Case illustration 2 - 'Susan': Integrating creatively?

Susan began her therapy by explaining she had had seven years of therapy previously and was returning to it after a twelve-year break. She regretted that her old "much loved" therapist was no longer practising but she felt "okay" about a new start, as her previous therapy had ended well.

Pretty, neatly dressed and quietly spoken, she also presented as an 'experienced' client, apparently both open and emotionally contactful. She readily shared her history of childhood sexual abuse, first by her father and then later by her gymnastics coach. Her father had long since died while her coach was in prison (Susan had been part of the group of women who had spoken out, resulting in a well-publicised court case that sent him there). Susan declared that all these issues had been "well worked through" in previous therapy.

Her reason for seeking therapy now – aged 45 – was her recognition that she seemed "unable" to find *and keep* a good relationship with a man. She had reached the stage where she wanted to settle down with "the One". Otherwise, she considered she had had a "good life", including a nice home and garden (her "safe, cosy nest"), lovely friends and rewarding work as a pharmacist.

The therapist, for her part, felt Susan might have disclosed this history a little too quickly and suspected the current picture Susan painted was too neat and positive. She felt Susan was 'covering over' more painful emotions but recognised they needed time to build a relationship. The therapist suspected the origin of Susan's current relational issues with men lay in her past, although Susan insisted she only wanted to work on future relationships.

As part of their initial **contracting**, the therapist agreed, for now, to go along with Susan's preferred focus. She kept her doubts to herself while indicating they could revisit this focus later. She felt secretly relieved that they would not have to legally follow up the father's sexual abuse (possibly having to formally confront and report him). At the same time, she suspected the issues would remain live for her client. Susan's mother, who was still alive, had been seemingly complicit when she refused to accept eight-year old Susan's accusations. While Susan had apparently "worked through her anger with her mother" in her previous therapy, the therapist doubted this was settled as Susan and her mother still had an ambivalent ongoing relationship.

Both Susan and the therapist agreed that the first step was to build their **alliance** and trust. The therapist encouraged Susan to acknowledge how challenging it was to adapt to a different therapist when nursing a sense of loss for her previous one. Susan soon recognised sharp differences between her old (person-centred) therapist and her new (more relational analytic) one. The therapist was careful to be respectful of the good work that had taken place previously while privately she could not help being critical. She wondered how Susan would handle her very different analytic approach, which -- while providing room for greater interpretation and self-disclosure -- was unlikely to offer 'unconditional positive regard'.

Once their alliance was in place, client and therapist faced Susan's **relationship problems** face on. At this point Susan confessed (with considerable embarrassment and self-disgust) that she had "blown it" again. The previous weekend she had gone to a pub, got drunk, picked up a "sleazy" man (one she would normally not have given the time of day to), and slept with him. Now it seemed he wouldn't leave her alone. She was torn between being 'nicely polite' and telling him brutally to stop harassing her and f*** off!

It turned out this was something of a pattern for Susan. The therapist was surprised. It was hard to imagine that the sweet-talking, home-loving Susan she had come to know would have drunken sex or tell someone to f*** off. Her instincts alerted, the therapist now wondered about the possibility of some DID (Dissociative Identity Disorder), given Susan's history of trauma and abuse. The therapist presented this idea to Susan and sought to probe the story of Susan's past sexual abuse. Susan froze and appeared angry. She rejected the idea of going back to the past, insisting she had "done all that". A mini-rupture and impasse seemed to come between them.

Taking this to **supervision**, the therapist realised she had become caught in Susan's past trauma story and possible linking diagnosis, losing a sense of Susan as a person. In the next session, she apologised to Susan and they processed their different perspectives, slowly re-building their relationship. Susan then admitted that the therapist might be right about the 'dissociation', which she described as "like having an alien" take her over at times. A door opened, allowing new explorations to proceed.

The therapist tentatively suggested they explore this 'alien' part Susan sometimes experienced. She invited Susan to sit on an **empty chair** and speak from that place. This proved an immediate epiphany. The 'alien' morphed into 'Susie' – a promiscuous, sexually provocative, extroverted 'party girl' who liked to pick up men for one-night stands. The therapist encouraged 'Susie' to express herself and talk about her relationship with Susan. 'Susie' obliged, saying she "felt sorry" for Susan, "locked away at home like some spinster", reading her "trashy romantic novels"; "afraid to say boo to a goose". 'Susie' saw herself as the strong one. She liked her own ability to have a "good time" and worried about how lonely and alone Susan was.

Susan was then invited back to her original chair to give her response. Susan was a bit shaken. At first, she found it hard to speak but they went slowly. She eventually admitted she found 'Susie' and her behaviour horrific. 'Susie' scared her, she said, as these men often turned violent or behaved in difficult ways. She declared she "hated" 'Susie' and wanted nothing to do with her as she was ruining her life.

