The use of self in adolescent sexual offending therapy:

An autoethnographic case study.

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ABSTRACT

This thesis is a single case study of my work as therapist with four different participants from a community-based treatment programme for adolescents who have sexually offended. Using an autoethnographic approach, the study seeks to contribute to understanding of how the therapeutic use of self can work to enhance the effectiveness of the treatment process. Central to this argument is the principle of optimal responsiveness, developed by Howard Bacal (1985). Optimal responsiveness is founded in specificity theory, which argues that we cannot predict in advance what intervention is going to be effective, because of the uniqueness of each therapeutic encounter: hence the importance of the individual practitioner's clinical judgment. I locate the theoretical understanding of the therapeutic use of self in the tradition of judgment-based practice (Polkinghorne, 2004). The research explores two questions: How might the therapist use their experience of self (their subjective and intersubjective experience) to guide their sense of being optimally responsive? How might research into the therapist's experience of their use of self in therapy contribute to the integration of the personal and professional self of the therapist?

The findings are expressed in the form of four autobiographic stories and four therapy stories. The autobiographic stories show how the personal life experience of the therapist is integrated with the process of clinical judgment. The findings are analysed from the perspectives of systemic-narrative therapy and relational psychoanalytic therapy. I identify a number of examples of how the use of self mediated a variety of

intentional therapeutic interactions such as reflexive questions, interpretations and self-disclosures *and* spontaneous interactions such as playful improvisations and the experience of intimacy. I argue that self reflexivity is at the heart of these processes.

The thesis shows the relevance of autoethnographic case study research to the practice of therapy in general and it shows how case study research can complement experimental research. This research also has a number of important implications for professionals working as therapists in the sexual offending fields. I argue that the risk-need-responsivity rehabilitation model will be strengthened by giving closer attention to the neglected principle of professional discretion; and that the effective implementation of evidence-based procedures is dependent upon the practical wisdom of practitioners. The research alerts therapists to the importance of paying attention to integrating their professional and personal selves as part of their ongoing professional development. The research highlights the relevance of the subjective experience of cultural discourse, in particular the social construction of masculinities, an area that often goes under-represented in the delivery of adolescent sexual offending programmes. The findings also support the argument that the experience of *caring for* and *being cared for* is central to treatment, and that self reflexivity can be both a process and an outcome goal for all therapy participants, both client and therapist. Finally, my research also demonstrates how the practice of honest introspection by the therapist can mitigate against the temptation (which is always there) to get caught up in viewing the person who committed an offence as the "other".

For my Dad

(1921-2004)

Thank you for not hitting me when I was small,
Thank you for playing football
And taking me to Old Trafford
To see “the reds” go marching in.
Thank you for being so gentle
And speaking out against war;
Thank you for your sadness,
And showing me how to bear sadness
Because life cannot always go your way;
Thank you for your laughter and joy
When we won the World Cup in 1966;
Thank you for all the Christmas toys
And helping me grow as a boy;
Thank you for being there.
Thank you for being there
When I needed you;
Thank you for your kindness and grace,
Thank you for your love of music and dance.
Thank you for controlling your anger
And never letting a harsh word be said.
Dear Dad
Thank you for your love.

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CONTENTS

PART ONE

1.

INTRODUCTION

"As a relationship, therapy is as much about who we are as therapists – and who we are in that relationship – as it is about who the members of this family or any client system are, and who they are in relationship to the therapist. It is as much about our self-narratives, the way we define ourselves as persons and our identities as therapists as it is about the client's self definitions and identities." (Anderson, 1997, p. 15)

1.1 The use of self and sexual offending treatment

The therapeutic use of self has been a construct used in the general counselling and psychotherapy literature for many years now, to refer to how therapists are inevitably personally involved in the therapy process and how therapists can consciously and intentionally develop their ability to integrate their personal self with their professional training and techniques to enhance the effectiveness of their interventions (Baldwin, 2000; Dewane, 2006; Reupert, 2007; Wolsket, 1999). Psychoanalysis introduced the concept of countertransference to refer to how the therapist can become emotionally involved in the treatment process. Although countertransference was initially framed as a negative process, it later became a central focus of the change process in relational psychoanalysis (Aron, 1996). Rogers (1957) also focused on the therapeutic relationship as being the main vehicle for change and introduced concepts such as genuiness and congruence to refer

to how *clients* experience therapists. These ideas were also developed by existential psychotherapy (Yalom, 2001) and gestalt psychotherapy (Polster & Polster, 1973). In 1977 Bordin suggested that a good therapeutic alliance is the basis for change in all forms of therapy. He formalised the construct of the therapeutic alliance based on three interdependent components: the quality of the *bond* between the therapist and the client; agreement on the *goals* of therapy; and agreement on the *tasks* of therapy (Safran & Muran, 2000, p. 11). Since that time numerous research studies have demonstrated the significant correlation between the alliance and therapy outcomes (Lambert & Barley, 2002).

Prior to the 1990s treatment programmes for adult sexual offending tended to only focus on treatment procedures and techniques to the neglect of therapy process factors such as the influence of the therapist, the participant's responsiveness to their perceptions of the therapist and the therapeutic alliance (Marshall et al., 2003; Serran, et al.,2003; Marshall & Serran, 2004). However, over the last decade, research into these therapy processes in adult sexual offending therapy has concluded that there is more to sexual offending therapy than discovering "techniques" which work (Marshall et al., 2005; Ward & Marshall, 2004). This research has demonstrated that the quality of the response of the therapist to the participant, such as genuineness, personal warmth, empathy, emotional responsiveness and self-disclosure, the participant's perceptions of the therapist and the strength of the therapeutic alliance are statistically significant when it comes to understanding treatment effectiveness (Drapeau, 2005; Marshall, 2005; Marshall et al., 2003; Marshall & Serran, 2004; Marshall et al., 2005). This research suggests that the personal self of the therapist will always be present and influential during the process of therapy. It therefore

follows that the skilful use of self in therapy will necessarily (some might say significantly) improve the effectiveness of the treatment process and help to facilitate therapeutic change. In this thesis I take the use of self for therapeutic purposes to include both the factors as outlined above and the use of self-reflexivity to guide intentional interventions.

Marshall and colleagues (Marshall et al., 2003, p. 226), have suggested that future research into sexual offending therapy should focus on the relationship between client change and specific therapist characteristics or what I would prefer to call, the therapist's use of self. If the use of self in adult sexual offending is something that is worthy of research, then of course the same argument applies to adolescent sexual offending treatment. Although working with adolescents presents different challenges, including the necessity to work with family members and other carers, it is just as important to be able to establish a trusting therapeutic relationship in adolescent work as it is with adult work. However, the use of self in adolescent sexual offending therapy (regardless of allegiance to any particular therapeutic tradition), has been largely neglected. This thesis intends to address this gap by studying the use of self in *individual* therapy with adolescents who have sexually offended. Following Ganzer (2007), I use the term use of self, in a relational way, to refer to both how the participant in therapy is able to "use" the self of the therapist for therapeutic purposes, and how the therapist "uses" their self as a therapeutic tool in the service of the participant. In particular, I was interested in studying how the therapist's awareness of their subjective and intersubjective experience contributed to facilitating the therapist's ability to be *optimally responsive* within individual therapy sessions. Optimal responsiveness is a concept which is based on *specificity theory*

(Bacal & Herzog, 2003) and maintains that everything a therapist does and says (or does not do and say) within a session can be experienced by a participant as being therapeutic. Specificity theory argues that each therapeutic encounter will be unique, therefore the ability to be therapeutic is grounded in the therapist's ability to be optimally responsive with each new therapeutic encounter (Bacal, 1998c; Bacal & Herzog, 2003).

Relational theories of therapeutic change can perhaps best be summarised by the emphasis they place on the inevitable participation of the personal self or subjectivity of the therapist in the change process, and the emphasis they place on non-verbal procedural processes as well as verbal narrative-interpretative processes, in laying the groundwork for change (Aron, 1996; Wachtel, 2008; Wallin, 2007). The participation of the personal self of the therapist in the therapy process is a combination of both an aware, intentional use of self, such as in some forms of self-disclosure; and a more spontaneous, affective participation of the therapist's personal self in the therapy process, such as when a therapist responds without premeditation. Therapist self-disclosure (Dewane, 2006) is a practice that is now well-established within the relational schools of psychoanalysis, but I am curious about its relative lack of presence in the literature on sexual offending therapy and other models of therapy, such as narrative therapy. I agree with Winslade, Crocket and Monk (1997) that:

> One of the things we find curious in the literature about narrative therapy is the scant mention of the counselor's use of his own experience as a resource to share with his clients … Particularly when the effect of oppressive

> problems is to isolate individuals, we think it is valuable to offer clients the alternative experience of shared knowledge and shared stories … Stories that lend encouragement or support can come, of course, from other clients or from books, films, or literature, but they can also come from the personal experience of the counselor … Such sharing usually comes after we have allowed the client plenty of time to find his own voice and develop his own story. It is usually brief, and it is supportive of the client developing resourcefulness rather than didactic in tone or instructive in intent. Our sharing of our stories needs to arise out of our response to the client's story rather than out of our desire for an audience. It represents a meeting of our storied experiences and hence a meeting between us as people (p. 72).

The use of self in therapy is by definition going to be influenced by the subjective and intersubjective experience of the participant and the therapist. For the purpose of this thesis subjective and intersubjective experience is defined as being produced by the unique configuration of interpersonal experience within a historical and cultural context from infancy onwards. These experiences are stored in both the implicit procedural memory and in the explicit autobiographical memory, hence our subjectivity has an unconscious as well as a conscious dimension (Siegel, 1999; Schore, 2003a; 2005). The meanings derived from these experiences determine how people respond to their worlds. Intersubjective experience refers to the ability of people to share in and understand the subjective experience of others.

The way in which people make meaning of the world they are born into is shaped by numerous personal experiences such as class and cultural backgrounds,

gender identity, family of origin, abuse related trauma, as well as their professional trainings and experience. For therapists working with sexual offenders, this includes assumptions, however derived, about persons who sexually offend, as well as the principal theories which inform the way in which they understand sexual offending behaviours. Self is defined for the purpose of this thesis as having both a subjective and objective aspect. The subjective experience of self refers to the experience of personal agency and the objective experience of self refers to the experience of seeing ourselves through the eyes of others (Benjamin, 1988; 1990; Aron, 2000b). I became interested in finding a way to study the use of self in therapy and the relationship between the personal and professional self of the therapist. In order to accomplish this I used a qualitative methodology called autoethnography. Autoethnography is a reflexive, narrative form of research which studies the self of the researcher within a particular socio-cultural context (Bochner & Ellis, 2002). The research reported on in this thesis took place while I was working as a therapist on a community-based adolescent sexual offending programme in New Zealand (Aotearoa) from 2004-2006.

Treatment plans and interventions are influenced by how the therapist (in collaboration with the participant) formulates the problem. Our formulations are influenced by our theory. In my literature review of explanatory theories for adolescent sexual offending, I was attracted to the view that relational traumas such as disrupted attachment, and physical, emotional and sexual abuse (Marshall & Marshall, 2000; Rich, 2006a; Ryan & Lane, 1997b; Smallbone, 2005; 2006; Ward, Polaschek, & Beech, 2006) and the social construction of masculinity (Marshall & Barbaree, 1990; Messerschmidt, 2000) help us to understand why adolescent sexual offending takes place. Cognitive and behavioral treatment (CBT) models have until

recently been the preferred treatment modality for adolescent sexual offending treatment following the precedent set by adult treatment programmes (Marshall, Anderson, & Fernandez, 1999). The emphasis in these earlier CBT approaches was placed on specifying the *procedures* implemented in treatment. This tended to emphasise risk management and relapse prevention which focused on deficits and negatives rather than strengths (Thakker, Ward, & Tidmarsh, 2006; Ward & Stewart, 2003). Some of these procedures also involved the use of confrontation. Research has shown that aggressive confrontational interventions in this field are counter-productive (Marshall, 2005; Marshall et al., 2005). The emphasis on procedures did not take into account the influence the therapeutic alliance and the personal characteristics of the therapist had on therapy outcomes (Marshall & Serran, 2004). However, contemporary developments of adolescent sexual offending treatment theory suggest that we need to develop *a holistic and positive approach* to treatment, in order to help participants increase their self-esteem and enhance their capacity to experience empathy (Marshall et al., 1999; Marshall et al., 2005; Ward & Marshall, 2004; Ward & Stewart, 2003). Positive approaches include more sophisticated CBT models (Marshall et al., 1999); strengths-based approaches such as narrative therapy (Jenkins, 1998) and the Good Lives Model (GLM) (Thakker et al., 2006; Ward & Marshall, 2004); and relationship based approaches based upon attachment theory (Rich, 2006a). These approaches have been influenced by therapy research which demonstrates the importance of the therapeutic alliance and therapist characteristics and style to treatment outcomes. Indeed some research has found that the quality of the therapeutic alliance is the single most important factor in determining successful treatment outcomes (Safran & Muran, 2000). Specific research into adult sexual

offending group therapy (Beech & Fordham, 1997; Beech & Hamilton-Giachritsis, 2005; Marshall, 2005) has also demonstrated how the personal qualities of the therapist (as perceived by the participant) such as empathy, genuineness, respectfulness, flexibility, warmth and a non-confrontational style are essential to the effectiveness of therapeutic interventions.

