 And I don't want to get it that way.

130 All I want to do is, I suppose be loved.

131 And for someone to be with me; [F: mmmm]

132 without having to get something from me. [F: Yes]

133 I feel a lot as I say it.

134 It's like a realisation.

135 And I don't say I'm going in on myself.

136 I'm kind of recognising

137 it must have been like that as a child: it just wasn't there.

138 So I developed a way of . . .

139 And that there's a void place.

140 I'm an adult,

141 or I'm sort of an adult,

142 and I'm just astounded that . . .

143 And I'm resonating with that and with Vanessa,

144 like that's what happens;

145 it's not fear comes up,

146 it's just kind of deadness,
147 there's nothing there.

148 A walk in the park on my own.
149 Painting on my own, not [indistinct].

150 Very few people who actually, I can say,
151 it sounds like a child's voice,
152 very few people are big enough for me.
153 It sounds like a child's voice,
154 that can just be with me,
155 without looking for something from me . . .

Purpose in speaking – subjectivity and intersubjectivity

This input seems particularly well suited to being presented in stanzas and reminds me of Gee's (Gee and Green, 1998; Poindexter, 2002) ideas about the poetic nature of natural speech. It seems to have a musical quality as themes are echoed from one stanza into another as her thought is moulded to reflect new learning and insight. This impression is created in part by repetition of significant phrases and in part by the way in which she structured her ideas in more or less discrete parcels.

Two ideas arise from Alison's use of repetition. Firstly, it seems likely that she repeated phrases not only to give emphasis and influence her audience but also because she had been moved by hearing herself speak the words. Hence she said, 'I feel a lot as I say it. It's like a realisation' (133/4). It may be that she gained access to herself by speaking in a manner that illustrates Riessman's (2008) notion that the narrative-self is born in the moment of narration. Elsewhere in the transcripts Alison talked about the need to speak so that she could bring herself into the group. It is as if, only when she heard herself speaking in the group, did she feel present to herself, and gained access to, or felt present to, the group.

An unrelated thought, perhaps influenced by subsequent references to 'a child's voice' (159/161) is that the repetition gives a rhythm to her words that is reminiscent of a child's rocking or self-soothing. This is reflected in the rhythmic character of the early sentence (105-108) where she described her movement toward recognition of the idea that she gave care to get care. It can also be seen in repetition of phrases like, 'I don't know' and 'I don't want' (109-112) 'just to be with me' and 'really lonely'.

In the above I want to suggest that there may have been a dual function of Alison's speech in the group. She was speaking to other people and wanted to be witnessed by them. But she was also allowing the group to witness a subjective and private experience in which she listened to the multiplicity of voices in herself. This complements my suggestion that it was in the act of speaking that Alison made real her presence in the group and made her own presence, and that of the group, real for herself.

In this process Alison seemed to be sifting through her experience and evaluating her emotional response to what she had said. Thus she recognised and reflected on changing realisations as they occurred. So it is in hearing from self and others that she got in touch with herself. And when she felt immediate contact with herself her awareness was expressed as feeling. She tells the group that it is when she felt a thing that it was 'realised', that is, it became real, for her (see 108/9 & 133/4).

Reversing Selective exclusion

When speaking about the realisation that she had given care in order to get care it seems that she was bringing into awareness something that had not always been consciously known. In a sentence that is incomplete she linked childhood experience to her experience of 'void' (138/9). Although resonating with a story told by Vanessa, what Alison said about her own experience was very different. Vanessa had talked about becoming very distressed and fearful during a period when her husband was away. In contrast to this Alison said, 'it's not fear comes up, it's just kind of deadness'. She may therefore be saying that, when she was in a frightening situation (similar in some way to that described by Vanessa) she did not feel fear but 'void' (139) and 'deadness' (146/7). Moreover, by

juxtaposing an incomplete sentence, 'it must have been like that as a child: it just wasn't there so I developed a way of . . .' with immediate talk about solitary activities (walking and painting on her own) I think she may have been indicating an element of volition in which 'void' described her withdrawal from the experience of distress. Within the story, therefore, Alison may be saying that void/withdrawal served a protective function but resulted in her being isolated and alone. She had moved away from self and from other.

In this reflection Alison recognised that it had been easier for her before she became aware that her caregiving was strategic. Awareness had meant that caregiving no longer had the power to satisfy her desire for care. When awareness closed down the option of defensive caregiving (getting care by caring for others), she was less able to mask the feelings generated by activation of her careseeking system. But stripped of this defence, she did not know how to get care for herself (109/110) and so may have felt the pain of dysregulated fear (McCluskey, 2013). This might also underlie her expressions of loneliness (117/118).

But it may also be true that, like Sarah, she had found a way of getting care by excluding from awareness the fact that she was doing so. Though describing avoidant defensives (void and withdrawal in solitary pursuits) she is not silent but shared her distress and loneliness with the group at length.

Realising and the experience of self

The counterpoint to realisation would be de-realisation or dissociation and there are similarities between these notions and what Alison said about 'void'. Dissociation and derealisation are associated in psychodynamic psychotherapy with trauma and defence of the self. Bowlby's (1980; 1988) 'selective exclusion' describes a related phenomenon. By invoking the idea of 'void' and 'deadness' Alison suggested that, in the absence of adequate care in childhood she had developed a dissociating strategy for dealing with trauma. I believe that her stories served to reverse this defence and create a bridge to feelings and 'realisation' and so bring Alison into greater awareness of in-the-moment reality. As with Sarah, therefore, affect is emphasised in the telling of her stories. However, Alison's

emphasis on void at the centre of her experience is counterexpectational and seems to express an idea that is integral to my second flow diagram rather than flow diagram 3.

Another way of describing Alison's presentation in the groups is that her narratives create a space in which she and others can listen to voices which are normally excluded or silenced. She possibly hints at this when referring to 'a child's voice' (151, 153). There seems to be a gradual progression in the process of realisation so that she began by saying she did not know how to seek care and moved on to the expression of loneliness (119/120). This then became a 'realisation' that she was looking for someone 'to just be with me' (116-119), adding later, 'without wanting to get something from me' (138). It appears that 'realisation' arose from and evoked strong emotion (139/140) that may have been excluded. Again, this may fit the picture of selective exclusion depicted in the second (rather than third) flow diagram.

Childhood wounds

At one point in her input Alison seemed to equate love with someone being with her and not wanting anything in return (130-132; 150-155). Toward the end she talked about it sounding like 'a child's voice'. In this she may be implying that she was speaking about very primitive pain reaching far back into childhood or infancy. It may also reflect ideas taken from psychotherapy literature on listening to the 'inner child'. This literature suggests that trauma excluded from awareness continues to reside within the individual in a frozen state that yet has influence over the feelings and behaviour of the individual. In this approach the inner child is first recognised and then encouraged to speak out so that he or she might be met with the empathy and care that had been deficient in childhood. Alison's allusion to a 'child's voice' can therefore be seen as recognition that space is needed for her to give voice to early trauma. However, she later expressed ambivalence about this child's voice in a manner that perhaps indicates a persecuting internal environment (see below).

The meaning of Love

Soon after Alison stopped speaking another group member, Annette, offered a resonance in the following words: 'I want to be loved for me, just for who I am, not what I can do, not what I can give'. On the face of it, this appears to correspond closely to a significant part of what Alison had said (130-132). Alison rejected the resonance in Annette's words saying, 'it's not that, it missed me'. A second group member, Geraldine, then gave feedback saying: 'I resonate with Alison, almost feels hopeless that it's ever going to be met . . . what you said about that disappointment that I'm never going to be able to get it . . . There was something, that met something in me, [. . .] it almost calmed that awful feeling.' In response to this Alison indicated that Geraldine's feedback had been accurate: 'When Geraldine spoke, I eased'. This difference may point to what 'love' means for Alison. Although Annette's feedback appears to mirror what Alison had said, her reference to 'love' seems to have provoked dissonance rather than resonance.

In session five, Alison offered a tissue to a distressed group member and subsequently described her actions as feeling like 'love'. I suspect that, despite what she said about no longer caregiving in order to get care (e.g. 128/9), and wanting to be loved and for someone to be with her (130), for Alison, at an implicit level, 'love' is to be given rather than received.

Expressing fear in the group

A lengthy exchange took place in session three which centred on the fact that Alison had missed the previous session and would miss the next session. Alison started by saying that she had been falling asleep in the group. Initially slow to use the word 'fear' (speaking of 'risky feeling' and 'feeling risky' until the facilitator mirrored this back as 'fear') she expressed concern about whether she would be judged 'uncommitted' and that she would not be accepted by the group. The facilitator worked with her at length and helped her to check out the reality of her fears with everyone in the group.

Early in this input Alison spoke about having nearly fallen asleep in the session until something aroused her caregiving. She said, 'I don't know how to be in the group unless I

am caregiving'. She also said, 'I'm noticing how I do the sabotaging when I get something I can't tolerate, I back off and go off on my own . . . I just leave'. This then is counterexpectational; the flow diagram for this section portrays people exaggerating their distress in order to get care; as seen in some descriptions of preoccupied attachment (Mikulincer and Shaver, 2007). But Alison describes avoidant defensive strategies. She appears to be saying that sometimes when she gets angry she backs off (I am reminded of Sarah's angry withdrawal from her husband). Yet, like Sarah, there are occasions when Alison is distressed in the group and her careseeking is definitely not deactivated. This may support Mikulincer and Shaver's insistence on retaining Bowlby's idea that contradictory working models can exist and be in conflict across different levels of consciousness (Mikulincer and Shaver, 2007: 98).

Narrative about two experiences of care

Alison returned to the link between childhood and adult experience in session six. She listened to other speakers before again asking if she could say something. She continued:

655 [. . .] and like Lucy there I'm not sure what is going to come out, you know.

656 As I was listening to people, 'cause I was feeling . . .

657 kind of falling into a victim place in me. [F: mm hm]

658 Like I can't remember anything good about my childhood.

659 [F: That's what you were thinking, I can't remember anything good about my childhood?]

660 Yeah. Like a lot of negativity and violence and that sort of thing,

661 you know. [F: mm hm]

662 And that is . . . it's like I'm . . .

663 that's my ground or something. [F: mm hm]

664 And er, the new ground

665 I find, I find the new ground hasn't really great roots.

666 You know, new ground . . .

In what might be called the abstract to her story (Labov and Waletzky, 1967), Alison sets the frame for a discussion about a struggle to overcome her past way of behaving ('my ground') and a new approach to life (represented by 'the new ground').

667 Somebody good, like that,

668 there was a pastor one time,

669 Emanuel was his name,

670 and he was wonderful to me;

671 probably saved my life really.

672 And I remember him asking me to work with him;

673 you know, on weekend workshops.

674 While one part of me was delighted that he saw me,

675 I didn't . . .

676 The other ground was so strong that,

677 actually, I didn't believe him.

678 I did work, I did it, [F: mmm] I went and did it

678 and probably did alright

679 but I never felt I did alright.

680 There was really no self-esteem I suppose,

681 but nevertheless I still got something from him asking me. [. . .]

682 And, like it's little tiny snatches like that,

683 and it's to have that.

684 Even last year, in the last few years . . .

685 I've been helping training with er, (she names a model of psychotherapy).

686 And the pastor that was doing it was absolutely gorgeous;
687 really strong, you know, doesn't take prisoners.
688 Or no time for negativity or victims or anything.

689 But I remember by the end of it, they had a prayer group [indistinct]
690 And then he said 'I want',
691 I was way down at the back,
692 'I want to thank Alison'.
693 And the few things he said about me,
694 and it was absolutely like heaven [F: And what did he say Alison?]
695 to be recognised.

696 Just thanking me for the work I had done,
697 for being there; that er, the time.

698 It was lovely.
699 It was like he saw the deeper part of me.
6100 He really saw into me.
6101 He saw I was bringing my truth to the work. [F: mmm, hmmm]
6102 It was fantastic, you know.

6103 And sometime after he left . . . ,
6104 I was playing golf and [indistinct] a bit of negativity bit you know . . .

6105 Suddenly his face came up in front of me;
6106 big yellow light all around his face.
6107 And it kept coming, way off, like down the golf course.
6108 Coming into the light, the light in his face.
6109 And he was smiling at me
6110 and it went right through me.
6111 And I had a wonderful er, game of golf after that, [laughs/group laugh]

6113 It was almost like that I triggered back into the, what I got,
6114 you know: [F: mm hm] self-esteem; belief in myself.
6115 I heard it. [F: mm hm]

6116 And it took him to do that.
6117 But that's only last summer.

6118 [F: Yes, and this is the 'new ground'?]
6119 And that's the new ground.
6120 [F: That's part of the new ground.]
6121 And, it is actually getting stronger.

6122 You know, I noticed falling back into the old ground,
6123 and feeling a bit sort of,
6124 'Oh god' you know, 'there's nothing good in my life'.
6125 [. . .]

The input above records two out of three stories that were told together and merged by Alison into one narrative. The first story (657- 683) was about the impact on her of being asked by Emanuel to help him to run weekend workshops. The second (684-6124) was about a more recent experience when she helped a different pastor run his training course.

Evidence of an unsupportive internal environment

The starting point for these stories appears to be Alison experiencing negative feelings about her past which she described as falling into a 'victim place'. In this place she could not remember anything good about childhood, only 'a lot of negativity and violence and that sort of thing' (660). She identified this 'victim place' as her 'ground'.

One purpose of the stories seems to have been to contrast this as old ground with a new ground in which negativity was banished. The tendency to slip back into the old ground prevented her from believing positive things about herself (678/9). It acted like a filter

through which positive messages from the environment could not easily pass; resulting in low self-esteem (680). In the picture created by these stories, therefore, self-esteem was conditional on her behaviour and depended on positive thinking.

Her description of the two men is very warm. Emanuel was 'somebody good'; he was 'wonderful to me; probably saved my life' (667-671). The second man 'was absolutely gorgeous; really strong', (686/7). Apart from the final story (omitted because of space) about an act of kindness performed by Emanuel, her warm descriptions of these men were not substantiated. The positive feeling created in the stories related to the experience of being 'recognised' for the contribution she had made to their training groups. It was, 'absolutely like heaven to be recognised' (694/695).

In the second story she talked about her colleague seeing deeply into her and seeing that she brought her 'truth' (6101) to the work (in the audio recording it is clear that she emphasised the word 'truth'). However, despite being asked (694), she gave no detail about the feedback he gave her beyond an acknowledgement of the work she had done and the time she had given. We cannot know from this account if he praised specific qualities but her story (699-6101) suggests that he did and that she chose not to repeat his comments or had forgotten the detail of what he said. What we know is that she was deeply affected by what he said. This may mean that she was moved by the fact that he had accepted and appreciated the care she gave in the course of their shared work. If so, her emotion may arise in part from the experience of caregiving. Though she is clearly communicating much more than this, the stories represent occasions when she experienced recognition (being seen and valued) for giving support or for caregiving.

The strength of emotion within this experience is captured in Alison's story about the subsequent apparition in which Emanuel's face appeared in front of her. Alison's story was told in a session focused on the internal environment and may illustrate how the memory of his praise had become a resource from which she could draw support. Her lack of detail about his feedback might suggest that verbal content was less important than the visual experience of his recognition; the experience of being seen and held in his approving gaze.

Culture and discourse

I think it likely that Alison was not describing a relationship of equals between her and these pastors (leaders within a religious community). They invited her to help them in their work and they gave her feedback that boosted her self-esteem. Recalling an image she used in session one, she sounds much smaller than both men and it may be that we hear implicit echoes of the 'child's voice' (152/153) in her stories. One message of the stories seems to have been that these men were big enough for her. And in the events described, Alison seems to have experienced being held and valued.

However, writing as a counsellor, the stories are disturbing to me because they suggest that these men prescribed what was acceptable and unacceptable as content of a life narrative? In the omitted final story, the only quotation we have from Emanuel, he spoke at her father's funeral saying, 'It wasn't all bad'. This is consistent with the second pastor's reported view that 'victim' and 'negativity' were unacceptable. Alison's struggle between old and new ground may therefore have been framed by her understanding of their beliefs.

Such attitudes may reflect an approach to therapy that de-emphasises personal history, such as the 'positive thinking' school of psychology (Seligman and Csikszentmihalyi, 2000), gestalt (Perls et al., 1951) or cognitive behavioural therapy (Hofman, 2012). Given that the two men are pastors it might also reflect a religious discourse, focused on personal responsibility, sin, forgiveness and redemption. Either way, there seems to have been a clash between this aspect of the stories and the psychodynamic approach espoused within the group which valued relational space in which personal trauma and other excluded material might be remembered in the context of supportive relationships and so brought into conscious awareness.

Alison's stories suggest that she experienced very powerfully the sense of being deeply met in her relationships with both of these men. The joy presented in these stories seems to have arisen from being *seen*: her 'truth' recognised and valued. It is therefore paradoxical that she struggled to give space to the 'child's voice' and the desire that her pain be witnessed and acknowledged.

Caregiving and double standards

Empathic meeting was repeatedly offered by Alison to other members of the group. When offering care to others she did not discourage them from talking about early trauma but encouraged them to acknowledge and honour their pain. Although we have insufficient evidence to be sure, I think it likely that some of her attitudes to self reflect attributions introjected in childhood when internal models of self and other were originally constructed. She sometimes appears to dismiss and mock her own distress with words like 'victim', whilst the filter which generates this response is inactive or blind in relation to others. These attitudes might indicate a measure of what I have called self-directed hate in which she is perhaps echoing a persecuting response to her careseeking in childhood.

In any event, Alison appears conflicted: asking for her own childhood pain to be seen and acknowledged is to be a 'victim'; yet she clearly feels this is necessary for the healing of pain in others. This may reflect the influence of two therapists mentioned above. It may be evidence that careseeking activates shame in Alison. However, if this is so, as has been seen in other case studies, her shame is excluded from awareness and is expressed only indirectly.

Overt careseeking in the group

There were two obvious occasions when Alison brought distress into the group to be met in extended interaction with the facilitator and wider group. The first (mentioned above) involved fear of being judged in the group for missing sessions. The second related to fear of violence from one of her siblings. My reading of both incidents was that Alison had felt acute distress when she arrived at the group and that the facilitator responded to this with an offer of care. I think Alison needed her concerns to be witnessed before she could have taken her place in the group. Incidents like this mark a clear difference between Alison (and Sarah) and the quieter people who appear more likely to hide their distress in the group.

Careseeking and hate

I have spoken about possible evidence of self-hate manifested by Alison in the sessions but in none of what I have written above is there obvious evidence of anger or hate directed at others (as might be predicted from flow diagram 3). Given what she has said in the group, it is possible that such feelings were suppressed by spiritual values, group culture, or perhaps, a desire to be liked. However, she spoke about occasions when she became angry outside of the group and in session five, resonating with input from another group member (Charlotte, chapter twelve), she focused particularly on anger that she felt when met with insincerity:

534 . . . when someone who is saying something to me
535 and the message I'm getting is like
536 'I don't believe a bloody word of that', or something,

537 and I get a different message
538 of somebody saying something so insincere
539 and I push them away.

540 I fight. [F: mm] I kind of,
541 either say something dismissive to them,
542 or like, it's a real fight.
543 Anyway, I go straight into a fight; self-defence and fight.

Elsewhere in session five she said her tendency to push such people away had sometimes caused her to become isolated. In somewhat broken or incoherent speech she linked this behaviour to her childhood experience:

569 . . . if someone doesn't meet me honestly, from my point of view
570 or if I don't pick up it is true or honest, er,
571 I kind of push him away and dismiss them,
572 'cause like, that's gone, I've dealt with that.

574 I feel I could walk over the person to the next thing,
575 but it's a fight thing and er,
576 it's something I would have done as a child,
577 I would have fought for . . .
578 or everything and you know,
579 but it's like there is another side to it too
580 that I don't want . . .
581 I want the connection.

582 And beginning, I am finding another way,
583 because I recognize I tighten up,
584 I don't think it is that freeze, I don't freeze
586 so much as I tighten up obviously, some emotions to fight, [F: mm hm]
588 do you know

I notice that her talk about insincerity seems highly visual: what Alison sees at such times does not match what the person is saying. Beneath this talk about the need for real connection with others Alison, may have juxtaposed careseeking and fight. It may be recalled that in session one she said she did not know how to careseek, adding, 'if they could just be with me; that would give me care' (115/6). In the above text she appears to crave meeting but is vigilant to the danger of counterfeit connection. I suspect that the 'fight' identified here has little to do with fear and relates to other-directed hate (as describe within this thesis); an internalised expectation that the other person will not meet her. And in this state she is vigilant to the anticipated pain experienced when her desire for meeting is not assuaged.

590 I do not like if somebody is talking to me sincerely,
591 or something like that and
592 maybe they're talking to me and maybe looking at the picture.
592 Or even with the drink saying 'cheers' looking down the table.
593 If you are saying 'cheers' to me, look at me.

594 My thing is definitely fight. Fight first and then collapse.

This may be evidence that for Alison, careseeking was excluded from awareness but motivated a strong desire for meeting. The final line about fight and collapse suggests the emotional importance (stress) of such encounters. I am reminded by Alison's words that Bowlby (1969) saw the goal of attachment being to create proximity. This raises for me the question of whether proximity includes psychological proximity and intersubjective meeting. I wonder if what Alison says about sincere and insincere meetings reflects her own ambivalence (perhaps linked to failed careseeking and shame and/or fear) which, sometimes at least, motivates fight.

Conclusion

There appears to be much in this case study that does not conform to flow diagram three. Although one of the most vocal people in her group, Alison's presentation differed from that of Sarah in some respects and she raises interesting questions about attachment style. She spoke about a level of withdrawal and presents a picture in which much of her personal life appears to be spent in deliberately solitary pursuits. This would not have been predicted from the flow diagram. Yet she does not appear withdrawn in the group and in that setting at least may hyperactivate attachment at times when she is distressed. Much of what she says (about withdrawal and anger) suggests that in some situations she may be angry-withdrawn. However, I have not seen the handbook in which this classification is described (Bifulco, et al, 1998) and this suggestion may be wide of the mark. Is it possible that she is angry-withdrawn in some attachment relationships but more hyperactivating in the group? Is she someone for whom a normally angry-withdrawn defence is broken down when she is in the context of the group?

Like Sarah, Alison seems to have experienced little fear in the group, except, perhaps, her very specific fear of being thought uncommitted because of missed sessions. In her extended exchange with the facilitator about this she sought reassurance that her absences would not threaten her acceptance or sense of belonging in the group. All Alison's other references to fear concerned fears external to the group.

We also see more evidence for caregiving than might have been predicted from the diagram (though I am not sure if this is defensive caregiving) and considerable evidence about attunement with others that suggests a focus on external rather than internal contingency. This may partly reflect personal traits and group culture. It may reflect the importance to Alison of spiritual values associated with meeting, being met and the meaning of love.

In Alison's contribution to the group I am struck by the importance of visual meeting; seeing and being seen. Another theme of these stories is the idea of being held by someone big enough to bear the child within her. Her references to anger being triggered by insincerity may show a flash of fury from an anxious-ambivalent child. The two stories culminating in Alison's vision on the golf course may suggest that self-esteem arises from the approving gaze of others. Like Sarah, therefore, Alison's self-approval was dependent on the affirmation of others.

Discussion of the two case studies in this section using predictions drawn from chapter eight

Containing numerous counterexpectational elements the two cases discussed in this section offer interesting evidence about flow diagram 3. Again I reproduce this diagram and my discussion of the findings will be structured using headings drawn from predictions made at the start of chapter eight.

Quantity of speech

As said in other data chapters, cases have been chosen for inclusion in the study on the basis of word count. Both Sarah and Alison were the second most vocal members of their respective group. Unlike the earlier cases, both Sarah and Alison show a readiness to speak which becomes urgent when they want to share distress with the group and/or facilitator. As seen in the diagram, it appears that when fear and or careseeking are activated, this is made visible in the group in urgent appeals for help. Both sought care from the facilitator in a manner that sometimes diverted the groups focus for lengthy periods. The urgency Sarah feels at such times is evidenced when she spoke in interview about counting to ten before speaking because she was afraid to be too dominant or controlling.

Expressiveness and fear

Although Sarah and Alison both emphasised affect in their narratives, contrary to expectation, only Alison expressed current fear in the group. Nevertheless, both Sarah and Alison diverted the focus of the group by emphasising their need for care. This contrasts starkly with the first three case studies and seems to reflect a hyperactivating attachment strategy.

From what they reported it is possible that outside of the group both Sarah and Alison sometimes defended against fear by translated it into anger and fight. This is consistent with descriptions of enmeshed/preoccupied attachment (see chapter two)

Careseeking

The findings concerning careseeking are interesting and not what I had expected. For both of these people careseeking is difficult and appears to be associated with shame. Sarah spoke about (but did not demonstrate) self-reliance while Alison said she did not know how to careseek. However, in contrast to the first three case studies, neither Sarah nor Alison deactivated careseeking at times when they felt a need for care. Their expression of neediness was sometimes urgent and diverted the group from its agenda for lengthy periods.

Though both sought care in the group, this appears to be more complex than the diagrams might lead us to expect. It may also be that their careseeking was most often implicit and acted out, rather than being explicitly sought. Nevertheless, both did ask for care indirectly and directly.

Most frequently both sought care by recounting stories that were expressive of distress and elicited reassurance, empathic attunement and the experience of someone being with them in their distress. Perhaps in keeping with descriptions of preoccupied attachment (Florian et al., 1995; Mikulincer and Shaver, 2007) rather than seeking practical support, both appear to have wanted the facilitator and group to witness and understand their distress.

As said above, it seems as though neither Sarah nor Alison could have taken their place in the group at times when they were distressed until their distress had been shared and their careseeking needs assuaged. This indicates perhaps that, at times when they were distressed, internal contingency was dominant for them. Such incidents mark their behaviour as very different from the people discussed in earlier case studies.