This began a stage of therapy where the outspoken 'Susie' joined the sessions regularly. It was clear that 'Susie' was not going to be silenced. The divide between Susan and 'Susie' was clarified. It showed up most markedly in the clothes that Susan imagined 'Susie' wearing: short skirts; tight, gaudy, revealing tops; thigh-high boots – all in stark contrast to Susan's more conservative, professional clothes. They diverged also in their responses to internet dating. Susan would go online looking for 'romance and commitment'; 'Susie' wanted 'hot sex'. While many relationships were begun, no man lasted long.

The therapist frequently felt that she was doing **couples' work**, helping Susan-'Susie' communicate and connect with each other, and also explore their different needs. Therapist and client were able to identify Susan's yearning for safety and absence of relationship demands versus 'Susie's' craving for love and attention, which she could meet in the only way she knew: by pleasing men. Susan began to see how she disowned, and dissociated from, the 'Susie' part of her, which she eventually recognised as a direct product of her early sexualisation. Later Susan learned an important lesson: that 'Susie' was also a source of strength for her. Indeed, 'Susie' could at times be helpfully assertive – she just needed some 'controlling'.

The therapist invited Susan to begin to make choices about who she wanted to be in the future. Could she and 'Susie' come to a compromise arrangement and help each other? A new persona – 'Sue' – spontaneously appeared during one session when the therapist sensed Susan was somehow

presenting differently; she was coming across with a different voice and manner. The therapist pointed out this subtly shifting new way of being, one that didn't seem to represent either Susan or 'Susie'. Susan promptly responded: "This is a new me. I'm calling myself Sue". In transactional analytic terms, the therapist suggested that 'Sue' was a more 'Adult', less adapted version of Susan – one who would eventually be a positive, integrating force for all the different parts of herself.

Over **two more years** of therapy, Susan/Susie/Sue lurched between her 'selves' and a series of disastrous relationships. These left Susan feeling victimised and were a source of concern to the therapist (who, in her maternal counter-transference, felt protective and frustrated at the way Susan kept sabotaging herself). Both therapist and Susan found the therapy tough: the therapist for what she had to 'hold'; Susan for facing her trauma and shame.

Susan eventually learned that her needy, shamed and shaming parts of herself would never disappear totally but could be managed better once she was aware of her needs. She became more mindful of her choices, learning to keep herself safe by putting a boundary between herself and those who were toxic to her while opening to more nourishing contacts. She also came to rely on 'Sue' and her ability to take responsibility for containing 'Susie's' more risky excesses while ensuring Susan was cared for. Eventually, it was 'Sue' who finally met a man with whom she could/would have a healthy long-term relationship.

Eighteen months **after their therapy ended** (and ended well with mutual sadness)**,** the therapist received a wedding invitation from Susan. The therapist would have truly loved to have gone to the wedding, but after consulting with her supervisor she compromised (reluctantly) by simply sending a card with a heartfelt message.

Concluding Reflections

The striking relational-ethical issues arising for me concern: diagnosis and formulation of 'multiple selves', respect for other professionals, the use of techniques, power and boundaries. You might find it interesting to compare your own thinking with mine…

1) I have immediate issues regarding the use of **diagnosis and formulation of 'multiple selves'.** While the therapist *may* have been right about the DID diagnosis, she was so beguiled by the possibility of it that she lost of sense of how Susan might react to it. I wonder if receiving this diagnosis felt objectifying to Susan or threatened her sense of self as having successfully worked through her trauma. Might she have felt let down by the therapist probing her past when she had explicitly asked for a focus on the present? I think the therapist needed to contain her clinical excitement, hold her diagnostic understandings more lightly and tentatively, and work more slowly.

   However, I appreciate the way the therapist apologised. Given such apologies were probably lacking in Susan's history of abuse, it might have offered a significant relational repair. That there had been a mini-rupture in the therapeutic alliance probably wasn't a disaster in itself. Seeing the therapist make and own mistakes might even have helped model something useful and promote authentic, mutual dialogue.

   I also have some ethical questions regarding the extent to which the therapist may have imposed on Susan her *interpretive formulation* of 'multiple selves'. The relational-ethical

position is to see our interpretations as provisional hypotheses that can be challenged but which may offer some new understanding. They are not 'fact'; we might be 'wrong'. Was 'Susie' around before or was she created in the session through therapist suggestion? Did the therapist herself subtly invent 'Sue' with Susan duly picking up her cue? In all probability, Susan and her therapist had plenty of opportunity to discuss the nature and function of the 'selves', and how real they felt. In ethical-relational terms, it would have been important for the therapist to clarify that this formulation of 'selves' was a metaphorical device: something they were using (playing with?) as part of a creative exploration.

There is debate in the field about whether engaging with 'alternate selves' is therapeutic or not. The ISSTD (International Society for the Study of Trauma and Dissociation) guidelines advise engaging with all parts of a person's personality in a non-judgmental, affirming way. In this way, the therapists act as a 'relational bridge' which helps the client relate to dissociated parts of themselves and disowned memories. However, its recommended that the therapist still holds in mind this is one client and not collude with the dissociation by encouraging unnecessary elaborations or strengthening the autonomy of 'alters'. (Spring, 2010). With the therapist feeling like she was engaging 'couples work', I wonder if she was in danger of colluding with the dissociation and splitting.

