# 1 Theorising 'Process': Contemporary Perspectives

> Put the emphasis upon a single method of treatment, no matter how diverse the problems which enter the office. Patients who won't behave properly according to the method should be defined as untreatable and abandoned. Once a single method of treatment has proven consistently ineffective, it should never be given up. Those people who attempt variations must be sharply condemned as improperly trained and ignorant of the true nature of the human personality and its disorders.
>
> Jay Haley, 'The art of being a failure as a therapist' (1969)

That you have picked up this book suggests that you have at least a passing interest in therapy. You may be an experienced practitioner, feeling the obligation to put aside reading the proper books that tell you about real life (literature) to engage with yet another account of the therapeutic process. Perhaps you are an enthusiastic trainee eager to learn how to do it from people who have been judged sufficiently 'expert' to convince a publisher that they are worth the risk of a print run. Equally, it is conceivable that you are a customer of therapeutic services – patient or client according to approach – interested in finding out what informs the sometimes puzzling behaviour of the person in whom you are investing your time and, possibly, money. This book is aimed primarily at trainees on counselling and psychotherapy courses, training in any approach whether humanistic, psychodynamic or integrative. However, it is also relevant to practitioners already engaged in therapeutic activity.

Whatever stage you are at in your career as a therapist, you will have made a commitment to a given approach. You will be discovering or know to your cost that this means hours of blood, sweat, toil and, significantly, tears as you engage with a complex literature, attend lectures, face public humiliation in 'workshops' and spent time and money on your own therapy. On the way you will have had to report regularly for supervision where your supervisor has the duty to ensure that you are conducting therapy in the right way (and yours to make sure that you present what you are doing according to the requirements of your modality, disguising or failing to disclose deviations). In short, you have developed or are in the process of developing an epistemology: 'how a person or a group of persons processes information' (Auerswald, 1985). All therapists make

sense of what is going on by reference to an explicit or implicit epistemology. As Gregory Bateson (1971) puts it:

> All descriptions are based on theories of how to make descriptions. You cannot claim to have no epistemology. Those who so claim have nothing but a bad epistemology. (p.142)

What you do with the client in an attempt to be helpful – methodology – follows from your chosen or implicit epistemology; 'rules one uses in making sense of the world and how we make sense of others' (Bateson, 1971).

While there are profound philosophical and theoretical differences between counselling and psychotherapy approaches, by their nature they share a common feature. A scene is set within which two or more people meet with a view to achieving a therapeutic outcome. In essence, therapy can be viewed as a series of dramatic events arising from the *encounter* between client and therapist.

Aristotle provides what is possibly the earliest account of the therapeutic process. In the *Poetics* he defines tragedy as the enactment of an action which gives rise to the experience of 'pity' and 'fear' with the purpose of cleansing emotions. Here, of course, he is referring to Catharsis, a notion which has found its way into therapeutic discourse and, though originating with Freud, is most commonly found in the more expressive humanistic approaches. Central to the tragedic experience is the notion of 'harmatia', literally missing the mark in archery. An incident in the plot leads the protagonist on to a path of tragic error and, thus, a noble man is caused to fall by a mistake in his actions. In therapy, the client is both the author and protagonist of his or her own tragedy. The solutions found in the face of the challenges of early experience have led to a life walked in 'tragic error'. That a mistake has been made is hardly surprising since the drama being lived out was written by a six-year-old or even an infant at the age of three.

As therapists, our appreciation of the client's courage in the face of adversity is not enough in itself. We are required to join the protagonist on stage and take an active part in the drama. In this we take the role of 'Deus ex Machina' – literally a 'god out of the machine'. This refers to a plot device much disapproved of by Aristotle (*Poetics*) and, later, Horace (*Ars Poetica*). An inextricable problem in the plot line is resolved by the contrived and unexpected intervention of an outside character or event. Typically a god would be lowered from a crane in order to intervene on behalf of the protagonist. This is taken to be bad form in that it interferes with the unfortunate end that is the proper outcome of tragedy. In the therapeutic encounter it is the therapist who is craned onto the stage in order to interfere with the tragic outcome of the client's drama. But this is not a pantomime and there is no place for a fairy godmother's magic wand. The human condition is far too conflicted and complicated for such simplistic intervention: even good endings are seldom happy and rescuers are asking for trouble. The role of the therapist as deus ex machina is not to simplify the plot but to complicate it. Predicted outcomes are confounded and the way opened for a richer narrative to replace a thin and predictable plot.

To join the drama is essential but insufficient. Once the therapist is part of the performance they are in position to introduce some carefully chosen lines of their own. The system, that is, the complex interrelationships which make up the client's internal and

external world, is joined by a polite but unpredictable outsider. The client system has become a therapeutic system and, all being well, nothing will be the same again.