Both also gave hints that suggest that careseeking is associated with shame. The invitation to participate in this study seems to have triggered shame in Sarah about her careseeking in the group. She also told the group that she sometimes provoked the thing she most

fears and that being rejected caused her to feel that she was a bad person. This may indicate that she sensed (and perhaps excluded from awareness) resentment in others that was provoked by her getting care by prioritising her own needs over whatever else might be happening. This supports the view that, by prioritising one's own distress and blocking perception of resistance, the hyperactivating strategy includes an element of conflict and prevents real, in-the-moment intersubjective meeting.

In flow diagram three (reproduced overleaf) I have depicted the cyclical nature of information processing in my symbols for the internal environment. This echoes Mikulincer and Shaver's (2007) idea that at every stage of the process information is informed by internal processes and the external environment (they refer to information processing being top down and bottom up). Thus when the hyperactivating strategy fails I have shown a loop in which the internal environment is again activated prompting memories and affect that support persistence in careseeking behaviours.

Although different for Alison, her use of the word 'victim' suggests that, for her too, careseeking is linked with shame. In both there is evidence that the link between careseeking and shame reaches back to childhood experiences. This might explain why careseeking seems frequently to be implicit, acted out rather than openly requested, with the careseeking intent being excluded from awareness.

The frequently indirect nature of Sarah and Alison's careseeking is consistent with the flow diagram and the hypothesised link between careseeking, fear of rejection and shame (again I have now added this to the flow diagram). 'Demanding' and 'victim' might reflect negative models of self. However, it is likely that negative internal models of self and other are perpetuated by the indirect means whereby care is achieved; a process in which love and hate are closely mingled. This would account for the appearance of higher levels of conflict in attachment relationships (as evidenced at least by Sarah).

Caregiving

Another aspect of the findings that would not have been predicted by the flow diagram is that caregiving, though complex, is important to both Sarah and Alison. Both responded to need in other group members but both also told stories in which it appears as though they gained care, self-esteem (and perhaps the regulation of their own distress), by giving care to others. This seems to be particularly so for Alison. She said she did not know how to be in relation with others once she became aware of the defensive nature of her caregiving.

Self-directed hate and other-directed hate

While both spoke about a tendency toward detachment and withdrawal from others when hurt (which may indicate flight rather than fight) they were also clear that they sometimes get angry when not met in their need; and that their anger sometimes manifested in fight. It may be that careseeking was more likely to trigger rage (Panksepp, 1998) for these people than for the quieter group members. But I can think of no reason why this should be so and it seems more likely that these people are just more likely to experience and express their anger than quieter group members. In what both said about fight there may be evidence that, for Sarah and Alison, fear of disassuagement may be incorporated into internal models in the form of other-directed hate; caregiver's cannot be trusted to give care.

Sarah and Alison may have manifested self-directed hate by disparaging their careseeking ('demanding'/'victim'); but their stories tend not to be self-critical in the manner typical of some of the quieter group members. Sarah's stories were frequently critical of other people.

Subjectivity and selective exclusion

In the transcripts it is clear that both Sarah and Alison excluded painful material from awareness. Both spoke of painful attachment histories and it is apparent that their

accounts are incomplete and selective. Sarah occasionally expressed surprise and even shock in response to new realisations about what happened in her childhood. Alison's 'realisation' may be similar to Sarah's surprise. For Alison it seems that being in contact with self and other was sometimes a struggle. Early in the course she talked about experiencing 'void' and 'deadness' when she gets frightened. She also spoke about withdrawing into solitary pursuits. In Alison's case study I suggested that she spoke in the group in order to be present; to herself as well as to the group. It is in speaking to others that Alison could hear and experience her own presence.

This does not reflect what I have shown in flow diagram three. This diagram suggests that selective exclusion might be minimised for these people who emphasise internal reality and their emotional experience. But in times of distress Sarah and Alison's presentation is consistent with George and Solomon's (2008) use of Bowlby's (1980) idea of 'cognitive disconnection'; perception, cognition and affect are edited in a manner that supports hyperactivation of attachment. This is also consistent with my diagram's depiction of the role of the internal environment and Mikulincer and Shaver's (2007) preconscious activation of systems. At times in the group when they were distressed, Alison and Sarah's memory and perception supported the hyperactivation of attachment (Mikulincer and Shaver, 2007).

Apparent contradictions between Alison's presentation in the groups and what is depicted in flow diagram three may support Mikulincer and Shaver's (2007) insistence on retaining Bowlby's idea that contradictory working models could exist and be in conflict across different levels of consciousness (Mikulincer and Shaver, 2007: 98).

I had not anticipated any great level of shame in these cases yet the data suggests that careseeking is associated with shame for Alison and Sarah. As a consequence of shame I suspect both may have excluded their careseeking intent from awareness when in the group; as well as any doubts they may have had about the willingness of the caregiver.

Internal contingency

On more than one occasion in group sessions both Alison and Sarah reported at length about distress, the source of which was wholly unrelated to the focus of the group. This should not be exaggerated. Whilst I believe that, for both Sarah and Alison, distress triggered closer focus on internal contingency over whatever was happening in the group, when not distressed both sometimes appear to be attuned to what was happening for other people in the group. I suspect that a key difference between these cases and the people discussed in earlier chapters results from the dominance of internal contingency at times of distress. This may also reflect the role of other-directed hate in motivating actions necessary to ensure that caregivers are held to task. As I write this I think the concept may be linked to defensive anger being triggered by attachment-linked shame.

Conclusion

In what I have written above it is apparent that both Sarah and Alison have some traits in common with flow diagram three. However, the picture is more nuanced than my diagram suggests. In accord with the flow diagram they both appear to hyperactivate attachment when distressed. While their careseeking could be urgent and direct, care was more often sought indirectly in the form of narratives in which negative emotion and personal neediness were emphasised. Although Sarah and Alison both offer evidence of self-critical or shame-linked elements within models of self, internal models of others appear to contain a blend of idealised images and critical distrust. I suspect that understanding the link between careseeking and shame is an essential element to working therapeutically with these people.

Issues arising from this analysis will be discussed in chapter fourteen. The next chapter examines people with word counts falling in the mid-range.

Chapter Ten: Cases with Mid-Range Word Counts (I)

Introduction to cases with mid-range word count

In this and two subsequent chapters I will look at three case studies with word counts in the mid-range in line with my decision to divide the sample on the basis of the amount spoken. The hypothesis underpinning this decision is that fear will reflect in either a minimal word count for people who deactivate attachment and avoid difficulty by remaining silent in the group and a higher word count for those who seek to hyperactivate attachment and so maximize opportunities for care. According to this hypothesis, the mid-range is where we might expect to find cases that reflect the restorative process functioning in a manner that indicates security in relation to attachment.

The choice of participants for this selection was complicated by a number of factors. Six people who met this criterion had to be discounted; two because they did not consent to participate, and four others because their voices were too similar for me to distinguish their speech accurately in the transcripts. I therefore had to compromise and instead of choosing participants who were clearly mid-range in terms of word count I selected one person that reflects high-mid-range, one mid-mid-range and one low-mid-range (see Appendix, 1). Two of these people are from Course B (high- and low-mid-range) and were interviewed; the other was from Course A. Although I was unable to interview the person in Course A (Charlotte had consented to the transcripts being used for research but I was unable to contact her), there was sufficient evidence in what she said in the group relevant to my discussion.

The two courses did have different average word counts (Course A = 1107 words per session and Course B = 849). This perhaps reflects the fact that two thirds of the people in Course A had attended a similar course with the same facilitator in the previous year; they were known to each other and appear to have negotiated a group culture that supported self-disclosure and careseeking. By contrast, only one person in Course B had attended a previous group series (she happened to be the quietest group member of the total sample)

and so at the start of the group most of the group members had yet to decide whether to trust each other (and the facilitator) and work out if the group was a safe place in which to share intimate stories about themselves. Without consciously choosing to do so, I selected three people for this chapter (one from Course A and two from Course B) who were attending their first group series.

Predictions from flow diagram one

As seen in chapter two, predictions based on flow diagram one¹ would lead us to anticipate the following characteristics of people with a mid-range word count:

- Openness to experience, including exploration and interest sharing.
- Balanced expression of emotion.
- Minimal selective exclusion and balanced accounts of personal history.
- Ability to seek and receive care in a direct and straightforward manner.
- Good ability to care for others but minimal defensive caregiving.
- Evidence of supportive internal environment.
- Minimal self-directed hate and judicious understanding of anger.

In the final three case studies I will continue the task of examining transcript and interview material, applying the theory to the cases (Brinegar et al., 2006; Stiles, 2007) in order to understand how closely they conform to these predictions and the meaning of occasions when they do not. In chapter thirteen I will apply the cases to the theory (Brinegar et al., 2006; Stiles, 2007) by focusing on the role of the course facilitator in anticipation of a wider discussion in chapter fourteen which will examine the findings as a whole.

¹ Because this flow diagram presents a balanced picture that is easily recalled I do not reproduce it at this point. It can be found in chapter one (page, 63) and is reproduced at the end of chapter twelve (page, 263).

Case study six: Antonio

Introduction

Antonio was in his late-forties when he attended Course B. The only man in that group, Antonio was a clinical psychologist in private practice. Course B was his first experience of the groups which he went on to repeat following a year's gap. He was clear in describing the groups as personal therapy. Born the eldest of two sons, he lived alone but was in a relationship at the time of the group. When I interviewed him he was again single.

Antonio said little in the group about his childhood and family history except when stories told by other people appeared to trigger his memory. An exception to this was his account of the impact on his adult life of bullying and violent behaviour from school teachers. He spoke of a tendency to attribute emotional problems to this rather than family history, though he also suggested that this may have been a defence against recognising problems within his family. In interview he informed me that when he was a child his father had had a drink problem and was violent to his mother. He told the group that later in life his mother also had a drink problem and cut off all communication with him for a number of years. Antonio also told the group that, following his father's death a few years earlier, he had been cheated out of his inheritance by the imposition of a forged will. We might therefore imagine that, at the very least, family issues exacerbated hurts caused by the violent abuse Antonio remembered suffering at school.

In group sessions Antonio said that trust problems in intimate relationships had led to numerous relationship failures. In our meeting he spoke about a high level of social anxiety and that, aside from his work as a therapist, he was socially isolated. In all the therapy he had undertaken, and the two courses reported on here, he told me he had hoped to lessen the fears that held him in this isolation.

Self-reliance and fear

In session one Antonio described himself as 'self-reliant.' Picking up on a phrase used in the introductory teaching he also said he has a tendency toward 'self-soothing.' The extent of his self-reliance is captured in his report that, for a number of years, he tried without success, to reach a state where he didn't need anyone or feel the 'disappointment' associated with being let down. Making clear the link between self-reliance and fear he said,

110 'I won't seek care even when I know it's available,
111 because I don't want to get it and then have it withdrawn again.'

Later he resonated with another group member who had talked about careseeking in an indirect manner. He used the following metaphor to describe his style of careseeking:

135 'I do it indirectly,
136 I put myself in the vicinity of care.
137 It's like walking up to a house where I know there's care inside,
138 but standing outside the door and not knocking.
139 And I'll hang around outside the door
140 on the off-chance the caregiver passes by and notices me.
141 But I won't knock.'

When asked by the facilitator about the cost of self-reliance he talked about 'isolation' and 'loneliness.' Later he reasserted his fear of careseeking:

150 The fear for me is, er, I want certainty you see.
151 If I seek care I want it to be consistent.
152 I want the care to be consistent and guaranteed;
153 and er, certain.

154 And my emotional belief is that,

155 if it's not going to be a hundred per cent guaranteed
156 that I don't want it; I'll do without it.

157 So that's what stops me shifting.
158 Because there is no certainty I also believe;
159 so I'm in a bind.

Here Antonio appears to have been talking about the pain of disassuagement. In a separate extract from session one he picked up on the facilitator's idea of using other people to regulate affect.

170 I think I'd do it,
171 I hadn't seen it that way before,
172 and it sort of, in my mind
173 I align myself to certain people.

174 And have a kind of, a mental kind of a contract
175 or partnership with them in my mind.

Like placing himself in the vicinity of care, this appears to have been a private process. He gave very strong indicators that he had been hurt very deeply by a failure to get good care. According to this account, his pain is such that he developed an aversion to careseeking and tried to live independently of others. His testimony thus far is good evidence for the attachment system because, despite his best efforts, he could not stop himself wanting care from others. The pain underpinning his behaviour might also be read as evidence about disassuagement.

Given what Antonio said about careseeking (and what he subsequently said about his fear in the group - see below) it is perhaps remarkable that he spoke as much as he did rather than remaining silent. Given what he said above I think it likely that, for Antonio, speaking in the group created proximity ('vicinity') between him and a potential caregiver.

Defensive Caregiving

In session two Antonio told a story about being a twelve-year-old and trying to comfort his mother when she had been very distressed. His failure to calm her distress was recalled with pain that he turned against himself: 'That was the first time I had a sense of inadequacy'. If this had been typical of his young life one could imagine that caregiving might be associated with pain and low self-esteem. Nevertheless, as a psychologist and psychotherapist it is clear that caregiving had become an important mode of relating for the adult Antonio. During the discussion of careseeking in session one, he commented on his work as a psychotherapist in the following terms,

180 'I substitute caregiving in place of careseeking.

181 I just kind of flip it around, and er,

182 I get some of what I would get from careseeking I get from caregiving . . . '

Reinforcing this in our interview he spoke about the relief that follows from his working for others in psychotherapy sessions.

Anger and selective exclusion

In session four Antonio talked about being cheated out of inheriting under his father's will and drew a link with sexual relationships (the theme of the session) saying that this experience had affected his ability to trust and surrender himself in relationships. However, it is clear that trust issues long antedated his father's death and the more likely explanation is that the story gave him access to awareness of wider trust issues that had also infused his discussion of careseeking.

The principal theme arising from the story about being cheated had been his limited ability to experience anger. When questioned about how it felt to be cheated Antonio spoke of a 'little tinge of anger' and said, 'I tend to go toward sadness' instead. When exploring why this would be so he talked about childhood and the need to be passive at school where any show of anger had been violently punished. He also said. 'I tend to back away from anger

because it doesn't get me what I want'. The facilitator encouraged him to remain curious about where his anger had gone and Antonio spoke about exclusion from awareness:

- 401 I think the problem is like, I don't have the controls, you know,
402 to turn it on: conscious awareness.
403 It's automatic so I don't know how to turn it on.

Elsewhere Antonio spoke at length about trying to control events as much as possible in order to anticipate everything that can possibly go wrong. For example, in session five (the focus of which was the system for defence of the self) he told a story about having ruined Valentine's Day celebrations by trying to micro-manage arrangements and eliminate mistakes made in the previous year. Avoiding trouble had become a way of life for Antonio who said, 'I try to compensate by over preparing, putting in extra hours and extra time' (s.6). This left little room for spontaneity in relationships and meant that he was always alert to the danger of things going wrong.

It is hardly surprising, therefore, that Antonio spoke of high levels of fear about attending the group. In session six he said he had stopped his car on his way to the group meeting because anxiety had triggered a tension headache and caused him to get angry. The facilitator picked up on this reference to anger saying:

- 658 [F: We were just on the edge of exploring this before I think, you and me, [. . .] do you have any sense of how angry you are?]
659 I'd say I'm very angry.
660 Pretty good at suppressing it.

If Antonio had been aware that the focus of the group session was to be defence of the self we might speculate that he had become frightened that the work of the group could challenge his normal methods of dealing with stress. This might also have accounted for his anger. However, in interview he told me he did not think he had known the focus of

sessions in advance and that his anxiety was general to all sessions. He also said that his way of dealing with this anxiety was to 'blank' the session from his mind afterwards:

*2101 I had a thing that I would forget totally each session from one to the next.

[. . .]

*2103 'cause I would literally leave the group session [. . .]

*2104 I'd be very shaky,

*2105 I would go straight to McDonalds for junk food to try and calm myself.

*2106 And I would think a bit about it that day.

*2107 The next day I would be a bit shaky as well.

*2108 And then, two days afterwards it would be totally gone from my mind.

*2109 And by the time we came to the next one,

*2110 I would have forgotten everything that had gone on.

*2111 Not just my stuff but everything; [P: Yeah]

*2112 it would be a complete blank.

Careseeking in the group

I have quoted above Antonio's image of placing himself in the vicinity of a caregiver rather than asking for care. At the start of session seven Antonio seemed to be in crisis and may have come closer than was normal for him to directly ask for care from the facilitator. Having talked on numerous occasions about a link between careseeking, fear and the tension associated with his efforts to eliminate danger from his life, Antonio began the seventh session saying he was not ready to attend the group because his fear was always too high. The facilitator then worked for a considerable time to help him regulate his fear and explore how fear operates to hold him back. A significant part of this work involved fear of surrendering to the unknown (see chapter thirteen).

In interview, I asked Antonio if he had been careseeking when choosing to speak about his fear in this exchange. He replied, 'No, I don't think I consciously was. I think I was genuinely

feeling I couldn't take it anymore.' But he went on to add, 'But by joining the group in the first place, that was careseeking.' This may suggest that placing himself in the vicinity of a caregiver was easier for him to envisage than active careseeking or seeing himself in direct, in-the-moment, interaction with a caregiver.

In interview Antonio spoke about his experiences in therapy. In response to a question about how his experience of the groups contrasted with one-to-one therapy he said,

*2020 Well in personal therapy I feel very much in control

*2021 I have this belief that I'm better than the therapist;

*2022 I know more about psychology

*2023 so I don't feel threatened by any therapist.

This attitude appears highly defensive and fits what is said in chapter two about avoidant self-models bolstering self-esteem and self-reliance. It is paradoxical that while describing therapy for which he had been paying, he spoke about controlling the therapist's efforts. This attitude may have helped Antonio feel strong but the question of whether this stance facilitated or impeded intersubjectivity or mutual person-to-person meeting is interesting. By viewing a therapist as an adversary Antonio may have been responding to the threat he experienced when face-to-face with a caregiver. But this defended stance may have been the best that was available to him allowing him to place himself in the vicinity of a caregiver.

Antonio explained that the principal difference between one-to-one therapy and the group was the size of his audience and that he did not feel the same strength in the presence of seventeen therapists. The above quotation is continued below (*2025-*2028) where it is clear that the principle threat felt by Antonio in relation to the wider group was that he would be judged. This may indicate a link between careseeking and shame.

Internal environment

Toward the end of session eight Antonio picked up on ideas concerning the intersubjective nature of fear. In particular he noted that two people could trigger each other's fear system and create a dysregulating vicious cycle. He then said,

848 I think it's useful to, sorry,

849 it's useful for me anyway, to bear that in mind.

850 Because I'm inclined to take it all on myself, you know:

851 'This is all to do with me,'

852 or 'I'm totally responsible for this problem,'

853 or whatever's going on.

854 And that I'm not inclined

855 to think that it's anything at all to do with the other person.

In this extract he identified a tendency to take responsibility for the feelings of others; I suspect that, 'I'm totally responsible for what's going on' (852), might be read as meaning, 'whatever happens is my fault'. It is easy to imagine that this links to an attribution dating back to stresses in his childhood family home. When set against the confidence he expressed in interview (*2020-*2023 above) about his abilities as a psychologist it is possible that his professional persona compensated for or defended him against profound personal insecurity. The operation of a vicious internal environment was particularly evident when Antonio talked in interview about his fears in the group.

*2024 But in a group I feel very threatened [P: Yeah].

*2025 Not by the the, [facilitator named] in this case, not by the therapist;

*2026 but by the audience if you like or the committee or the judge.

*2027 I see them as a kind of panel of judges

*2028 who are going to determine whether I'm worthy or not.

In the presence of these judges he said he was constantly watching very closely and monitoring what he said. He also said he was especially wary of one group member who he believed thought he was 'self-pitying' and 'whining'. It is clear that the person concerned had not called him self-pitying or whining and I think it likely that these labels reflect Antonio's particular sensitivities about careseeking and probably link back to attributions from childhood. If careseeking is self-pitying/whining, at the level of implicit representations it is likely to be profoundly shameful.

Evidence regarding hate and shame

Antonio appears ambivalent in the direction of his 'hate'. He speaks of a belief that he is totally responsible for what goes wrong in relationships – this is self-directed. At the same time, his relationship with the 'panel of judges' and his attitude toward one-to-one therapists appears to include other directed hate: they are a threat to his wellbeing that has to be dealt with. It might be another reflection of the close link between careseeking and vulnerability (shame).

I think it may be significant that Antonio does not talk about shame. This may be because he did not experience shame in relation to careseeking. It is more likely that his defensive stance excludes shame from awareness and that, consequently, it remains unsymbolised and deeply implicit.

Overview of Antonio's interaction in the group

In the transcripts there appears to be a progression in which, in successive sessions, Antonio edged closer toward directly expressing his need for care to the facilitator culminating in their extended encounter in session seven. In this progression Antonio moved from abstract discussion of his fear and need toward manifesting that need and fear in the group in the present moment; in a manner that allowed the facilitator to work with him directly whilst he owned his state of extreme fear. It is possible that this apparent progression was a move toward increased intersubjective meeting in which he allowed

himself to be vulnerable in the present moment of that relationship. Alternatively, placing himself in the vicinity of a caregiver and challenging himself to participate actively (see below), may have undermined his avoidant defences.

There is evidence in the group transcripts that, at the time of the group, Antonio also saw a change in his behaviour following session seven. When giving feedback in the next session about the extended work in session seven he reported a major shift in his feelings and behaviour. However, when I met him a couple of years after this group Antonio said he could hardly remember this incident even though it had seemed to me to be an unusually significant encounter. Moreover, he reported little if any change resulting from his group attendance.

His inability to remember the extended exchange between him and the facilitator in session seven seems remarkable to me. The strength of his amnesia in relation to this has to be set against the fact that he did recall her offering empathy and challenging his suggestion that he was not in the right group. He also told me that by opening the group session in this way he had not been careseeking, just stating the facts about how he did not think he could take the level of fear any more. It may be that when speaking to me he was not able to access positive cognitions about the incident. His amnesia may also support the idea that his avoidant defences had been eroded in the group but had since been re-imposed so that attachment was again deemphasised and deactivated.

Evidence of a critical internal environment, selective exclusion and fear of careseeking, suggest that Antonio fits flow diagram two rather than flow diagram one. It might usefully be asked therefore why he spoke as much as he did in the group. Some light was shed on this in our meeting when I asked him about the facilitator's role, he said,

*2120 I saw her as a facilitator, you know.

*2121 She's very good at group work, you know.

*2122 She would draw me out a bit;

*2123 encourage me to stretch myself, you know, that I generally did.

*2124 That would be one of my policies in a group:

*2125 if I am challenged to do something I would nearly always do it,

*2126 no matter how much I didn't want to do it, you know, [P: Yeah]

*2127 and I remember she coaxed me.

Two distinct elements in this answer seem to be significant. Firstly, when compared with what he had said about other group members and therapists in one-to-one therapy, Antonio expressed a trust in the facilitator that implies acceptance that she cared about him. When asked he also told me he thought she had liked him. Secondly, he imposed a rule on himself in the group which meant he pushed himself and rose to any challenges that were thrown at him. Both of these elements in combination might account for a tendency to speak more assertively in the group than flow diagram two might predict. Asked in interview about how his way of being in the groups differed from what he saw in the behaviour of other group members he said that, except for his 'go getting' attitude in groups he would be like the quiet people, who don't say much and are very tame in what they say. At the same time, he said, unlike some of the more vocal people, he was selective in what chose to speak about in groups.

Conclusion

It is perhaps no coincidence that Antonio has the lowest word count in this section. Rather than representing flow diagram one (optimal functioning of the restorative process) Antonio seems more closely to fit the presentation in flow diagram two. I say this because he presented himself as self-reliant, had difficulty with careseeking and used selective exclusion and defensive caregiving in order to regulate fear, loneliness and distress.

But despite his efforts to deactivate careseeking, Antonio has been unable to become self-reliant. He described a process in which care is received in an essentially private process as he controls the extent to which he reveals himself in the external world. This suggests that at an implicit level shame is powerfully active in inhibiting careseeking behaviours.

When talking about the experience of fear and placing himself in the presence of a caregiver rather than directly seeking care, Antonio may have spoken about something that would be recognised by Stephanie and Rebecca (for whom working in private subjectivity seems to have been the primary strategy for dealing with fears associated with group attendance). Yet, he seems to have pressed through his fear to become an active (if subliminal) careseeker in group sessions.

Chapter Eleven: Cases with Mid-Range Word Counts (II)

Case Study Seven: Charlotte

Introduction

When she attended Course A, Charlotte was in her mid-thirties. She was the second born of four children (one sibling having died). She was employed as a therapist. One of four members of Course A who were attending their first group series she repeatedly expressed discomfort about the group culture. She drew parallels with her early life when, for example, she described her birth as joining a group that had already existed; adding that then and in the group, she had not liked what she found.

Charlotte talked about a radical life-change having taken place in her mid-twenties. Prior to that she described herself as 'asexual' and said her life was characterised by 'self-hatred', 'self-doubt' and 'deadness'. Here it sounds as if she is describing an early life in which shame and depression were very powerfully active. The change followed a random, terrifyingly violent attack in which her life had been threatened. Following this event she reported, 'I gave myself the authority to live my life'. This memory was recounted in session four (the focus of which was affectionate sexuality) and her story focused on becoming 'sexually ambitious' and enjoying the innocence and play of sexual relations. In a subsequent session she spoke about her strong spirit of adventure and getting in touch with the 'primitive' and 'animal' within herself.

Resonance and group culture

Charlotte spoke for the first time about one hour into session one. The first speaker had told a personal story using language derived from the theory in a manner that, I think, may have sounded unnatural to new group members. Subsequent speakers also used this language as they recounted memories linked to careseeking. The session quickly became emotionally charged as several people expressed fear about the start of a new group and

talked about loss and distress associated with failed careseeking. A key concept belonging to the group culture and used by several of the group members was 'resonance' and 'resonating' with previous speakers. Charlotte began by saying how this had affected her:

1001 I'm feeling confused by the demands to resonate,
1002 so it's sort of like I'm trying to resonate with myself at least.
1003 And it's like I feel I've landed into this cultural way of communicating
1004 that is not yet my own.