That said, the metaphorical use of 'selves' to represent parts of self in therapy can be a useful way of 'containing' problematic aspects of clients (which may or may not be owned). In this case 'Susie' had a contained space to express herself while the disparate selves (Susan/Susie/Sue) were held by the therapist until the client was ready to take them on herself.

This way of working figures regularly in my own practice. It makes sense to me and helps me attune to the parts-of-self in others. I like the way it calls forth an integrating energy that gives voice to a person's ambivalent, dissociated, and fragmented self-experience while also highlighting the value of having an accepting, compassionate relationship with oneself (Finlay, 2017). That one part may be vulnerable and in pain also allows the possibility of having some containing distance from it, something particularly useful when working with rage, disgust or shame. At the same time, I'm aware of the need to avoid over-using (imposing) this device and to attend more to the client's experiential reality.

I like Patricia DeYoung's (2015) formulation, which highlights the role of respect and compassion when working with chronic shame and multiple parts of self:

> Bringing shame to light often illuminates a needy part of self who is despised by a tough, independent part of self. Listening respectfully to both parts and helping each to find compassion for what drives the other brings better balance and harmony to the whole self system…Parts of self can find space to speak the unspeakable about need, longing, and humiliation, and in their speaking and being heard, integration happens. Often a time of working with "parts" comes and goes in therapy, and later clients look back with fond nostalgia on parts they once encountered as "other" but that are not just everyday aspects of the self they know (pp.132-133).

2) This case study draws attention to the kind of work we sometimes have to do when following in the steps of another therapist. There can be a tricky line to tread here: that of

showing **respect for other professionals** even when we are critical of what we hear of their actions or approach. Of course, we rarely have access to the full story. In this particular case, it's possible the two therapists might have had a professional disagreement over theoretical approaches. But it would be important not to undermine previous work by being competitive or encouraging splitting processes between therapy experiences, perhaps by positioning a previous therapist as 'bad' and oneself as 'good'. This also applies to our attitudes to clients' parents or significant others. It's too easy to become confluent with clients' negativity whereas a healthier position might be to re-engage with past significant relationships in more realistic, even compassionate ways which acknowledge the positive along with the negative. The relational ethic here is one of respect for self and others.

I am saddened by our competitive professional 'turf wars', which can lead to us disrespecting other practitioners or positioning them as somehow less effective. The differences between theoretical approaches should not blind us to the similarities. Aren't we all agreed on the need for an initial therapy aim to develop the therapeutic alliance? Don't we all try to be sensitive and empathetic? We might surmise that the therapist here – like her predecessor, was non-judgmental about Susie's excesses, which allowed Susan/Sue to better accept that side of herself. I'm interested in the way the current zeitgeist favouring 'relational' work brings our approaches together (Finlay, 2016). For instance, it's likely that a relational psychoanalytic therapist has more in common with another relational therapist coming from a different modality than with a traditional psychoanalyst.

3) The **use of techniques** like chair-work raises interesting issues that apply more widely to other techniques (such as role-play, bodywork, standardised assessments, etc). Research shows that clients may experience embarrassment and awkwardness in such interventions and that even though they find it meaningful it can be deeply demanding. The relational ethical position is to respect the client's choice if they find it *too* artificial or intense and to allow time for clients to process their work, for instance, realising how they are active agents in their internal critical dialogue. *Thoughtful care* needs to be given to how the technique is going to be received and special attention to the therapy alliance is needed before clients are invited to engage (Stiegler et al 2018). In other words, it's not the technique under debate, it's *how* it's used which determines its ethical-ness.

4) The issue of **power** is implicated when considering who controls the agenda and choice of interventions. Ideally therapy should be mutually negotiated. We don't generally impose our ideas of what would be best without the client's consent (except in extreme situations); likewise, we're not there to offer knee-jerk succour by complying with clients' every expressed need and demand. In this case, Susan initially didn't want to work with her past whereas the therapist had other ideas. They needed to find a compromise position, and this involved working -- slowly, respectfully and creatively -- with Susan's 'resistance' (and scare?) to reopening the door on her past. I like Richard Hycner's dialogic take here:

> The challenge to the therapist is to meet the client at that point of contact in a manner that encompasses that resistance, rather than threatens it. It is to genuinely see the resistance as a point of contact *between* rather than as merely an oppositional force. (1991/1993, pp.151-152)

5) Finally, the therapist was right, I believe, to hold the **boundary** and not go to the wedding or send a present, however tempted. What would you have done and why? While you might have sent a present as well as a card, would you too have kept a safe professional distance from the wedding celebrations?

Spring C (2010) A brief guide to working with dissociative identity disorder. Available at: www.carolynspring.co.uk/a-brief-guide-to-working-with-dissociative-identity-disorder (accessed April 2018).