While researching the use of self in adolescent sexual offending therapy I became interested in *relational theory* and applying relational theory to adolescent sexual offending therapy. Relational theory has its origins in feminism and contemporary psychoanalysis (DeYoung, 2003; Freedberg, 2009; Safran & Muran, 2000; Wachtel, 2008). It also shares similarities to systemic and narrative therapy and fits well with the core values and ethics of social work. Relational therapy works on the premise that therapy is a process of mutual influence and recognition between two or more subjects – therapy is therefore practised as a two-person or two-way process that engages *both* the therapist and the participant in the change process. The use of *self* is a core concept in relational theory and social work practice. Relational theory suggests that the micro-world of the therapeutic relationship is an important resource for therapeutic change. Furthermore, this often occurs in the domain of implicit (procedural) relational interactions that occur on a moment by moment basis (Schore, 2003a; Stern, 2004b; Wachtel, 2008) as well as the more familiar explicit domain of the co-construction of meaning (Anderson, 1997; Stern, 2004b; White, 2007). The participant's experience of relationships and the sociocultural context *outside* of therapy are also important, and the therapist must use the therapeutic alliance to help the participant negotiate the real world of relationships and the various cultural forms

of oppression that continue to marginalise young people (Altman, 1995; Freedberg, 2009; Winslade et al., 1997).

In this thesis I explore an integrated approach to adolescent sexual offending therapy, drawing on both the systemic-narrative traditions and the relational psychotherapy tradition. I will show how therapeutic change and personal growth take place within the unique intersubjective configuration of the therapist – participant relationship and the wider relational context of the therapist's and participant's life. The structure of the thesis is founded upon the weaving together of three different narrative voices: the autobiographical voice (my story in four parts), the researcher's voice, which describes the methodology together with the literature reviews on the influential explanatory and treatment theories used in the field of sexual offending including relational therapy; and finally, the voice of the therapist who narrates his experience of the therapy sessions, including the voice of the participants from the programme. The final two chapters return to the research questions and relate the findings of the stories back to the theory. It finishes with a discussion of the implications of these findings for treatment theory and policy.

1.2 What is the meaning of "the use of self"?

I first came across the concept of "the use of the self" (Baldwin, 2000; Butler, Ford, & Tregaskis, 2007; Elson, 1986; Wolsket, 1999) in my social work training. It has been argued that the most important tool the social worker possesses is her self (Elson, 1986). David Brandon (1979), who is also a practising Zen Buddhist, writes that social work practice "concerns who we are rather than what we may know" (p. 30). As discussed above, the use of self is also an important concept in various

therapy traditions, including psychoanalysis, person-centred therapy, existential therapy and family therapy (Baldwin, 2000). A point which is central to the argument of this thesis is that the use of self is present, regardless of the specific tradition, model or approach used by the therapist:

> This involvement of the therapist's "self," or "personhood," occurs regardless of, and in addition to, the treatment philosophy or the approach. Techniques and approaches are tools. They come out differently in different hands (Satir, 2000, p. 19).

It follows that if the self or person of the worker is significant to therapy outcomes, then the biography of the worker is crucial to the practice of all the various forms of therapy. Who we are as a person, our developmental and cultural history, how we relate to others, our ideological beliefs and practices, in short, the subjectivity of our self, both known and unknown to us, is the most important gift (or hindrance) we bring to our helping practice. However, this "self" is a very difficult concept to define, and perhaps the most talked about question in philosophy and religion is the question of personal identity: who am I?

Counselling, psychotherapy and social work theories have paid a lot of attention to the emotions and to our thinking or narrating self. In the helping process we spend a lot of time listening to the participant's story and asking them how they feel. The expression of feelings and the telling of stories is a never-ending process, representing the movement from experiencing to reflecting, from feeling to talking (Fosha, 2000, p. 163). As Paul Ricoeur argued, cited in Madison (1990, p. 94) "it is in

telling our own stories that we give ourselves an identity". We recognise ourselves in the stories we tell about our selves: "The self is the story we tell ourselves and others, weaving together into a single fabric, as any good storyteller does, actions and events; it is the autobiography we are constantly writing and rewriting" (p. 162). However, this is only part of the story. Apart from the ability to reflect on our lives and relationships we are also embodied experiential beings, experiencing sensations, feelings, thoughts, wishes and intentions, flowing and changing on a moment by moment basis like a never-ending stream. Here, there is nothing permanent to be found. The awareness of this stream of consciousness is often called the observing or witnessing self (Beck, 1989, 1993). This awareness of awareness is empty of all content, or, as expressed in the Buddhist tradition, emptiness itself! However, although nothing permanent can be found, we still have a sense of continuity and coherence, which is essential to our emotional well-being (Magid, 2002). This sense of continuity comes about through the repeated experience of familiar self states and affects, and the organisation of our experience (including memory) into a continuous and coherent account of our personal history and identity. I refer to this as our narrative or autobiographical self (Anderson, 1997; Bruner, 1990).

The word "self" is used to refer to many aspects of our personal being. It has been usefully defined as tripartite in structure by Russell Meares (2000), corresponding to the use of "I", "me" and "myself". When we use "I" we are referring to the sense of personal agency. I make decisions, I act in certain ways, I enter into conversations. I am an active subject. However, the "I" is best thought of as a plurality of different "self-states" (Bromberg, 2006), each with its own different "I". Even during the course of a single day we may enter into and out of different

self states. “I” can also refer to the “observing self” or reflective function. I am aware of being an embodied experiential presence. I am aware of the constant flow of thoughts, images, feelings, sensations and sounds. If we are very skilful we may also start to be able to identify different self states. I am aware of being self-aware. Only I have access to this experience. “Me” refers to in this sense my world, my thoughts, and my feelings, my different self-states. This world is unique to me and dies with me when I die.

“Myself” refers to my existence as a public *identity,* the experience of knowing I exist as an object for someone else. The sense of being observed enables us to experience the so-called social emotions such as embarrassment and shame. I have a name, I have a profession, I am married, I was born in England. The sense of myself therefore refers to the sense I have of my personal identity. I am also conscious of speaking and writing myself into being through the telling of stories. I can tell stories about “myself”.

I am also aware of having the capacity to be both subject (“I”) and object (“myself”) at the same time and to relate to others as subject or object (Aron, 2000a; Baldwin Jr, 2000; Benjamin, 1988; Flaskas, 2002; Fosha, 2000; Safran & Muran, 2000). The self is therefore experienced as both an object, which can be hurt in the same way our body can be hurt, and a subject (or person), experienced as an active centre of personal agency or initiative and as an awareness of the present moment experienced as the stream of consciousness only experienced in the present moment.

To recount the story of our life, even in a slightly different way, is to transform our narrative self or identity: “To understand an experience, to reconstruct the past, is not to ‘represent’ it to ourselves; it is to transform it” (Madison, 1990, p.

168). Thus we have the possibility to continually re-create our identity by retelling our stories to others. What occurs in therapy conversations, on one level, is precisely a transformation of the narrating self. Alternatively, Madison states "some conversations, such as a bad marriage or family situation, hinder us from becoming ourselves and sometimes lead to our self-destruction" (p. 168). Therefore, we can conclude that the conversations we are located in are powerful contexts which influence our future life course. These understandings of the multiplicity of self and identity fits well with both narrative therapy as originated by Michael White in Adelaide, Australia and David Epston, in Auckland, New Zealand (White & Epston, 1990) and the collaborative approach to therapy developed by Harlene Anderson (1997).

1.3 The research problem

As I became interested in doing some kind of research into the therapy process as experienced by therapists and participants on adolescent sexual offending programmes, I was also aware of the growth of interest in attachment theory and its relevance to the treatment of adolescents who have committed a sexual offence (Marshall & Marshall, 2000; Rich, 2006a; Smallbone, 2005). In fact, it seemed to me to be no accident that was the case. The practitioner-researchers in the field who were becoming more interested in the role of the therapist and the therapeutic relationship were also drawing on attachment theory to justify the need for treatment interventions to think beyond the application of techniques and procedures (Chorn & Parekh, 1997; Marshall, 2005; Marshall & Serran, 2004; Marshall et al., 2005; Rich, 2006a, 2006b). Attachment theory suggests that during childhood the client may form

an internal working model of (particularly) intimate relationships (a relational template) that can become problematic as they get older and potentially interfere with the development of healthy attachment in adulthood (Sable, 2008). Extrapolating from this, the therapeutic relationship needs to become a secure base for the client, before the client will be able to explore the other tasks of therapy. It also suggests that the relationship itself is the key transformative factor in the change process. It seemed to make sense therefore that cognitive- behavioural interventions needed to be supplemented by an appreciation of the therapeutic relationship and the personal characteristics of the therapist. Practitioners began to bring what may be called an attachment-informed approach to therapy (Rich, 2006a), or what I would call a relational perspective to their work.

These researchers also seemed to accept the notion that "therapeutic techniques and therapeutic relationships are not (and cannot be) mutually exclusive: they are inherently interrelated and interdependent" (Mahoney & Norcross, 1993). On the basis of my own experience and theoretical understandings, I did not believe the application of any particular intervention could be separated off from the person and subjectivity of the therapist. To separate interventions from the participants' experience of the therapeutic relationship did not make sense to me because the skilful use of interventions is dependent upon the therapist's self-awareness and their awareness of the relational field on a moment-to-moment basis. If interventions are reified and separated from our ability to respond spontaneously on a moment to moment basis, they hinder, rather than help, therapeutic effectiveness (Safran & Muran, 2000). I therefore began to be interested in researching therapeutic change as a relational process, taking into account the subjectivities of the therapist and the

participants, the unique intersubjective field they created, and the sociocultural context in which the participants lived. I was particularly interested in researching the understanding that therapeutic interventions cannot be separated from the subjectivity of the therapist and that all participants, including the therapist, are potentially changed as a result of participating in therapy. Indeed, I felt a number of different relational traditions intersected on this point, and I began exploring what has been called the "principle of mutuality" (Aron, 1996) in different bodies of theory and therapeutic traditions including feminist theory and therapy (Chodorow, 1999; DeYoung, 2003; Freedberg, 2009; Goldner, 2004; Jordan, 1997); systemic/narrative therapies (Anderson, 1997; Bird, 2000; McNamee & Gergen, 1992; Monk, Winslade, Crocket, & Epston, 1997; Pare & Larner, 2004; White, 1997); contemporary relational psychoanalysis (Aron, 1996; Benjamin, 1988, 1990, 2004; Buirski & Haglund, 2001; Orange, Atwood, & Stolorow, 1997; Safran & Muran, 2000; Stolorow, Atwood, & Brandchaft, 1994; Wachtel, 2008); experiential approaches (Baldwin, 2000; Polster & Polster, 1973; Wolsket, 1999) and contemporary developmental/attachment theory (Holmes, 2001; Schore & Schore, 2008; Siegel, 1999; Solomon & Siegel, 2003; Stern, 1985/2000).

As I saw it, the problem with the scientific practitioner model and the focus on *procedures* (to the exclusion of the non-specific factors such as facilitative conditions and the therapeutic relationship) was that it set up a "them and us" situation (Williams, 2006), in which the offender was constructed as the object or the person "done to" and the therapist was constructed as the subject or "the doer" (Benjamin, 2004) . I did not want to separate interventions from the relational context of the therapeutic relationship (Safran & Muran, 2000). I therefore began to

think about how I could use autoethnography to design an alternative way of researching the therapeutic process within adolescent sexual offending therapy which did not reduce therapy to disembodied techniques and "us and them" dualities and which recognised the importance of studying interventions within the relational context in which they were experienced by the participants.