You might want to reflect on this in relation to a client you saw recently. If you are person-centred in orientation, you may have taken the view that the client's difficulties are a function of unhelpful self-perceptions that are restrictive when it comes to achieving their full potential. The psychodynamic reader would have been inclined to focus upon the tasks of early life and tales of repressed desires replayed in a contemporary context, drawing upon the notions of transference and repetition compulsion.

Each of these positions suggests a particular mode of intervention or method: supportive/expressive or transferential/insight. Interestingly, while there are clear differences between each of the above, they share a common 'psychological' position in that: the view is taken that family life shapes personality; the therapeutic goal is changing internal experience; and the vehicle for change is an exclusive relationship with a therapist in a controlled environment.

There is now a convincing body of research into positive outcomes, which privileges the relationship over any particular approach or modality (Wampold, 2001). Importantly, the research also tells us that this is predicated on the practitioner having a coherent framework within which the relationship is understood. As we have seen, there are a number of well-established professional accounts, which have proved their worth in responding to and dealing with human distress. They are to be respected as such. What we are proposing in this book does not require you to give up on your commitment to your approach to therapy and its associated knowledge base.

The position we take is that there are enduring themes in human relatedness arising from human growth and development, family context and social arrangements around which the narratives we live by are constructed. These have relevance across therapeutic differences. Your client brings with them a 'problem saturated story'. This tells of anger, abandonment, hurt, confusion and other forms of human distress providing the content around which the session takes place. Significantly, as the story is told, it is also enacted with the implicit invitation for you to join the drama. What you do next matters. If you take the allocated role and allow the predictable to be re-enacted, you become part of the problem. Each therapeutic model has its own version of how this might be avoided. However, focusing on phenomena which is common to all approaches – narrative and enactment – opens the way to establishing some general principles. These have the potential to enhance intervention making for creative and effective therapy. An openness to new possibilities permits us to benefit from the contribution of: social constructionism; systems theory; communications theory; and pragmatic models for working with resistance. So armed, we are better placed to respond to the predictable with the surprising – the stuff of therapy.

## Postmodernism, social constructionism and the drama of therapy

This is first and foremost a book about practice and it is unreasonable to expect the reader to engage with a complex debate which might appear to be several levels of

abstraction away from the therapeutic encounter. If you are impatient to get down to business, you may be inclined to engage with other chapters before returning to the philosophical and theoretical underpinnings of the approach. However, in this instance, Kurt Lewin's assertion that 'there is nothing as practical as a good theory' is applicable (1951). That we set out to write and that you are taking the trouble to read this book can be located in what has been called the 'postmodern or linguistic turn'. Traditionally, it might be anticipated that each of us would confine ourselves to the literature associated with our own corner of the field. For some, this might have meant grappling with the demands of the dense and extensive body of knowledge, which comes under the broad heading of 'psychoanalysis' to the exclusion of other potential lenses which might equally shed light on the human condition. Others would have their time cut out directing their efforts towards the abstruse arguments following the latest 'paradigm shift' that the systemic world had inflicted upon itself. Those of a person-centred inclination might find themselves engaged in working out to which 'tribe' they belonged. A new position with regard to the status of theory is proposed; one that is sceptical of claims to truth but has a high regard for knowledge. This opens the way for a climate where, despite a clear commitment to our own modalities, we can value the other.

Postmodern ideas are slippery and hard to grasp but cannot be ignored since they have had a profound effect upon the field of counselling and psychotherapy. At the same time, we need to keep in mind Best and Kellner's warning:

> The confusion involved in the discourse of the postmodern results from its usage in different fields and disciplines and the fact that most theorists and commentators on postmodern discourse provide definitions and concepts that are at odds with one another and usually undertheorized. (1991, p. 29)

Postmodernism as it relates to therapeutic activity is informed by a conflation or coming together of two distinct but related developments: American social contructionism on the one hand, and French post-structuralism on the other. While the former has had the most direct impact on the activity of therapy, a brief detour into the European philosophical tradition is not without value since it sheds light on some general contemporary pre-occupations in our field. The origins of poststructuralism lie in a post-1968 attempt to challenge enlightenment principles in general and, specifically, the work of Hegel and Marx. The poststructuralists, in effect, turned their back on the grand but flawed enlightenment programme of humanity, progress and freedom in favour of a number of themes, many of which find their origins within the writing of Nietzsche. These are: the rejection of a programme of cumulative and progressive historical change; the celebration of difference over conformity; the privileging of local and irrational knowledge over the universal and objective; moral relativism; and a fascination with the surfaces of things. The relevance of this position to us remains an open question in that there is much that is at odds here with the beliefs and practices which inform helping others. Traditionally, these have tended to look to a secular version of precisely the enlightenment Judaeo-Christian tradition that Nietzschean poststructuralism rejects. However, a number of ideas have significance in relation to what happens in the consulting room.