1005 I'm full of feelings about these themes, but,
1006 my biggest feeling is probably fear;
1007 ambivalence and some hostility towards . . .
1008 You know.

Although I think she gave voice to fears shared by some of the new members, in this statement she stood against what had been the flow of the group. She heard the word 'resonate' as a 'demand' and says she felt 'confused' (though she does not sound confused). The attempt to resonate with herself sounds like a defensive device that helped her stay grounded. That her strongest feelings were, 'fear, ambivalence and some hostility' suggests that within her ambivalence she felt threatened and defensive. It is unclear whether the threat came, as she said, from the group culture, or if it was a reaction to the high emotional charge in what was a very a new group. Several months later (session 5), she spoke about trusting herself and her own perceptions above everything else when feeling threatened (see below).

In a sense Charlotte had echoed earlier speakers who talked about fear at the start of a new group; but her experience was different. Those speakers had attended the previous year's group and knew most other members. From a social constructionist perspective (Averill, 1982) it is possible that they spoke about being frightened in order to create and reconnect with support they expected to find in the group. By contrast, Charlotte linked her fear to ambivalence and hostility. In her second input to the group she repeated the idea that the group culture caused her to feel 'quite hostile'.

Although Charlotte objected to the culture of the group she did not specify what she meant by this. She said she normally enjoyed group work and it is likely that she was referring to groups which had no set theme and where the facilitator took her lead from whatever group members chose to discuss (see for example, Yalom, 1995; Barnes, et al., 1999). The groups being studied use McCluskey's idea of 'goal corrected empathic attunement' to support exploration and interest sharing based on Heard and Lake's model of the self as a means of deepening self-understanding (McCluskey, 2005; Heard et al., 2012). Dyadic relationships (between group members and the facilitator) and resonance are central to this style of group work in which the careseeking/caregiving exchange is linked to exploration (see chapter two).

Later in session one Charlotte said that, for her, resonance was 'subtle', 'fleeting', 'non-verbal' and 'so constantly flowing that if I say to someone "I resonate with that" it is already gone'. This description of resonance may reflect the gap between 'core experience' and verbal description (Stern, 1985) but, given the theory underpinning the groups, this is not something that would have divided her from the facilitator. Although I believe the facilitator agreed with Charlotte's description of resonance a gap separates them in which questions about resonance were rarely if ever acceptable to Charlotte (see below). Given what Charlotte said (above and elsewhere) about resonating with herself, it is possible that, when threatened, she became self-reliant. This might suggest that the gap between her and the facilitator involved differences in activated behavioural systems. By this I mean that in questions about resonance the facilitator may have sought to support self-exploration but her questions triggered self-defence in Charlotte. Possible reasons for this are suggested below.

Echoes of early experience

Charlotte repeatedly explained her current experience in terms of her childhood. Early in session one she said that she had been very anxious about attending the group. I have already alluded to her description of birth as joining a group that she did not like. She then drew a parallel between her parents and the facilitator:

1051 I had very clear, mentally clear parents
1052 and I got almost terrified by your mental clarity in the presentation. [F: All right]
1053 Terrified is too strong; there was a reaction, 'Oh fuck';
1054 an elemental place.

The first part of this involved being a new person in an established group and not feeling safe. This may be a normal response to joining a group that had its own language and mores. But it is not clear why she was frightened by mental clarity. Her reference to early experience may be significant. I suspect it is normally reassuring to infants/children that their parents have higher levels of cognitive ability or 'mental clarity'. In the same way, a mentally clear teacher is not normally perceived to be a threat. Charlotte may be suggesting that mental clarity was somehow used against her in the past and that she is therefore sensitive to the risk of manipulation (and or fusion).

Given the differences between this group and what is likely to have been her previous experience of groups, she might have objected to the controlling role of the group facilitator. From what she said about her mother and early life experiences, it maybe that the facilitator controlling presence in the group, coupled with the offer of care, evoked powerful fears that were linked to depression and shame. Finally we might speculate that it may also be that the re-storying engaged in by the facilitator (retelling Charlotte's story to reflect the theory being taught in the group) was somehow threatening to a story already valued by Charlotte. In Charlotte's story, freedom from shame and depression had been hard-won. Whatever the precise meaning of her words, Charlotte's objections throw light on what it meant to her to join this group.

About Careseeking

In her first input to the group, after objecting to the idea of resonance, Charlotte posed the following questions (1010/1011): 'Is this a safe place to be cared for? Do I want to be cared for; is that for here?' In these questions it is likely that she was reacting to what she had already seen in the group where it was apparent that many group members knew each

other, cared for each other and sought care from the group and facilitator. It may therefore be significant that Charlotte's questions drew a link between careseeking and threat. Later she spoke about a tendency to idealise care:

1070 There's something going on for me around, erm,
1071 the idealising I have of a particular feeling about care,
1072 that feels like perfect care.

1073 And if I don't get that, I panic, and I fight, [small laugh]
1075 for the other to realise that their job
1076 is to care perfectly in sort of Charlotte [faint laugh] style attunement;
1077 pre-verbal, non-verbal.

The link between care and threat is seen in 'panic' and 'fight' (1073). It is significant that 'perfect care' in 'Charlotte style attunement' prioritises 'pre-verbal' and 'non-verbal' relating. Using the language of psychodynamic psychotherapy she may be indicating that careseeking triggered primitive and highly defensive aspects of Charlotte's self.

Charlotte then picked up on references other people had made to disappointment in attachment relationships saying that there were times when she felt deeply hurt because her partner repeatedly let her down and couldn't always be there in the way that she wanted. At such times she questioned whether she should stay with him:

1080 one part of my authentic self says authentically,
1081 'you so fucking hurt,
1082 how can you be with this man'

I notice that she emphasises the truth of her statement about being hurt by use of strong language and attributing it to her 'authentic self'. She then drew another connection with the group.

1093 And I know that's what I'm struggling with here again today.

1094 It's, can I let what's there be enough?

1095 What'll I do with my rage and my sadness when it doesn't feel like enough?

Later she talked about 'the incredible vulnerability' and 'fragility' of careseeking and cited an idea (which she attributed to Winnicott) that delinquency can be a sign of hope and self-care. Reflecting on what this means for the work of therapists she said,

1108 Everybody who comes to us is looking for care

1109 but they're also telling us to 'fuck off' when we try and give it to them.

When heard in context I think Charlotte was possibly saying that she feels very vulnerable and frightened in attachment relationships in which she is a careseeker. And that she will say 'fuck off' when she was really seeking care. This interpretation is supported by her final words in session one:

1124 [. . .] it's almost easier to be feisty and irreverent and difficult and all that,

1125 than to go with this fucking so sad.

1126 This territory is somehow so sad to me [sounding like she is on the edge of tears]

1127 and so painful [. . .]

Careseeking seems to evoke pain and sadness perhaps fear of profound disappointment.

In an affect regulating intervention the facilitator asked Charlotte to look around the group to see that people had understood her. Charlotte then continued:

1129 It's absolutely terrifying.

1130 It's like part of me wants to say,

1131 'Look Charlotte, you're not going to trust this group

1132 I'm going to do this thing but I'm not really going to be here

1133 because you could get really hurt'.

1134 I think the fear of hurt is this old, old . . .
1135 but it's very strong, fear of damage actually.

Charlotte may have been threatened by the suggestion that she join and see understanding mirrored in her fellow group members. Given the depth of feeling expressed by her it is possible that she became frightened in the presence of a caregiver (or a caring group) and defended herself by becoming 'feisty'. This may indicate a powerful (perhaps implicit) linking of careseeking and (perhaps shame-filled) vulnerability. Because of the central role of the facilitator in this type of group I think it possible that Charlotte sometimes talked about 'the group' and 'culture' when her reaction was more personally linked to the authority taken by the facilitator (see below).

Caregiving in childhood

In session two Charlotte spoke about her childhood relationship with her mother. She drew a close connection between caregiving to her mother and abandonment of self.

2020 When I think about it
2021 I see it not as an actual event but I see sort of,
2022 a raising of myself reading of my mother's expression,
2023 and protecting her from feeling unpleasant about me;
2024 [. . .] a chameleon like constant adjustment to her harmony.

2025 That any price could be paid.
2026 I wouldn't even notice I was paying a price;
2027 just simple regulation of her mood by becoming a certain type of child.

2028 And I think that, you know that's . . .
2029 You guys didn't see that last time;
2030 still quite a strong defence.
2031 I think, in a sense of what's required, become that, abandon yourself.

2032 I know that doesn't sound like caregiving, but it's . . .

2033 giving something away, I don't think it's care

2034 [F: Mmm, mmm, do you think it is regulating the other?]

2036 [. . .] It's regulating the environment being safe for me to exist in in some way.

Here it is significant that she talked about 'raising' herself and regulating her mother's mood rather than seeking and receiving care. In language that is sometimes strained she told the group that she had to become someone she was not in order to prevent her mother 'feeling unpleasant about me' (2022-2024). Aspects of this may have been excluded from awareness so she did not know what price she had paid to regulate her mother's mood (2025-2027).

This is paradoxical because of what she had said before about preferring non-verbal and fleeting attunement over verbal resonance. It appears to have been sensitivity to fleeting attunement that characterised her early relationship with her mother and involved abandoning herself. Yet this appears to be the very threat that triggered her fear in the group. Woven into her wider life-narrative it might be imagined that regulating her mother's feelings at the expense of herself had characterised her memories of life before she reached her mid-twenties. Later (session four) she describes that life in terms of 'self-hatred', 'self-doubt', 'deadness' and being 'asexual'; she seems to be describing a time when she had been deeply and chronically depressed. It may therefore be that the call to resonate tapped into deeply threatening memories (implicit and explicit); and for her to stay safe she had to fight for her own space so that any resonance was private and/or self-determined.

Resonance and defence of the self

Early in session five Charlotte observed the facilitator working with another group member. The facilitator invited Geraldine to look around the group to see how people were responding to her. Later Charlotte reacted by saying,

5010 Something's going on for me
5011 around the right not to feel connected;
5012 or the space maybe, the right is there [F: Mmmm]
5013 but the freedom or ease not to feel connected.

She added:

5023 When you said, 'can you look at everyone;
5024 do you feel more here or less here?'
5025 I just felt, 'fuck off'.

5026 Not, not on a personal . . .
5027 I just feel like, but I just felt,
5028 'Can I not just sit [F: mmm mmm] here
5029 and feel not connected or intimately bonded with everybody'.

This may support what is said above about 'resonance' and the importance of resonance with herself. I think it worth noting the apparent ambivalence in which 'fuck off' was immediately mitigated by 'not on a personal . . .' and the question that follows. It sounds like she wants both to express anger and maintain relationship; perhaps on terms that obviated any risk of loss of self. But if this expresses ambivalence, it is a very skilful and eloquent ambivalence.

Later in the session Charlotte reacted to an exchange between two group members that included conflict. She reported that when she watched Annette responding to a challenge from another group member she did not believe the expression on her face:

5052 I looked at your face which was smiling
5053 and I felt you were fucking raging.

5054 And I don't know if you were or not
5055 but my head was going, she's raging, she's raging, she's raging.
5056 And I got really uncomfortable with that dialogue . . .

After this input she was silent for over an hour but returned to comment on her reaction. She began by saying she had been 'feeling very bored and deadened and disconnected' and that this may have been a reaction to what happened with Annette. Given her normal level of engagement I wonder if she was here describing defensive withdrawal from the group.

5081 But what happened for me was a fear
5082 that somebody might get away with something that wasn't said.
5083 And that is something that is old for me. [F: mm]

5084 When I say 'get away with',
5085 I mean that something would be missed, energetically.
5086 And and, and I got scared by that.

5087 And I then go into a very self-righteous er, relationship with my own mind
5088 where I think, 'I know what's happening here, [F: mm]
5089 somebody has to say it'; [F: mm, mm]
5090 vigilant, rigid, [F: Yeah] et cetera. [Yeah]

5091 And then, that comes to dominate everything for me; [F: Yeah]
5092 that conviction that I am right. [F: Yeah]

Soon after this she reemphasised the isolation of her defence saying,

5097 But what really happened to me is
5098 I decided it wasn't safe to relate [F: Yeah]
5099 and I then go into a judgmental, rigid, sealed off [F: Yeah] [p] place.
5100 And that is very strong, [F: Yeah]

The phrase 'that is very strong' is ambiguous and may mean that it dominates her or that it gives her strength to withstand or respond to threat. She then drew a connection with

her childhood:

5102 I honestly think what happened to me in my childhood is
5103 that I didn't trust my mother
5103 and I withdrew from all possibility of being met by anyone. [F: mm]
5104 I mean I didn't trust intimacy.
5105 And I didn't trust connection. [F: mm]

This seems to be highly significant and may account for her reaction against resonance. Charlotte continued by saying that she didn't learn to build safe relationships until later in life and that she has a primitive awareness of danger:

5109 but the [pause] the sense of
5110 not being in relationship in a safe way with anyone for for any moment
5111 is I think an early experience for me.

5112 And it kind of,
5113 when once it goes wrong,
5114 once it goes wrong, [F: mmm] [pause] I withdraw [pause] from something.

The facilitator asked her if she was cut off from external reality when in this state and she said she could see but was not emotionally available to it. She then summarised what she had said,

5128 [. . .] I get very convinced I'm right. [F: mm]
5129 And even now, [F: mm] regardless of what you tell me
5130 or even anyone in the group tells me,
5131 I, there's a part of me going,
5132 'I have to trust myself' [F: mm] and that's old. [F: mm]
5133 I feel the only safe thing in the world [F: mm] is trusting the defence; [F: mm]
5134 that's what it feels like.

If there had been space to report this exchange in full I think it would have been possible to illustrate better the complex nature of the relationship between Charlotte and the facilitator. Paralinguistic interjections indicate that the facilitator was closely involved in supporting Charlotte as she recounted her experience. Listening to the recording there seems to have been a high level of attunement as the facilitator made clear that she was listening closely and supported what Charlotte said. My reason for saying this is to highlight the fragility of the attunement which appeared to be momentarily shaken when Charlotte was asked to describe her experience in terms of the theory:

5135 [F: Do you know what system is firing in you?]

5136 Well on that map it sounds like fear and [pause] fight-stroke-freeze, I suppose. [F: mm]

5137 I don't think that way, so I . . .

5138 What concerns me is how comfortable I can be in the definiteness

5139 and the lack of relationship

5140 [F: Mmmm, mm. That's what concerns you.]

5141 What concerns me is finding a way back to the world of people and flow.

5142 [F: So the concern is to find your way back?]

5143 er, er, I don't know, I'm just trying to describe something that happens to me.

As I read (and hear) the above it appears as if any attempt to tell her story in a frame that is not of Charlotte's choosing was experienced as an interruption or imposition and was resisted. She may be a little disorganised in this extract. This exchange may indicate a history of impingement in which she had not been allowed her own emotional or mental space. It also appears to signal unwillingness to accept the facilitator's authority to retell her story in alien and, to her, meaningless terms.

Charlotte's metanarrative included a life-threatening attack that triggered radical change;

following which she took power to decide the direction of her life and self-expression. By repeatedly attempting to retell Charlotte's story in terms of an alien theory the facilitator may have been experienced as rejecting something of sacred value to Charlotte's self-concept.

Shortly after this another group member offered a resonance using Charlotte's language about becoming self-righteous when confronted by deceit or injustice. The facilitator asked Charlotte if she was 'getting any connections' and Charlotte appeared momentarily bewildered; as if the question had interrupted private thoughts, though in light of all that has been said, Charlotte may have been reeling from an apparent invitation to join with a resonance. Charlotte acknowledged similarities and pointed to further links between what was happening for her and her childhood experience:

5171 I think it is very much for me about mother.

5172 There's different things get triggered

5173 but I was thinking that the combination of [Facilitator name] and Annette;

5174 if I could join you up,

5175 you could together trigger my mother stuff.

5176 Or almost cover about ninety eight per cent of it, right [laugh - group laugh].

She then told a story about her mother's behaviour toward her (Charlotte's) god-daughter. Her mother said nice things to the child but never wanted to touch her and constantly said unpleasant things behind her back. Believing that her mother hated this child Charlotte said it was painful for her to see. She then returned to what she had said to Annette:

5193 That's why I got so triggered:

5194 the smile and the sense of anger or whatever,

5195 that's what I felt.

5196 And it became very frightening to me.

5197 And I needed to go, 'I'm not having this'.

An overview of Charlotte's interaction in the group

Charlotte's response to the offer of care is complex. Offers of care in the group setting (most of which come from the facilitator) seem to activate fear, distrust and self-defence in Charlotte. And it may also be that the activation of careseeking triggered preconscious memories of pain, disappointment and fear (expressed as hostility). I suspect that the facilitator's attempts to retell Charlotte's story in the terms of an alien theory triggered a sense of threat; perhaps the loss of her own narrative and consequent dominance by another person.

Conclusion

Although I have evaluated Charlotte's interaction with the facilitator and group through the lens of Heard and Lake's (1997; Heard et al., 2012) theory it has to be born in mind that Charlotte would surely have told her story in different terms; and if only because chosen by her, that these terms may have been better suited to presenting her experience.

Charlotte was in a training group and by interpreting her experience in terms of a particular theoretical model the facilitator was perhaps upholding her commitment to the contract that joined them. But this seems to have been provocative for Charlotte. Notwithstanding the teaching role of the facilitator, it might reasonably be asked why the facilitator repeatedly spoke to Charlotte in terms of a theory that Charlotte actively rejected without acknowledging the impact this was having on their relationship. With Charlotte as with everyone, the facilitator always offered explanations and interpretations in line with Heard and Lake's theory. In chapter fourteen I propose that any theory might be used defensively to orientate and protect a therapist from threat.

It seems likely that Charlotte's reaction against the group culture reflects wider difficulty with attachment relationships and that she negotiated these difficulties by means of a relational style in which, though always 'feisty' (defended), she sought and accepted a lot

of care while maintaining a clear defensive boundary. This suggests that she may have been avoidant in a way that does not conform to any of my flow diagrams.

I suspect that Charlotte was a voice for fearful and daring or renegade ideas in the group and was valued and supported in this role by other group members. Charlotte sometimes drew links between her discomfort with the group and facilitator and her relationship with her mother in childhood. In this too there seems to have been deep ambivalence. In the final session, a group member expressed anger about how Charlotte's mother had treated Charlotte in childhood. Charlotte responded by saying she felt protective toward her mother.

I am reminded of Suttie's description of hate as, 'a standing reproach to the hated person [which] owes all its meaning to a demand for love' (1935: 31). So we must recognise that within Charlotte's feisty rejecting words, while she is telling a caregiver to 'fuck off', there is the plea for love and care. This is perhaps acknowledged in closing remarks made to the facilitator: 'I think you have been really generous to me and really fair', and 'I really want to thank you for how you've been with the place I've been in'.

I think Charlotte's input to the group attests to the strength of her desire for care despite feeling deep ambivalence and fear in the presence of a caregiver. Despite her apparent ambivalence about the theory and culture of the group (including the central role of the facilitator), she appears to have experienced care and exploration. At the same time, I suspect that there was much more going on for Charlotte that was invisible to the group; and perhaps unknown to her. I will return to this in the summary in chapter twelve.

Chapter Twelve: Cases with mid-range word count (III)

Case Study Eight: Denise

Introduction

Denise was in her early forties when she attended Course B. This had been her first experience of the groups and she returned to attend a series in the following year. Born the eldest of three children she was a psychologist and therapist. She was married with three young children living at home. She was selected for inclusion in the study because she represents the high-mid-range word count.

My experience of Denise is of someone who spoke fast with ideas seeming to fall over each other. She often appeared to be wrestling to understand herself and was sometimes haltering and uncertain. When typing her words I sometimes found it difficult to follow the line of her thought.

Denise spoke very positively about her parents and described childhood in a secure home. Nevertheless characteristics of her speech (manner and content) lead me to question how accurately she is represented by flow diagram 1.

A word about reflexivity

Although reflexive processes are active in all of the case studies, I am especially conscious of my limitations when writing about Denise. I found her more difficult to understand than other participants. In the absence of unlimited space in which to explore what this means I have confined my focus to a small number of theory linked observations. This limited focus necessarily means that my case study is both incomplete and shaped by my needs. I have tried to be no less faithful to Denise's truth.

Careseeking

In session one Denise said, 'I've done the self-regulating part'. This appears to be similar to the 'self-reliance' described by other group members because she went on to say she worked things out for herself. However she sought to differentiate herself from earlier speakers by saying 'mine has come from a totally different place'. She did not say what she meant by 'self-regulating' and the difference may reflect increased emphasis on the emotional consequences of her needs not being met. As an adult (and dating back to adolescence) she said she seethed with anger because her needs were neither recognised nor met in her closest relationships. By contrast she said,

1033 I had an expectation that things would be . . .

1032 needs would be met.

1033 They were met when I,

1034 Or my sense is they were met when I was younger;

1035 without ever being asked for as such.

[. . .]

1038 it's like, 'Darn it! Why can't you mind read?'

1039 And realise that this is what I need.

1040 And so I go around seething,

1041 and actually what it is about is not asking for it,

1042 because I expected it to be seen.

[. . .]

1047 I suppose what I'm thinking about now is that the anger comes from

1048 the fact that it hasn't been noticed that I need that . . .

[. . .]

1051 Or yeah, yeah, that, because I haven't, identified . . .
1052 Or I haven't identified that I needed,
1053 I was seeking help,
1054 I assumed that I was seeking care . . .
1055 That I assumed that it would be picked up.
[. . .]
1057 Or that seething kind of [F: Seething anger] yeah, yeah, yeah. [F: Right, OK]
1058 Which is an internal dialogue.

The expectation that her needs would be met without being asked for seems to be important. Although she repeatedly talked about 'seething' because her needs were not recognised or met, she does not seem to ask for care; she expected attachment figures (in omitted text she spoke particularly about her husband) to recognise her needs without her asking. I wonder if there is a contradiction indicated by the strength of her word 'seething' and the apparent weakness of the phrase, 'darn it!' Given that she presents a secure childhood in which her parents were loving and anticipated her needs, I am struck by the question: what is it that stops her asking for what she needs?

Denise's experience of fear

In the surprises and learning section that followed the experiential part of session one Denise spoke about fear:

1053 I guess I would perceive myself
1054 as a person who always approaches things
1055 from a point of curiosity [F: Yes]

1056 And I just, don't know what fear is.

To understand just how remarkable this statement was it is worth pointing out that it was made at the end of a session in which fear had been talked about many times. In one form or another, the word 'fear' (fear, fearful, fear system) was used by the facilitator twenty

seven times in her teaching input. Subsequently the facilitator used the word twenty times when interacting with group members. Nine group members also used the word fear twenty times between them. There were other less indirect references to fear in affect regulating interventions such as when the facilitator asked the group to 'tension down'. In all of these references to fear Denise's statement was unique.

During my interview with her I reminded Denise that she had said that she did not experience fear and again she said,

*401 Yeah so it's not something that I experience . . .

*402 Er, it's not generally something that I experience for myself [. . .]

*403 [P: What does that mean?]

*404 Er, I guess I would have an approach to life that is 'have a go,

*405 see what it's like, try it out' kind of thing;

*406 so I wouldn't be fearful of trying it out.

How is Denise's assertion about not feeling fear to be understood? Whilst there are people who do not experience fear for organic reasons (LeDoux, 2002a), it is unlikely that she could reach middle-age relatively unscathed without a fear system functioning to maintain her wellbeing. I therefore think it likely that Denise's statement is a matter of exclusion from awareness rather than a non-functioning fear system. When making her original statement she hinted at this saying,

1062 So is it a kind of denial of it,

1062 or is it just not actually knowing it?

I have repeatedly drawn on the information processing idea that access to emotional and cognitive material is state dependent (Mikulincer and Shaver, 2007). I have also quoted the idea that self is created in the process of storytelling (Riessman, 2008). It would therefore be nonsensical to seek perfect coherence across sessions and in different stories. I think the focus of sessions one and two may offer an explanation. In session one, when

she first said she does not experience fear, the groups focus is careseeking. In session two, the focus of which is caregiving, Denise told a story about becoming very frightened when cut off from her children at a time of flooding. In this story she was clearly able to access fear. I am reminded of George and Solomon's description (quoted in chapter two) of the role of affect in the caregiving system: 'Mothers . . . experience heightened anger, sadness, anxiety, or despair when they are separated from the children, or when their ability to protect and comfort the children is threatened or blocked (George and Solomon, 2008: 835). She experiences fear linked to caregiving. This might reflect the significance of her words 'for myself' (*402).

Denise also informed me in interview that she is afraid of heights, so there is at least one category of situation in which she has access to the emotion of fear in relation to herself. I suspect that the absence of fear is linked specifically to careseeking and that, because she feels her needs are not seen or met, she has developed a defensive response in which anger ('seething') displaces the fear and pain (perhaps shame) of unfulfilled careseeking. As said elsewhere, the absence of emotional expression does not mean the absence of emotion. It is possible that the group context, in which she saw others seeking care from an identified caregiver, inhibited her access to attachment related cognition/affect (including fear) causing her stories to focus on the positive.

In an intriguing sentence spoken soon after the last quotation from the end of session one she again juxtaposed curiosity with the absence of fear; but this time she spoke in terms of negative consequences,

1071 maybe that's why I sometimes feel so,
1072 like there is that kind of raw emotion around,
1072 because I don't have the fear to kind of protect me.

The meaning of 'raw emotion' was not explained or explored by Denise. Yet, notwithstanding the earlier reference to 'seething', her normal presentation involved laughter and making light of difficulties. So, however oblique her references to 'raw

emotion' and personal protection, these were important statements about her experience of self.

Selective exclusion and emotion

In her statement about fear Denise appeared to be speaking specifically about the felt experience of fear. Thus defined, we might see fear as arising from both preprogrammed instinctive cues and as a learned response to threat and pain (Bowlby, 1980) encoded in memory systems. So when speaking about excluding fear from awareness there are two possibilities: firstly, fear and pain may be excluded at the time of the original experience; as when someone dissociates from their current reality. Secondly the memory of pain might be excluded in the process of recall.