Adolescent sexual offending treatment programmes (modeled on adult programmes) have in the past been organised around "one person psychology assumptions" (Williams, 2006) – or "a one-way account" (White, 1997) of the therapy process. The therapist is seen as an objective expert or technician (Drapeau, 2005) whose job it is to "fix" the participant through the application of procedures – for example, to help the participant identify his cognitive distortions and change them (Marshall et al., 1999). This "us and them" problem (Williams, 2006) also contributes to the possible abuse of power by the therapist in the name of rehabilitation, such as the use of shaming techniques (Jenkins, 1994).

In this thesis I present an alternative way of thinking about therapeutic change, from a relational, rather than a dualistic perspective; one which understands therapy to be a form of "practice"; that is, as essentially a practical-moral activity concerned with developing self-reflexivity, understanding and personal agency (Aron, 2000b; Drury, 2006; Gray & Mcdonald, 2006; Orange, 1995; Orange et al., 1997; Pare & Larner, 2004; Parton & O'Byrne, 2000). I will show, through my research, how therapy can be understood and studied as a relational two-way process, involving a meeting of two (or more) differently organised subjectivities, within a specific cultural context – and that an important part of the work of therapy is a collaborative "making sense together" which takes place in the intersubjective "third"

(Benjamin, 2004), a shared space in which these two subjectivities overlap – hence each therapy is always a unique process (Buirski & Haglund, 2001; Orange, 1995). This is why "no method, technique, or procedure will yield understanding" (Orange, 1995, p. 16).

In the current climate of social policy in which the theory of evidence-based practice is dominant, I believe we need a more even balance between subjectivity and process, on the one hand, and objectivity and outcomes on the other (Butler, Ford & Tregaskis, 2007). At the moment I think the pendulum has swung too far to the outcomes end, and the importance of subjectivity has been lost because it cannot be measured. Having said that, I still think therapists can teach skills – such as relaxation and mindfulness, to help participants manage themselves better – within a collaborative approach. And I am not opposed to developing outcome measures, but I do question the idea that outcomes can be causally linked to the application of disembodied interventions while by-passing the non-specific factors such as the person of the therapist and the therapeutic relationship.

Given that the focus of this thesis is on the subjective and intersubjective experience of the therapist, and the meanings the therapist and the participants make of their experience, consideration must also be given to how our experience of subjectivity is produced (Weedon, 1997). In this thesis I take the position that we are "psychosocial" subjects (Hollway & Jefferson, 2000). Our experience of subjectivity cannot be reduced to either a position in discourse or to some psychological essence (Benjamin, 1988, 1990, 2004; Chodorow, 1999; Hollway & Jefferson, 2000). For example, how we experience gender relations is always a uniquely personal process. I agree with Chodorow (1999) that meanings as we experience them always come

from without and from within: “Meaning is an inextricable mixture of the sociocultural and historically contextualized on the one hand and the personally psychodynamic and psychobiographically contextualized on the other” (p. 2). I therefore found autoethnography to be a research method that was ideally suited to studying the subjective experience of therapy from both a personal and a sociocultural perspective.

Finally, this study can also be seen as an account of my personal and professional journey as a therapist. By personal, I mean firstly, becoming self-aware of my motivations for wanting to work as a therapist and to work with adolescents who had sexually offended; secondly, becoming aware of how the process of participating in this work and reflecting on it in supervision and research contributed to my own personal growth; and thirdly, the enormous contribution participants can make to the personal and professional life of the therapist (Gerson, 1996; Lax, 1996; Sussman, 2007, 1995; White, 1997). By professional I mean reflecting on theory and practice issues related to the field. I argue that the subjectivity of the therapist cannot be filtered out of the process of adolescent sexual offending therapy and that therapeutic change can be constructed as a two-way process, which involves *both* therapist and participants in critical reflection on their self and their conduct. Thus, the research is exploratory and descriptive, focusing on relational therapy processes, in conjunction with stories from my personal life which illustrate how my personal and professional lives are intertwined.

1.4 The research questions

Although there is accumulating evidence to suggest that after client factors, the therapeutic relationship (and hence the use of self) is the single most important factor in psychotherapy outcome research (Hubble, Duncan, & Miller, 1999; Wolsket, 1999), very little attention has been paid to this area in offender rehabilitation research. As discussed at the beginning of this chapter, this is now changing with research starting to focus on three interrelated process issues: the influence of the person of the therapist, in particular the expression of empathy, the participants' perceptions of the therapist and the therapeutic alliance (Marshall, 2005; Marshall et al., 2003; Marshall & Serran, 2004; Marshall et al., 2005; Serran, Fernandez, & Marshall, 2003; Williams, 2004). The perception of the participant is crucial to the therapy process because if the client does not experience the therapist as empathic then the therapist's response is not optimally responsive.

I have sustained an ongoing interest in researching people's experience of therapy for a number of years now. In my qualitative research for my Masters Thesis, I undertook to interview therapists and clients about their experience of participating in a solution-focused reflecting team. I was surprised to discover that *both* therapists and clients thought it was important for therapists to be present in the consulting room as persons, not just as professionals. For example, one of the clients I interviewed in my research spoke about her experience of therapist self-disclosure and her comment was: "you saw that they were just ordinary human beings too, people that have problems"(Tootell, 2003, p. 135); one of the therapists interviewed spoke of reflecting from "the heart" rather than doing "technique-driven" reflections (Tootell, 2004). I therefore became interested in furthering my understanding of the

therapist's experience of therapy and of the relationship between their professional and personal selves.

Most research into counselling and psychotherapy has focused on the process of therapy as *experienced by the client* (McLeod, 1990a). This is understandable, given that therapy's *raison d'etre* is facilitating client change. Some of this research has focused on the experience of therapists (McLeod, 1990b). This is also important, given that clients and therapists may experience therapy quite differently and therefore have differing perspectives on what was helpful. Some researchers have focused on the textual analysis of therapeutic transcripts, hoping to discover the conversational or discursive factors which therapists use to create the context for clients to experience change (Grafanaki & McLeod, 1999; Kogan & Gale, 1997) . The textual analysis of segments of their own transcript of a therapy session is also a form of learning often incorporated into therapy training programmes (White, 1997). However, few practitioner researchers have ventured into the muddy waters of studying their own subjective and intersubjective experiences of the therapy process including making linkages with their personal histories.

In particular I became interested in researching the therapist's experience of being "optimally responsive" (Bacal, 1998c; Bacal & Herzog, 2003). Optimal responsiveness refers to the quality of what a therapist does or says (or doesn't do or say) within a therapy session. It is a relational concept which emphasises the specificity of the participant-therapist relationship and the mutuality of this relationship. It was a concept that also seemed to fit well with the current interest in treatment responsivity in the sexual offending treatment field (Ward & Eccleston,

2004). The following research question was formulated in regards to my work on the adolescent sexual offending programme:

1. *How might the therapist use their experience of self (their subjective and intersubjective experience) to guide their sense of being optimally responsive?*

However, as the research progressed, I became more aware of the recursive effect of the research on integrating my personal and professional selves. It is usually agreed that the personal self of the therapist will influence the professional self (no matter how hard we might try to neutralise it) however it is often less understood that the professional experience of the therapist will also affect the personal self. This is quite clearly the case in terms of negative effects such as vicarious trauma or burnout (Sussman, 1995), but it can also have a positive transformative effect. I therefore formulated a second research question:

2. *How might research into the therapist's experience of their use of self in therapy contribute to the integration of the personal and professional self of the therapist?*

These questions followed on from my intention to study myself within the context of an adolescent sexual offending programme, and became the research questions for the study.

1.5 Justification for the research

The main reason for doing this research was my concern to develop an experience-near understanding of the therapeutic change process from the perspective of the therapist, including placing the micro-world of therapy within the larger macro-world context of my personal life. This included focusing on how I was changed by my participation in both the therapy process and by my choice of methodology. It has been argued that autoethnography can make a significant contribution to "improving the quality of the therapeutic alliance, and thus improve forensic psychotherapy outcome" (Williams, 2006 p. 23). Also, although I was aware of the possible therapeutic effects of autoethnographic writing (Bochner & Ellis, 2002), I found that engaging in this research acted as a form of self-therapy in a way I could not have predicted before-hand.

Disclosing the personal in the professional and giving a space for the voices of the boys and young people I worked with is also a political act (Williams, 2004). I want to challenge the duality between "us and them" in which treatment providers can easily get caught up (Williams, 2006). Practising self disclosure in both a research and therapy context can express the equality of a therapy process based upon a mutual two-way process (Aron, 1996). I also want readers of this work to understand that these young people have engaged in behaviours which were harmful to others, but it doesn't mean they are all sexual predators or monsters. In fact, they could easily be our fathers, brothers or sons. I think it is important to remember that only a small percentage of adolescents who sexually offend actually experience a deviant sexual arousal to children (Zimring, 2004). I also want readers to appreciate these young people as whole people, not as 'sex offenders'; I would hope that readers

might gain an empathic understanding of their personal history, which is often characterised by episodes of abuse related trauma. I think the voice of youth in general is marginalised and I think boys and young people who offend, particularly when one of those offences is a sexual offence, are marginalised even more.

I see the audience for this thesis as being all those professionals and paraprofessionals who work in the rehabilitation and treatment field such as police, correction staff, caregivers, residential workers, teachers, therapists, psychologists, social workers, legal people and also anyone who has been affected in some way or other by this problem such as the primary, secondary and community victims of sexual offending. I think this thesis is unique because I was not able to find any forms of narrative research which have focused on the subjective and intersubjective experience of the therapist in adolescent sexual offending therapy. Also, in all the discussion about this problem we rarely hear the voice of the young people themselves (Williams, 2004). I hope that my work will be one small contribution to developing a more holistic presentation of both the therapist as a person and the participant as a person.

Conceptualising therapy as an intersubjective process, which is (potentially) mutually mutative of *both* therapist and participant (Aron, 1996; Fosha, 2000; White, 1997), is relatively new to the sexual offending field. It is therefore important that this is recognised as part of professional training, in this field in particular. This is important because adult sexual offending treatment theory and research has been based on a one person psychology (or one-way account of therapy). It has in the past tended to ignore the relevance of process variables (such as the person of the therapist) to treatment effectiveness (Drapeau, 2005). And it has only been in recent

years that research has drawn some attention to the role of the therapist (Marshall, 2005; Marshall & Serran, 2004; Marshall et al., 2005; Rich, 2006a; Williams, 2004). Although this research has begun to recognise the importance of the personal qualities, attitudes and style of the therapist to treatment effectiveness, we don't yet have an articulation of how the therapist or participant experiences the therapy process. If it is accepted that therapy is a relational activity unique to the persons involved, attempts to reduce therapy to a set of disembodied techniques in order for them to be isolated and researched in randomised controlled trials, tells us more about the research design than the actual clinical process. This also has extensive implications for how therapy and research is practised in the field of offender rehabilitation where the participant is often positioned as the 'other'. Let's not throw the baby out with the bathwater for the sake of objectivity! In order to study therapy as it naturally occurs in the field, we have to get our hands and knees muddy in the gritty reality of our subjective experiences.

I also have my personal reasons for choosing to work in the area of adolescent sexual offending therapy and to engage in researching this area. All therapy involves facilitating, one would hope, the skills and capacity of the participants for self empathy – including the therapist. It is a common story to hear that people who become therapists do so in order to heal themselves and/or to make sense out of the suffering of their own or loved one's lives. In some therapy traditions, such as Jungian analysis, the myth of the "wounded healer" has been taken as a metaphor for understanding the therapy process (Sedgwick, 1994). In retrospect, I believe I was drawn to working with adolescent boys initially because of my needs to compensate for the loss of my relationship with my son, following the aftermath of a traumatic

separation and divorce. At first this was in the general field of child and adolescent mental health. Many adolescent boys who are referred to sexual offender programmes are also often disconnected from their fathers (and/or their mothers) and the knowledge that my son had experienced his father as largely physically absent from his life was often close to my heart when listening to the stories of these boys.

In choosing to work with adolescent boys and young men who had sexually offended, I was also always conscious of the knowledge that my own father had sexually offended (exhibitionism) when I was an adolescent and he was in his fifties. In terms of my own adolescence, although my father was always physically present (except for a period of a few months in hospital when he was receiving treatment), I often experienced him as emotionally distant or disengaged from me. The full impact of his offending only hit me when I discovered what had happened after finishing High School. My mother and sister and I were therefore secondary victims of my father's sexual offending (Ward & Marshall, 2004; Ward et al., 2006). We were never offered any family counselling at the time and as a result we were never able to talk about how this had affected us as a family while my father was still alive (I was able to talk to my sister about this and later, with my mother). Therefore, there was already a powerful field of personal emotions and associations that I experienced while working as a therapist in this field. The combination of these personal and professional experiences led me to work in this field as a therapist and ultimately, to embark on this research project.