The first is to be found in a much quoted line by Jean-Francois Lyotard (1979) in his attempt to define 'the postmodern condition'. Lytotard draws on Wittgenstein's notion of 'language game', where Wittgenstein argues that, contrary to common-sense, words do not gain their meaning from their capacity to picture reality but through social interchange. In essence, a language game is a conversation we engage in to determine reality. On this basis, Lyotard declares 'an incredulity towards meta-narratives'. This brings into question the bid by any particular approach to claim supremacy over others. Each modality merely exists within the language by which it is constructed and, as such, there is no basis upon which to privilege one over another. An extension of this is that we are required to give up on the quest to find an over-arching global therapeutic theory, which will finally provide all the answers. Instead, we are required look to the enduring therapeutic narratives which have shown themselves to serve our clients well – a local endeavour. Next, we might take note of Derrida's (1974) familiar proposition: '*Il n'ya pas d'hors texte*' – there is nothing outside of text. This questions the adequacy of language in accounting for the objective world. We are left with interpretation, since language can only ever refer to other language. If this is the case, therapy might be viewed as a process where the client's taken-for-granted linguistic reality is deconstructed, opening the way for new possibilities to be brought into language. Finally, Foucault merits attention. Much of the impetus for the 'postmodern turn' in therapy is derived from what has come to be seen as oppressive 'modernist' practice. Foucault provides a convincing analysis of the implicit power imbalance in the therapist–client relationship – identifying the subtle forms of domination which follow from restricted access to knowledge (1975).

For some, this brief encounter with poststructuralism may have served to frustrate rather than edify. If you are inclined to engage with these ideas at greater depth than the focus of this text allows, you would be well served by Sarup (1993).

The other strand of postmodern thought, social constructionism, has had a profound and direct impact upon therapeutic practice, most significantly in the field of systemic family therapy. These ideas belong to the other side of the world, an ocean away from European preoccupations. They reflect a North American cultural world-view characterised by optimism, openness and pragmatism. The underpinning principles of social constructionism date back to the work of G.H. Mead (1934), subsequently to be developed in the 1960s and 1970s by social theorists like Becker (1963), Goffman (1956) and, notably, Berger and Luckmann (1967). Recently, there has been a resurgence of interest by contemporary thinkers, pre-eminent amongst these is the academic psychologist Kenneth Gergen. There is now an expanding literature which addresses the implications of social construction for the field of counselling and psychotherapy.

According to Mead's theory of symbolic interactionism, the human infant is born with a rudimentary capacity to relate to and adjust to others. Initially, the infant responds to 'gestures' in the form of vocal sounds, movements and facial expressions. Subsequently, the development of language allows for the assimilation of a shared set of mental symbols which, in turn, creates the conditions whereby it is possible for the individual to take symbolically the place or role of the 'other': 'When I am with you I will see myself through your eyes. Further, I will be able to complete mentally your reactions to my actions.' Mead accounts for this process by distinguishing between the 'I' that is

unique to the subject and the 'Me', the internalised other. Minded activity, our sense of self, consists of a conversation between the 'I' and the 'Me'. In this way the development of personality can be understood in terms of moving from a 'significant other', the primary care-giver, to the incorporation of a 'generalised other' – the social world. This deceptively straightforward account has profound implications for the way in which we understand the human condition. It presents a direct challenge to our common-sense view of ourselves as boundaried, psychological entities. From a social constructionist perspective, the self does not arise through our exchanges with others. The self *is* our exchanges with others. The contemporary literature in counselling and psychotherapy is littered with references to Berger and Luckmann's classic text *The Social Construction of Reality* (1967). This takes Mead's original position forward, arguing that what we perceive as reality is based on taken-for-granted assumptions. Social arrangements arise from repeated actions, which are passed on to the next generation as social facts.

The relevance of this to our endeavour will have become apparent. From this perspective, the therapeutic relationship can be viewed as an engagement between the client and a potential 'significant other', the therapist. A problematic socially constructed self is exposed to an unfamiliar context where taken-for-granted assumptions are challenged as new possibilities present themselves. So far, so good, but things are not as straightforward as they might at first appear. To understand why, we need to visit the work of Erving Goffman.