In several sessions it was apparent that Denise struggled to know what her feeling or thought had been when speaking in the group. This had been an important part of the focus of work done by her in later sessions. When we met in interview she said that the most significant event in either of the two group series she attended occurred in session eight of Course B. In that session she became very distressed and can be heard crying in the background as two group members spoke about the death and serious illness of family members. Denise told me that this event was significant precisely because she became distressed and was helped to understand that her distress had been a substitute for anger (in relation to an issue at work).

Denise's confusion about feelings can be seen in a brief extract from session six. After a long period of listening to others she returned to a question the facilitator had posed earlier in the session concerning what she felt about being misunderstood by her parents:

6030 I think I was struggling,

6031 like I was struggling with that question that you said

6032 'OK, how does that leave you, how did that leave you feeling?'

6033 And as I was hearing people's stories about, you know . . .

6034 And there was sadness and anger, and it's like,
6035 'No, I don't feel sad, no, I don't feel angry, what is it I feel?'

6036 And I think it was when you said to Katie, you know, 'annoyed' . . .
6037 was one of the ones that she kind of . . .
6038 Almost like 'Oh, that's it' [F: Annoyed]
6039 you know what I mean; there was something about
6040 'OK, yeah, that makes more sense'.

Here she described the process of searching through the experiences of others to find her own feeling. The facilitator gave time for Denise to explore what her feelings had been in response to her parents' misunderstanding her. In feedback to this session a month later she said this question had been important and challenging. She also said she realised that she found it easier to think about things than to know what she felt about them.

In interview we spoke about her experience of resonances in the group and Denise said that this almost always involved difference. By this she meant that when others spoke about unhappy experiences it would trigger recognition in her that her experience had been different. For example, she spoke about people saying that their parents had been emotionally unavailable during their childhood and said this had caused her to realise that her parents had been very available to her. This and other examples given by her may be evidence of real differences between her experience and that of other group members but it might also be evidence of information processing operating in such a manner that, when she heard people talk about unhappy experiences, she accessed positive and reassuring memories or cognitions. The nearest Denise came to resonating with anyone disclosing unhappiness was in a memory of ruminating as an adolescent (see below). However, when she spoke about this it was a historic problem and the point of speaking was to assert that she had resolved her unhappiness by adopting a positive 'working attitude'.

The incident when she became distressed (session eight) was remarkable because, though apparently triggered by other group members' expressions of grief and fear, the source of

Denise's distress was wholly unrelated to their accounts of personal loss. Whilst I think it likely that she was resonating with their distress, I think she did so at an unconscious level.

Life choices and 'working attitude'

In session four Denise, who was married with young children, informed the group that she had had just one sexual partner. Whilst she said she had sometimes wondered what she missed she made clear that she was not tempted to find out. Reading this I was reminded of Yalom's (1989) assertion that 'alternatives exclude' and that all life choices inevitably involve the renunciation of other options. Later in the same session Denise gave a hint about a personal experience of renunciation and the emotional distress that had underpinned her choice:

4112 [. . .] But to, that sense of like

4113 having that recollection of going into university

4114 and having spent kind of sixth year with all this like

4115 'he fancies me', 'she fancies me', going on

4116 and just thought I can't be bothered with that.

4117 I just want to talk, you know,

4118 to be able to go and chat to people

4119 because they're a person in front of me sort of thing.

4120 And once I adopted that attitude I had a great time in university.

4121 I had loads of friends, you know, male, female,

4122 here, there, everywhere.

4023 Great conversations and great philosophical debates;

4024 and all those things that you should have as a, as a late adolescent, I think.

4025 And you know, and nice romantic walks on the beach.

Using Heard and Lake's model of the self we might describe her behaviour as substituting attention to sexuality with a focus on interest sharing. It may be that she was just not interested in sex, but that appears to be at odds with her concern in sixth form about who fancies whom (4114/4115) and her reference to romantic walks (4025). Further suggesting the operation of selective exclusion she went on to say that, years later, she had been surprised (and I think delight may be reflected in her voice) to hear that she had been attractive to other members of the student body. The facilitator asked if she had excluded her sexuality:

4042 [F: For the sake of being with people, [. . .] for the sake of having an interpersonal relationship that isn't infiltrated by sexuality; one actually dissociated from one's own sexuality and one's own attractiveness; or not?]

4043 Erm, I don't know about dissociated, I'd say I wasn't aware of it.

If the facilitator was accurate in what she mirrored back to Denise, it is interesting that Denise rejected the active verb, 'dissociated' in favour of the more passive phrase, 'I wasn't aware'. Presumably, for exclusion to work it is necessary for its operation to be excluded from awareness.

In session five Denise picked up on a word used by another group member who, in a state of some distress, spoke about a tendency to 'ruminate'. Denise said she had been like that as a teenager: 'I so remember that ruminating, and kind of having twenty thousand solutions to any situation'. Despite her use of the word 'situation' rather than 'problem' I think we here get a hint that in adolescence she experienced anxiety and distress. The nature of this is not described as she focused on the change to a more positive spirit:

5073 . . . but how did I change to that person

5074 that was actually much more positive, you know?

5075 And I suppose that would be some of my experience,

5076 [. . .]

5077 'Oh you're too positive, how can you be positive about this situation?'

In the shift from ruminating and anxiety in adolescence to fun in adulthood she here suggested that her change in attitude resulted from an act of will. If set alongside what she said in the previous session about university then it may be that her ruminations centred in part at least on burgeoning sexuality. Her earlier account suggested that her fun at university began only when she put her sexuality aside.

The final sentence quoted above (5077) may come from a sceptical voice and we might wonder if this arises from an internal or external observer. If the speaker holds that positivity is a good thing the words might be heard as a complement. Alternatively, it may be sceptical and disbelieving, as if saying, 'you should not be feeling so positive given the reality that surrounds you'. Soon afterwards Denise recalled a discussion in session one and quoted Catherine as having said,

5097 "I have an expectation for these things to happen,"

5098 you know what I mean, "that my needs will be met".

[...]

5100 And I think it was like 'yeah, actually that's my expectation:

5101 that things will work out, that things will . . .'

5102 you know, there's a, there's a reason for things.

5103 There's whatever sort of thing.

5104 So there's a kind of expectation there.

5105 So for me, yeah, that's just been fascinating,

5106 and yeah, then I think what the original question is:

5107 Where did that take you?

5107 Did I leave my interests?

5108 Actually I just found another way of doing that interest [F: Yeah]

Here Denise had changed what Catherine actually said. Catherine had been talking about an expectation or belief that people would want to offer her care. When echoed by Denise this was depersonalised and was not about care but about things happening for a reason and things working out. Absent from this account was her seething anger about needs not being met (which she spoke about in the session that Catherine had spoken about her expectations).

Again the questions posed in this extract (5108/9) sound as if they give voice to an internal dialogue. Here she settled the matter with an assertion that she found another way of doing what she wanted (5108).

In session 6 (the focus of which was the supportive or unsupportive internal environment) Denise used a discussion about attributions to explore her parents' view that she was lucky:

6006 when I've explored it with my parents,

6007 it is about that thing like 'things seem to work out for you',

6008 you know what I mean.

6009 And I suppose my argument would be

6010 'but that's because I choose to see them as working out for me'.

6011 So I might have said, you know,

6012 'I'd like to do A', but because A didn't work out I'll make B

6013 [F: you'll make B happen] happen, you know, or B is, I'm happy with, I'll make . . .

Later she added that 'lucky' was,

6024 [. . .] not an attribution I would choose, you know,

6025 I think it's about working attitude.

At this point a discussion about lack of contact with her feelings took place (quoted above, page 254/5) at the end of which Denise moved on to explain why the misattribution 'lucky'

had mattered. Early in this extract she appears to suggest that 'lucky' fails to credit the efforts she made (6007). But her principal point was that things had worked out only because she chose to see them as having worked out (6012/13). As she developed this argument she said that in childhood she had been allowed to settle for second best and as an adult often failed to put in the effort required to achieve what she really wanted.

Careseeking revisited

If we now return to the issue of careseeking we might wonder if 'seething' defined the limits of what can be achieved within Denise's practice of excluding from awareness what she really wanted but did not think she could have. Although she spoke about 'seething' in relation to failed care, it appears that she did not ask for care. She also described seething as an 'internal dialogue' (1058) and did not express her anger where it might be directed. In session eight, she says, it became apparent to her that she became sad as a substitute to becoming angry.

In interview Denise confirmed that she had difficulty expressing anger and said that this was something that her husband normally did on her behalf. She also told me a story in which she reported that, while talking to her parents about her attendance at the group, her father had told her that she should not be angry. In response to this her sister told him he had no right to tell Denise not to be angry. I think that the point of this story may have been to express criticism of her father through her sister's voice. Outside of this story, Denise only ever said positive things about her parents.

When asked in interview about whether the group was a place where she could seek care Denise said she had seen others doing so. Except for the distress shown in session eight she had not used the group in this way and showed an overwhelmingly positive face to the group. Her reference to 'raw emotion' in session one and the display of raw emotion in session eight appear to exist in isolation as if not joined to the rest of her experience. It may be that these experiences had been quarantined (in a segregated system) as the cost of choosing a positive working attitude.

In interview Denise talked about 'being overwhelmed by other people's feelings' and said her defences were 'porous'. In a brief exchange in session five she answered a question directed to another group member about what she needed to defend against. She said, 'I think the sense of, er, being swallowed up, kind of, you know what I mean, getting integrated into someone else, so it disappears all together'. Although this idea was never developed, in the light of her presentation in the group (including her distress in session eight), I am tempted to see this answer as a hint that intersubjectivity may have threatened 'fusion' and/or loss of self in another person's emotion.

Conclusion

Whilst there is a limit to what I feel confident about saying in relation to Denise, she seems to exhibit high levels of selective exclusion and disorganisation. It seems telling that the threat to self she identified most clearly was that of fusion and loss of self. But there is little in her stories to account for this. It may be that her apparent lack of coherence in the group reflects the conflict of disorganised attachment in which the impulse to approach and withdraw are in constant, baffling tension as systems for attachment and self-defence are activated simultaneously (Hesse, 1999). I suspect that disorganised responses to threat mean that she was unable to careseek when in distress. The 'seething' spoken of in session one may indicate that she does not know how to seek care and has to find defensive strategies with which to manage distress.

Denise expressed confusion about her feelings and is often unable to say what she feels. This may indicate that she deals with distress by dissociating or distracting herself with positive cognitions in line with her 'working attitude'. Her distress in session eight appears to have been triggered by grief and loss expressed by other group members. The reason she gave for this distress (being criticised at work) was wholly unrelated to the emotion expressed by others in the group. I suspect that her emotion on that occasion appears 'raw' because it is normally excluded and so is unprocessed. I think it was triggered by contagion in which her defences were broken by contact with the distress of others. This may underpin what she said about her greatest anxiety being fusing with others.

Discussion of the final three case studies using the predictions made in chapter ten

On the basis of word count alone this chapter was anticipated to reflect the restorative process with secure individuals as depicted in flow diagram one which I reproduce (overleaf). Discussion of the findings will be structured using headings taken from the predictions made in chapter ten (page, 221).

Quantity of speech

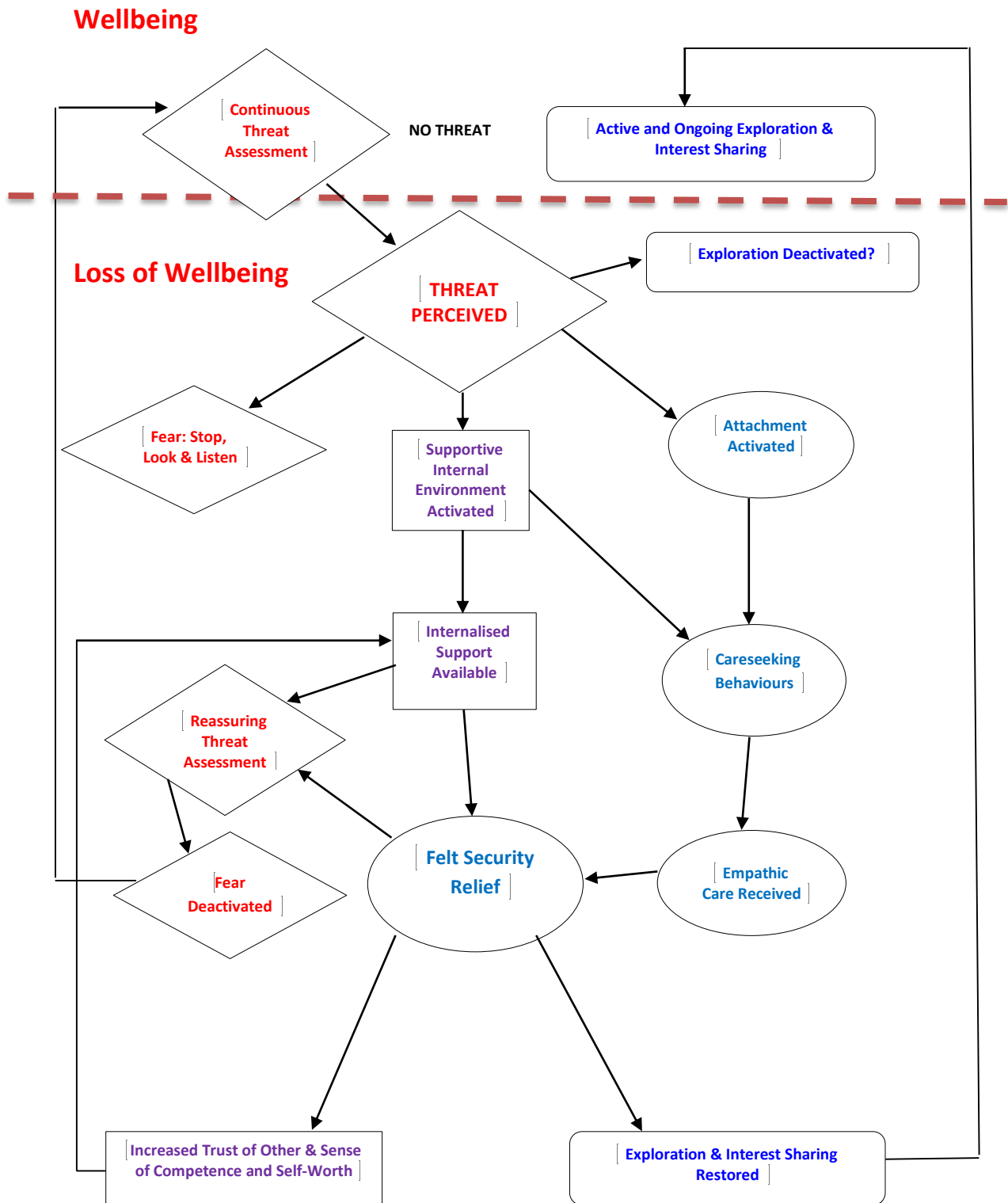
From these case studies it seems that identifying people with moderate word count is not the same as identifying people who are secure in their careseeking. None of the three case studies conform to the flow diagram. Whilst it is tempting to see Antonio as fitting most easily into flow diagram two there are aspects of his behaviour that are not depicted there. Charlotte and Denise are not described by any of the diagrams.

However, whilst writing the above I am struck by the fact that the last sentence reifies the self. If the self in any moment arises from context and relationship, then functioning of the restorative process is created in that context (and in relationship) and will not merely reflect the attachment status of either party.

Openness to experience and exploration

Antonio talked about high levels of fear and self-reliance, and low levels of trust in intimate relationships. Nevertheless, both he and Charlotte demonstrated willingness to risk new experiences in their respective groups. In both of these cases I am tempted to see this as reflecting a measure of fighting spirit; which Antonio described as rising to challenges in the group and Charlotte called feistiness. Both pressed through their anxiety to make the most of what the facilitator offered them in the context of their respective groups.

Figure 2: THE RESTORATIVE SYSTEM (OPTIMAL FUNCTIONING)



Flow Diagram 1. The restorative process (optimal functioning) (FLOW DIAGRAM1).

The Diagram shows the fear system interacting with three of Heard and Lake’s seven attachment related systems as they work to restore wellbeing. Diamond = Fear; Oval = Attachment (Complementary systems for Careseeking and Caregiving); Rectangle = Supportive Internal Environment; Rounded rectangle = Exploration and Interest Sharing with Peers.

Despite having the highest word count in this section, Denise appears to have had the most difficulty in both careseeking and exploration. If I am right to think she edited self-expression (probably in preconscious processes) in favour of what she deemed positive, her interaction in the group was largely motivated (again, probably at an unconscious level) by self-defence. It seems possible that she had not achieved a settled strategy for dealing with attachment related trauma.

Expression of emotion

As suggested above, Denise's emotional expression was normally biased toward the positive and involved exclusion of negative affect (including fear). On the one occasion when she expressed distress in the group she appears to have been overwhelmed with feeling as if a defensive barrier had collapse. This may indicate the presence of a 'segregated system' (but being untrained in attachment assessment I suggest this very tentatively).

Charlotte and Antonio seem to experience and express fear more easily. This expressiveness does not fit easily into flow diagram two but, as suggested elsewhere (Helena and Alison), this may be a result of defensive strategies being eroded within an expressive group. Antonio also appears to have become increasingly willing to allow himself to be joined in his distress. However, he had difficulty feeling and expressing anger and like Denise tended to express sadness instead.

Despite their fear and self-defence, Antonio and Charlotte accepted care, support for exploration and some degree of intersubjective meeting with the facilitator. I am less confident that Denise was so open to participate in this way.

Careseeking

It is clear that for all three people discussed in this chapter careseeking was more difficult than is suggested by the first flow diagram (at least in the context of the group). Both Antonio and Charlotte had found a way to seek care in the group in a manner consistent

with their defensive strategies. In session one Antonio described placing himself in the vicinity of care as a private process. Much of what he said about careseeking suggests that his normal defences are avoidant; with active careseeking suppressed in favour of a private form of proximity seeking. In the course of eight sessions he demonstrated increasing willingness to take risks until, in session seven, he entered into direct sustained contact with the facilitator.

Charlotte also optimised the care available to her in a form that fitted her personal defences. She displays few of the characteristics found in the pen-sketch of preoccupied attachment (chapter two) and does not show the expressiveness seen in flow diagram three. However, she appears ambivalent about interacting with the facilitator and maintained proximity with her in an oppositional manner. This seems to have allowed her to receive care while safeguarding a clear boundary between her and others.

Denise appears not to have a strategy for achieving the goal of careseeking and though she appears to have disguised much of her input as exploration she was not, I think, really open enough to experience achieving the goal of exploration.

Defensive caregiving

Only Antonio described caregiving as a means of meeting his need for care.

Selective exclusion

Denise and Antonio offered most clear evidence of selective exclusion from awareness though there is also much missing in the life-story related by Charlotte. I suspect that in the group setting, Charlotte's percepts, cognitions and affects were filtered at a preconscious level to support her 'feisty' defences.

Denise seems to edit her feelings (including fear, motivation and desire) in order to maintain a positive 'working attitude'. The account she gives of her childhood family is entirely positive but lacking in detail. When this appears to have broken down in session

eight, Denise seems unable to account for the depth of her distress. Both she and Antonio spoke about excluding or suppressing anger.

Antonio and Denise also seem to have difficulty remembering and used other people's stories to trigger reflections on their own experience (which in Denise's case were then edited to produce favourable comparisons). Antonio appears to have edited his personal history in a way that attributes most of his difficulties to schooling rather than an undoubtedly difficult family history.

Supportive/unsupportive internal environment

An unsupportive internal environment is particularly evident in Antonio's fear of being judged unworthy and his tendency to take upon himself responsibility for what goes wrong in his relationships. Internal models of self and other are likely to be reflected in the tentative and guarded manner of his careseeking. His fear of being judged 'self-pitying' and 'whining' suggests that careseeking may activate shame. His internal environment supports self-reliance, for example by emphasising professional competence. This may serve to counter more negative aspects of his internal model of self in situations when (as a careseeker facing a potential caregiver) he might otherwise feel highly threatened.

Charlotte's apparently ambivalent careseeking behaviours in the group suggest that her internal environment did not support careseeking in that setting. As well as distrusting the group facilitator, she expressed high levels of ambivalence about her romantic partner and stressed the importance of trusting her own judgement. For Charlotte, it seems, the activation of attachment creates the possibility of being deeply hurt and let down.

Denise offers little insight into her internal environment except indirectly in the credibility gap suggested by her 'positive working attitude'. Using Mikulincer and Shaver's terms, we might suggest that preconscious activation of careseeking did not support careseeking behaviours but instead triggered information processing that separated her from painful feelings and thoughts. This may sometimes have prevented intersubjective meeting between her and others.

Self- and other-directed hate

Charlotte's feistiness appears to be directed at self-defence rather than achieving the goal of careseeking. This may support a development of the concept of hate to make clear the link between hate and defence.

Other-directed hate may underpin Antonio's description of the 'panel of judges' by which he dismissed other group members as a hostile or threatening 'them'. This is not consistent with what I have tried to depict in flow diagram two except in the fact that he clearly felt threatened in the group situation.

Denise offers little if any evidence of hate.

Conclusion

None of these cases reflect my depiction of Heard and Lake's restorative processes in a straightforward manner and it is apparent that the differences between them are as great as that between the other two groups of case studies. Their lack of fit with flow diagram one seems to be because the three individuals are not secure in their careseeking.

Antonio's increasing willingness to careseek and engage in intersubjective meeting with the facilitator demonstrates the strength of his urge to seek care and the growth of his trust in the facilitator. I suspect he fits more naturally into flow diagram two than flow diagram one, but as said above, this is not unproblematic. Charlotte's apparent ambivalence may suggest that she is a closer fit with flow diagram three rather than two; but there is much more that does not fit. She and Antonio might support Bifulco's (Bifulco et al., 2002a, 2002b) division of avoidant attachment into angry-dismissive and withdrawn-dismissive; thus creating a classification that was unknown to me when I drew the diagrams. However, as said elsewhere, my judgement is impeded by unfamiliarity with the method for classifying angry-dismissive attachment. Denise does not fit easily into any of the flow diagrams.

The three case studies in this section offer ample evidence for the operation of defensive strategies. In writing these chapters I have become more convinced of the need to link Heard and Lake's ideas more intimately with wider research on attachment strategies. None of these people sought care in a straight-forward manner and each required an individualised response that saw beneath their mode of self-defence.

The link I am proposing between shame and failed careseeking may be less clear in these chapters than it is in most of the preceding case studies. I am not clear if this is because shame was less active in these people or if it was more hidden (which may point to greater rather than lesser levels of shame).

The fact that all of the group members in the study are professional caregivers may suggest a link between painful attachment histories and caregiving. All eight cases in this study are interesting for what they say about the restorative process. Conclusions will be drawn from these findings in the discussion of chapter fourteen, along with my discussion of the work of the group facilitator to which I now turn.

Chapter Thirteen: Facilitation of the Courses

Introduction

In the case studies I have sought to apply the theory described in chapter two to cases (Stiles, 2007) drawn from two courses in order to examine whether understanding the behaviour of individuals in the group is enhanced by use of that theory. In this chapter there is a move toward reversing this process and applying the cases to the theory (Stiles, 2007, Brinegar et al., 2006; McLeod, 2010). In what follows I examine selected incidents from the group transcripts in a manner similar to that used in the case studies but paying particular attention to the role of the facilitator. Evaluation of the theory is pursued by examining what happens when the group facilitator using this method is presented with the behaviour of real people in a present-moment of therapeutic meeting. In the analysis that follows I will pay particular attention to the following questions:

- How are Heard and Lake's (1997; Heard et al., 2012) ideas about the dynamics of attachment translated into course facilitation in a real-life setting?
- Does the theory enable the facilitator to offer fear free caregiving (McCluskey, 2013)?
- What do these courses tell us about viewing psychotherapy as exploration?

The Translation of Theory into Practice

The application of Heard and Lake's model of the self in exploratory courses

In the courses from which the data have been drawn the facilitator was guided by McCluskey's ideas about exploratory group psychotherapy (Heard et al., 2009: 183ff; McCluskey, 2011, 2013) and the idea that, 'As an exploratory psychotherapist one tries to create fear-free conditions where the other person may discover what they must do to reach the aims of the self' (Heard et al., 2009: 133). McCluskey develops these ideas in a recent paper:

‘This work is not about identifying attachment patterns, it is an in-depth exploration of what someone knows about what activates careseeking in the here and now, how they express it and whether they are met. It is about exploring the aetiology of this and what people know about their own care-seeking patterns.’

McCluskey, 2013: 61

Later she adds:

‘The work that I have been describing is to provide an exploratory space where [course members] can explore the biological systems within themselves that interact to enable them to maintain as much well-being as possible. The work of the facilitator is to enable the person(s) to identify what system is aroused in the here and now and to interact with them in such a way that the person experiences reaching the goal of that system’.

McCluskey, 2013: 63

The rationale is explained further:

‘It is important that we begin to understand the processes involved in reaching and maintaining a state of well-being. It is the state we aspire to. So in exploratory psychotherapy, the goal is the achievement of the state of well-being and the means by which we maintain it. It is in this state that we feel most ourselves, we feel most alive, most creative, most in touch with the here and now, the physical and spiritual realities of now. We have a sense of our own vitality and our own capacity to become co-creators with life itself’.

McCluskey, 2013: 64

These quotations mark out the territory of ‘exploratory goal corrected group psychotherapy’ as described by McCluskey (2008, 2011, 2013; Heard et al., 20012). It is different from most other models of psychotherapy that have arisen from attachment theory because it focuses on behavioural systems, has little direct or explicit interest in narrative and has little to say about attachment styles. The individual is encouraged to focus on their actual in-the-moment experience in relation to identified behavioural systems.

When focused on the present, a therapist or group facilitator's interventions might include questions about what is happening to the client or group member at a physiological level and at the level of internal cognition and affect. The therapist might also encourage the client to distinguish between what is actually occurring in the present moment from what their internal environment or internal representations might prompt them to think is happening. This might involve relating present events to circumstance, past and present, in their external environment. Recognising the different consequences of assuagement and disassuagement of behavioural systems is integral to this type of exploration.