In summary, the reason for engaging in this study is that I want to challenge the dualistic nature of rehabilitation culture, in which a "them and us" ethos dominates, including within the field of adolescent sexual offending. I also wish to

support the international and local movement in the adult and adolescent fields towards a positive and collaborative approach to therapy and the growing attention to the centrality of the therapeutic alliance and the style, role and influence of the therapist (Ayland & West, 2005; Jenkins, 1998; Marshall, 2005; Marshall & Serran, 2004). I also appreciate that most adolescent programmes are now adopting a holistic and developmental approach to treatment, with an emphasis on helping these young people discover their values (Maruna, 2001; Nisbet, Rombouts, & Smallbone, 2005; Ward, Hudson, & Keenan, 1998). However, the implication of moving to a genuine relational and collaborative approach to therapy raises a number of issues and dilemmas, such as how does this fit with risk management?

This study therefore seeks to begin to remedy this gap by exploring the treatment process from an autoethnographic perspective (mine as therapist's). It does this by *showing* how the subjectivity of the therapist enters into the treatment process and how the therapy/research process changes the therapist just as much as the other participants. It does this by weaving together my personal life stories and stories about my work as a therapist-researcher into a series of interconnected narratives. This qualitative research is exploratory. My intention and hope is that this kind of research will draw attention to this topic and its findings will be developed and researched further.

Denzin (2003) argued that one of the key evaluative criteria of "subjective" or "personal experience" research is that it contributes something to public policy debates. I hope this is one of the outcomes of this thesis. It is my hope that this research will generate dialogue and debate on the importance of the subjectivity of the therapist to the therapy process in adolescent sexual offending treatment both

locally and internationally. The treatment of persons who commit sexual harms is an issue that is regularly discussed, often in an atmosphere of intolerance, in the media. Although the research to be presented in this thesis does not claim to provide a 'how to do it' manual, I believe it makes a contribution to research findings that are beginning to stress the importance of the role of the therapist and the therapeutic relationship to maximizing treatment effectiveness when working with people who have committed sexual harms. I also believe the treatment narratives I have documented for this thesis will, in turn, provide a resource for further research, theorising and teaching in this field. If my research also allows outsiders who have no experience of working therapeutically with these clients, to gain some insight into the humanity of the young people who were responsible for the harm that was committed, then my efforts will have been worthwhile.

As I stated at the beginning of this section, autoethnography has the potential to contribute to improving the quality of the therapeutic alliance and hence therapy outcomes. It is my belief that the clinicians who work weekly with participants, often over a two year period, are well placed to develop an experience-near understanding of sexual offending treatment on the basis of their personal experience of the therapy process. I believe this research will give other practitioners (and the general public) a unique experience of reading several stories of one practitioner's attempt to do justice to this complex and challenging field of work. I hope that this research will inspire other practitioners working within the field of adolescent sexual offending to explore autoethnography with their own work and that young people starting a programme may also read some of the stories presented in this research. I also hope it will be of some interest to professionals working in the criminal justice and child protection

agencies as well as the families, caregivers, friends and the general community of those who have been affected in any way by sexual abuse.

1.6 Methodology

I locate my research methodology in the hermeneutic, reflexive and narrative research traditions (Etherington, 2004; Speedy, 2008), and in particular, in the autoethnographic tradition (Bochner & Ellis, 2002). I found practising autoethnography deeply challenging, and also profoundly healing on a personal level. Autoethnography also enabled me to empathise with the participants and utilise this empathy to good effect in the therapy process (Berger, 2001). In this study I write both autobiographical stories and therapy stories of my work with the participants. The rationale for including the autobiographical stories alongside the therapy stories is based on my belief that understanding our own vulnerabilities and frailties can enable us to better understand and support the people we meet with in therapy contexts (Butler et al., 2007 p. 282; Foster, McAllister, & O'Brien, 2006; Williams, 2006). I also found practising autoethnographic research acted as a kind of internal supervisor (Casement, 1991), enhancing my ability to empathically attune to the participants. Hence I agree with Williams (2006) that autoethnography can make an important contribution to the development of the therapeutic relationship and therefore to treatment outcomes. Apart from the work of Williams (2004), I am not aware of any other attempts to apply autoethnographic research to sexual offender rehabilitation; however there has been a growth of interest in the field on the role of the therapist in the treatment process (Marshall, 2005; Marshall & Serran, 2004;

Marshall et al., 2005). I think autoethnography can make a significant contribution to this discussion.

As far as I know, this is the first time that autoethnography has been used to research *adolescent* sexual offending therapy. Autoethnography can be understood as an example of a postmodern approach to research which grew out of the post-colonial critique of modernist research and the narrative turn in the social sciences (Chase, 2005; Ellis & Bochner, 2000). It is a form of personal experience research that studies the self within a social context. Autoethnography allowed me to consider the social context of adolescent sexual offending, while keeping a focus on my introspective and empathic experience of the therapy process. An autoethnographic perspective also allowed me to explore cultural factors, like gender and the "us and them" divide, and their impact upon the therapy process, such as, the concern that in the process of providing therapy for adolescents who have offended we do not reproduce abusive practices (Jenkins, 1998)

Autoethnography builds on the method of participant observation, by including observing the participation of the researcher, and how the act of doing research influences the subject being researched, in order to compose evocative stories about the relationship between the self (of the therapist) and the other (of the participant) (Tedlock, 2005). Autoethnographies come in many forms, along a continuum ranging on how much focus is given to "the self" towards on the other pole "the other" (Ellis & Bochner, 2000). It is intended that the autoethnographic account presented in this thesis will tend towards the middle of the polarity, focusing on the experience of both therapist and other participants from the perspective of the therapist. It presents two interwoven narrative threads: the personal and professional

journey of the therapist and short stories describing clinical exchanges, interspersed over the length of treatment, from a number of individual therapy sessions. These stories of clinical exchanges are written from therapy case notes, collected during the treatment process. These notes recorded details of my observations of participants, fragments of conversations with participants, and my introspective observations of my subjective experiences both before and after sessions. This method of data generation (Crocket, 2001, 2004) is similar to a supervision technique employed in psychoanalytic psychotherapy called "process notes"(Gabbard, 2004).These notes were then used as the basis for crafting the autoethnographic stories after signing an informed consent agreement with the participants. The stories were eventually given to the participants for their feedback before being incorporated into the thesis text.

Autoethnographic research uses various literary forms and techniques to involve the reader/audience on an emotional level, therefore giving the reader a direct visceral and emotional experience of text, giving a selective representation of my experience of the therapy session. I make links between narratives from my personal life to the themes explored in the clinical exchanges (for example the culture of hegemonic masculinity). This structure is employed in order to illustrate how the personal and political are always interconnected and to investigate how the subjectivity of the therapist enters into the treatment process. Choosing autoethnography helped me to clarify how the person or *subjectivity* of the therapist-researcher *inevitably* enters the treatment process, either consciously or unconsciously. For example, autoethnography allowed me to show how we have to be always vigilant about the fragility of personal and professional boundaries and to face up to emotions or past conduct we like to keep hidden or avoid, rather than

pretending we have somehow worked through all these issues as part of our professional training. I don't think it is appropriate for us as clinicians to expect these young people to expose their own vulnerabilities and shame without going through a similar process ourselves. I am not saying that we need necessarily be disclosing this in treatment (although self-disclosure may at times be helpful), but to be facing ourselves by writing and telling about it in other contexts such as autoethnography or personal therapy and supervision. Autoethnography therefore becomes a form of self-supervision or self-correction in this context (Williams, 2006). I am therefore interested in the overlap between what are regarded as the therapeutic pathways to recovery as documented in many programmes such as assessment, empathy, addressing personal victimisation, values and the acceptance of personal responsibility and how these pathways are relevant to the continuing personal and professional development of the therapist. In this way, the therapist remains authentic to their values, and goes through a rigorous self-examination in the same way as this is expected of the other participants.

Autoethnography is dependent upon the subjectivity of the researcher and like other forms of ethnographic research, autoethnography does not claim to be a method of objective representation of the external world (Ellis & Bochner, 2000). It cannot measure outcomes or compare techniques. However, using thick description, it can describe the subjective and intersubjective experience of the therapist and the other participants. Hence this is another reason for using autoethnography because there has been a lack of research into the therapist's subjective experience of therapy (McLeod, 1990b; Muran, 2002). In reflecting on my practice through the lens of autoethnographic research, I am able to capture insights which arguably would not

have been possible through more orthodox forms of qualitative research. For example, video/audio tapes or interviews do not allow the viewer to observe the therapist's internal dialogue and feelings; these have to be inferred (Balint, Ornstein, & Balint, 1972). Writing autoethnography also positioned me as both a therapist in transformation and as a compassionate witness (Weingarten, 2003) to myself and others, thereby deepening my empathic connection with clients. On a more personal note, writing autoethnographically is also a form of self-therapy and has involved a process of revisiting the shame-based wound, previously mentioned, experienced as an adolescent when I was told about my father's "illness". The wounded healer (Sedgwick, 1994) is a metaphor that I relate to and one that has influenced my choice of autoethnography as my preferred research strategy.

1.7 Organisation of the report

Chapter 2 sets the legal and theoretical context of adolescent sexual offending therapy. It discusses the relationship between explanatory theory and treatment theory and gives an introduction to a number of explanatory theories that account for the origins of sexual offending in boys and young men and contemporary treatment theories. Chapter 3 introduces the origins of relational theories of therapeutic change and explores the relevance of relational theory for adolescent sexual offending therapy, with a special focus on empathy, optimal responsiveness and specificity theory. Chapter 4 focuses on autoethnography as a methodology. It describes my research procedures, discusses ethical issues and concerns, and concludes with a discussion on how to evaluate autoethnographic writings. Chapter 5 tells Billy's story. Chapter 6 is the first part of my autobiographical story. Chapter 7 tells Peter's

story. Chapter 8 continues my autobiographical story, focusing on my relationship with my children, the disruption to this relationship and the turn to therapy as a wounded healer. Chapter 9 tells Adrian's story. Chapter 10 continues my autobiographic story. Chapter 11 concludes my autobiographical story and Chapter 12 tells Jamie's story. Chapter 13 provides a comprehensive a meta-analysis of the use of self in the autoethnographic stories, focusing on a number of examples of the therapeutic use of self and how this relates back to the literature on systemic-narrative therapies and relational therapies. Chapter 14 completes the thesis by focusing on my experience of the autoethnographic journey and the implications of the findings for practice and policy.

1.8 Conclusion

In this chapter I have introduced the research problem and the research questions. I have justified why I think this research is significant and worthy of consideration and the possible implications it has for others working in the field of adolescent sexual offending and for therapy in general. I have also briefly described and justified my choice of methodology. I have also argued how autoethnography has the potential to become an option of choice for practitioner researchers wishing to use qualitative methodologies to research client and therapists' subjective and intersubjective experience of therapy, including adolescent sexual offending therapy. I have introduced my research questions within the context of a clear outline and an extensive introduction to the literature relating to the use of self in therapy and research. I argue that the use of self has the potential to make a significant contribution to improving the therapy process in the rehabilitation of people who

have sexually offended by enhancing our capacity to create an empathic therapeutic relationship and by challenging the “us versus them” culture of some more traditional programmes.

2.

EXPLANATORY AND TREATMENT THEORY

2.1 Introduction

In this chapter, following a discussion on the relationship between explanatory theory and treatment theory, and the legal and social constructions of sexual offending behaviour, I give a selective overview of some influential explanatory and treatment theories within the contemporary fields of both adolescent and adult sexual offending. I do not have the space to review all the literature on this topic and there are a number of works that make an attempt to summarise some of the vast literature in this field (Barbaree & Marshall, 2006; Nisbet et al., 2005; Rich, 2003, 2006a; Ryan & Lane, 1997b; Ward et al., 2006). I therefore discuss some of the explanatory theory that seemed most relevant to the work of this thesis. In particular, I was concerned to complement attachment theory by including a feminist analysis of gender relations. The chapter concludes with a discussion of the premier treatment theory - the risk-need-responsivity model. I build on the argument of Ward and colleagues (Ward et al., 2006) that this model would benefit from the incorporation of a strengths-based, collaborative approach to rehabilitation. This would have the effect of recognising the importance of both the person of the therapist and the therapeutic alliance to treatment outcomes.