Given the focus of this book, Goffman warrants particular attention since his primary concern is with the place of 'performance' in social life. For Goffman (1956), the social world is a stage on which identity is constructed and maintained through a series of dramatic acts. Social life consists of turn-taking, where each of us is actor and audience in turn. We give an 'impression' through the presentation of signals which invite the other to confirm us in our identity or sense of self. For example, on entering the lecture hall, we, the authors, must present ourselves as credible academics. There are inevitably those occasions when we have but a flimsy grasp of some aspect of our material. This presents us with the dilemma of how to convince our audience, the students, that our role as lecturer is legitimate. A strategy is called for. We might confuse the issue by drawing on language to which only the academically initiated have access or we might fall back on easy charm to avoid challenge. Whatever we do, there is an implicit request for the students (audience) to take seriously the impression that we actually possess the attributes we appear to possess. In the absence of this our identity becomes unsustainable or is 'spoiled'. By the same token the students are presenting a complementary performance: taking notes (or doodling), feigning interest and, the brave, asking the odd plausible question. If all goes well and everything goes on as normal, we find ourselves convinced by our reciprocal performances and confirmed in our respective identities.

But things do not always go well. There are contexts where opportunities for constructing a satisfactory identity are severely constrained, and some individuals are disadvantaged when it comes to inviting a satisfactory confirmation of self. We might consider the relevance of this for the therapeutic encounter. In *Asylums* (1961), Goffman uses the term 'total institution' to denote an organisation where sleep, play and work happen in the same place: prisons, psychiatric hospitals, care homes and so on. When faced with the absence of a range of contexts and thus opportunities for establishing a

desirable identity, the prisoner/patient/resident must decide whether to enter with enthusiasm into the arrangements by which the organisation functions or to find another way of dealing with an unsatisfactory situation. This is a matter of resourcefulness and subversion, where practices are employed precisely because they are forbidden. The intention is to reserve something of oneself from the clutches of the institution. An accompanying volume, *Stigma* (Goffman, 1963), addresses the dilemma of the individual who is disqualified from full social acceptance by virtue of a discrediting attribute or negative label. This may arise from: a physical disability; a blemish of character; or a tribal stigma associated with race, culture or religion.

There is a world of difference between a total institution and the consulting room but there is, nonetheless, a totalitarian quality to the therapeutic hour. It is intentionally a closed world where only two roles or identities are available: therapist and client. One is desirable, whereas the other has an element of stigma attached to it. We would be fooling ourselves if we did not acknowledge that there is a good feeling attached to the therapeutic role and that there are times when we find ourselves seduced into an idealised persona of the one who bestows wisdom upon the client as luckless supplicant. Therapeutic models set out to provide antidotes to this: remaining congruent; taking a not-knowing position; declining the positive transference; and, most significantly, doing time in the other chair. All that said, there is no getting away from the social construction that being a therapist is a desirable identity (even if we have to put on a disguise at parties to avoid fellow revellers involving us in their problems). The 'client' or, worse still, 'patient' is left with a stigmatised identity and no chance of escaping it for at least 50 minutes. This puts a different complexion on notions like 'identification' and 'resistance'. From this perspective these cease to be properties of the client becoming a function of the therapeutic relationship and the context in which it is located. In your training, you may have become familiar with the phenomena whereby the client starts to take on something of your presentation to the extent of dressing like you, adopting your language and even wanting to train in order to become you. By the same token you will also recognise clients who give every appearance of getting on with things only to sabotage the possibility of any real progress. Despite your best intentions you find yourself looking forward to seeing the former, while the latter are given stigmatising labels like 'passive aggressive'. If these dynamics are allowed to go on undisturbed, nothing therapeutic will happen. Poignantly, both client and therapist are caught in a bind. If the therapist resorts to self-disqualification, the therapeutic relationship will begin to feel unsafe and uncontained. For the client, it will have been bad enough to have come for help without finding that the very context in which it is delivered confirms them in an unsatisfactory sense of self. This is the stage upon which the drama of the therapeutic encounter is set.

As we suggested earlier, the client comes to therapy with a story of human distress. This has been written in conjunction with others and may have been a lifetime in the making. For one reason or another, the story has become unsustainable. The client may have grown tired of the lack of possibilities contained in an impoverished narrative and is in desperate need of new themes and characters. They may have encountered writer's block and are facing the existential terror of the blank page – a nervous breakdown. Relationally, the dramatic performance of the story is failing to convince the audience.

This is where we come in. Our training has entitled us to claim special knowledge about stories. In essence, we have a story about stories in the form of a professional narrative and this can be brought to bear on the situation. We need to be careful about how we do this. There are dangers in the imposition of an established therapeutic account on a client's failing narrative. These need to be addressed regardless of modality. Social constructionist principles would suggest that the therapeutic encounter needs to be understood as a context in which new meanings and their associated narratives can be *co-constructed* by client and therapist.