Such inquiries can address the cause of distress by asking about early attachment experiences (attributions and other content of the internal environment), that the individual has internalised in childhood and which influence how they experience self and other. By reframing Bowlby's idea of internal working models in this way McCluskey's approach creates a situation in which inferences that are normally implicit, and decisions normally taken outside of awareness, can be consciously experienced, become explicit, be explored and so brought into the purview and conscious control of the individual.

McCluskey (Heard et al., 2009), has argued that caregivers must recognise the uniqueness of each individual and that the emotional state of every careseeker is peculiar to them.

It therefore becomes essential that the communication between a caregiver and a careseeker is achieved within dyadic exchanges between caregiver and careseeker to carry information from the caregiver that is increasingly accurate.

Heard et al. 2009: 130

As described by McCluskey (2005, Heard et al., 2012), careseekers present to a caregiver in diverse and sometimes problematic ways. In the case studies I have suggested ways in which what people do in the groups sometimes obscures their intent from the facilitator.

Micro events and wider context

McCluskey (2005) demonstrates that caregivers are human beings and so are prone to lapses in concentration, tiredness and the activation of fear. Therefore, interaction in

which a caregiver always understands and meets a careseeker's needs is not possible. As has been noted, every therapeutic relationship inevitably involves rupture and repair (McCluskey, 2005; Heard et al., 2009). It cannot be expected, therefore, that any one exchange will be a true reflection of the direction of therapeutic travel and in the discussion of case material that follows I am conscious that my observations should not be taken as a comment on the wider relationship between facilitator and group member or the overall progress of any individual in the course of their group attendance.

In selecting incidents for discussion in this chapter my intention was to examine microevents to learn what they might have to say about the operation of fear. In what follows I examine individual moments in time and, as such, these incidents have little to say about the general quality of the relationships from which they were taken. I have not examined how the facilitator followed up these incidents; whether she subsequently spotted what had happened and repaired any rupture in the relationship (in a subsequent moment or on another day). It is apparent from feedback in the group sessions and evidence from my interviews that the facilitator was thought to be skilled and capable of high levels of attunement. Nevertheless, by examining these events, light may be shed on the normal influence of fear (and other factors) on interaction between a careseeker and professional caregiver; and on the theory's ability to describe such incidents. The absence of any such human incidents in the transcripts would have provided the greatest possible disconfirmation for the theory.

Exploration in the groups

Facilitating exploration and detoxifying shame

The first two extracts examine moments when the facilitator supported group members in their exploration of personal experiences that had been deeply linked to shame and fear. In the third extract I move on from talking about how the theory supports exploration to examine extracts in which fear, whether in the facilitator or group member, may have impeded interaction.

This first section of the transcripts begins with a group member talking about the shame she felt in early adolescence when, following a major family bereavement, she had begun to masturbate. She made a link between her shame and her 'religious, sexually repressed background'. She reported that this memory had long been associated with a deep sense of shame. The facilitator's response used the theory of different behavioural systems to normalise what Hannah had said:

4200 Facilitator: Yes, the act and the shame,

4201 so one's own self,

4202 sort of the critical . . .

4203 The criticism of the self and the shaming of the self,

4204 and the lack of compassion;

4205 because what you're talking about is you started it in grief.

4206 [Hannah: 'Huge grief'].

4207 Facilitator: In huge grief, yeah, yeah,

4208 as a way of managing huge grief;

4209 and the upshot is a shaming of the self.

4210 So you know, one needs to just catch that in one's body;

4211 even as we're talking about it.

4212 Catch the response in here;

4213 when we talk about shame and collapse like that.

4214 So anyone else,

4215 keep coming in,

4216 and keep it coming fast so we build a rhythm that also gets . . .

4217 Try and throw out the shame barrier,

4218 because the shame barrier is going to inhibit us in here.

Though a relatively brief exchange, the facilitator had given nuanced feedback to Hannah which reflected the behavioural systems theory underpinning her approach:

- She mirrored back what Hannah had said in a manner that signalled that she understood both the shame and grief (4200-4205) beneath the story. She picked up on Hannah's emphasis of 'grief' (4207/09) supporting Hannah's understanding.
- The facilitator's use of 'we' (4212/13) inferred a connection between herself and the group member (and the rest of the group) so normalising what Hannah had talked about creating intersubjective connection with Hannah.
- By emphasising the embodied nature of affect (4210-4213), the facilitator helped Hannah recognise the physiological/emotional impact of shame and helped her to use the same physiological systems to regulate her emotional arousal. This might have helped Hannah retain the ability to hold onto and address her more difficult experiences.
- She pointed to the affect regulating or self-soothing role of masturbation (4205-4208). In the context of the group, a behavioural systems perspective is implied in which the sexual system can be seen to have offered affect regulation at a time when the course member was in great distress. This uses the behavioural systems theory to detoxify and normalise Hannah's behaviour in order to eliminate shame and support a more compassionate attitude to the self.
- She inferred the way in which Hannah's critical internal environment lacked 'compassion' so helping her to separate herself from the critical voice(s) underpinning her shame (4204; 4217/18).
- She invited contributions from other speakers (4214) in a manner that was 'up-regulating' (4216 – for discussion of this kind of intervention see chapter 4); supporting the energy in Hannah, and the wider group, so that people did not become paralysed by fear and so Hannah was not left feeling exposed. In this way she created the possibility for Hannah to be joined by other group members and thereby have the normality of her experience confirmed from within the group.

- We might add that she recognised and legitimised several different voices in Hannah's account¹, including that of an adolescent stricken with grief (4207/8); someone who has found a way of regulating grief (separation anxiety - a distressed attachment system) via sexual gratification (4205 & 4208); an individual who was the victim of religious sexual repression (4209); and a woman who had an internal environment that could be self-critical and unsupportive (4200-4204).

In this extract the facilitator's response seems to reflect a balance between caregiving and exploration. The facilitator met Hannah in the painful experiences of grief and shame whilst working at the level of cognition and affect. I suspect this reflects accurate attunement not only to the words but also to the underlying affect. Although Hannah introduced two potentially traumatic issues, she did so in a manner that was not obviously careseeking. I suspect the facilitator correctly judged that Hannah did not want a lengthy exchange at this point yet managed to incorporate multiple supportive messages in what was a brief response to what Hannah had said.

This short exchange may illustrate much that McCluskey (McCluskey et al., 1999) has said about psychotherapy as exploration. Hannah was supported in talking about potentially traumatic history in a manner that acknowledged the pain, regulated her affect and thereby empowered higher cognitive systems to remain active in a manner that supported Hannah's self-understanding.

Therapy as disclosure of self

Exploration may not be the principal purpose of the story. It is possible that the disclosure of self was also important to Hannah. In her exchange with the facilitator it is likely that Hannah had not said or heard anything that she did not already know; but in offering self-disclosure in this way she made explicit what may normally have been implicit: shame-laden memories that infected her internal environment. She allowed herself to be heard

¹ In this chapter again, the idea of different voices is used to sensitise me to the possible involvement of different behavioural systems.

and accepted more fully as a person, by herself, by the facilitator and within the group. I think this may be an example of Hannah seeking 'core support at the centre of the self, transforming and strengthening the self' (McCluskey, 2013: 63) by sharing her shame in an accepting relationship. By this I mean that the exchange in which shame is shared and met with profound acceptance is inevitably affect-laden. This is not a mundane occurrence and may work to bring healing at an implicit level. If this interpretation is valid, it stretches our understanding of 'exploration' to include ideas such as Stern's (2004) 'present moment' and Lachmann's (2001) 'heightened affective moments'.

Supporting someone for whom shame and fear trigger deep ambivalence

In the next excerpt from the same session we see the facilitator responded to someone who presented ambivalent careseeking.

4260 [Jane: I didn't realise until [pause] today.]

4261 Facilitator: Yeah, so make a lot of space and tension down everyone.

4263 And let your own tension down. [Pause]

4264 You didn't realise until today.

4265 [Jane: (Pause) Sorry]

4266 Facilitator: That's OK;

4267 and take your time.

4268 And it's very important if you've just had a shot of something,

4269 you know,

4270 that you give yourself a lot of time;

4271 you make yourself as big as possible;

4272 you breathe into your chest and you make a lot of room in your belly.

4273 Because you've got a new experience to bring in,

4274 you don't want to bring it in in a state of shock;
4275 all tense [Jane: Yeah] you know.
4276 You want to bring it in, you know, big.

4277 [Jane: Maybe I'm not ready to bring it in.]
4278 Facilitator: You may not be ready yet to bring it in.

4279 So keep breathing,
4280 keep making space,
4281 keep making yourself as big in your chair as you can.

4282 You've got a new perception of something,
4283 and when you're ready you'll come in. [Jane: mm]

4284 That may be today,
4285 it might be the next time;
4286 when you're ready.

4287 But you think you've got hold of something.
4288 So, you signal me if you want to come in.
4289 I'll carry on.

4290 [Jane: OK]

4291 Facilitator: Anyone else,
4292 because that's what can happen in here,
4293 suddenly something can go bajingos.
4294 Anyone else?

In this exchange Jane was clearly distressed and ambivalent about speaking. Although she said very little, she did not stay silent. The facilitator recognised and sided with the part of Jane that did not want to risk speaking (4278) and the part of her that wanted to speak

(4282/3). In this extract the facilitator legitimated and allied herself with both aspects of Jane's ambivalence; the defensive self and the careseeking self. When the facilitator had worked with other people for a few minutes she checked whether Jane wanted to say more. On that occasion the exchange included lengthy work about a childhood trauma that had always been associated with profound shame.

Much of what the facilitator did in the opening exchange involved demonstrating that she was attuned to Jane and regulating the fear that appears to have kept her in a state of frozenness. Although Jane said very little in this exchange, the facilitator appears to hear and mirror back to her far more than her words. She gives a clear message that Jane should take all the time she needed. The facilitator again acknowledged the embodied nature of Jane's fear and by emphasising control of the body ('breathe into your chest' - 4272) and encouraging her to make herself as big as she could (4281) she encouraged Jane to assume control over her distress. Whilst acknowledging Jane's state of shock, the encouragement for Jane to make herself 'big', presented a choice about whether to collapse in shock or stand tall against it. In this way she allied herself with the part of Jane that wanted to be met by an attuned caregiver.

Again, this might reflect the concept of psychotherapy as supporting the potential for exploration. If Jane can be helped to regulate the evolutionarily more primitive fear system, this might allow her continued engagement of higher cognitive systems. Without such regulation she would remain overwhelmed by affect, perhaps locked into careseeking and unable to think clearly. We might guess that Jane achieved her goal in speaking by the fact that, after a period of silence, she responded to the facilitator's next invitation by speaking at length about the shame that had triggered her state of shock. A month later she reported that she no longer felt shame about this event. We have no way of knowing what this declaration meant.

I think it noteworthy that in both instances the facilitator recognised more than one voice in the speaker. She heard and regulated the fear and shame and in so doing she helped them achieve the goal of careseeking. The group members were then both able to explore and detoxify shame-filled memories that were associated with an unsupportive internal

environment. Whilst the first extract may reflect the facilitator working in a more exploratory mode, it is perhaps accurate to say that the second group member was actively careseeking and was met with active caregiving.

Jane sought contact in a way that recognised her fear/distress. She then appears to have spent time reflecting silently on the meaning of this before choosing to share more fully the detail that underpinned her shame and shock. In this brief exchange I think we see the working of both intersubjectivity and subjectivity as described by Heard and Lake (1997; Heard et al., 2012). Jane took a short step forward, retreated for reflection and then took a much greater step forward.

Challenges to the Idea of Exploration

Fear and intersubjectivity

I next turn to a piece of work the facilitator did with Antonio (chapter ten) in session seven that again illustrates the use of techniques for facilitating exploration. In this lengthy exchange an issue arose that, for me, raises questions for the theory.

In interview Antonio remarked that he had challenged himself to speak in every session. As noted in the case study, I think there was a progression in the level of trust he showed toward the facilitator so that he moved from speaking more abstractly about fear in the past-tense toward speaking about an immediate and present state of fear. This culminated in session seven which he opened by saying that the high level of his fear meant that he was not ready to attend the group. In her intervention the facilitator attuned to Antonio and helped him to regulate his fear. She again responded in a way that normalised his experience ('We're all full of [fear]'), joining his experience to herself and to other members of the group. I think the facilitator's affect regulating interventions may have allowed Antonio to feel stronger in himself and enabled him to access his emotional experience without freezing or collapsing.

The facilitator then used a cognitive exercise which, I think, raises questions about exploration. I too have been taught this exercise in a number of training groups. In accordance with this exercise the facilitator explained to Antonio that there are three sources of fear which can be paraphrase briefly:

- a) Scaring one's self with a thought.
- b) Something happening in one's body.
- c) Fear of being on the edge of the unknown.

She then asked Antonio to identify one of these options that most applied to him and using his engagement in the exercise worked with him for some time on the basis of the idea that he was scaring himself with a thought. In the course of this work she continued to show the same mix of empathic attunement, occasional up-regulation and normalisation to maintain a close connection with him as he explored his distress and fear. Her empathic-mirroring included a physical response to his 'vicious internal environment' when she appears to have noisily breathed out her own tension in response to something he said. She also drew in the wider group by inviting them to say that they understood and were working along. In this way she kept them engaged and mirrored back to him that he had 'a lot of company' in the important work he was doing.

In the course of this work the facilitator helped Antonio explore the link between curiosity and fear, summarising this saying 'you go very fast to the fear, even when you begin to touch up against curiosity'. She invited him to try to hold the curiosity a little longer before going to fear. Antonio responded that he would like to be able to do this and was tired of his fear. This drew another empathic response from the facilitator. At this stage I believe the attunement between Antonio and the facilitator enabled them to experience increased intersubjectivity. By this I mean that they appear to have shared a single focus and, to some degree at least, a shared emotional space. Shortly after this Antonio said, 'I feel a little bit tearful I notice', and the facilitator invited him to 'let the tension go . . . because if you can get your emotion, Antonio, you're finding yourself'. I think that the attunement in this response encouraged Antonio to stay stronger than his fear and conveyed an implicit message; something like: 'you are not alone here but I am with you and there is more of you to be known than your fear'.

At this point I want to draw attention to the subtle message at the heart of the facilitator's affect regulating intervention, which has been seen repeatedly in all of the case material. In asking Antonio, and her wider audience, to let the tension go, she drew a distinction between tension (a bodily response) and emotion. I think this recognises that bodily tension is triggered by the (felt and unfelt) fear response and in turn activates the processes of exclusion from awareness. By encouraging Antonio to extend his awareness of self beyond the experience of fear the facilitator encouraged him to access other feelings and so have increased access to self.

By working closely with Antonio in this way and helping him to own his feeling I think she helped him come close to a precious and important experience of intersubjective relating, in which his feeling was allowed to *be* in the space of their relationship. This experience may have validated aspects of self which, from other things he said (see the case study in chapter eleven), Antonio normally kept hidden from self and other. Therefore, I think this is an example of sensitive attunement leading to deeper intersubjective sharing with the potential to extend awareness.

Possible limitations to the cognitive exercise

Notwithstanding the positive nature of this work and the likelihood that it opened the way for intersubjective relating for Antonio, I have doubts concerning the facilitator's use of a cognitive technique in response to Antonio's expression of fear. In what I say from here on I am consciously highlighting just one possible interpretation of the exchange. This is risky because there will always be more than one plausible explanation for any event involving people. It is not unlikely that the facilitator's choice of intervention at this point reflected a learned strategy that she used in specific circumstances (a technique shared by some other facilitators trained in this method). McCluskey (2009) links this exercise to Systems Centred Therapy and Cognitive Behavioural Therapy. This does not answer the question of why, in a specific moment in time, one approach was favoured over another.

Using ideas developed by Argyris and Schön, (1974), McLeod (2009) draws a distinction between two types of theory. In contrast to formal theory that is 'espoused' by practitioners, he describes 'implicit theory' as 'implicit mental maps', 'a mix of intuition, rules-of-thumb and habit, alongside some thought-out principals' (McLeod, 2009: 61). There may be a link between McLeod's 'implicit maps', and Bowlby's (1969) 'internal working models' that are expressed in habitual ways of responding and serve the purpose of protecting an individual from harm.

My doubts about the facilitator's use of this exercise concern, firstly, whether it primarily served to keep her on safe and familiar ground (and so may have been motivated by fear) and, secondly, notwithstanding what I have said about positive movement in the interaction, whether it interfered with the intersubjective spontaneity of their exchange.

By offering a structure to the discussion ('three sources of fear') the facilitator had taken control of Antonio's input and eliminated different kinds of discussion about fear that might have arisen from perceptions that did not fit the theoretical schema she was using. This might mean that, rather than assisting Antonio to symbolise or make tangible his own experience, the exercise allowed the facilitator to influence how Antonio defined the meaning of his fear and provided the language and structure of what he said. So whilst appearing to be exploratory, this may be a departure from the spirit of exploration.

Although Antonio appears to have gone along with the facilitator throughout this exchange, and may have been helped to get closer to his feelings through it (see below), these factors may not be an indication that the facilitator was wholly attuned to him throughout the exchange.

This interpretation may be supported by an examination of the closing moments of the exchange. At one point the facilitator invited Antonio to,

7737 . . . let some of the tension down,

7738 and find out what the tears are.

7239 Antonio: The tears are about er, a belief that I'm not wanted,
I'm not good enough or something'.

And the facilitator responded to this saying,

7230 Facilitator: The tears are 'I'm not wanted'. [Antonio: yeah]

7231 So let's deal with that one first:

7232 You thought 'this was not the right group for me'.

7233 Can I just see if there's anyone here who agrees with Antonio

7234 that it's not the right group for him;

7235 genuinely think that maybe he should be somewhere else;

7236 in another kind of environment.

7237 Well would you say what you're shaking your heads about?

Two group members come in to say, 'I think he adds a lot to the group' and 'I think you are very brave Antonio'. Immediately after this the facilitator ended the exchange with Antonio by inviting other group members to explore their own versions of what Antonio had been talking about.

As indicated above, my commentary at every point has to be tentative. The facilitator was with Antonio and could see how he and the rest of the group were responding and was therefore in a better position than me to judge how to respond to what was happening. My study is based on audio recordings and transcripts and I have not discussed this event with the facilitator to ascertain what influenced the choices she made in the session.²

² I have not interviewed the facilitator because it may have put her in the position of justifying choices she made or raised the suspicion that she was doing so. A downside of my decision is that my analysis lacks important information – she might well have seen something that caused her very legitimately to deal with this in the manner that she did. With people for whom attachment wounds are raw the early activation of attachment may not be recommended (see for example, Cortina and Liotti, 2010).

Nevertheless, I think it possible that Antonio and the facilitator diverged at the point when he said 'a belief about I'm not wanted, I'm not good enough or something' (7239). When considering the words of both Antonio and the facilitator I think it important to recall Stern's (1985) distinction between words and core experience and the idea that explicit thought is frequently properly understood as *post hoc* rationalisation of experience and decisions made outside of awareness (Claxton, 1997; Greene, 2003; Kahnemann, 2011). The facilitator's interpretation of Antonio's belief, 'I'm not good enough' linked it to her paraphrase 'this is not the right group for me' (7232) and made it something that they could 'deal with' (7231). Thus she was continuing the exploration that had brought him to what I think was a very important moment.

I suspect that their work up to this point had enabled Antonio to access other aspects of his experience and speak at a more profound level. Therefore, 'I'm not wanted' and 'I'm not good enough' arose from wounds at 'the core of the self' (McCluskey, 2011: 15). In chapter eleven I alluded briefly to this episode when I summarised Antonio's fear as being about 'surrendering to the unknown'. This reflects Antonio's use of the facilitator's language. Early in the exchange currently being considered he had said that fear prevented him from engaging and I think it likely that it was the relational context of the unknown that was frightening for him. From things he said in other sessions I believe relating to potential caregivers triggered fear for Antonio and took him close to the core of his most profound wounds. In this lengthy exchange he had been enabled to remain with a caregiver and look into her eyes (which I imagine he did) and say, 'I'm not wanted and I'm not good enough'.

Notwithstanding my interpretation above, it is possible that the facilitator's choice to use a directive, cognitive style had been helpful in allowing Antonio to reach this point. However, I think this was a potentially major event in which Antonio got in touch with and expressed primitive, preverbal wounds. If this is right, Antonio's words may have expressed a profound, foundational fear which was about exposing his vulnerability and trusting her not to hurt him. His words at this point, therefore, expressed a wordless reality at the core of his being. In the context of this study I think it reasonable to suggest that

this wordless reality beneath his words 'not good enough' was the experience of profound shame.

When presenting the research underpinning her concept of goal-corrected empathic attunement, McCluskey puts forward 'the idea of at least two different types of careseeking: one that is a request for care and protection, and the other that is a request for support to carry on exploring' (McCluskey, 2005: 121). In this moment I think the facilitator was perhaps using the language of exploration when what Antonio sought was support to *be* 'not good enough' (or to allow his experience of being 'not good enough' to be present in the moment of their meeting). In this statement he may have been realising (bringing into reality) a desire for what Winnicott (1971) calls a 'holding' relationship. By this I mean a moment in which to stop play/exploration and whatever else might be happening while his caregiver communicated to him, primarily perhaps in eye contact (Ayers, 2003; Hughes, 2006), that she knew what he was feeling; staying in 'primary intersubjectivity' (Stern, 1985; Trevarthen and Aitken, 2001; Hughes, 2006); not seeking to change anything but just giving time for his fear (which I think was fear of exposure, i.e., shame) to be known and silently held in the space of their relationship. If exploration might then have been helpful to articulate and symbolise what had happened, it first needed to be allowed to happen.

I therefore think the facilitator could have met Antonio more deeply than could the group whom she sparked into action (7233-7237) in line with her more cognitive (verbal) and (perhaps) exploratory interpretation. If Antonio had indeed been experiencing primitive trauma, it would have been very difficult for him to understand, let alone articulate, the nature of his fear/shame. This may not have been helped by the constraints implicit in the facilitator's structure and ideas about the three sources of fear.

In summary, therefore, I question whether the exploration the facilitator engaged in with Antonio was always exploration. Using the theory of goal-corrected empathic attunement it is possible to suggest that on this occasion 'exploration' was infiltrated by fear and masked controlling behaviours designed by a fear system to protect the facilitator.

Alternatively we might ask about the nature of exploration. When the facilitator enrolled the services of other group members to up-regulate Antonio's self-doubting presentation she seems somewhat strident: 'Lets deal with that one', 'Can I just see if there's anyone here who agrees with Antonio' and 'Well would you say what you're shaking your heads about?'. The assertiveness in these phrases leads me to question whether, at times of threat, bushwhacking (hacking at undergrowth and other obstacles) may come more easily to the exploratory therapist than naked empathy.

Careseeking and exploration

The following extract is drawn from an exchange between the facilitator and Stephanie (see chapter eight) toward the end of the first surprises and learning section of session one (Course B). In response to the facilitator offering a general invitation for members of the group to speak, Stephanie's opening words appear to start mid-sentence as if she is perhaps continuing a discussion that started in her head.

1119 [Stephanie: Because where I'm at, it's kind of I feel my guard is up again, in fact I can be open but I don't know what [indistinct]]

1110 Facilitator: So you came in open

1121 and somehow or another your guard went up.

1122 So did I not respond or did somebody not respond, yeah?

1123 So maybe you're not the only one, in the group.

1124 [. .]

1126 So Stephanie, if you can make space,

1127 because you notice

1128 you're collapsing at the moment,

1129 and if everyone can kind of . . .

1130 Exactly, let the tension go;

1131 so Stephanie only has her own tension.

1132 And if you can keep talking, Stephanie, as to what . . .

1133 It's a very important observation you've made:

1134 that you were open and now you notice a guard has come up,

1135 and whether you could track what it was maybe that happened in the group.

1136 [Stephanie: I think it was something Louise, Louise actually said]

1137 Facilitator: It was something Louise said, right so you know that.

1138 [Stephanie: And when Louise said she looked back and it was happier,
she was surprised that things weren't as bad as she thought.]

1139 Facilitator: She had the one memory of her sibling in the sand, yeah.

1140 [Stephanie: Whereas maybe I try and put on that things were fine [F: Take your
time] and happy [F: yes] but it wasn't all happy.]

1141 Facilitator: So right,

1142 so you think maybe you'd say it's all fine and happy.

1143 Make a lot of space,

1144 in your stomach Stephanie.

1145 Don't . . .

1146 You see we take the stress in our bodies folks.

1147 So try and let the body relax;

1148 we're only talking about emotions here.

Up to this point it appears as though the facilitator senses that Stephanie is battling with fear or distress and she offers affect regulating words to calm her and encourage her to speak. But her next sentence appears to change gear:

1149 And Stephanie,

1150 you're making a discovery,

1151 that maybe you do say things are all fine,

1152 maybe they weren't so much all fine.

1153 And noticing that when you bring in the one thing: 'that they're all fine',

1154 maybe you deprive yourself

1155 of being able to explore the fact that they're not all fine.

1156 Is that what you're bringing in?

1157 [Stephanie: Yeah]

1158 Facilitator: Yeah.

1159 That by presenting yourself in one way

1160 you're kind of excluding yourself from being able to explore equally real things.

1161 Now how do you feel now?

1162 Do you feel more here or less here?

1163 [Stephanie: I think more here.]

1164 Facilitator: More here, great!

1165 This is what this work is about,

1166 you see,

1167 if we haven't got Stephanie here

1168 we've got a whole person that we haven't got present.

1169 And you, you miss us as well;

1170 connection.

1171 So that's a really . . .

1172 And you found something that would be meaningful for everyone I think;

1173 that the way we present in the group,

1174 and what you're talking about is an idealisation,

1175 you know.

1176 I talked about excluding things from consciousness Stephanie,

1177 if we exclude things from consciousness,

1178 we're unable to explore the whole thing.