2.2 Explanatory theory and treatment theory

Explanatory theories are distinct bodies of knowledge, and they should be considered separately from treatment theory. The purpose of explanatory theory is to

explain the reasons why someone offended, or has a certain diagnosis – its origins lie in medicine, in the search for the underlying cause of disease. It answers the question, *why?* Treatment theory, on the other hand, is concerned to work out how therapeutic change happens, how disorders or problems are solved or healed. It answers two questions - *what works?* ("outcome" studies) and, *how does it work?* ("process" studies). Sometimes treatment theory references explanatory theory for support, for example, contemporary attachment research and neuroscience seems to lend empirical support to the importance of the therapeutic relationship and non-verbal communication to treatment outcomes (Wallin, 2007). Explanatory theory guides us through the complexity of real life and helps us during the assessment phase of treatment to develop an understanding of the problem. It therefore helps us to design a treatment plan. However, explanatory theory is experience distant, and the therapist has to rely upon their own interpersonal skills to read non-verbal communications and to determine the most appropriate response on a moment by moment basis.

As therapists, our understanding of explanatory theory and indeed our years of clinical experience, can help to guide us in the initial stages of the therapy process, however, we need to be careful that an understanding of diagnostic categories and explanatory theories does not blind us to the unique person before us. The psychoanalyst Heinz Kohut argued that the therapist's understanding of the problem needed to be based on their subjective understanding of the patient's subjective experiences. Kohut argued that it was not possible to derive objective reality from subjective experience. He was more concerned to respond to the patient in such a way that the patient experienced a feeling of being understood. I agree with Kohut,

that a subjective empathic orientation is effective from a treatment perspective because every person we see in therapy is unique. We need to be careful not to let diagnostic boxes or any other explanations get in the way of us trying to understand the unique "lived experience" of each person. No matter how much knowledge a therapist has of explanatory theory, it doesn't follow that this will mean he or she is an effective therapist.

Treatment theories are closely related to how we conceptualise change and therefore evaluate change. Most treatment theories, either explicitly or implicitly, are based upon some assumptions about what constitutes a subject or person, what constitutes a problem and how change comes about. The dominant discourse in contemporary mental health, including the sexual offending field, argues that assessments, treatment planning and interventions should be soundly based on empirically grounded explanatory theory, which should be testable or open to evaluation. It is also the case, that most of these theories are organised around the assumption that the problem lies in some kind of psychological dysfunction located within the individual offender. However, for people trained to think systemically or relationally, this is problematic. For example, within a positivist approach it is usually assumed that problems or disorders exist independently of the language that constructs them and that a causal explanation can be found to explain why they exist. This view is often referred to as objective realism. The epistemological position of objective realism is central to the project of modernism and contemporary psychiatry, attachment research and developmental neurobiology.

Modernism has been extensively critiqued from the perspective of philosophical postmodernism. Vivian-Byrne is one of the few treatment theorists

working in the field of sexual offending treatment who is interested in applying postmodern therapies to sexual offending treatment. She defines postmodernism, quoting Goldner, as "… a contemporary philosophical tradition that offers a critique of all 'objectivist' claims to knowledge – the belief that the 'world-out-there' can be separated from the stance of the observer constructing it – and argues instead that all knowledges should be viewed as 'texts' that reveal as much about their authors as about their subject" (2004, p. 189). She argues that postmodernism is relevant to sexual offending treatment because it questions:

> … modernist assumptions that underpin many psychological treatments or therapies. These indicate that we can *know* what the problem is, agree on the truth about this, and they lead us to assign expert status to the holders of the truth. Methods arising from this truth can then be applied to the problem with a positive, predictable outcome (Vivian-Byrne, 2004, p. 190).

While I agree that there are a number of problems with objective versions of realism, I am reluctant to dispense with epistemological realism altogether. When it comes to explanatory theories, I believe epistemological realism is appropriate for studying the domains of biology and I have a preference for a multi-disciplinary, pluralistic approach to understanding human development and relationships. I take the position that explanatory theory needs to take into account the domains of biology and the psychosocial world but that the methodologies developed to study physical and biological domains are not always applicable when it comes to the study of subjective domains. I take a pragmatic position about the use and value of identifying so-called

explanatory or risk factors for the purpose of assessment and treatment. I agree with Marshall et al. (1999) that all our attempts at developing comprehensive explanations of sexual offending will come up against the limits of human knowledge:

> … an all-encompassing account of any complex human behaviour may not be able to achieve the status of a true scientific theory in the sense that it could serve to reasonably precisely predict the behaviour in question. The best we can hope for is to link by speculative connections those factors that the evidence suggests are present in either the history or current status of sexual offenders (p.27).

However, I do believe that these "speculative connections" can be *helpful* in orienting treatment practice. In fact, I agree with both philosophical hermeneutics (Gadamer, 1975/1989) and the critical realist position (Ward, et al., 2006) which argues that we always start with some set of theoretical conjectures or presuppositions; our observations are therefore always theory-laden.

When it comes to treatment theory, I prefer the position of perspectival realism as opposed to objective realism (Orange, 1995). Perspectival realism argues that we can only describe subjective reality from our particular perspective and we cannot separate the observer from that which is observed. In other words, it is impossible to bracket ourselves outside of reality in order to observe or describe it from a God's eye point of view, so to speak. Or, to put it another way, observation is never passive, it is an active form of interaction and the act of observation changes

that which is observed. This was indeed the main insight of what came to be known in family therapy as second order cybernetics (or the cybernetics of cybernetics):

> One of the factors essential in second-order practice is the recognition of the therapist as part of the system that he or she is trying to change. There has been an acceptance of the principle that therapists do not sit apart from their clients and cannot act objectively. Rather, they influence and are influenced by the subject area with which they work, and all of their prejudices and beliefs play a part in their practice. It is the recognition of this, which allows those beliefs to be taken into account, and their potential undue influence to be modified. Thus, the relationship between the therapist and the client grows enormously in importance in the therapeutic process. Further, our allegiances to our employers, the state, our personal beliefs, our experiences of sexual offenders, and indeed, sexuality itself, all become important in our practice. This, in turn, leads to a much more tentative and 'non-expert' position within therapy, to less certainty about what needs to change and how this might be brought about (Vivian Byrne, 2004, p. 189).

It was the move to second order cybernetics that created the context for a renewal of interest in the therapeutic relationship and the use of self (and hence the rapprochement with psychoanalysis) within narrative and systemic family therapy (Flaskas & Perlesz, 1996; Real, 1990). By placing the therapist as another person within the system, it was easy to move to the idea of a collaborative therapeutic relationship. The therapist is a person first, with professional expertise; but the client

also became a person with expertise on their lives. The ability of the therapist to be with the uncertainty of not-knowing, reflecting on and sharing their inner thoughts and feelings with families present became one of the defining features of postmodern family therapy (Andersen, 1999; Anderson, 1997; Baldwin, 2000; Bird, 2000; Flaskas, 2002; Flaskas & Perlesz, 1996; Safran & Muran, 2000).

As a therapist I acknowledge the influence of both the systemic-narrative traditions and the relational traditions, and I take the position that the use of self is the core element of how I work. In my philosophy of therapy each therapist must over time develop their own unique professional style and technique of doing therapy that "fits" their personal self. This journey takes time, often requiring the therapist to try on "different clothes" for fit. This is what I call the journey of integrating the personal and professional self:

> Herein lies a deeper demand for the therapist: with our clients we cannot be other than who we are in our ordinary lives. We cannot "turn on" collaboration, respect or compassion for the therapeutic moment if these qualities are not part of our day-to-day selves … To be present therapeutically requires awareness of the baggage, the pre-formed narratives and the texts we bring with us into the therapy room. We find it useful to make an arbitrary split into two kinds (recognising this split is the very one we are critiquing – no one said we have to be consistent!): professional and (even more demanding) personal (Cantwell & Stagoll, 1996, p. 136).

However, the very fact that our professional self places demands upon us, and places us in situations that we would never have been in, meeting with people we would never have met with and listening to stories that we would never have heard, means our personal self is also transformed during this process of integration.

I think the relationship between explanatory and treatment theory is therefore best understood by clearly distinguishing treatment theory from explanatory theory (rather than giving explanatory theory precedence over treatment theory). They can therefore be seen more helpfully as *mutually* informative but separate domains of scientific inquiry. That is, treatment theory can inform explanatory theory and explanatory theory can inform treatment theory. For example, research into the neurobiological effects of trauma, abuse and neglect can inform psychotherapy, and research into the subjective experience of therapy participants can inform neurobiology. This also fits with the distinction developed in philosophical hermeneutics between explanation and understanding (Gadamer, 1975/1989) which is similar to Bruner's (1986) distinction between paradigmatic and narrative modes of knowing. Explanation seeks a universal theory based upon reasoning which can be productive of predictions, whereas understanding refers to a *dialogical* event (an agreement) between two or more individuals who are relating as equals. Explanations are a form of knowing about, a kind of expert outsider's perspective; whereas understanding is a form of knowing from within. If we attempt to reduce a person to a brain we are reducing them to an object, an "other". However, if our stance is one of understanding through dialogue or empathic inquiry, we are relating as subject to subject. In this mode of inquiry, understanding is always partial and subjective, and is developed locally in participation with the client we are working

with. This form of understanding is experience near, becoming a form of "emotional understanding" (Orange, 1995). Explanations (for example, those based on brain research) can therefore act as resources to the treatment project but take a secondary place to the dialogical understanding developed during treatment; however, in turn, understanding developed through treatment can influence the formation of explanations – this is in fact, how the psychoanalytic method of case history works. In the treatment of adolescent sexual offending, attachment theory is a useful theoretical "lens" through which to understand behaviour which may otherwise be interpreted as "bad"; however, this understanding needs to be balanced by attempts to understand the client clinically or phenomenologically, primarily through the mode of empathic inquiry. The dialogical understandings that develop from empathic inquiry can then be linked back to findings gained from attachment-based research.

2.3 What is sexual offending behaviour?

The field of adolescent sexual offending treatment is now a specialist area of work, within the larger industry of adult sexual offending treatment. Like the legal response, the therapeutic response initially failed to take into account the developmental status of young people who had engaged in sexually offending behaviours (Zimring, 2004). To begin with, adolescent treatment was influenced by ideas drawn from work with adult sexual offenders, with a focus on the individual and social risk factors of young people such as deviant sexual arousal; but in recent years practitioners have argued that work with children and young people is quite different from adults because of developmental considerations and the need to take into account the social ecology within which the young person is embedded such as

family, school and peers (Nisbet, 2005; Nisbet et al., 2005; Rich, 2006a; Ryan, 1999; Swenson, Henggeler, Schoenwald, Kaufman, & Randall, 1998).

This understanding is also reflected in the creation of separate juvenile justice systems to deal with children/young people who offend. In most western countries children aged 10-17 who offend are dealt with in the Children's Court. It was only during the late 1980s that the term "juvenile sexual offender" emerged as a distinct therapeutic identity; earlier discourse did speak about abused children acting out in sexually aggressive ways (victim-victimiser) but did not constitute a legal or psychological subjectivity on the basis of such behaviours (Brownlie, 2001).

Sexual abuse (like all laws and the social world in general) is a socially constructed phenomenon but that doesn't mean that it is any less serious or doesn't exist in reality; it just means that the reality, if you like, is constructed differently according to the particular culture and historical period we are living (Hacking, 1991; Jenkins, 1998). At the moment the construction of sexual acts committed by children/young people as abusive occurs within medico-legal discourse. Once a child has been found guilty of a *sexual offence* or has been charged with a sexual offence and then diverted into a treatment programme, the child/young person is constituted as a person who will be held accountable for the crime and who will be expected to take responsibility for the harm his behaviour has caused. Children/young people who offend are often considered to have some form of sexual deviance, or paraphilias (Ryan & Lane, 1997b). This distinguishes adolescents (children aged over 10) who sexually "offend" from children (under 10) who engage in problematic "sexualised behaviours" (Friedrich, 2007). A child under the age of 10 is not regarded as a person who can be held accountable for their actions because it is assumed they have

not yet reached the developmental stage where they can distinguish between right and wrong (Zimring, 2004). Once the facts have been established, this usually leads the young person who offended to be legally classified as a "sexual offender". This officially constitutes the young person as someone who poses a risk to other children in the community by definition, for on the basis of risk theory (Worling & Langstrom, 2003), the commitment of one or more sexual offences constitutes a stable or static risk factor that the person concerned will reoffend.