Writing from a psychoanalytic perspective, Spence and Wallerstein (1982) make the distinction between the search for a 'historical' and 'narrative truth'. The former would have it that there is a factual basis for the client's 'neurosis', whereas a narrative position places meaning at a given place and time. Narratives may be characterised as thin, unchangeable descriptions full of problems imposed upon us by others, or they may be thick with multiple possibilities and full of rich descriptions. To quote John McLeod: 'Therapy is in the business of enabling a client to achieve narrative truth, to create stories they can live by and live with' (1997, p. 86).

As we shall see when we come to script theory, a narrative approach to therapy would have us reviewing earlier attempts at story construction in favour of a richer account that is a better fit with consensual reality and our potential within it.

However, the full implications of social constructionism take us beyond the position that we give meaning to our lives through narrative to one where we *are* the stories we make up about ourselves in conversation with others. As Gergen (1999) has persuasively argued, narrative is not a personal possession. Traditional therapeutic accounts would have it that the client's problem-saturated story is the expression of an internal model of the world, and this is then brought to bear on their dealings with others. By contrast, a social constructionist view suggests that the self is a product of relatedness and is to be found in the space between the individual and others. As we have seen, the story is not limited to spoken language, taking dramatic form as a social performance. This will include non-verbal communication, dress and assorted props. Further, the therapist is no longer an objective observer of the client's process but a co-participant in a shared event.

## Family systems theory and the therapeutic dance

Family systems theory provides the theoretical underpinning for work with families and couples. It would be understandable if practitioners who deal solely with individuals were to question its relevance. However, in taking the view that therapeutic encounter is a shared dramatic event, there are a number of ideas and principles within systems theory which have utility. The origins of the principles which underpin the therapeutic application of systems thinking are to be found within developments in mathematics and physics during the late 1940s and 1950s and the attempt to model mechanically aspects of human thinking (Guttman, 1991). At the same time the project for general systems theory was to arrive at functional and structural rules, which could describe all systems. In

this process Norbert Wiener (1954) recognised the importance of self-regulation as an aspect of systemic functioning, focusing on the way that information on past performance is fed back into the system, influencing future behaviour. He coined the term 'cybernetics' for the study of this self-correcting feedback process.

Gregory Bateson, working as an anthropologist in the 1950s, is to be credited with recognising the significance of these ideas for the realm of human activity, noting the way in which self-correcting patterns of behaviour are manifest in cultural activities and ceremony. He went on to develop these ideas within the Palo Alto group, which was funded to study communication with particular attention to families with a schizophrenic member. In applying principles from cybernetics to human communication and organisation, this group had enormous influence on the development of family therapy as not just a new mode of treatment but a radically distinct way of thinking and intervening. Bateson, himself, although regarded by many as the founding figure in the development of family systems theory and family therapy, was not primarily interested in therapeutic intervention and subsequently moved on to study communication in porpoises.

The central principle that underpins systems theory is a shift from the taken-for-granted linear view of the world as a matter of cause and effect, in favour of circularity where each cause is at the same time an effect. Cybernetics concerns itself with the way that the output of a system is reintroduced into itself via a feedback loop. Negative feedback will result in stability or homeostasis as deviations are corrected, while positive feedback will lead to disruption and change. The classic example of a negative feedback loop is to be found in the operation of a central heating system where the thermostat 'feeds back' information about heat, turning the boiler on and off to maintain a constant temperature. This may come across as dry and mechanistic but it has significant implications when it comes to the therapeutic encounter. As we shall see, theories of process and resistance can be understood as attempts to counter the homeostatic tendency of the therapist–client system. Salvador Minuchin (1976) has coined the term 'family dance' to provide a metaphor for the intricate way in which family members maintain their positions in relation to one another and deviating family members are brought into line. There is an important caveat here. As Nichols (1987) reminds us, to suggest a family is like a system is a world away from seeing it as a system. The convenience of a metaphor should not be confused with the richness of family life.