1179 So that's amazing, anyone else?

1180 Another minute and a bit;

1181 anyone surprised by our group?

1182 Anybody learning anything?

My reason for including this incident is that it may be an example of the facilitator misattuning because, having moved out of the experiential session into the first surprises and learning session, the facilitator's goals did not match those brought by Stephanie (different systems activated). Here I think we see the idea of exploration being used to deflect Stephanie from careseeking.

It may be recalled that Stephanie told me in interview that she came to this first session (which she viewed as 'therapy'), to address a specific experience of childhood sexual abuse. Reading between the lines it seems likely that when she contrasted her experience with that of Louise (1136-40), Stephanie was making a veiled reference to this issue. The facilitator cannot have known about this but her affect-regulating phrases suggest that she sensed distress of some kind. However, she did not ask what Stephanie had meant or why Louise's statement had caused Stephanie to become tense. Instead the facilitator

interpreted what Stephanie said as meaning Stephanie was reporting a discovery (1150-1152) and she drew numerous connecting conclusions predicated on her interpretation of what Stephanie had said (1172-8). So from this point onwards the exchange changed course in confirmation of the facilitator's interpretation.

By interpreting what Stephanie said as a 'discovery', rather than asking what Stephanie had meant the facilitator closed down exploration of Stephanie's affective meaning. I think it likely that Stephanie's speech had been motivated by fearful careseeking but that the facilitator (perhaps purposefully though not necessarily consciously) misattuned and deflected her away from this. This was a first session and the facilitator would not have wanted Stephanie to become over exposed and vulnerable. Moreover, the exchange happened in the surprises and learning section of the meeting so there was insufficient time for either caregiving or exploration.

This incident perhaps illustrates the role of exploration in caregiving: 'A caregiver whose exploratory system is not activated to understand the needs of the careseeker will not provide effective care' (McCluskey, 2005:74). I suspect that both effective session management and care for Stephanie required the facilitator to override any impulse to caregive or explore at this point and prompted her to down-regulate the affect that Stephanie expressed. The fact that Stephanie does not challenge what I think was the facilitator's deflecting interpretation illustrates an observation made by McCluskey (2005) when reporting on research about attunement. She observes that she has never seen a client insist that a therapist 'stick with the affective meaning of what they were saying [. . .] in lieu of the direction being presented to them by the therapist' (2005: 11). There is frequently a power imbalance between caregiver and careseeker in which fear can easily be evoked. The style of group facilitation used in the groups may increase this imbalance.

It might reasonably be argued that establishing contact, however briefly, might well have been sufficient for Stephanie to achieve her goal in speaking at that moment. She was treated with kindness and so her tentative careseeking was met with caregiving without her becoming inappropriately vulnerable.

But the vignette serves to illustrate the subtle nature of affect regulation: when the facilitator moved away from exploration and caregiving (for whatever reason) she took Stephanie away from careseeking. And when the facilitator terminated Stephanie's careseeking Stephanie seamlessly adopted the facilitator's language. Whatever the facilitator's motivation may have been, at an implicit level, the in-the-moment truth of Stephanie's affect was denied.

Awareness and fear

Different issues appear to influence the facilitator's work with Rebecca. From her case study we know that Rebecca was the second least vocal member of her group. At the end of the experiential section of session five she had not yet spoken. Just prior to the next extract the facilitator finished work with Louise and explicitly invited Rebecca to speak.

5513 Anyone else, I know we're very near . . .

5514 Rebecca, I'm not sure if you're coming in or not with anything?

At this point Rebecca spoke about problems arising from her 'fear system': 'anxiety', 'a tendency to be a worrier' and to 'ruminate about things on the inside'. She also linked this to problems with security and careseeking (see chapter six, lines 501-523; page, 142-143).

Apart from making a link to another group member [F: 'Like Vera was talking about'] and offering brief paralinguistic encouragement (F: 'yeah') the facilitator made no comment on what Rebecca had said and immediately closed the experiential session (only to have it extended at the request of another group member):

5500 Facilitator: Well we've reached the end of the exploration time,

5501 and just to say to you Hannah you know, what you brought in,

5502 and what you're saying now [possibly aimed at Rebecca],

5503 is again the kind of work that we were doing with Sarah:

5504 it's how do you find space in yourself to get away from these extremes.

5505 What's the middle place,
5506 or a place where you can feel support?
5507 And not kind of oscillate from one to the other,
5508 and catching the fear.

5509 We're not going to do it in a minute but it's about . . .
5510 the journey is an inside journey,
5511 isn't it? Change from the inside.

This is a curious incident. It is possible that the facilitator had noticed that Rebecca was on the point of speaking but there is no evidence to support or refute this. It may be that the facilitator invited Rebecca's contribution to meet her own (conscious or unconscious) need not to have a totally silent person in the group rather than because she was attuned to her (Rebecca had not spoken at all prior to this invitation). Either way, it is interesting that she did not explore any of what Rebecca then brought into the group. She may simply have been conscious of the time issue and the need to end the experiential part of the session. However, Catherine, the most vocal member of the group, then asked to make a further statement and was allowed to do so.

In this brief exchange the facilitator appears not to have heard what Rebecca said for its own sake. Instead, while Rebecca was speaking the facilitator drew a link with what Vera had said earlier and then, when Rebecca had finished speaking she referred back to work done by Hannah and Sarah. Whilst it may be argued that the facilitator had heard Rebecca and included her in the wider exploration, she did not appear to respond with any depth to what Rebecca said *for Rebecca's sake*.

It may be that we are seeing the facilitator up against the schedule and that, at the end of the experiential session, her energy had been flagging; but, she appears to have listened attentively to Sarah, Vera, Hannah and Catherine.

Given the fact that Rebecca was consistently one of the least vocal group members it may be that there was something in what or how Rebecca presented that turned the facilitator

off; deactivating her caregiving and failing to engage her exploratory system. When saying, 'I suppose that's just something that, that I do continuously work on' (5502) and that, 'I have been working on it for a long time, and it's getting easier' it is possible that she was signalling self-reliance. It was normal for Rebecca's input to include signals of competence and self-reliance and to exclude any obvious careseeking. Nevertheless, Rebecca signalled a good deal more that was worthy of empathic exploration. For example, she had said that she felt different on the inside to how she presented on the outside; that she was anxious and ruminated. In a confusing sentence she also appears to say that, when attachment became aroused in her, it was more difficult for her to manage her feelings (chapter six; page, 143).

This exchange came at the end of an experiential session and Rebecca had not explicitly asked for either time or care to be given. But in the transcripts there are numerous examples of the facilitator hearing implicit and veiled references to distress and encouraging group members to take the necessary time and space to articulate their issues more clearly. Sometimes she was also willing to ignore time-boundaries for important work (this is seen in relation to Sarah and Alison) or to bookmark important issues to be picked up in later sessions. She does none of these things for Rebecca. Collins and Ford (2010) say that secure caregivers modulate their responses so that greater need is associated with increased caregiving. However, it may be that in her modulation the facilitator sometimes responded to defensive strategies rather than underlying need (Dozier, Cue and Barnett, 1994; George and Solomon, 2008); spending more time with those inclined to hyper-activate attachment. Like other dismissing people it appears as though Rebecca may have sometimes pushed the facilitator away by presenting herself as invulnerable (Dozier, Cue and Barnett, 1994), but in this input her defences appear somewhat transparent. Yet the facilitator's caregiving system was not activated. Indeed, it is possible that the experience of being pushed away influenced the threshold at which the facilitator's caregiving was activated.

Other explanations are possible. Generally, when invited to speak in the group, Rebecca was very frightened (she said this in interview) and she may have communicated this fear in some way. Therefore, the facilitator might (unconsciously or consciously) have attuned

to that fear and so not prolonged her discomfort by holding her in the spotlight. What Rebecca said in interview about her fear when anticipating her turn to speak and about her discomfort with careseeking suggests that she would have been too hesitant to challenge a time-boundary. But, as we see above in relation to Jane and Antonio, this would not be the facilitator's normal response to the perception of fear. If she had consciously sensed that Rebecca was frightened the facilitator could very easily have offered empathic, affect-regulating interventions and made a start in helping Rebecca unpack some of what she had said; before bookmarking issues for later work. Therefore, it is possible that something happen to prevent the facilitator from acting in a manner that is elsewhere seen to be normal for her. This interpretation is supported by the fact that this exchange seems to be part of a trend in which Rebecca became relatively inactive, and possibly, invisible, in the group.

One possibility is that the facilitator was working in an exploratory manner with Vera, Hannah and Sarah immediately before she invited Rebecca to speak and so her own exploratory system was active but directed toward them. She therefore dealt with Rebecca as an extension to that work without recognising the 'bat-squeak' of careseeking³ in Rebecca's references to fear, ruminating and being different on the inside.

Rebecca next spoke in session six when she talked about difficulties in her relationship with her father arising from his tendency to become overwhelmed by fear. Because of this, she said, his fear dominated her childhood and that of her siblings (see chapter six, page, 144). In her main response to this the facilitator appears to ignore all of what Rebecca said about the influence of her father's behaviour on her and instead focused on Rebecca's management of her father:

6450 Facilitator: So Rebecca, with this new insight,
6451 and again what you're bringing is a self, observing a self, isn't it;
6452 and you're saying you had more empathy for him.

6453 Have you any evidence so far of the effectiveness of your empathy,

³ To adapt a simile suggested by Evelyn Waugh

6454 the effect it's having on him?

There is little if any empathic understanding of Rebecca's distress in this response. She suggested that Rebecca was presenting a new insight, though we don't know if this was the case or if Rebecca was telling a story that was familiar to her and perhaps again presenting only her competent self? It may also be that she was somehow telling history as if it had no present impact except that she had learned to empathise? We do not know because Rebecca's story was not explored. Instead the facilitator asked a question that accepted what Rebecca had said at face value. Rebecca's answer does not convince me that she and the facilitator are working together:

6455 [Rebecca: I'm not so sure it's having a . . .

6456 I suppose the only way I can see a positive effect is, [Facilitator: uh hnn]

6457 we're closer now.

6458 Like we seem to have bridged that difficult gap that we had in our relationship,

6459 without really ever talking about it.

6460 We've moved forward and we're closer,

6461 and we can sit in the same room together and get along

6462 and not be sparking over small things]

6463 Facilitator: Well that is huge.

6464 [Rebecca: Yeah, yeah]

6465 Facilitator: Yeah, you put it . . .

6466 That's the only thing I can see,

6467 that's a big thing Rebecca. [Rebecca: yeah]

6468 And to talk about and to keep exploring the effect of that,

6469 living in that anxious household, [Rebecca: mm]

6470 where his anxiety's very easily triggered,
6471 the effect of that on your own life,
6472 because you looked at the effect of it on your relationship with him,
6473 but has it had an effect on your life?

6474 [Rebecca: Absolutely]

6475 Facilitator: Yeah, anyone else coming in?

It is possible that a momentary incoherence (4465-4467) indicates that the facilitator had become a little disorganised in her feedback to Rebecca. There is little evidence of attunement to Rebecca in the facilitator's responses and in most of what she said she appears to have missed the point that the change spoken about by Rebecca was achieved at the expense of self. Rebecca had said that she can now sit in the same room as her father *because she decided to be more empathic* about his anxiety and so she can catch and *stop herself as she moves into anger*. There is nothing in what she said about her father meeting her. Neither is there anything in the facilitator's response that recognised the cost to Rebecca's self of the caregiving strategy she has adopted. The final comments of the facilitator (6468-6473) suggest that, at some level, she was aware that there was much more for Rebecca to explore about the impact of her father's behaviour but instead of inviting Rebecca to talk about this she invited contributions from 'anyone else'.

Reflexive response to Rebecca

As said previously, Hollway and Jefferson (2000a) suggest that the researcher repeatedly ask themselves why they notice what they notice. In this spirit I record that when writing the above I was reminded of an incident in a session of Course A (which I attended). In that session, Geraldine told a story about her mother beating her with a stick because she was screaming and not letting the rest of the family get to sleep. She said she had been screaming because it was the only way she got attention in a large family; and the more violent her mother became the more she would scream in defiance. In part, the story was told 'for laughs' and it provoked considerable laughter from the group and facilitator. I

was affected by elements within Geraldine's story and became angry that the child Geraldine had not been seen, either in her family or in the group. Several minutes after the group had moved on to matters brought by other people I expressed my anger that Geraldine had not been seen and attention was then given, in that and subsequent sessions, to the pain which underpinned her story.

I draw this connection so that the reader can be aware that something about failure to be seen in a large group triggers my own issues. That the facilitator had only heard a part of what Geraldine was saying does not signify failure. Geraldine spoke in the persona of a joker, no doubt reflecting a learned defensive strategy (Heard et al., 2009: 66/7). Only indirectly did she present the child who desperately wanted to be seen within her family. She invited the facilitator (and group) to respond to her defensive strategy. Because she spoke in a group, it is not surprising that someone else picked up the veiled communication. This is one of the many advantages of working in a group. Moreover, the fact that on that occasion I heard the pain in her story was not a reflection of my empathy, but rather because she happened to say something that resonated with my experience. My response was to become angry rather than empathic.

I think a more usual course of events was for the facilitator to notice when someone was jumping over painful parts of their experience, slow them down and help them understand what they were doing and why they were doing it. That the facilitator did not read between the lines of Geraldine's story (Siegel, 2003) or hear the multiplicity of voices (Holstein and Gubrium, 1995; Clandinin and Connelly, 2000) in the way she frequently did with other group members may be evidence of the strength of Geraldine's personal defences.

My choice of the stories concerning Rebecca for inclusion in this chapter may reflect a personal connection with the events related. Nevertheless, it seems that the incidents cited suggest that Rebecca had at no time engaged the facilitator's caregiving. She appears indeed to withdraw from involvement in the group after this incident. In session seven, she again spoke only once after specific invitation when she briefly said something general and bland about the external environment (the focus of the session). She did not speak at all in session eight except for giving her name when asked as part of a round of eye contact

undertaken by Sarah. In interview Rebecca said she had valued her group attendance and while the work she did there was largely undertaken in a state of silent subjectivity, this fitted what she said in interview about her level of fear and the stress associated with careseeking. It may be that the group process allowed her to work hard on personal issues whilst maintaining silence. However, I suspect that change at the level of internal models of self and other requires a breakthrough into intersubjective meeting for which Rebecca had not been ready.

Hate and group facilitation

There is insufficient space in this chapter for detailed consideration of hate but the ideas underpinning flow diagrams two and three might suggest that, as with all humanity, the facilitator would sometimes have acted on the prompting of rage or hate when she was frustrated in relation to achievement of the goal of a system. I will, therefore, very briefly, revisit an incident discussed in chapter eight (see page, 190-191). There I recounted a charge Sarah made in interview that the facilitator had engaged in work with her in session eight only after expressing unwillingness. I also said that, having listened to the audio recording carefully after she told me this, I believe her charge to be unsubstantiated; that the facilitator had not spoken the words she recalled being said and that the work shared by them was sensitive and thorough. This is still my view.

However, two things might be worth calling to mind. Firstly that, because of childhood experience it appears that Sarah felt shame whenever she sought care for herself (introjected as 'demanding'). Secondly, vitality affects register in milliseconds and careseekers read the faces of caregivers minutely in an instant (Stern, 1985; McCluskey, 2005) at a conscious and unconscious level (Pally, 2001). Therefore, even though no verbal communication was made suggesting reluctance on the part of the facilitator and the subsequent work was sensitive and successful, it is possible that Sarah saw something fleetingly as the facilitator redirected her attention to her request for care which triggered Sarah's unsupportive internal environment prompting the suggestion that the facilitator did not want to work with her.

In chapter nine I interpreted this accusation as evidence that shame associated with careseeking distorted Sarah's memory of the incident in the intervening period. That remains a plausible explanation. However, other explanations are possible. For example, the facilitator may in that instant have been reluctant to respond to someone who was using a hyperactivating attachment strategy. Alternatively, the theory taught in the groups suggests that careseeking/caregiving is a stage on the way to exploratory interest sharing. If the facilitator was motivated by exploratory interest sharing at the point that Sarah was careseeking, then it is possible that being pulled from exploration at that moment triggered fleeting frustration (rage).

Therefore, in her account in interview it may be that, rather than inventing a sentence unspoken by the facilitator, Sarah interpreted a fleeting facial expression that triggered core experience which was articulated via self-punishing internal models of self and other. However, Witkin's warning may be pertinent at this point: saying what we notice is risky because it 'creates it', inviting others to see and perhaps misinterpreting as we misinterpret (Witkin, 2000: 103). My interpretation must therefore remain tentative and theoretical.

Conclusion

Analysis in earlier chapters suggests that, for some course members, being in the group situation, in and of itself, triggered fear. Attachment theory suggests that for some people the presence of a caregiver activates fear. Rebecca told me that she was very frightened when it was her turn to speak and she, Stephanie and Antonio each said they found sessions very stressful. Antonio spoke at length about his fear in relation to careseeking and Helena's feedback (chapter five) in session three was all about stress experienced following her lengthy interaction with the facilitator a month earlier. Careseeking and the presence of a caregiver were therefore problematic for several people in the group.

Neither Rebecca nor Stephanie explicitly sought care in the eight sessions of Course B despite the fact that at least one of them (Stephanie) attended the course with the clear intention of doing so. Stephanie said that she had grown up to have no expectation that

her careseeking would be heard. Sarah described how in childhood, careseeking had been labelled 'demanding'. Careseeking was directly implicated in the fear and distress experienced by many group members included in the study. An argument could also be made for the idea that in several cases (for example, Sarah, Helena, Stephanie and Antonio) careseeking was linked to shame.

In her case study I suggested that Sarah coped with careseeking by excluding her careseeking intent from awareness. Others, perhaps the quieter group members, seem less transparent in their careseeking; sometimes it was disguised as, or converted into, caregiving or exploration. All this increases the facilitator's difficulties.

It might be asked if the facilitator's fear, like that of the group members, could be disguised as something else. I think it possible that we have an example of this when she introduced a cognitive exercise that ensured that she stay on what was, for her, familiar territory; and also when she enrolled the group to address what I believe may have been Antonio's expression of profound and preverbal distress. In the facilitator's behaviour during these incidents I am reminded of the role of self-soothing behaviours and perfect contingency (Kooz and Gergely, 2001) in regulating self and warding off threat.

Moreover, if my understanding of the incidents involving Stephanie and Rebecca are correct, then what sometimes happened in response to the facilitator's interventions was that group members responded to the facilitator by adopting her language; cooperating with her active behavioural system rather than pursuing their own goals. In the input from Antonio, Stephanie and Rebecca we may see examples of careseeking being abandoned or disguised as exploratory interest sharing. It is possible that, in the power dynamics of the group, course members may have abandoned their own truth in order to match the system active in the facilitator. Rebecca suggests that learnt defensive strategies (Heard et al., 2009: 66) that are entrenched can further derail the process of careseeking by rendering the individual invisible to the facilitator.

In some incidents it appears that the facilitator identified new discovery in what the group member said but did not check out what the group member had meant. In relation to

Antonio I questioned whether misattunement had been motivated by exploration or defence. Whilst again speculative, it is plausible that this points to a distinction between real exploration, in which openness for new learning is supported, and a defensive form of exploration, in which the language of exploration is used to direct the group member but the spirit of inquiry and openness is missing. Here again Witkin may be instructive: 'If we want to know what our clients notice and what we fail to notice, we need to create relational spaces where divergent noticing can be safely expressed' (Witkin, 2000: 103). I have no doubt that the facilitator knows this to be true and frequently achieved it. But I suspect her motivation may sometimes have been overridden in favour of self-defence or exploration at the implicit level from which behavioural systems direct behaviour.

My suggestion that Sarah made explicit something that was communicated non-verbally at an unconscious level by the facilitator is also (inevitably) speculative. It is possible that her report in interview arose entirely from her own internal environment (and shame). But the idea that she made explicit a nonverbal communication is also a plausible explanation of what Sarah said. If valid, it raises questions about what happens when the facilitator is diverted from achieving the goals of her own activated systems.

The identification of incidents when the facilitator may have failed to provide a space in which group members could do what they needed to achieve the goals of the self is inevitable in human relating. It is also wholly consistent with McCluskey's (2005) findings and a concept of self that includes goal-corrected behavioural systems. Nevertheless, such findings raise questions about whether a more nuanced understanding of behavioural systems is required. I believe that most of the processes, interactions and responses examined above arise from a level of self that operates outwith (or prior to) conscious awareness (Mikulincer and Shaver, 2007). I am reminded of Pally's (2001) assertion that non-verbal channels account for the major part of communication between one person and another. Therefore, it is necessary to question the extent to which, for therapist and client, the processes of fear, self-defence, rage, hate (self- and other-directed) and other behavioural systems operate at an unconscious level outside of the normal control of the individual. This may have a bearing on the operation of McCluskey's (2005) goal-corrected empathic attunement.

I close this chapter by repeating that it has not been my intention to present a complete and balanced picture of relationships in the courses. Hence the absence of most successful careseeking, caregiving and exploratory exchanges. By directing my focus toward the edges of the therapeutic encounter I have sought to understand the limits of the theory and identify aspects that might be developed. In my final chapter I explore the meaning of everything that has been discovered in the data chapters.

Chapter Fourteen: General Discussion

Introduction

Developments in my understanding of the study

At the start of this project I knew that I wanted to use work I was then doing with Una McCluskey to examine how fear influences the processes of psychotherapy. This had meaning for me on many levels but I did not understand where the study would lead. In this chapter I will identify and discuss some of the waymarks on my journey through the study: highlighting new learning that has arisen from the data as it relates to my main themes.

Firstly I will discuss behavioural systems as they relate to the self. My reading of the case studies suggest that Heard and Lake's conceptualisation of the autonomous self is over reliant on simple expectations of what happens when careseeking and caregiving are activated. Their theory fails to adjust to research findings within attachment theory which suggest that an individual's response to the activation of a behavioural system can be complex. I discuss systems as nonlinear and complex processes that generate self in a therapeutic moment (Stern, 2004) and use Lachmann and Beebe's (1994; Lachmann, 2001) idea of 'organising principles' to examine the regulatory function that theory may play in psychotherapeutic encounters. I suggest that theory may serve to protect and regulate a therapist from fearful events in a session at the expense of intersubjective meeting.

In what I think is an important criticism of the theory I discuss the relationship between fear and shame; proposing that the therapist has to look beyond fear to the presence of shame. I also suggest that, while exploration may be facilitated by affect-regulating interventions, successful psychotherapy may require more than exploration. A paradox at the heart of psychotherapy is that those in most need of in-depth meeting may feel compelled to hide from or repel a therapist.

A brief restatement of the theory being developed

Heard and Lake describe an 'autonomous self' that is 'immersed in the dynamics of attachment and exploratory interest sharing' (Heard et al., 2012: 43). They propose that seven innate and preprogrammed behavioural systems, most of which are interpersonal and goal corrected, work in concert to maintain survival with wellbeing; and to restore wellbeing following a threat to the self.

The study has examined just a part of this theory focusing on the nature of interaction between therapist and client. Therapists using this model of the self try to attune to their clients in order to understand which system is active (Heard et al., 2009: 185) and help them achieve the goal of that system. The principle example being that careseeking, when activated, wants to be met in attuned and empathic caregiving (McCluskey, 2005). Achieving the goals of careseeking and caregiving may be signalled by the experience of relief and satisfaction in careseeker and caregiver. The client's careseeking again becomes quiescent while their exploratory system (or exploratory interest sharing) becomes active. With an active exploratory system and the supportive companionship of an attuned, affect-regulating caregiver, the person may be helped to remain open to more of their experience and competence while they explore salient issues. It is suggested that this may lead to an expansion of consciousness (Heard et al., 2009: 200).

This restatement of the theory underpinning the courses does not reflect everything seen in the case studies. In interview, each of the respondents spoke highly of the facilitator's competence and skill. However, perhaps because I have chosen to look for problematic, potentially fear-linked events, what we see is a much more chaotic picture in which the activation of fear and careseeking can lead to a number of outcomes. Although some of these difficulties are recognised in McCluskey's research (2005; Heard et al., 2009: 134ff) I think they have not been allowed sufficiently to influence the facilitation of the courses.

The main argument to be made in this chapter is that, by presenting a linear model of behavioural systems, the theory sets up the facilitator to believe that they should be able to recognise what is happening inside another person; and that the facilitator can (and

should) behave in a manner that is 'fear free' (McCluskey, 2011, 2013). Whilst the theoretical model underpinning the courses may work with many people, it may also serve to mask what is happening at significant moments of group interaction.

Continued application of the Cases to the Theory

Therapy as exploration and symbolising experience

In my introductory chapter I cited Polkinghorne's demonstration that therapists are pragmatic and view theories as useful 'models and metaphors that "assist in constructing cognitive order" ' (quoted in McLeod, 2010: 160). The goals of exploratory psychotherapy can be described as constructing cognitive order; surfacing and symbolising implicit forms of knowledge (including affective knowing), so that it can be integrated into an expanded and coherent self-experience (Heard, et al., 2009). In the longer term this may give rise to the coherent self-narratives characteristic of attachment security (Hesse, 1999; Holmes, 1998). In the moment of psychotherapy, cognitive order may relate to what Pally (2001) calls 'equilibrium': the fulfilment of expectancies in contingent, regulating interaction. Thus, affect-regulation is integral to the creation of coherent narratives.

McCluskey (2005, 2011, 2013; Heard et al., 2012) speaks about 'goal-corrected empathic attunement' as a primary means whereby careseekers are helped to recover from threats to wellbeing and restore or maintain their capacity for exploration. She describes the job of the course facilitator as being to act as an 'effective and empathic caregiver [who] must be attuned to each and every member of the group'. She says this is 'achieved by means of tone of voice, eye contact and reading non-verbal signals (such as weeping, fear, over-arousal) intention movements, and tiny symptoms of postural collapse' (Heard et al., 2009: 186). As seen in chapter thirteen and elsewhere, I think that this is not always achievable. I also think the case studies show that it is not always apparent to the facilitator when it is not achieved.