Although the term sexual offender is a legal construction, not a psycho-diagnostic category, it still has the potential to be constitutive of a young person's identity, leading him to be stigmatized as a "sex offender" in the same way that the word "pedophile" or its more colloquial expression "rock spider" constitutes individuals as a low form of humanity. A humiliating and shame producing dominant narrative can therefore be inadvertently imposed upon these young people, at the family, community and political level, as well as at the treatment level. This identity often overshadows the traumas many of these young people have experienced in their early lives and the relationship between dominant forms of masculinity and abusive practices in the wider culture. The identity of sex offender is also counterproductive to successful treatment outcomes; when the trauma context is not acknowledged, a "responsibility overload" is potentially imposed on the young person (Jenkins, 1998). If the young person's own experience of trauma goes unacknowledged and the adults responsible for causing this trauma have not been held accountable, then it is asking a lot for the young person to acknowledge responsibility. This is not to say that being a victim of prior abuse is an excuse. I believe young people need, and ultimately want, to be held accountable and to take responsibility for their offending behaviour.

However, the community and the adults involved who failed in their duty to protect these young people when they were young must also shoulder some burden of the responsibility. All too often, the dominant discourse of the sex offender individualises the problem, creating an "us and them" scenario in which questions about the relationship between sexual abuse and other potential influences such as the social construction of gender are rendered invisible (Brownlie, 2001).

Definitions of what constitutes sexual abuse are culturally and historically contingent, however in recent years a fairly stable and standard consensus has been achieved. The factors usually recognised as useful criteria for assessing the absence or presence of sexual offending are equality, consent, and coercion. Equality refers to considerations of age and power differentials. Usually three to four years age difference and including other power differentials such as size, physical strength and intellectual capacity. Lack of consent refers to being against the victim's will. It is also a legal construct that a person under 16 years of age by law cannot give consent. Finally the use of coercion can be covert, such as the use of bribes or overt, such as the use of force or threats (Ryan, 1997). These are the criteria that are used in both the assessment and treatment process to help the participants and their families understand the meaning of sexual offending.

This field of work is also different to general counselling practice because practitioners are required to assess risk on an ongoing basis and to work in collaboration with the criminal justice and child protection agencies. Finding the balance between social control and a relational approach can be challenging. This extra responsibility that is placed on the clinician can sometimes create tensions in the therapeutic relationship between an empathic stance and risk management concerns.

It can also contribute significantly to stress and burn-out (Ryan & Lane, 1997b). The agency in which I worked maintained the position, prevalent in the practice standards, that the community should be seen as the primary client. Considerations for the safety and well-being of the children who were the victims of abuse are always given priority in the making of decisions surrounding the person who offended, during all stages of the therapy process. For example, the young offender is often required to leave the family home in the case of sibling incest or if there are children living in the home.

Adolescent treatment programmes have become more adolescent and family focused over the last twenty years, recognising the need to create a flexible and responsive treatment milieu taking into account the special needs of adolescents. Most programmes these days have a developmental and contextual awareness and have a holistic approach to treatment (Rich, 2003, 2006a; Ryan & Lane, 1997b). Also, in recent years there has been a coming together in the juvenile justice system, of ideas known as therapeutic jurisprudence (Birgden, 2004) and restorative justice (Daly, 2002; Jenkins, 2006). Together these ideas underpin the diversion of young offenders to family conferences or victim-offender conferences, on the requirement that the offender has acknowledged guilt (Daly, 2002). At these conferences, the offender and his family meet with the victim (or victim representative) and their family. The victims have the opportunity to tell their story and the offender has the opportunity to acknowledge the wrong, and the harm, and to offer an apology. Reparation is also decided at these meetings, usually including some form of community service and a commitment made to attend treatment. In some jurisdictions, such as in the Australian states of South Australia and Queensland, the

offender attends assessment and some preliminary treatment before attending conference (Daly, 2002). In this way the legal system works in collaboration with the treatment system.

2.4 Explanations of adolescent sexual offending

Theories explaining adolescent sexual offending have obvious overlaps with theories explaining adult sexual offending, and the references detailed below include adult as well as adolescent theorising. Ward and colleagues (2006) have categorised explanatory theories according to levels of generality. Level one theories are multifactorial, aiming at integration, and aspire towards comprehensive explanations of sexual offending such as Marshall and Barbaree's integrated theory (Marshall & Barbaree, 1990). Level two or single factor theories focus on what could be described as the key factor, for example attachment disorder/intimacy deficits or empathy deficits (Chorn & Parekh, 1997; Marshall & Marshall, 2000; Rich, 2006a; Smallbone, 2005); theory of mind or intersubjective deficit (Keenan & Ward, 2000); cognitive distortions (Marshall et al., 1999) and feminism and gender theory (Brownlie, 2001; Herman, 1990; Messerschmidt, 1999, 2000). Level three (micro-level or offence process) theories are "descriptive models of the offence chain or relapse process"(Ward et al., 2006 p. 13). These would include the cycle of offending models often used in both individual and group treatment interventions (Lane, 1997; Ryan & Lane, 1997a).

A distinction can also be made between "distal" or predisposing causal factors (vulnerability factors) and "proximal" or precipitating or situational factors:

> Vulnerability factors exert an effect only when they co-occur with another risk factor, for example, the presence of a victim or sexual arousal. Proximal factors function to disinhibit the self-regulation of behaviour and thereby erode an individual's capacity to control strong internal states such as deviant sexual fantasies, strong affect or negative cognitions. The failure to adequately deal with these states increases the chances of a sexual offence, particularly once the opportunity arises (Ward et al., 2006 p. 211).

These concepts are similar to the way in which psychiatric formulations are structured. Like psychiatry, most of the explanatory theories are based on modernist/realist assumptions.

As it is not possible to cover all the theories in this field, I will first of all discuss attachment and gender theory before outlining one of the more influential general theories, which seeks to integrate many of the factors generally considered to be associated with sexual offending. I seek to build on this theory by incorporating an analysis of the effects of hegemonic masculinity and gender harm. Although some of these theories were developed to explain why adults sexually offend, it can be argued that many of the ideas developed in theories about offences by adults have definite applicability to adolescents and the research that informs the development of assessment instruments for adolescent sexual offending, such as the ERASOR (Worling & Langstrom, 2003), (to be discussed further in section 2.8) tends to identify similar explanatory factors to those identified in adult assessments such as disrupted attachment relationships and abuse related trauma.

2.5 Attachment theory and intimacy deficits

It is not possible for me to give a comprehensive overview of the field of attachment theory and research, which is covered in some handbooks on the topic (e.g. Cassidy & Shaver, 1999); and in books on the relationship between attachment theory and psychotherapy (Dallos, 2006; Fonagy, 2001; Holmes, 2001; Hughes, 2007), even as applied in particular to adolescent sexual offending (Rich, 2006a). Attachment theory has become increasingly popular as a lens through which to understand the origins of sexual offending (Marshall & Marshall, 2000; Rich, 2006a; Smallbone, 2005). Attachment theory grew from the work of John Bowlby (Bowlby, 1969, 1973, 1980, 1988) and it was developed by Ainsworth and colleagues and Main and colleagues (Fonagy, 2001). Since these early beginnings, attachment theory has been increasingly integrated with findings from infant research, neurobiological research and developmental psychology in what may be described as a new *attachment trauma – affect regulation* paradigm which explains both healthy and pathological socioemotional development (Schore, 2003a; Schore & Schore, 2008; Siegel, 1999; Sroufe, 1995; Stern, 1985/2000).

Bowlby was a child psychiatrist and psychoanalyst and he was influenced by the object relations school of psychoanalysis. However, he rejected Klein's (Klein, 1988) position that the cause of infant and child pathology lay in the intrapsychic realm of internalised fantasies; Bowlby focused instead on the world of interpersonal relations. Bowlby observed the effects of attachment trauma on children who were separated from their parents for safety reasons during the Second World War. These experiences led him to be appointed to lead a research programme funded by the United Nations to study the needs of homeless children who had been orphaned or

separated from their families and needed to be cared for in foster homes, institutions or other types of group care. One of Bowlby's main findings was that one of the main causes of mental ill-health was maternal deprivation (Bowlby, 1953/1965) and eventually he formulated his attachment theory in a series of books (Bowlby, 1969, 1973, 1980). Bowlby's ideas were influenced by his knowledge of ethology and he saw the key concepts of attachment as being grounded in biology. One of these was the concept of the secure base. Bowlby hypothesised that infants were hardwired to seek out the safety of a secure base provided by the caregiver when they felt threatened in any way. The availability of the secure base also provided the impetus for the infant to explore his or her environment with the expectation that the secure base was not far away. Bowlby later developed these ideas into a framework for understanding the process of psychotherapy (Bowlby, 1988)

Bowlby's initial insights have been further developed over the years by ongoing research in the fields of infant, child and adult development and neuroscience research. Ainsworth and colleagues invented the Strange Situation experiment in order to be able to measure attachment (Solomon & George, 1999). From observations of how infants and toddlers responded when a stranger entered the room to their reactions when their mother left the room and then returned, they developed three attachment classifications with respect to a particular parent: secure attachment, insecure *ambivalent* attachment and insecure *avoidant* attachment. Since their initial work a fourth category has since been added, insecure *disorganised* attachment (Solomon & George, 1999). Narrative research utilising discourse analysis developed by Mary Main and colleagues, has recently opened up the field of adult attachment research (Hesse, 1999). The combination of adult attachment

research with the observation of infants, has led to the startling conclusion, replicated a number of times by research studies, that attachment patterns are intergenerationally transmitted, leading some theorists to draw analogies between attachment theory and the human genome project (Dallos, 2006; Holmes, 2001). In recent years attachment theory has been increasingly linked with affect regulation; in fact, some researchers have argued that attachment should be seen as a form of affect regulation and show how the interactions between the infant and the primary caregiver in the first year of a child's life are crucial for the development of affectional bonds (Schore, 2003a).

Attachment theory has grown in recent years as one of the major single-factor explanations for adult and adolescent sexual offending. It is not a new theory, and it has been extensively researched by Bill Marshall over the years, usually under the heading of attachments, intimacy and loneliness (Marshall et al., 1999; Marshall & Marshall, 2000). It is argued that insecurely attached children are seen as being more vulnerable than securely attached children, and this vulnerability increases their risk of being sexually abused and increases their use of sex (initially masturbation) to avoid problems and feel better. Over time sex becomes used as their primary coping mechanism to deal with stress and lifestyle problems. Repetitive use of deviant sexual fantasy eventually leads to thoughts of abuse. When social constraints are overcome by alcohol, negative affect or cognitive distortions and the opportunity arises, the offence takes place (Marshall & Marshall, 2000). Many victims are already vulnerable, that is, "characterized by low self-esteem, poor relationship skills, and a desire for affection" (Marshall & Marshall, 2000, p. 259) even before the abuse takes place.

Marshall's theory draws heavily on attachment theory research to explain the presence of vulnerability factors. However, unlike Marshall's initial formulations, attachment theory does not have to depend upon the idea of the fusion of sexual and aggressive *drives* to explain sexual offending behaviour. Rather, as with other forms of relational psychoanalytic theory, aggression is understood to be either a reaction to frustration or to threat (real or perceived); in fact, severe pathology is seen to arise when the caregiver (secure base) is at the same time a source of threat (Perry & Szalavitz, 2006).

It can be argued that attachment theory has confirmed the primary psychoanalytic assumption that the roots of healthy emotional development are laid down in the first year of life, within the matrix of caregiving relationships. However, we also need to remember that caregiving is a social practice, emotional development is always intertwined with social development (and cognitive development); in fact, the general course of emotional development can be seen as a movement from dyadic affect regulation to the self regulation of affect (Sroufe, 1995). During this course of development the child gradually internalizes the capacity of the caregiver to regulate both positive and negative affects. It is in the regular daily and moment by moment interactions of affect regulation between infant and caregiver that the attachment relationship develops in the first year of life. In the second half of the first year the infant increasingly takes the initiative to signal to the caregiver, thereby gaining a response (Fosha, 2000; Schore, 2003a; Sroufe, 1995). This is why attachment is not considered to be a characteristic of the individual but of the relationship. Hence, it is possible for a child to be securely attached to say the mother and insecurely attached to the father. In order for a child to develop resilience it is hypothesized that a secure

attachment relation with one person will be a good enough secure base (Bowlby, 1988). The basic pattern of affect regulation takes the form of attunement, disruption and repair (A-D-R) (Fosha, 2000; Schore, 2003a); a classic example would be the infant and mother engaging in escalating rhythms of positive affect exchange through facial expression, voice tone and pitch, followed by the infant grabbing and pulling the mother's hair, thereby unintentionally hurting the mother. The mother's face registers anger for a split second but this is enough to scare the infant who then begins to cry. The mother quickly responds with soothing interactions to repair the disruption and the infant begins to smile again and the cycle begins again (Fosha, 2000). Stern (1985/200) has described these experiences as "vitality affects" as distinguished from the categorical emotions such as joy and anger. It can be said that "vitality affects are to emotional communication what words are to verbal communication" (Fosha, 2003 p. 237).