Family life is characterised by a series of crises which arise when the developmental needs of members are no longer met by current arrangements. Symptomatic behaviour is understood in the context of crisis avoidance on the part of the family where the tendency towards homeostasis is at the expense of its members' individual needs. This will be particularly evident at the point where a young person is leaving home (Haley, 1980), which can be a time of multiple crises with all generations of family members facing challenging transitions. At the same time that the young person faces the challenges of independence, the parent generation have to re-establish a relationship as a pair and pick up new responsibilities for the grandparental generation who, themselves, may be facing failing health, dependency and death. The situation will be exacerbated if tension in the spouse partnership has been mediated through parenting or where there has been a separation and the young person has assumed a pseudo-spouse role. If transgenerational

themes of loss and separation also feature, an intolerable family crisis may be avoided at the expense of the young person concerned through failure or emotional breakdown. In systems terminology, deviation-amplifying events activate feedback mechanisms, which have the potential to affect family life and organisation in one of two ways: either the basic rules and equilibrium of the system are maintained in homeostasis; or there is a dramatic overall change in the rules of the system and a fundamental re-arrangement in the interrelationships between the elements of the system. In this case, the threat to the family status quo presented by the young person's departure can either introduce positive feedback to the family system, taking it forward into a new set of rules and a re-arrangement of relationships, or it can present negative feedback that keeps the family frozen and unable to move on. It follows that systemic intervention is directed towards introducing new information into the system with a view to promoting deviance-amplification in such a way that it cannot be ignored or disqualified.

In the therapeutic encounter, the 'family dance' becomes the 'therapeutic dance'. The client comes to therapy with an open invitation for the therapist to join the dance. This should be graciously accepted. It would be counter-productive to do otherwise, since the dance has been developed over a lifetime and carries with it a heavy investment. There needs to be a note of caution here. What can look like effective therapy can be no more than helping the client to perform old moves with more fluidity and skill. In systems terminology this might be viewed as the therapist being inducted into the system, giving rise to first order change – 'change within the system'. Effective intervention requires that the therapist introduces positive feedback with a view to inducing the crisis that has the potential for 'change of the system'. This may require some nifty and unpredictable moves, not to mention the risk of falling over.

Kenneth Gergen (2008) recounts a story told by the Puerto Rican therapist Egardo Morales about his early days as a therapist:

> He was given a highly difficult case to treat, a young woman with a history of drugs and antisocial behaviour. When she was brought to his office, she sat sullenly before him, her stony face set off with dagger eyes. Egardo began with a congenial greeting and gently outlined how talking together might be helpful to her. She stared silently. After more false starts, Egardo recalled that she had owned a white cat. Abandoning the therapeutic chatter, he asked about the cat. Although the stare was never broken, Egardo did notice a slight movement of her mouth, as if she were ready to speak. Egardo then sat himself behind the desk and began to tell the girl that at night when he was working at his desk, his cat became jealous. He wanted attention. Then, role-playing the cat, Egardo, with a loud '*Meow*', leaped with all fours on to the desk top. The patient suddenly screamed out, 'You are crazy!' Egardo responded, 'Yes, but I get paid for it.' The girl burst into laughter and with that, an engaging and productive conversation began. (p. 347)

This provides a vivid example of the way in which a therapeutic encounter was creatively transformed from being more of the same to something different. It starts with each participant prepared to engage from the position of the assigned role. The 'passive-aggressive' client, exhibiting all the telltale signs of resistance, is met by the well-meaning and patient therapist. The stage was set for another miserable predictable experience

where the client would go away confirmed in her beliefs that 'they' would always let you down, leaving the therapist defeated and disillusioned in the face of yet another client who refuses to be helped.

It follows that at the centre of the therapeutic encounter is the enactment of a story. It is a story so foundational that it provides the blueprint by which the client engages with life. As stated earlier, the position we take is that there are enduring themes of human experience which can be extrapolated from the vast field of human growth and development. These themes constellate around a series of dilemmas, or challenges, which confront the human infant on his journey into adulthood. As the client enters the room and begins a relationship with you, the therapist, he not only begins to tell you about this journey (the problem-saturated story) but he also begins to enact it. This is a story whose origins were written under desperate circumstances. Immature cognitive functioning, helplessness with regard to physiological needs and a fundamental lack of autonomy provide the backdrop against which the infant sets about discovering himself, the other and, in turn, the world. The human infant is, essentially, at the mercy of those in whose care he finds himself and it is from this asymmetrical position that he discovers the world.

The vast body of knowledge that informs our understanding of human growth and development draws largely from the fields of psychoanalysis and developmental psychology. Writers such as Bion, Bowlby, Erikson, Freud, Kohut, Klein, Mahler, Lacan, Rogers, Stern and Winnicott have all offered valuable and insightful accounts of the infant's developmental trajectory. Despite their considerable and important differences, what emerges from this collective body of knowledge is a set of themes which privilege the influence of earliest relationships in the development of the adult personality. The development of a human infant is inextricably linked to his social, emotional and relational world.