My reading for the study leads me to think that the differences between what we see in Heard and Lake's theory and what sometimes happens in the case studies arises because,

despite what is said about the mutually regulating nature of therapist/client interaction (McCluskey, 2005: 25), the theory presents behavioural systems as linear processes whose outcomes can be anticipated. Moreover, it overwhelmingly describes attunement as something that a therapist does to a client.

Despite the fact that humans have a prodigious capacity for intersubjective relating, when describing attunement between mother and infant, Stern (2004) acknowledges the need for interpretation and guesswork on the part of an attuned mother. If this is true on a one-to-one basis, between a mother and infant, it must be more so when a facilitator is dealing with multiple members of a group of adults; more complex in their ability to attune to a caregiver's intentions, restrain their own desires and dissemble or disguise what they feel.

At several points in the case studies I have attempted to guess which system was active in an exchange. On several occasions I have suggested that a course member may have been careseeking though they appear to have been using the language of exploration (for example, Helena, Rebecca and Antonio). I think it is often impossible to determine what motivates an individual to speak at a given moment. Indeed, it is sometimes not possible for people to know for themselves why they speak. Too often, what a person thinks was his or her motivation appears, on reflection, to have been post-rationalisation (Kahneman, 1999). Difficulty may arise because the theory sees motivation as arising from what Bowlby (1980) calls 'executive ego'. Yet attachment theory suggests that much done in exchanges between careseekers and caregivers (Collins and Ford, 2010; George and Solomon, 2008) is subject to non-conscious processes involving internal representations of self and other.

When therapy is viewed as something one person does to another, the therapist role is to help the client to explore and symbolise their experience. This is a good description of what many schools of psychotherapy see as the core of their task. However, this may not always describe what happens in the therapeutic situation. In her research on attunement McCluskey (2005) observes that she has never seen a client insist that a therapist 'stick with the affective meaning of what they were saying [. . .] in lieu of the direction being presented to them by the therapist' (2005: 11). By the same token I suggest that when a group member adopts the theory and language of the therapist (and they are actively

encouraged to do so), it is likely that, sometimes at least, they are diverted from their own goals in speaking and instead cooperate with the therapist in symbolising something that has meaning for her. For example, soon after joining the group people talk about their 'fear system' becoming active when they mean they feel afraid. I think they might get closer to the truth of their own experience if they were left to find their own words.

Nonlinear systems and intersubjectivity

It may be argued that insufficient attention has been paid in the theory to the idea that, in therapeutic encounters, therapist and client create a mutually-regulating system (Lachmann, 2001; Siegel, 2014). My understanding of the case studies has been deepened by reaching beyond Heard and Lake's descriptions of behavioural systems, to see the self as something arising from emergent self-systems (Stern, 1985; Lachmann, 2001). When viewed with these ideas in mind, therapy is not something that one person does to another; rather, it is something that creates both persons in a present moment (Stern, 2004); a moment in which both parties are changed in mutual regulation (Lachmann, 2001; Tronick, 2001).

Several authors, who use the concept of motivational systems in psychotherapy, distinguish between simple and complex, and linear and non-linear, systems (see for example, Cortina and Liotti, 2010; Lichtenberg, Lachmann and Fosshage, 2011; Siegel, 2014). In chapter two I quoted Siegel's (2001) description of the mind as an emergent, self-organising process that exists within and between individuals and is characterised by non-linearity, openness and the capacity for chaos. If the sense of self is emergent (Stern, 1985), arising from interaction with principal caregiver(s), then selfhood is intimately bound to what Stern calls the 'intersubjective matrix' (Stern, 2004: 75ff). While this supports emphasis being placed on the importance of affect regulation within psychotherapy (McCluskey, 2005; Heard et al., 2009/2012; Schore and Schore, 2010) it imposes constraints on what we say about it.

Behavioural systems shape the experience and behaviour of both careseeker and caregiver, so regulation between them will operate in both directions. When activation of caregiving

and careseeking triggers preconscious memories, affect and cognition, linked to frustrating and painful experiences, it will give rise to defensive forms of careseeking and caregiving that reflecting internal models of the careseeker and caregiver. Expressed by both parties in 'vitality affects', information processing shapes the dyadic exchange; regulating both the facilitator and group member in a body-to-body process (Pally, 2001). The conscious intentions of the facilitator do not reach deeply enough to be a guard against the two-way nature of affect-regulation. Therefore, the description of careseeking being assuaged when met by an attuned empathic caregiver fails to acknowledge the possibility that when caregiving is activated, the facilitator (therapist) may seek regulation in the responses of the group member (client).

On one side of this, what the caregiver sees and how they interpret and respond to careseeking behaviours is influenced by internal models of self and other. This shapes the care they give (Collins and Ford, 20010; Dozier, Cue and Barnett, 1994; George and Solomon, 2008). Similar processes work on the other side of the dyad; resulting in complex and paradoxical behaviours being triggered by the offer of care (Dozier et al., 2001; Feeney and Kirkpatrick, 1996; Florian et al., 1995; Mikulincer and Shaver, 2007). Behaviour seen in the case studies is consistent with this research. Several of the group members did not seek attuned mirroring or intersubjective exchanges with a facilitator when they were distressed. I have suggested that those who appear to hyperactivate attachment when in distress do so by focusing on internal contingency at the expense of intersubjective meeting. This is consistent with the idea that enmeshed attachment involves anxious ambivalence: the simultaneous desire for engagement and fear of intimacy (Bifulco et al., 2002a). I suggest that this may be associated with shame-linked internal representations of self; and fear that true engagement may require them taking a caregiver's (feared) feelings and wishes into account (see below).

Theory as a regulatory principle in psychotherapy

In view of the potential for chaos in any system, it is remarkable that the courses in this study all take a more or less predictable form. This may reflect the competence of the facilitator, composition of the groups and/or strength of the group model. It may also be

a reflection of the fact that they were training courses using experiential learning based on a contract that privileged the facilitator's expertise, perceptions and theoretical biases over ideas brought by course members. If course members spoke using ideas derived from other theoretical models they were sometimes encouraged to 'stay within the paradigm' created by Heard and Lake. This raises questions about how free the facilitator of this type of group may be to stay within a group member's experience.

The theoretical language used by a therapist defines the form and conditions of their caregiving. The classical analyst, using concepts such as the blank slate and transference, offers a different form of care to a Rogerian counsellor or Cognitive Behaviour Therapist. I suspect that careseekers normally adopt the language and theoretical stance of their particular therapist as the way to maximise the care they get. Consequently, what they seek from a therapist, and the language they use in doing so, will reflect what is on offer in the particular therapeutic situation. By adjusting to what is on offer the client may be said to be regulating the therapist as much as the therapist regulates the client.

My reading of much of the transcript data is that privileging the facilitator's perspective is innate to the method of facilitation being used. The facilitator exerts a considerable amount of power in the groups. Almost exclusively she interprets narratives brought by group members; she frequently invites contributions from specific speakers, interprets their narratives according to the theory as she defines it and determines when the group member has finished speaking (by inviting contributions from 'anyone else'). She also offers affect-regulating interventions which interpret the group member's inner experiences. Sometimes she invites people to make connections with other people in the group, for example, by instructing them to make eye contact with others. While this helps the facilitator to make sense of everything that arises in terms of Heard and Lake's dynamics of attachment (which may have been consistent with the didactic goals of the courses), it may sometimes serve to protect her from percepts that were discomfiting or did not fit the model she was using.

McCluskey (2011, 2013) has argued for the importance of fear free caregiving as a condition that protects clients from taking on the therapist's (of facilitator's) fear. In some

senses this may equate to 'marked mirroring' (Fonagy et al., 2004), by which the mother (or therapist) edits what they express in facial expression so as to demonstrate empathy without adding to the infant's (or client's) fear or distress. I suspect there is a danger that the call to offer fear free caregiving may sometimes motivate the exclusion of fear from awareness.

Yalom's (1989) description of psychotherapy as a meeting between two frightened people cannot be less relevant to a facilitator working with a group of psychotherapist who have paid for her services. A question then arises about how therapists regulate their fear during sessions. I think it unlikely that the absence of explicitly expressed fear on the part of the facilitator reflects a true absence of fear any more than the absence of shame in Farmer and Andrew's (2009) young offender sample evidenced the true absence of shame. It may be that a therapeutic model acts to mask emotion in much the same way that machismo protects young offenders from experiencing shame.

At times in the case studies I have suggested that the theoretical stance taken by the facilitator excluded other explanations, language and ways of expressing core experience. A systems model that does not include the idea of chaos may use defensive exclusion to ensure that a facilitator sees what he or she expects or wants to see. Privileging (inevitably selective) perceptions is likely to mean that her expectations are confirmed in a clinical manifestation of Baron's (Baron et al., 1988) confirmatory bias.

The work of Lachmann and Beebe (1994) highlights the role of contingency detection and expectancies, in regulating affect. Lachmann says,

Infants detect order, repetition, and predictable consequences following their own actions. The confirmation of expectancies yields predictable "ongoing" regulation. The violation of expectancies yields disruptions that range from playful and pleasurable to traumatic and difficult to repair. The . . . confirmation and violation of expectancies operate throughout life and can also be applied through metaphor and analogy to the psychoanalytic treatment of adults. Our understanding of therapeutic action in adult psychoanalysis is thereby enhanced.

Lachmann, 2001: 169

Abstracting from the central role played by theory in the structure of group sessions that have been studied, it is possible to argue that the confirmation of theoretical beliefs may be one mechanism by which therapeutic relationships are regulated. Freud famously marked his pleasure (pride in achievement) during analytic sessions by lighting celebratory cigars when he thought he had uncovered the roots of a neurosis. This may indicate that he had achieved the goal of exploration. I do not know how often his patients shared his satisfaction.

It might be argued that therapists do not have to express fear to their clients; it can be ritualised in set procedures, contained in a strong theory and excluded from awareness. When necessary, fear can be projected into the client (or group) and treated. In this way theory may protect the therapist from the effects (and awareness) of their fear.

Another lesson can be drawn from Freud. Drive theory replaced seduction theory following a very painful rejection of the latter by Freud's peers. The subsequent direction of his theoretical base can be regarded as a means whereby Freud regulated his own distress/fear in the face of unbearable revelations from clients and a professional milieu that was defensively hostile to evidence of childhood sexual abuse (Masson, 1884). This suggests one way in which a therapist's beliefs (theory) may develop in order to regulate the therapist within the therapeutic relationship; thereby preventing them from making clean and disinterested interpretations (Guntrip, 1971). The fact that the facilitator adheres to a single specific theory limits her ability to just be with a group member in that person's in-the-moment experience; supporting that person in the development of their own voice rather than guiding their narratives within the bounds of a preferred theory.

As a regulating principal, theory creates or defines expectancies that may or may not be realised. Whether or not these expectancies are realised will impact on the therapist and when repeatedly not realised they will cause dysregulation. For example, if the theory creates expectancy that people will share their distress with the therapist, then quieter people who hide in the shadows of the group may create discordance or disequilibrium (Pally, 2001) dysregulating the therapist. But so long as there are enough people in a group

who are willing to speak in the desired manner, the therapist can edit out of awareness any disequilibrium so caused.

Exclusion from awareness might be mutually regulating because it serves to keep avoidant people invisible within the group when they do not feel able to participate directly. In this way I think some people were allowed to regulate shame by staying undercover until they felt sufficiently safe to reveal themselves. My meetings with Rebecca (chapter six) and Stephanie (chapter seven) impressed upon me the benefits each felt in being allowed to work quietly while learning from the experiences of others. Antonio (chapter ten) and, in subsequent courses Stephanie, both appear to have used this learning to develop the trust necessary for intersubjective engagement.

As said in chapter one, we might see theory as something that empowers therapists at the cost of client autonomy (Gergen, 2007; Cushman, 1990, 1995); creating a special caste or priesthood to whom a faithful clientele can turn for succour or enlightenment. Alternatively, theory can be something that therapists offer in order to empower their clients and enhance client autonomy. Theory may be offered as tentative suggestions which client's may or may not find useful; or theory may be presented as truth with which the client can be taught to construct their images of self.

Careseeking, shame and intersubjective meeting

Labov and Waletzky point out that telling stories 'requires a person to occupy more social space than in other conversational exchanges . . . to hold the floor longer, . . . the narrative must carry enough interest for the audience to justify this action' (Labov and Waletzky, 1997: 13). The content of any contribution to the group has to be of sufficient moment to justify taking time from others. This probably takes a particular slant in an experiential group composed of psychotherapists who take on a defined remit to explore personal attachment experiences. The speaker in such a group implies that the subject they talk about has particular salience for them, which they invite others to share. As indicated above, this may be difficult for people whose distress (salience) has been ignored or disparaged in formative years (as, for example, in the history recounted by Sarah). What

each person means by speaking will be shaped by their attachment style. If the activation of careseeking triggers preconscious activation of fear-linked shame (which is implied in several of the case studies), then the individual may feel exposed merely by speaking and daring to assume that what they have to say is worth hearing. I suspect this was so for many course members. It may explain why Rebecca appears to have hidden and why Helena was apparently shocked that she shared her vulnerability in the group. Shame can motivate hiding and silence (Ayers, 2003; Nathanson, 1993; Wurmser, 1987).

Evidence in several case studies suggests that for some people careseeking is associated with shame. Rebecca's interview testimony suggests that sometimes she spoke only because being silent rendered her paradoxically visible. We might, therefore, suggest that the speech of some people was motivated by self-defence. An alternative way of hiding in the course might involve using the language of the course; mimicking the facilitator (and other group members) and valuing what the group appears to value. In an exploratory group that uses a language drawn from attachment theory and psychodynamic psychotherapy, an individual will adopt the appropriate language and express him or herself in terms of the appropriate theory.

The eagerness of some group members to be heard and seen at times when they were distressed may suggest that, for them, careseeking was not associated with shame. However, some of the evidence calls this into question. It may be recalled that in a personal communication following our meeting, Sarah confirmed my view that, at the time of our interview, she had been ashamed of careseeking in the group. When she accuses herself of being 'demanding' (and when she talked to me about counting to ten before speaking), it is likely that she was reflecting a link between careseeking and shame. Alison was active in caregiving to others in the group yet she used the word 'victim' as a pejorative term that stopped her sharing her own historic pain. This may suggest that, for her too, careseeking was linked to shame.

But shame did not stop either Sarah or Alison from seeking care in the group when they were distressed. In her case study, I suggested that Sarah's shame could be excluded from awareness until sometime after she had finished speaking. I am reminded that, as well as

hiding, shame motivates anger and aggression. It might be argued that anger, as defence against shame, is integral to the hyperactivating defence; motivating the person to focus on perfect contingency (Koos and Gergely, 2001) by exaggerating their distress (Mikulincer and Shaver, 2007) at the expense of intersubjective meeting. Allowing one's self to see and attune to a caregiver runs the risk of being exposed to their real feelings; including potential reluctance and exasperation.

Whilst I have outlined this only in terms of insecure careseeking, it is inevitable that shame plays the same role in the behaviour of insecure caregivers (George and Solomon, 2008); as part of internal models of self and other shame influences what is seen and shapes the responses given to requests for care. Theory may provide a means whereby a caregiver can achieve perfect contingency.

Although shame is actively involved in shaping therapeutic interaction it may be difficult to regulate because it is a largely invisible emotion (Farmer and Andrews, 2009; Nathanson, 1992). The fact that shame was rarely disclosed in the groups adds to the facilitator's difficulty in knowing why people spoke at any given time.

Group processes, attunement and careseeking

In view of issues raised in this chapter it is necessary to question some of the assumptions made in the theory underpinning the courses. Particular assumptions that should be questioned include,

- The expectation that fear/need will motivate careseeking behaviours.
- The idea that careseeking and fear are assuaged/regulated by an attuned caregiver.
- The idea that careseeking motivates a desire to be met in intersubjective relating.
- The idea that exploration is an indication of a good working alliance.

I would hazard a guess that each of these assumptions is true for secure course members. For a significant number of the study participants, fear and careseeking appear to have triggered hiding rather than careseeking. Shame is barely touched on in the theory and is

rarely discussed in the courses. When Heard, Lake and McCluskey (2009/2012) refer to shame, it is usually in terms of something one person does to another (see for example, Heard and Lake, 1997: 35). The idea that shame can be woven into the fabric of the self is not sufficiently recognised. Moreover, I suspect that because shame was rarely spoken about or identified in the courses it was largely unregulated, unrecognised and unsymbolised.

Information processing viewed as the internal environment

Heard and Lake's theory reifies the internal environment as a distinct system although it comprises processes that are integral to other behavioural systems. The careseeking and caregiving systems do not exist except with the information processing that informs them. Separating these systems from information processing runs the risk of reifying careseeking and caregiving as systems that are distinct from personal history.

Nevertheless, I believe it may be therapeutically useful to conceptualise information processing as a distinct system because it helps people focus attention on attachment-related cognitive and affective processes; to examine whether they support or hinder careseeking and caregiving and how internal models (and introjects) impede careseeking and caregiving. But my examination of the group data leads me to think discussion of information processing needs to be expanded to include greater awareness of the role of selective exclusion. Selective exclusion, in the form of avoidance, cognitive disconnection or segregated systems (Bowlby, 1980; George and Solomon, 2008), is a profoundly unconscious process that is vital to understanding the insecure self; influencing how individuals perceive (which necessarily involves recollection) and experience events in a present-moment. Introspection and symbolising will expand consciousness only if it is recognised that perceptions, memory, affect and cognition may be defensively biased to maintain homeostasis.

The theory of the internal environment might also be strengthened by drawing on the concept of 'mentalization' (Fonagy et al., 2004). This makes clearer the interpersonal origins of self and in so doing facilitates exploration of how an individual's defences arise,

at least in part, as a response to the defended nature of care received (Cassidy, 2001). Understanding the defences of caregivers is necessary to understanding the defences of the self.

The caregiving system

Much of what has been said above implies that caregiving, like careseeking, is subject to attachment defences. This means that a caregiver's perceptions, memory, affect and cognition are shaped by the needs (and personal history) of the caregiver as well as their perception of need in the careseeker. I have spoken above about how clients may subtly alter their behaviour outside of consciousness to regulate the caregiver; this is an inevitably two-way process.

The group transcripts suggest that hyperactivating group members were invited to speak more frequently and at greater length than avoidant group members. I have also suggested that the facilitator sometimes assumed exploration was taking place when she did not know the group member's motivation. This may suggest that group members were sometimes responded to at the level of defensive strategies (including those of the facilitator) rather than to their underlying need (Dozier, Cue and Barnett, 1994). In what is said here and above it is clear that apparent compliance between the behaviours of therapist and client cannot be taken to mean that an appropriate working alliance has been established.

Using the flow diagrams in psychotherapy

The flow diagrams were drawn to help me make sense of what I saw in the transcripts and attachment literature and were not intended for use outside of the study. Nevertheless they may prompt reflections that are useful in therapy.

New diagrams created for this study appear to describe secure, enmeshed/preoccupied and a type of avoidant attachment. They do not resolve difficulties created by blending different research traditions and are affected by a limitation in the study. The composition

of the groups being studied (professional caregivers) and the context of the groups probably mean that compulsive-caregiving is overrepresented in the case studies of those group members who rely on deactivating defences, while anger and aggression are underrepresented. Groups in a different context or with a more typical clinical composition would probably show markedly different characteristics linked to avoidance. For example, it is unlikely that flow diagram two would have been created to depict Farmer and Andrews (2009) young offenders. Conflict is a common feature of insecure attachment relationships (Bifulco, 2002a, 2002b) and the link between shame and defensive anger (Hejdenberg and Andrews, 2011; Tangney and Dearing, 2002) suggests that a diagram reflecting Bifulco's (Bifulco et al., 2002a, 2002b) 'angry-withdrawn' attachment style may be a useful addition.

The flow diagrams encourage the therapist to look behind the client's self-presentation. My representations of insecure careseekers attempt to reflect the critical role played by selective exclusion from awareness; with what is consciously known and expressed appearing on the right side of the page and that which is excluded from awareness placed on the left. Thus, in diagram three I have suggested that the expressiveness of preoccupied people is powered by an internal environment (information processing) that compels careseeking behaviours. In the highly expressive presentation of preoccupied people, fear, distress and careseeking behaviours are clearly visible. The internal environment, what the person (consciously and unconsciously) thinks about self and other, is normally less visible. Affect which is expressed; whether it is sadness, anger, or fear, is influenced by fear that the individual's careseeking will be rejected. The diagram depicts this as a circular process in which evidence of reluctance or resistance on the part of the caregiver feeds back into the internal environment, triggering a redoubling of the careseeker's efforts. At the same time I have tried to convey the idea that preoccupied expressiveness serves as a defence against shame (which now appears in flow diagrams two and three as content within the internal environment for insecure careseekers).

According to flow diagram three (page, 175), offering care in a manner that is complementary to the careseeker's attachment style (Dozier, Cue and Barnett, 1994) would not mean containing their expressiveness for its own sake. It means helping

individuals get behind what they are expressing, to understand what motivates their expressiveness. Helping him or her to be more open to what is actually happening in the here-and-now moment, rather than seeing through the filter of internal models and what, as a consequence of this filter, they imagine is happening (this is an idea that I take directly from McCluskey's teaching and the groups).

Flow diagram two (page, 120) contrasts with what is described by flow diagram three. Here affect may be invisible and is perhaps excluded from awareness, so that, what is revealed comprises the thinly veiled persecuting internal environment (that serves to deactivate attachment) and the acceptable image or false self by means of which the individual gains approval and maintains self-esteem. Though Rebecca and Stephanie showed little emotion in the group, in the interview situation at least, they were very aware of the fear they felt in the groups. Fore-armed with knowledge of this discrepancy, it may be possible for the therapist to invite them to reach behind their defences so they can experience and express affect within the therapeutic meeting.

Limitations in the study mean that the diagrams do not depict all attachment styles. I did not attempt to represent disorganised/disoriented attachment and have depicted anger only as it relates to preoccupied attachment. Moreover, the diagrams focus on the experience of clients (or group members). It has become clear to me in the course of the study that the therapist also has to be aware that much that they do will be motivated by the need for regulation and self-defence. This will be largely automated; operating at a body-to-body level of communication outside of the awareness of either party. Another study might usefully examine how possible it is for the therapist to reach behind his or her own defensive strategies.

The people to talk most about anger (but not expressing it directly in the group) were those who were most expressive. Although Helena talked about experiencing rage between sessions, it was unusual for quieter people to express anger. Some of them spoke of a propensity to lose their anger or substitute it with sadness or fear. But it is clear that this is far from the only expression of avoidant individuals (Bifulco, 2002a, 2002b). It may be that for 'angry-dismissive' individuals the 'false-self' symbol used in diagram two could be

replaced with another symbol including the idea of reactive anger. For this to be tested another study using a different sample is required.

The diagrams sensitise the therapist to question what behaviours are being motivated by their own internal environment and that of their client; what is being excluded from awareness and whether the internal environment supports hyperactivating or deactivating defences. Although shame was not depicted in the diagrams as originally presented, they have been amended in light of the findings to depict an internal environment in which shame informs the fear that underpins defensive strategies.

Conclusion

Reflections on the expression of fear and shame

I set out on this study believing that for some people the presence of a caregiver activates fear. I originally thought this was particularly true for quieter people but have come to think it is equally true of insecure people generally. I have also come to believe that, for insecure people, shame is intimately bound up with careseeking. It may be the expectancy of shame (preconscious activation of shame linked memories) that activates fear in the presence of a careseeker and so deactivates or hyperactivates careseeking.

A number of people in both courses identified themselves as self-reliant at times when they experience need. In session one of Course B, Antonio spoke about placing himself in the vicinity of a caregiver in the hope of obtaining care. Although not what he was saying, it may be that, at such times, his careseeking had been satisfied by proximity. This would support an argument for separating careseeking from intersubjectivity and treating each as separate system as proposed by Stern (2004). This might also account for the contentment of some course members to be in the group without engaging in direct work with the facilitator. However, Antonio's progress in the sessions of Course B seems to have been in a clear direction toward ever more self-revelation until, in the seventh meeting, when he spoke with immediacy about the intensity of his fear in the group. My interpretation of this is that he tested the relational waters and gradually opening himself

up to increasing levels of intersubjective relating. I have suggested that this culminated with him sharing pain from the core of his shamed self by saying, 'I am not good enough'.

The expression of fear requires trust that it will be understood, accepted and regulated. It is noteworthy that the people who expressed most fear in the first session of Course A were those who had been in the same group in the previous year. It is unlikely that these people were more frightened than those who were relatively quiet on the subject of fear. Rather, I think it more likely that they felt sufficiently safe to express their fear. This supports Averill's (1982, 1983) social constructionist view of affect. Averill argues that anger is expressed in contexts when it is safe rather than when it is justified; and that the expression of anger serves a regulating function within relationships. From this perspective we may see the expression of fear (and careseeking) as part of a course's culture; when it may be expressed primarily by those who feel most secure within the group (safe enough to expose their vulnerability).

A biological perspective might modify the social constructionist view by suggesting that, though the expression of affect will be innate, individuals learn what they can express and will inhibit feelings that are socially and culturally unacceptable (Ekman, 1999). The effect of both explanations may appear similar but in the biological view, it is inhibition of affect that is socially constructed. This is consistent with LeDoux's (1998) description of the inhibiting function of the prefrontal cortex.

Early in my analysis of the data I had expected that fear would be expressed by more vocal people bidding for control within the group. While Sarah and Alison both engaged in lengthy exchanges addressing the issue of fear, neither became obviously frightened in the groups. Whilst Alison expressed fear that she may be thought uncommitted to the course because she would be absent for a second session, and this was interpreted by the facilitator as an expression of fear, the extent to which she was actually frightened is not clear to me. Apart from this incident, neither Alison nor Sarah appear to have been troubled by the immediate experience of fear in their respective courses and both were more likely to relate stories containing other forms of distress (including loss and frustration or anger) that elicited care and attention without expressing fear.