The A-D-R sequence was observed by Heinz Kohut who hypothesised on the basis of his clinical work with adults, that the child internalises the caregiver's affect regulating function from his or her experience of optimal frustration. It is not always possible for the caregiver to be perfectly attuned to the infant – but this is not a bad thing. The fact that the caregiver is not always going to be perfectly attuned or able to perfectly respond gives the infant an opportunity to practice self-regulation. Over time, and repeated experiences of optimal frustration, the child grows in their ability to self regulate when the caregiver is not around. However, if the disruption is not optimal then it becomes traumatic; for example, if the caregiver is not present when the child wakes in the middle of the night in discomfort, or if the child's enthusiastic efforts to connect with the caregiver are continually rebuffed. It is the repeated

experience of these small "t" relational traumas that lead to the development of attachment and affect regulation disorders. Kohut was historically ahead of his time in the ways in which his work has been largely supported by the findings of contemporary neuroscience (Schore, 2003a).

2.6 Gender relations and domination

Although most boys who sexually offend have attachment-trauma problems, proponents of attachment theory recognise that it cannot in itself explain why some boys sexually offend and others do not (Rich, 2006a). It is therefore acknowledged that other factors are involved. I believe one such factor to be the cultural context of gender relations. Attachment theory helps us to understand why adolescents sexually offend, however, what is often neglected in the attachment literature is that these relational and developmental traumas also take place within a cultural context of gender and power relations in which masculinity dominates over femininity. The boy identifies with his father, disidentifies with his mother and repudiates his own femininity (Benjamin, 1988). The formation of gender identity occurs not only in relations between the sexes, but also in relations *within* the same sex. The term "hegemonic masculinity" (Connell, 1995, 2002) was introduced in order to describe how boys and men participate in dominant and submissive relations in our school playgrounds, sporting fields and workplaces based on the masculinity---femininity polarity. In this thesis I use hegemonic masculinity to refer to a way of being a man which disavows and devalues feminine qualities such as subjectivity, nurture, nature, emotional vulnerability, sensitivity and empathy. It is hegemonic because it reflects a dominant form of power relations, and is thus self-perpetuating and largely hidden.

This culture of hegemonic masculinity makes it hard for male victims to speak of their sexual abuse because of their shame of being ridiculed by other men and their fear of being labeled homosexual. Those boys who do not fit into the prescriptions of dominant ways of doing masculinity are degraded and abused by other boys. Many of the participants on the programme were affected by their fear of not measuring up to the prescriptions of "hegemonic masculinity". These prescriptions of hegemonic masculinity provide another perspective on helping us to understand why adolescent sexual offending occurs.

Since the late 1970s, many family therapists and relational psychoanalysts, under the influence of feminism, have incorporated the issue of gender and power into their clinical practice (Altman, 1995; Aron, 1996; Benjamin, 1988; Goldner, 2004; Luepnitz, 1988). Constructionist, feminist and narrative therapies also link the perpetration of intimate violence and sexual abuse by boys and men to dominant ways of doing masculinity (Goldner, 2004; Jenkins, 1990; Law, 1999; Slattery, 2003; Tootell, Wright, Hall, & Jenkins, 1997). However, discussions of the relationship between gender, power and sexual abuse have remained marginalised in the field of sexual offending explanatory and treatment theory (Brownlie, 2001). Gender is infused with power because of the way in which masculinity and femininity are constructed as binaries:

> Masculinity and femininity are inherently relational concepts, which have meaning in relation to each other, as a social demarcation and a cultural opposition … Masculinity as an object of knowledge is always masculinity-in-relation … Knowledge of masculinity arises within the project of knowing

> gender relations … masculinities are configurations of practice structured by gender relations. They are inherently historical; and their making and remaking is a political process … (Connell, 1995, p. 44)

These relations define masculinity as the dominant subject and femininity as the submissive object: "gender casts masculinity as an illusory state of omnipotence from which dependency must be externalised by being projected onto a female Other, and femininity is reciprocally constituted as the site of all that masculinity repudiates" (Goldner, 2004, p. 350). This relation between masculinity and femininity has been compared to the master-slave relationship (Benjamin, 1988). However, in order to understand relations of domination between men and men Connell introduces the concept of dominant and subordinate relations among masculinities and incorporates the concept "hegemonic masculinity" to illuminate how the cultural and historical formations of masculinity are a result of social practice, and are therefore open to change (Connell, 1995).[1]

Hegemonic masculinity, as defined by Connell, refers to the dominant culture of masculinity, which legitimates patriarchy, the dominance of men over women (Connell, 1995, p. 77) and subordinates alternative forms of masculinity such as gay masculinity:

[1] Hegemony (or "rule") is a term originally coined by the early twentieth century Italian Marxist Antonio Gramsci to explain why the inevitable working class revolution had not taken place as predicted by Marx. Unlike most Marxists of the time, Gramsci thought that the cultural domain was the key to revolutionary movement rather than the economic. Cultural hegemony (or the ruling culture) was a theoretical concept Gramsci used to explain how the capitalist state was able to maintain the economic system by a combination of force and ideology. He argued that the working class were culturally colonised and came to understand themselves through the values and ideology of the middle class which were also tied to Christianity. Cultural hegemony therefore represented the domination of middle class values on the rest of society (;Laclau & Mouffe, 1985).

> Gay masculinity is the most conspicuous, but it is not the only subordinated masculinity. Some heterosexual men and boys too are expelled from the circle of legitimacy. The process is marked by a rich vocabulary of abuse: wimp, milksop, nerd, turkey, sissy, lily liver, jellyfish, yellowbelly, candy ass, ladyfinger, pushover, cookie pusher, cream puff, motherfucker, pantywaist, mother's boy, four eyes, ear-ole, dweeb, geek, Milquetoast, Cedric, and so on. Here too the symbolic blurring with femininity is obvious. (Connell, 1995, p. 79)

Apart from gay masculinity, heterosexual men who identify with metrosexuality can also be seen as taking up an alternative way of doing masculinity, because they share "an unashamed interest in shopping, fashion, fitness, and personal grooming … the importance of the concept , according to reports, is that it liberates the young male from the macho straightjacket where overt care for personal appearance is viewed with askance and interest in any cosmetic beyond shaving gel and deodorant is anathema" (Euromonitor-Archive, 2006, p. ??). Another example I came across in my work was young men who identified as "Emo's". This was an expression that came from a particular genre of pop music but also involved a dress code that would transgress hegemonic masculinity, such as the wearing of eye make-up. However, hegemonic masculinity (and homophobia) was still the dominant form of masculinity even in the 2000s and represented the dominant sociocultural context for many of the participants on the programme.

Hegemonic masculinity is reproduced in the dominant cultural prescriptions that boys operate under. For example, Pollack's (1999) sociological research identified a social code for boys consisting of four dominant prescriptions for boyhood:

> *The "sturdy oak".* Boys do not share pain or grieve openly, i.e., boys don't cry. To do so is to be weak = feminine.
>
> *"Give 'em hell".* The prescription to be dare-devils, ride fast cars, take risks and not be scared. Be tough and macho.
>
> *The "big wheel".* The need to achieve status, dominance and power. To avoid shame at all costs, to look cool, and to act as if everything is going okay (even if it is in reality falling apart).
>
> *"No sissy stuff".* The gender straitjacket that prohibits boys from expressing feelings or desires seen as "feminine" – dependence, warmth and empathy. (Pollack, 1999)

These prescriptions and their variants are played out every day in our school yards and also act to make it very difficult to engage boys in the process of therapy because to go into therapy is to contravene all those prescriptions. For boys who are have been sexually abused, apart from the initial trauma of the event, the meaning of the event is filtered through the culture of dominant masculinity and this affects the way they come to view their self and their sexuality. Male and female rape victims are traumatised in a variety of ways: they feel their physical integrity has been invaded, their personhood as having been diminished, they feel humiliated and ashamed

(Sanderson, 2006). For boys and men, they may also fear they are now destined to become homosexual. Therefore for some boys who have been sexually abused or bullied in various ways for not fitting in with the prescriptions of hegemonic masculinity, one theory is that they may choose to sexually abuse, in order to re-affirm their lost sense of power and control or in some cases to "prove" to themselves they are not homosexual or that they do match up to these prescriptions (Messerschmidt, 2000). For a boy who is already insecurely attached, the sexual abuse or bullying only thickens a negative story of self such as personal failure, by comparing himself to the specifications of hegemonic masculinity.

The decision to incorporate explorations of the effects of gender and power in my therapy with adolescent boys who have acted in sexually abusive ways was an explicit political decision as a male therapist to challenge the prescriptions of hegemonic masculinity. As Jenkins once said:

> As a therapist, I am a political agent, whether I like it or not. I make political choices, and have political influence, even if I choose to deny my own power and the power relationships in which I participate. I can choose to acknowledge my power and my political role and attempt to exercise it responsibly – in fact, I believe I have a responsibility to act in this way (Jenkins, 1994).

Inviting boys and young men to consider alternative forms of masculinity which embody and enact different values of personhood holds the promise of not only personal change but also social change.

2.7 Towards an integrated theory

Marshall & Barbaree (1990) (subsequently revised by Marshall & Marshall (2000)) and Ward and colleagues (Ward et al., 2006) have paved the way in attempting to develop integrated theories of adult sexual offending. These comprehensive theories attempt to integrate a wide variety of factors considered to "play a role in the explanatory causes of sexual offending and lead to its persistence" (Marshall & Barbaree, 1990, p. 257). Integrated theories attempt to account for both distal (predisposing) factors and proximate (precipitating and perpetuating) factors.

Marshall and Barbaree seek to integrate biological, psychological and sociological factors around a unifying core assumption that "the task for human males is to acquire inhibitory controls over a biologically endowed propensity for self-interest associated with a tendency to fuse sex and aggression" (p.257). Accepting animal research that males are innately aggressive, they argue, however, that an appropriate caregiving environment and healthy socialisation enables the male to inhibit the natural tendency to fuse sex with aggression:

> In this respect perhaps two of the most important outcomes of appropriate parenting are to instill in the young boy a sense of self-confidence and a strong emotional attachment to others. Since appropriate adult sexual interactions usually occur within the context of an intimate, loving relationship, then the growing child needs to develop skills essential to attaining such an intimate bond (1990, p.262).

The origins of sexual offending are therefore seen to lie in the failure of these parenting and socialisation processes to provide an adequate developmental context for the male to distinguish between, and develop capacity to inhibit, his sexual-aggressive drives. These conclusions are based on research into the childhoods of men who have raped, which have persistently found patterns of parental violence, especially male violence, harsh and inconsistent punishments, and humiliation handed out by parents or caregivers. Other contributing factors include the wider aspects of culture such as male socialisation. Marshall and Barbaree argue that self-esteem in adolescent males is strongly associated with perceptions by peers of their sexual ability. Hence, "the young boy who cannot develop a relationship with a female may turn to aggressive sex or sex with children as a way of proving to himself that he is masculine" (1990, p.262). Given the failure of the caregiving environment, it is also unlikely that the boy has developed the capacity for intimacy, leading to social isolation and feelings of loneliness. They argue that loneliness is also associated with a higher risk of susceptibility to hostile and aggressive feelings. Failures in the caregiving environment also lead to empathy deficits: "If a man is indifferent to the feelings of others, he will be able to ignore their rights and abuse them however he wishes" (p.263). Other general sociocultural features they identify include the predominance of violence in the media and the effects of pornography both of which serve to desensitize males and disinhibit their aggressive-sexual drives. Finally, these predisposing or distal factors only become activated when situational factors arise (proximal factors), that are high risk situations. For example, a man loses his job (proximal factor) and at the same time has a fight with his wife because he perceives her as criticizing him (proximal) leading him to get drunk (proximal

factor) in order to cope with the negative emotion that has been generated. (The difficulty with regulating negative emotions goes back to poor parent-child relationships and is the distal factor). The alcohol only serves to depress him more and at the same time act as a disinhibiter which leads to him sexually abusing a child.