Recent years have seen convincing research findings, some from the realm of neuroscience, which have mirrored much of what social scientists have suspected for some time. The 'social construction of the mind' is a familiar notion and one which has been extensively theorised. Contemporary debates around development, however, are having to engage with transdisciplinary discussions regarding what amounts to nothing less than the 'social construction of the brain'. The human infant, born prematurely with regard to neurological development, depends on stimulus from another brain in order to thrive. This has seen a return to the insights of attachment theory, and subsequently the primacy of early relationships in personality development have acquired a broader dimension. The human and natural sciences are now colliding. As if more evidence was needed, these new developments cement the notion that experiences in infancy and childhood are the cornerstone of the adult personality.

These themes privilege the first relationship between baby and primary care-giver as the vehicle for the discovery of, and differentiation between, Self and Other. Furthermore, this primary relationship provides the context from which the infant takes up his place within the social and cultural networks that surround him. The way in which that early relationship is negotiated will inform the manner in which the infant encounters the world.

When one considers the extensive knowledge base informing our contemporary understanding of human growth and development, it is clear that this material is

attempting to theorise what could be described as the fundamental questions of the human experience. Who am I? What are other people like? What is my place in the social world? These are the basic existential questions for which the human infant must construct answers. These answers are found within the context of our first intimate relationships and, in this sense, are co-constructed. Human development emerges out of the dialectic between Self and Other.

The very notion of Self, however, merits discussion and exploration. At first glance the concept may appear unproblematic. We are accustomed to referring to 'ourselves' and to other 'selves' in a manner which suggests a certainty about the differentiation between ourself and other people. We have, after all, separate boundaried physical bodies. However, the wish to 'discover' oneself, or the sense that one has 'lost' oneself are, as the therapist reader will recognise, extremely common themes in general therapeutic practice. As we know, individuals will go to great lengths (often distances) to try 'to find' themselves. These phenomenological assertions point to the conclusion that the Self is not a coherent, boundaried and unitary entity which is recognisable, but instead a fluid and changing construct. The Self can be said to be in a process of 'emerging' throughout a lifespan.

The 'postmodern turn', in its social constructionist variant, has pushed the 'Self' squarely into a relational realm. Symbolic interactionism, centred on Mead's notion of the 'I' and the 'Me', Lacan's theorising of the 'mirror phase', and Kohut's development of 'self-psychology' are all examples of how the second half of the 20th century saw differing intellectual knowledge bases converging upon one idea: the Self, in as much as it could ever be known, is located within the intersubjective sphere between Self and Other. The question 'Who am I?', therefore, can only be answered with reference to the Other. Despite their important differences, writers such as Mead, Lacan and Kohut all address the distinction between the Self as subject and the Self as object. It is through relational experiences, mediated by a subjective sense of self, that we are able to construct a view of ourselves as others see us, our 'self as object'.

Our sense of Self, therefore, has evolved throughout our life according to our relational experiences. The event of birth marks the hatching of the baby from inside the mother's body. A separate and psychological 'birth' needs also to be negotiated. Postnatally, mother and baby undergo a subtle, gradual journey of psychic differentiation and it is through this process, this unravelling between Self and Other, that the baby begins to discover himself (Winnicott, 1971). The mother must make space for the infant's new, growing personality to enter the relational space between them.

French psychoanalyst Jacques Lacan theorised the infant's earliest encounter with himself as the 'mirror phase' (1949). In the 'mirror phase', the young infant, who experiences himself as fragmented and uncoordinated, becomes captivated by his reflection in the mirror which provides him with an image of completeness and coherence, which is in contrast to his experience of a disorganised internal world. In a symbolic sense, the mother's eyes and those of significant others provide the 'mirror' through which the infant discovers himself. We find ourselves through the perceptions we imagine others have of us. These will bring with them the weight of all the ambitions, hopes, desires and fantasies our parents had for us prior to our birth (Lacan, 1949).

For child psychoanalyst Donald Winnicott, the discovery of the 'I' is to be found in the intimacies of our earliest relationship. For Winnicott, the mother's capacity to 'hold' her baby symbolises her ability to attune to the baby's needs in such a way that his 'continuity of being' is not interrupted in too traumatic a way. You may well be familiar with Winnicott's notion of the 'good enough mother' who is able to place her infant's needs at the top of her agenda. The 'good enough' mother is able to place her baby at centre stage and contain the infant's anxieties so that they are not too traumatic. Over time, however, she intuitively senses when her infant can tolerate greater levels of frustrations and disappointments (or 'impingements', as Winnicott called them). It is through these moments when the infant's needs are *not* met that he starts to emerge from this state of enmeshment and begins the process of psychic differentiation from his mother. It is these ruptures which provide the opportunity for the infant to see that he and his mother are different separate beings. The pulling away, however, between the baby and his mother is something of a dance which must happen gently, fluidly, with both partners feeling their way. For Winnicott, this dance facilitates, or otherwise, a space into which the infant can bring the 'self' into being. The Winnicottian 'good enough mother' allows her baby to create himself. If, however, she is unable to provide enough containment for her infant, this will confront the baby with his own vulnerability too early. Conversely, and just as importantly, if the mother is unable to provide the baby with increasing space and intuitively 'pull back' enough, the baby will experience a type of psychological suffocation which will leave him equally traumatised. The infant's response in the face of these traumas is to learn to place the mother and her needs at the centre of his story rather than the other way around. This infant will then be preoccupied in getting to know her, at the expense of engaging in the process of getting to know himself (see Chapter 4).