I believe my study of fear becomes more comprehensible if we see pride and shame as affective poles which act as 'organising principles' of the self (to risk misusing a term borrowed from Beebe and Lachmann, 1994). I suspect that at some level pride and shame underpin the experience of assuagement and disassuagement of careseeking and denote worthiness and unworthiness of love/care. I therefore propose that if we want to understand how fear manifests in psychotherapy we need to understand the role of pride and shame; and consider the ways in which these affects are regulated.

The facilitator routinely intervened to regulate fear in the group (and perhaps in herself) by instructing people to 'get centred' or 'tension down' (and related phrases). There are also many examples of her recognising, celebrating and supporting pride (by praising group members who reported positive changes in their behaviour or at times when she thought they attained a new insight or discovery). But as has been said above, shame is much less visible in the group and is, therefore, less easily regulated. Just as fear seems to be expressed least by those group members who were most afraid, shame is expressed least by those who are affected most profoundly by shame. This idea is supported by Farmer and Andrews' (2009) study of young male offenders.

Shame and hate

Throughout the study I have used a concept of hate that draws (as said in chapter five) on a blend of ideas originating with Suttie (1935), Winnicott (1949) and Panksepp (2002). I have suggested that 'hate' is (conscious or unconscious) rage that has been internalised in the form of implicit working models of self and other. The study findings do not favour my conceptualisation of hate over alternative views of the role of negative emotion in attachment relationships. I am unclear if this is because my notion of hate is without foundation or because, like other negative emotions, the presence of hate can be masked or hidden from self and other. Nonetheless, I am drawn to the idea that, to be effective, therapy must help the client to explore and understand their (conscious or unconscious) hostility.

My attempt to conceptualise hate was an attempt to understand what motivates hyperactivating and deactivating defences. It preceded my reading about shame and may cover ground that is better explored in studies examining links between attachment, childhood experiences, low self-esteem, shame, anger and depression. As quoted in chapter two, shame has been described as ‘a particularly intense and often incapacitating, negative emotion involving feelings of inferiority, powerlessness and self-consciousness, along with the desire to conceal deficiencies’ (Andrews, Mingyi and Valentine, 2002: 29). Empirically linked to adverse experiences in childhood (Andrews, 1995; Andrews, Mingyi and Valentine, 2002) and adult depression (Andrews, 1995; Andrews, Mingyi and Valentine, 2002), shame can be intimately bound up with attachment relationships. Farmer and Andrews, (2009: 59) explain their findings about the relative absence of shame in young male offenders with the idea that the infrequency of an emotion indicates its significance rather than insignificance. Shame can activate defences in some people that hide its presence from self and other. It may therefore be implicated in deactivating defences in which the individual also hides distress from self and other.

However, shame is also empirically linked to anger (Hejdenberg and Andrews, 2011; Tangney and Dearing, 2002). Anger may serve a life-long function in defending against the pain generated by shame (Gilbert, 1997), by deflecting blame onto the sources of criticism (Farmer and Andrews, 2009; Hejdenberg and Andrews, 2011). While, for some people, shame may be defended against in a manner that deactivates attachment in times of stress, for others, the experience of shame may be actively displaced by focusing on and expressing anger. This may underpin the expressiveness typical of preoccupied individuals and the ‘angry-withdrawn’ attachment classification (Bifulco et al., 2002a) used to describe dismissing people with high hostility to attachment figures they perceive to be unavailable or unsupportive.

When careseeking is engaged in by exaggerating one’s distress or need (Mikulincer and Shaver, 2007) it may generate a measure of resistance or resentment which the careseeker has to exclude from awareness. To achieve this, the careseeker cannot allow real, two-way, intersubjective understanding because this increases the potential for perceiving

rejection. However, I suspect that careseeking cannot reduce shame if it does not include profound intersubjective sharing.

This leads me to assert that psychotherapy is more than exploration. Whilst much is achieved by exploration in terms of creating order from cognitive and affective material that might otherwise be excluded or remain implicit, the case studies suggest that this is not everything that people want from the therapeutic relationship.

Exploration is akin to 'secondary intersubjectivity' (Trevarthen and Aitken, 2001) in which partners in a dyad share an external focus. People hide and bully because of their fear of shame. And I suspect that no amount of reasoning or cognitive order will change this. At key moments in her contribution to the group, Alison (chapter nine) expressed a longing for someone 'just to be with me' in a real way; and for her truth to be seen and mirrored back in loving presence. Sarah appears to have wanted someone with whom to share the pain she felt when at her mother-in-law's deathbed and to know the loneliness of repeatedly being misunderstood. Antonio and Stephanie both wanted someone to be with them and accept them in the knowledge of their profound shame. However reticent or pushy an individual may sometimes have been in the group, they did not press for attention merely because there was something they wanted to explore; they wanted someone to see them; to sit with them and know them in their distress. That is to say, they desired 'primary intersubjectivity' (Trevarthen and Aitken, 2001). But intersubjective relating is frightening for insecure people who constantly wrestle with the problem that their shame may be reflected back in the eyes of the other (Ayers, 2003).

Finally, I believe attachment theory can bring enormous benefits to the tasks of psychotherapy. The findings of this study indicate that affect attunement is subtle and complex; that the process of attunement is influenced by unconscious processes of mutual regulation and is sometimes corrupted by the intrusive imposition of theory. I think it unreasonable for one person to believe they can attune to multiple individuals in a large group without being influenced by their own fear and shame. I recommend that the facilitator's role be changed so that they are not seen to be the primary caregiver in the group and that they work in support of all group members as they attune to, and help each

other in the task of co-constructing a theory and language that best describes an individual's experiences. There is a wealth of information and wisdom in attachment theory that support the processes of psychotherapy. Freed from the role of offering omniscient attunement, it may be possible for a facilitator to stand back and take a position wherein he or she offers insight drawn from attachment theory (and other therapeutic resources) that help in the groups exploration.

Limitations of the study

My study began with an offer of PhD supervision and a pre-existing data set that had been produced for purposes other than this project. Because it has been conducted as a doctoral thesis, the study has evolved alongside my developing skills and knowledge; growing organically to expand beyond one theory to incorporate insights from wider literature.

As the sole researcher I have had to work alone. I am not trained to use the various measurement scales that the study draws on. The study's focus on the work of Heard, Lake and McCluskey has meant that I included detailed consideration of attachment styles relatively lately. This affects the organisation of the thesis. If I had included attachment styles from the outset I could have been more thoroughly versed in the relevant theory and more systematic in my analytical approach.

The study uses two training groups for purposes for which they were not designed. As a consequence it may sometimes be difficult to differentiate group effects from the study findings. My closeness to the groups (including my relationship with the theory and theoreticians) has brought many benefits but has meant that it has sometimes been necessary for me to separate my analysis of data from wider connections to the project. There is also a danger that informants responded in interviews in ways that reflected their past relationships with the facilitator and/or the groups.

Research inevitably involves compromise. In these case studies I have used a qualitative design that examines detailed data from a relatively small number of cases. In contrast to hypothesis testing studies, theory building research relies on the cumulative impact of

multiple observations to increase confidence in theoretical tenets that are forever in development (Brinegar et al., 2006). Rather than establishing facts that can be generalised to large populations, qualitative research typically seeks unique meanings in individual stories (Clandinin and Connelly, 2000; Cooper, 2009; Hollway and Jefferson, 2000; Poindexter, 2004; Riessman, 1989, 2008). Events must be interpreted in a quest for the most plausible and credible explanations (Hammersley, 1992). Whilst I have tried to be faithful in reporting what I have seen, felt and heard, as Van Maanen says, this means that what is known is inevitably braided with the knower (quoted in Elliot, 2005).

The study explores questions about psychotherapy using training groups rather than group psychotherapy. Some observations made in the study will reflect factors particular to the setting. These include:

- Pressure exerted by a shared professional ethos; including unknown factors such as the groups' unseen professional hierarchy.
- Ambiguity in the function of the facilitator (teacher/therapist) and the control exerted by the facilitator using a particular model of group facilitation.
- A theoretical frame within the groups that privileges one theory and theoretical language while excluding much that is known from attachment theory.
- The mixing of new members within a previously established group (which had an established shared culture and pre-existing relationships with each other and the facilitator).

Whilst some of these factors are perhaps useful for theory development within this study, further research may be required to ascertain which of the findings are relevant to other therapeutic situations. I see no reason why analysis using similar questions (about the role of fear and shame, attachment styles and working alliance), could not be applied to data sets taken from other therapeutic settings that are wholly unrelated to the work of Heard, Lake and McCluskey.

Appendix 1

Average Word Count per Session for the two courses

Word count for the two courses was used to identify potential participants. Because a group of participants had to be deselected from Course B when it was not possible to reliably distinguish them from voice alone I decided to select people to represent a spread of speakers in the mid-range (picked out in the table in blue).

Course A		Course B	
Course Member	Average Words	Course Member	Average Words
A01	354.00	B01	258.4286
Helena	497.5	Rebecca	374
A03	703.42	Stephanie	389.875
A04	766	B04	420.375
A05	789	B05	575
A06	804	B06	615.5
A07	962.57	Antonio	693
Charlotte	1,084	B08	732.1667
A09	1,162	B09	750.6667
A10	1,326.12	B10	817
A11	1,377	B11	829.5714
A12	1,404	B12	900.2857
A13	1,705	B13	1,121
Alison	1,786	Denise	1,215.875
A15	1,893	Sarah	1,734.714
		GM16	2,171

Although used to select cases for analysis and structure data chapters, word count is complex and of limited value to my qualitative study. The average number of words spoken by people in the two groups differed (in group A this was 962 words per session while group B it was 849). I suspect the higher average word count in Course A reflects an established group culture. But there was a wide spread (between 258 – 2171 words per session) and with relatively large margins both the least and the most vocal people were in Course B. With an average word count of 693 per session, Antonio spoke considerably less than the combined average for the two groups (899) and it was this fact that originally led me to include him in the chapters for quieter course members. Within the context of his group however, he is more clearly in the mid-range. Denise was chosen to represent high mid-range because her word count was considerable less than both of the more vocal people in her group and she represents the mid-range for the combined averages of the two groups.

Appendix 2

Mikulincer and Shaver's (2007) model of attachment systems activation in adults.

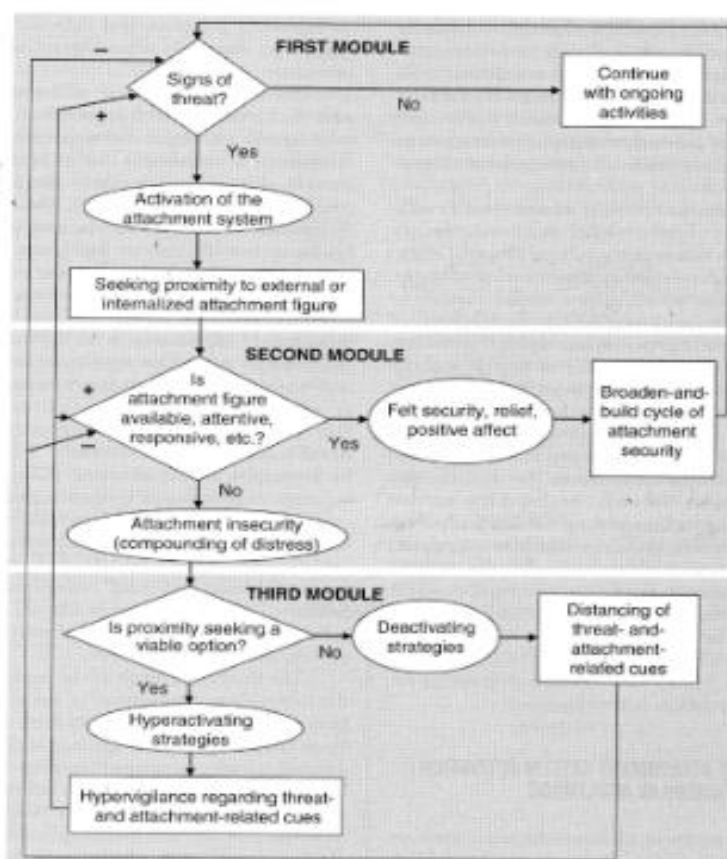


Figure 5. A model of attachment system activation and functioning in adulthood; from Mikulincer and Shaver (2007: 31). Copyright 2007 by The Guilford Press.

Mikulincer and Shaver's model of attachment describes what happens when the careseeking system is activated. It is based on three 'modules' that represent stages from the perception of threat to the expression of an insecure attachment response. The decisive factor in their first module is the presence or absence of threat. When a threat is perceived the attachment system is automatically activated and this motivates the 'primary attachment strategy' (Main, 1990): seeking proximity to an attachment figure (internalised or external).

The second module concerns the availability of a responsive caregiver. If such a figure is available, the experience of proximity and care lead to felt security, relief and a positive outcome. This in turn informs a 'broaden-and-build cycle of attachment security' in which memories of positive outcomes of careseeking inform internal representations of self and other which support future careseeking. However, if the attachment figure is not available, attentive or responsive, a negative cycle ensues in which insecurity compounds the individual's distress.

For the distressed insecure careseeker (module three) the choice is between secondary attachment strategies (Main, 1990): that is, hyperactivating attachment by focusing on and expressing distress in order to elicit care; or deactivating attachment by excluding distress and need from awareness.

Although not represented explicitly, every moment of this model is informed by information processing. Mikulincer and Shaver talk about the preconscious activation of attachment in which memories, affects and cognitions are accessed which either support or inhibit careseeking. In this way, before activation of attachment has become conscious, external stimuli trigger working models and selective exclusion from awareness so shaping the person's perception, cognition and affect, thereby controlling the manner in which they respond to threat. Responses to offers of care (and other events) therefore arise from an assessment of external reality that is based on memory (cognitive and affective) of past events.

Appendix 3

Course Facilitator's Consent Form:

<h1>EXPLORING THE DYNAMICS OF ATTACHMENT IN ADULT LIFE</h1>

Offered by

[Facilitator Named]

Dates for commencement of course

Address of Course Venue

CONSENT FORM

I consent to participate in this course knowing that it may be audio and/or video taped and transcribed. No identifying names will be used in the transcription. Material generated will be used by [Course Facilitator Named] of the University of [Name], Dr Una McCluskey of the University of York, Dr Dorothy Heard (formerly of the University of Cambridge and the Tavistock Clinic in London) and colleagues; for teaching, training and research purposes as part of an ongoing research project into attachment, affect attunement and regulation. All participants are free to withdraw from the research at any time.

Signed: _____

Name in capitals: _____

Date: _____

Appendix 4

Participant Consent Forms

How Emotion Affects Psychotherapy

Lead researcher: Patrick Winter
University of York

Supervisor: Una McCluskey,

Consent form for Participants

This form is for you to say whether or not you are willing to participate in this research study. If there is anything that you don't understand or you would like to discuss, please contact the lead researcher (contact details on the information leaflet).

I have read and understood the information leaflet about the study. Yes No

I have had an opportunity to ask questions about the study? Yes No

I understand that if I consent to participate in this study my name and contact details will be sent to the lead researcher in Canada (where my confidentiality will be protected at all times)? Yes No

I understand that the study examines anonymised transcripts of the group I attended with [facilitator named] in [year of course]? Yes No

I agree to be interviewed by the lead researcher? Yes No

I understand that I may withdraw from the study at any

Yes No

time, without needing to give a reason?

I understand that the data and information I provide will be destroyed within 5 years of the end of this project unless I give separate consent for it to be retained for use in future research?

Yes No

I agree to take part in the study?

Yes No

I agree to interviews being recorded and transcribed?

Yes No

All data is held in accordance with EU regulations and the Data Protection Act (UK).

Your name (in BLOCK letters):

Your signature: _____

Date: _____

Researcher Signature: _____

Date: _____

Appendix 5

Introductory Letter and Information Leaflet for Participants

Invitation Letter to Participants

Researcher Address
and contact details

Date

Recipient address etc.

Dear Ms Other,

I am a PhD student looking at the role affect plays in psychotherapy and counselling and am writing to you with [Facilitator's name] consent to invite you to take part in a research study that I am conducting.

My research is supervised by Una McCluskey and hopes to draw on the experiences of people who have taken part in training courses 'exploring the dynamics of attachment in adult life'. I believe these groups offers a range of different experiences in which affect and affect regulation play a significant role. Participation is described more fully in the accompanying information leaflet but would involve me meeting with you to discuss your experiences.

Participation is entirely voluntary and I recognise that not everyone will be able or willing to participate. This invitation has been sent by Una McCluskey's secretary so that the course facilitator does not know the identities of people who have been invited to participate. Please feel entirely free to decline, but if you do give your consent, I very much value and appreciate your contribution.

The enclosed information leaflet tells you who I am. It also outlines the purpose of the research, gives details about what would be involved in participation and sets out the arrangements in place to protect the confidentiality of participants.

I would be very grateful if you would please read my information leaflet and consider taking part in this research. I enclose two copies of the consent form. If you give your consent, please sign one copy and return it in the envelope provided. Please be aware that your consent can be withdrawn at any time in the future.

Thank you for taking the time to read this. Please contact me if you require any further information (I will happily phone anyone who lets me know that they would like to speak with me).

Yours sincerely

Information Leaflet

How Emotion Affects Psychotherapy

Lead Researcher: Patrick Winter, University of York

Aims of research

My particular interest is the way in which emotional experience affects how individuals experience *self*, and how this then affects their *careseeking* in therapy. A hypothesis to be explored in the research is that, because of attachment experiences, some people find it more difficult than others to take care when it is offered to them in therapy. By exploring a range of very different experiences of people in the groups I believe we may learn much about this in a way that could lead to the development of new interventions to help to address disparity. Because of their particular experience and expertise I believe group members have a significant contribution to make to understanding in this area.

Who will be conducting the research?

A PhD student registered at the University of York and supervised by Una McCluskey I am a counsellor and have worked in student counselling and health services in England and Ireland for 10 years. Prior to this I worked as a probation officer and family court welfare officer. I have been training with Una McCluskey for 7 years and have been a member of 4, 9-month group-series (including one to be used in this study), as well as other training and conferences.

Although supervised by Una, my research is independent and not bound by the theory taught in the courses. A second supervisor, Prof Ian Shaw, is working with me to ensure that impartiality and objectivity are achieved in the research.

Who is being asked to participate and what will it involve?

I have specifically chosen people whom I think may give a representative range of different experiences. I hope to speak to at least 9 people selected from two series of groups, including the group you attended in [year identified] (and another from [year identified]).

Initially, my research will focus on an examination of group transcripts. I would then like to meet with participants at a time and place to suit them (this may be at their home if they are comfortable with this). Interviews will last between one and two hours and will be recorded on a digital voice-recorder. I will then transcribe the interviews and invite participants to check the accuracy of transcripts.

Participation must be wholly voluntary and everyone will be free to withdraw their consent at any time, before and after interviews, without giving any reason.

Interviews

In the interviews I will ask participants about their experiences in the groups, personal history and comparisons between group experience and experiences of careseeking (including any experiences of therapy).

Some participants may find they will talk about distressing events in these interviews and care will be taken to help people cope with whatever comes up for them.

However, it is my hope that people will view the interviews as an opportunity to review and explore their experiences in some depth with an experienced, non-judgmental and empathetic listener. I believe that the research will make a valuable and meaningful contribution to the practice of psychotherapy.

I currently live in Canada and plan to interview participants in September or October this year and to complete the transcripts by the end of December. If this time-frame does not suit participants I can be flexible in my arrangements. My plan is to complete the research by the end of 2013. On completion, I will send participants a summary report of the research findings.

Confidentiality

Close attention will be taken to protect participants' confidentiality. I currently have no personal details relating to most of the potential participants. Contact details for those participants will only be passed to me when consent has been given. Contact details will then be kept separately from other data at all times. All transcripts will be anonymised during the research process (using a coding system known only to me) and care will be taken to disguise the identity of participants in all reports of the research (though the personal nature of some discussion means it is possible that some family members would recognise events described if they read the research).

Because it is important that participants are able to speak frankly about their experiences, when possible to do so, care will be taken so that individual participant's identities are withheld from [the group facilitator]. This may not always be possible and following interviews, I will seek explicit consent before disclosing anonymised contributions to her and either of my supervisors. Identities will always be totally withheld from my second supervisor.

The data, including group and interview transcripts, will be anonymised and held in encrypted, password-protected computer files. All the material collected by the lead researcher will be destroyed within 5 years of the end of the research project unless specific new consent is sought and given for it to be retained for future research.

As well as being reported in my PhD thesis (where it will be publicly available at York University library) the research may be used in professional journals and other publications concerned with attachment, psychotherapy and related subjects.

Researcher Contact Details:

If you would like any other information or would like to talk to me about this research please do not hesitate to contact me by email, letter or telephone:

Email: [university email address given] (I will phone anyone on request).

Telephone: (001) XXX XXX 9086

Address: X XXX Crescent, Markham, Ontario, LXX XX6, Canada.

Complaints Procedure:

The research will comply with the Economic and Social Research Council's (UK) *Framework for Ethical Research*. If participants have any complaints they are invited to contact (Contact details given).

Appendix 6

Interview Topic Guide:

Introduction:

Thanks for agreeing to meet me and take part in my project. The important outcome of this meeting is that I get a better understanding of your experience as clearly as possible without distorting it with my own experience – so if you think I have misunderstood or changed something that you have told me, please tell me so. And if there is anything you want to say in addition please feel free to do so. Protect yourself – say only what you are comfortable saying.

Topic 1

How did you come to attend the group in 2010?

What did you expect from the group?

How would you describe the aims of the groups?

Were they **training/therapy** or what **other words** describes what they were?

Topic 2

I would like you to talk about the process of the group:

In what ways did group members contribute to or ask questions in the sessions?

Were you able to speak freely in the groups? If not, what prevented you? Can you think of a specific instance that illustrates this?

How easy was it for you to **think clearly** in the groups? Were there times when you could not? If this was an issue, what sense do you make of this? **Did** it change (for better or worse)? **What** caused it to change?

Did anything you learned in the groups help you understand your inner experience in the groups?

Did you disagree with anything being said in the groups – what did you do about that?

What was the **facilitator's role**? Did this change: from one session to the next?
From one group member to another?

Did the facilitator do anything to help you get what you wanted? Did it work – why?

Did you want her to do anything different?

Were the groups a place where people would **ask for help** or give help to anyone else? **Did you?** Did this change? How does this fit with your experience outside the group – in your family (original/present) – on other training courses - at work?

Did you see other group members doing things differently – did this prompt any feeling or thought? (Can you remember an incident?) How do you understand the difference?

Did you see the facilitator doing anything different with other people?

What was the facilitator's role in relation to feelings?

Were you ever annoyed/angry in the group? Did you express this?

Did you have any regret about what you did or did not do in the sessions?

Topic 3

My particular interest is people's emotional experience in the groups – were the group sessions emotionally significant to you?

Were the groups a place of heightened or lowered feelings? If so or if not – what sense do you make of this?

Did you experience any particular **feeling before/during/after** each group session? Did this change in the course of 9 months? What sense do you make of this?

How did the environment of the group influence your internal voices?

What in your emotional experience of the groups echoed other experiences – of family life (original/present)/professional life/other?

Topic 4

If you have not already done so, can you please talk about the most significant event for you in the nine sessions?

What was the **most positive** experience?

What was the **most negative/difficult** experience? How did you manage this difficulty in the group session?

Was any one session more significant than another?

Topic 5 (Only if there is time).

Did you get what you wanted – in part/fully - did you get nothing - did you get something different? Did you get something negative?

Why did you get or not get what you wanted from the groups?

If you got what you wanted from the groups, what did *you* do to achieve what you wanted?

Did the facilitator help you get what you wanted?

If you didn't get what you wanted – what prevented this?

Were there times when you were not getting what you wanted – did you try to change this? Can you think of a particular instance: how did you change this?

Did you learn anything about how you behave as a person? Can you remember any event in which this became apparent to you?

CLOSING COMMENTS AND INFORMATION FOR PARTICIPANTS:

THANK YOU FOR YOUR HELP. I WILL NOW EXPLAIN ONE FURTHER FACTOR – MY PARTICULAR INTEREST IS IN FEAR – AND HOW FEAR INFLUENCES THE PROCESSES OF THERAPY. I AM SORRY THAT IT HAS NOT BEEN POSSIBLE TO BE MORE EXPLICIT ABOUT THIS BEFORE NOW BUT A LOT OF RESEARCH ON FEAR SUGGESTS THAT DATA CAN BE CORRUPTED BY DIRECT QUESTIONING – IS THERE ANYTHING THAT YOU WOULD WANT TO ADD NOW THAT YOU KNOW THIS?

Appendix 7

A brief comment about Heard and Lake's External (Supportive/Unsupportive) System

In my diagrammatic depiction of the self I have focused on four principal systems: the system for exploratory interest sharing, the fear system, the attachment system (careseeking and caregiving) and the internal environment (which can be supportive or unsupportive) including the idea of selective exclusion from awareness (Bowlby, 1980, 1987). Missing from this description is what Heard and Lake (1997; Heard et al., 2012) call the external supportive or unsupportive system (again I prefer the easier term, external environment).

Despite its omission the external (supportive or unsupportive) environment plays a key role in the maintenance and restoration of wellbeing. Heard and colleagues (2009) point out that humans attempt to build an external environment that supports their need to achieve the goals of many different behavioural systems. The environment they build might include such elements as a safe, comfortable and nurturing home space, a constellation of supportive relationships and meaningful and sustaining employment. Motivation to create a supportive environment is continuous so long as there are improvements to be made or damage to repair. The external environment created by an individual builds on past experience of times when they were happiest; which means circumstances in which the goals of systems were achieved (Heard and Lake, 1997). At times of threat the individual may be motivated to seek refuge in the external environment that they have built or in other ways use resources they have put in place. The relevance of this system to therapy is most apparent when, because of some neglect or deficiency, loss, catastrophe or other factor, the external environment is unable to support the person.

Because each external environment links to wider cultural realities, theory about this system may come closest to addressing Gergen's (2007; Gergen and Gergen, 2001)

concerns about the potential for therapy to individuate and pathologise human distress. Therapeutic work on the external environment has the potential to include political and social realities.

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