John Bowlby, as the founder of attachment theory in the early 1950s, stressed the formative nature of this relationship with specific reference to the development of the infant's emotional world. Contemporary attachment theory (through writers such as Fonagy and Schore, for example) stresses the function of our earliest attachments as one of 'affect regulation'. This means that the infant learns how to manage his emotional world through the responses he gets from others. Challenging emotions such as anger, fear, jealousy, envy and desire are experienced by the human infant in the context of being part of an 'attachment couple' (Bowlby, 1979, 1988). The responses, or feedback, he receives will shape and mould the manner in which he learns to handle these emotions. Our earliest relationship has taught us to suppress, express, moderate, manipulate or simply cut-off from our extremes of emotions. The key concepts here are that of 'affect regulation' (the mother helping the infant to moderate extremes of emotion) and 'attunement' (the mother's capacity to reflect back to the infant his emotional states). By attuning, the mother helps the infant to understand himself and to begin to regulate his own emotional states for himself (see Chapter 8).

These are some narratives which can shed light onto the answers of the first two questions we raised earlier: Who am I? What are other people like? We might equally have focused on others: Freud, Mahler, Rogers or Stern, for example. They each have their own unique narrative describing the discovery of Self through Other. Now it's time for us to explore the third question we raised earlier: What is my place in the social world?

We would invite you to stop for a moment and consider the answer to this question for yourself, right now. The thoughts that will be percolating through your mind will undoubtedly relate to your current relationships (your role as partner, parent, sibling, offspring, colleague and friend), your current professional standing perhaps, as well as other key demographic issues (your gender, your sexuality, your age, your life stage, your financial standing etc.). Your responses to this question speak to the complex series of social and cultural networks in which you exist. The current status of your professional activities, the politics of the day, the impact of class, the role of men and women in our culture, are but some of the discourses which will be influencing your reaction to our question. In the end, your answer will be a story involving love, power, identity, rivalry, jealousy, hope, desire, pride and pain. The human infant's answer is no different.

As mother and baby begin to move away from each other with the passing of time, the space between them grows and widens. Mother returns to work, perhaps has another baby, and other significant others begin to (re)enter the life of the mother and infant. In short, the baby learns the devastating news, if he's lucky, that he is not all that mother needs or desires: he is not enough. The exclusivity of this seemingly endless first love affair – this most intimate dyad – is shattered. It is from this position – that of a broken heart – that the infant enters the world. The meaning of this heartache, however, is the stuff that will contribute the fundamental plot line of the narrative. Is this a story of unrequited love or one of star-crossed lovers? Is this a bitter divorce or do the partners maintain a secret liaison?

The infant must now take up his place in the social world, informed by the answers to the previous questions regarding Self and Other. Entry into a pre-given set of social and cultural arrangements makes for a puzzling and scary journey into the world. What does it mean to be a girl? A boy? The youngest? The eldest? Who is in charge here? How can I get the best deal for myself? Who are my allies in this family? How do I succeed in getting loved? These are some of the challenges facing the immature and physically vulnerable child. These experiences will further compound, confirm or adapt our notions of who we are (our identity) and what other people are like.

Much like the study of history, the developmental literature suggests that we are bound to repeat our past. Central writers such as Freud, Berne and Bowlby theorise the notion of the compulsion to repeat as being a distinctly human characteristic. Freud suggested we repeat the stories of the past in an attempt to master and process them. Bowlby spoke of 'internal working models' as the expectations of others with which we enter intimate relationships. Recent neuro-scientific studies (for a good summary see Sue Gerhardt, 2004) suggest that we repeat because we are 'hard-wired' to do so – as those aspects of our brains which are dependent on experience are responsible for our capacity to reflect on our feelings and emotions.

In the drama of the therapeutic encounter, a story will be enacted as well as told; scripts will be handed out and roles allocated. Whether what happens next is predictable repetition or the opportunity for a rewriting of the play is the key to effective therapy.