Since 1990, Marshall and Barbaree's integrated theory has continued to evolve. Marshall and his colleagues (Marshall et al., 1999; Marshall & Marshall, 2000) now place more emphasis on the development of deficit or vulnerability factors, which emerge primarily from childhood experiences. Vulnerability is placed on one side of the pole with resilience or protective factors found at the other end. Resilience is defined to include personal characteristics, skills, beliefs, preferences and values (Marshall et al., 1999). They focus in particular on poor parent-child attachment bonds which make the child vulnerable to developing low self-esteem, a poor relationship style and a desperate need for attention. This combination of factors increases the risk the child may be sexually abused, which in turn leads to the child turning to sex as a coping mechanism. On the other hand, on the basis of attachment research they argue that a child with secure attachment bonds is characterized as resilient, confident in themselves and in others' love for them. In contrast, Marshall and Barbaree detail research to show that the families of persons who commit sexual offences are characterized by violence and abuse, inconsistent parenting, severe punishments, criminal activities, drugs and alcohol use and social isolation. They also detail research which shows poor attachment to fathers to be correlated more strongly than poor attachment to mothers among child abusers, and that *insecure attachments to fathers* leads to the enactment of coercive sexual behaviours as adults (Marshall & Marshall, 2000, p. 251-253). Because the child

lacks other coping skills they turn to sex as an avoidance strategy. Because the child is isolated they may also be open to the advances of adults, leading to them being sexually abused. Marshall and Barbaree detail research to show how adults who have committed sex offences have a much higher likelihood that they were sexually abused as children. The abuse in turn fuels masturbatory habits and the use of deviant fantasies. When the child reaches adolescence and they are unable to cope with various stress and problems in their life, if the opportunity arises, there is a good chance they may offend. In order for this to happen, there has to be the presence of disinhibiting factors and the situation or opportunity to offend. Alcohol and cognitive distortion are common disinhibiting factors; in fact Marshall and Barbaree cite evidence that up to 50% of sexual offences are committed under the influence of alcohol. The young person will then either seize or seek out (plan) the opportunity to offend.

This model is coherent and makes sense. However, I do have a problem with the core assumption of the notion of biologically based sexual-aggressive drives. I think the argument that the motivation towards sexual gratification is genetically wired in to all human beings is reasonable (Lichtenberg, Lachmann, & Fosshage, 1996), but I have never been convinced by the argument that all human beings are innately aggressive. I much prefer the theory of aggression, derived from the work of Kohut (Kohut, 1971; 1977), which I discuss in more detail in chapter 3. Kohut made a distinction between healthy aggression, best understood as assertiveness, and destructive aggression, understood as anger, rage and violent behaviour directed against others or the self, that arises from traumatic injuries to the self (Ornstein, 1999).

I believe an appreciation of how our sense of self and personal meaning is derived from without by sociocultural discourse is highly relevant to understanding the origins of sexual offending. For example, an appreciation of the effects of the power of homophobic discourse to shape a man's sense of self and how this is expressed on a micro-level through the practice of shaming (Harker, 1997; Law, 1999; Sinclair & Monk, 2005) help us to understand the need for boys to assert dominance over other boys physically, verbally and sometimes, sexually. There is therefore a problem with focusing exclusively on explanations which seek to understand abusive behaviour by relating it to deficits in the child's upbringing (abusive and neglectful parenting) or prior victimisation history, or generally a combination of both (Marshall & Marshall, 2000). The problem is that these explanations can inadvertently render the dominant culture of hegemonic masculinity invisible, or at least non-problematic. This therefore maintains the focus on dysfunctional families rather than cultures. One-factor explanations such as attachment theory are therefore in danger of inadvertently diverting attention away from the responsibility we need to take at a community level, to question the reproduction of sociocultural discourses which promote forms of masculinity which define themselves by denigrating femininity and homosexuality. We therefore need to pay attention to the dialectical relationship between individuals, families, peer groups and community.

The paucity of space given to gender and power in the treatment literature struck me as paralleling the history of sexual abuse treatment. Understanding of incest as a form of family dysfunction has a long history in family therapy (Luepnitz, 1988). However in the 1970s in response to feminist critique of circular theories of

causality, a new analysis of power led to adult males being held accountable (Herman, 1981; Kamsler, 1990; Luepnitz, 1988). When sexually abusive behaviour is placed within the larger spectrum of abusive acts committed (or sanctioned) by *boys and men,* it can be seen as a form of "gender harm" (Daly, 2002); and the discourse of dominant or hegemonic masculinity can be seen as acting as a restraint on *all* boys (and girls) towards showing care and respect to their peers and younger children.

Gender harm is an umbrella term used to refer to the related crimes of domestic violence, family violence, sexualised violence and violence against children. Gendered harms are indicative of gender power relations (Daly, 2002 p. 67). Unfortunately, most of the studies of adolescent-male sexual violence are gender blind even though it is estimated that 96-98 per cent of adult sexual offenders are male (Messerschmidt, 2000, p. 287). The majority of these adult men will also start their offending as adolescents. I believe the thesis of gender harm is a necessary complement to one-factor explanations such as attachment-trauma theory. In my view, developmentally-informed explanations of sexual offending can be enhanced by understanding how boys' perspectives on problems such as sexual abuse or school bullying are formed through the lens of dominant masculinity discourse. It can then be argued that boys boost their sense of masculine self-esteem through the use of physical or sexual violence; or see no other alternatives to the use of violence to solve interpersonal problems. Sexual violence can therefore be seen as a form of "doing" or "performing" masculinity and expressing their needs for intimacy too. That is, boys and young men respond to "masculinity challenges", challenges to their

masculine self esteem, by resorting to physical and sexual violence and exercising power and control over younger and smaller children (Messerschmidt, 1999, 2000).

Hegemonic masculinity is constructed in relation to subordinate masculinities, such as gay masculinity (Connell, 1995, 2002), and in relation to a disparaging construction of femininity. Hegemonic masculinity also interpolates with race, class, sexuality and ability hierarchies. The stories documented in Part II of the thesis show how I seek to understand the meanings that participants had made about the events in their lives and of how the discourse of hegemonic masculinity shaped these meanings. I engaged the participants in a reflective dialogue, to think about these meanings and to evaluate if these meanings were similar or dissimilar to their own values.

The requirement to sort through multiple and conflicting messages about masculinity and create a personal identity, can be understood as a major developmental task that boys must complete (Pope & Englar-Carlson, 2001). From this perspective, boys and young men are thought to become more self-conscious of the consequences of not identifying with the dominant discourse of masculinity and heterosexuality when entering adolescence and their actions are driven by fear of becoming marginalised and stigmatized by other boys and men. The dominant prescriptions of masculinity also impoverish the ability of boys to enter into intimate relationships (Mesner, 2001).

Acts of sexual abuse are often described by the metaphor of darkness (Latta, 2003). Indeed, they often take place in a space of both literal darkness and within the darkness of fantasy. They are conducted in secret, in the dark. They take place in a borderland, on the boundary of both fantasy and reality. In this sense, adolescent

sexual offending can be interpreted as not only the enactment of a sexual fantasy but also the enactment of a fantasy of maleness. Therapeutic work with adolescent boys who have acted in sexually abusive ways is therefore politicised when we study how the claims of hegemonic masculinity can restrain boys from acting non-violently and expressing emotions which are commonly referred to as feminine. The problem is then located in a patriarchal production of men's culture rather than individual or family pathology. Thus, the point I want to argue is that insecure attachment and traumatic injuries to the self render boys vulnerable but do not cause violence. It is generally speaking, a combination of development deficits in conjunction with an unstable or dangerous environment, such as a violent father or peer abuse, in conjunction with the dictates of hegemonic masculinity, which results in the young person reacting with violence to property or persons (Saxe, Ellis, & Kaplow, 2007).

Sexually abusive acts can be interpreted as acts of self-formation, intended to define one's place in the hierarchical order of masculine identity and sexuality. Within patriarchal men's culture femininity is still ridiculed and disparaged as a sign of weakness. Most of the boys and young men I have worked with are so fearful of being categorised as "gay", "wimp", "faggot" or "pussie" that they will act in violent or abusive ways and knowingly break community norms in order to *identify* with and *perform* their understanding of hegemonic masculinity norms. For example, in my clinical experience, it is common for boys to identify with the violent aggressor, father, as a defence against the pain and fear of traumatic stress.

Like the concept of internal working models or attachment representations, beliefs that are produced from our immersion in cultural discourse tend to operate (influence us) outside of our conscious awareness. Prior victimisation experiences are

crucial to understanding sexually abusive behaviours, not only because of the need to treat the attachment-trauma issues involved, but also because of the *meanings* adolescent boys come to make out of these experiences once they become more knowledgeable about sexuality practices and hegemonic masculinity. For example, I found Jamie's story to be in agreement with Marshall & Barbaree (1990), that some boys and young men therefore sexually abuse in an attempt to compensate for their sense of being deficient in their masculine identity because of prior victimisation experiences. For boys who feel powerless and out-of-control when confronted by violent fathers, or who feel picked on and bullied in the school ground, acting in sexually abusive ways provides an opportunity to feel powerful and in control, however temporarily. It is also the case that boys with insecure attachments are more likely to bully or be the victims of bullying (Sonkin & Dutton, 2002).

Boys generally learn how to perform hegemonic masculinity from older males in their family and from school. I also think sport is an important site for the reproduction of hegemonic masculinity. Rugby union is probably the defining iconic symbol of masculinity for both Maori and Pakeha boys growing up in New Zealand. Many boys will measure their performance of masculinity in a hierarchy determined by rugby. Young women are also positioned in this discourse through the idealisation of this form of masculinity and become willing participants in the idolization of the same masculine image. I was therefore captured by the relevance of research into masculinity and sports, which had me remembering my own sporting accomplishments and the link between sexual conquest and sporting prowess. However, as demonstrated in autoethnographic research, sport can also be a site wherein boys develop resistance strategies to hegemonic masculinity (Pringle, 2001).

The culture of hegemonic masculinity is also circulated through the mass media. I especially remember the films and television that shaped my boyhood days. I believe that images and narratives of hegemonic masculinity portrayed in mainstream television and films are enacted by boys in the school grounds and neighbourhood, starting in the form of play fighting and ending in real fights and violence. It has also been argued that Hollywood war films (Donald, 2001) act as propaganda to recruit boys and young men into military service and to legitimise the use of state violence as the solution to domestic and international conflict (such as the film, *Pearl Harbor*).

When the personal is political, therapeutic change becomes social change. By resisting the discourse of hegemonic masculinity we are resisting the call to war and the reproduction of gendered harms in our homes and communities. Feminist theory alerts us to the need for treating all forms of violence, including sexual violence, as a community issue:

> Women and men must oppose the use of violence as a means of social control in all its manifestations: war, male violence against women, adult violence against children, teenage violence, racial violence, etc. Feminist efforts to end male violence against women must be expanded into a movement to end all forms of violence (hooks, 1984/2000, p. 132).

On these terms, community development strategies (such as discussion groups in schools about the harmful effects of homophobia) are necessary to challenge the dominance of hegemonic masculinity and the patriarchal values that are reproduced in the performance of hegemonic masculinity. If we are to be serious about violence

prevention as a community, then what is required is a thorough going revision of our community values and community wide resistance to the current hegemonic image of masculinity by challenging dominant cultural practices such as the glorification of male violence in sport.

2.8 The risk-need-responsivity (RNR) model

Offender rehabilitation theories are commonly organised within a human needs based paradigm (Ward et al., 2006). A distinction is usually made between *criminogenic* and *noncriminogenic* needs (Andrews & Bonta, 2003). Criminogenic needs are also dynamic risk factors, that is, these are needs that the offender seeks to meet through offending rather than by other pro-social means. The Risk-Need-Responsivity (RNR) model is defined as a rehabilitation theory which serves as a bridge linking explanatory theory (factors which cause offending) and how treatment interventions are selected and implemented (Ward & Eccleston, 2004). Four principles for effective rehabilitation have been developed. These are firstly, the *risk* principle. Risk is an estimate of treatment needs; according to this principle high risk clients should receive more treatment than low or moderate risk clients. Risk is typically divided into *static* and *dynamic* risk factors. Static factors are historical and therefore unchanging, such as the number and type of past offences. Static risk factors are the main factors that are assessed to predict the probability of future re-offending. Dynamic risk factors are more useful for clinicians because they target factors which can be changed, such as antisocial attitudes or difficulties regulating affect. Secondly, according to the *need* principle, treatment should primarily target criminogenic needs (dynamic risk factors), characteristics which when changed

reduce the probability of recidivism. In contrast non-criminogenic needs are seen as aspects of the individual or his circumstances that if changed will not necessarily reduce the probability of recidivism. These would include needs such as self-esteem needs and mental health problems such as depression and anxiety. Thirdly, the *responsivity* principle is used to refer to the style and mode of intervention in order to successfully engage and motivate clients to change. It is concerned to tailor treatment interventions to match the cognitive abilities, personalities, age and cultural backgrounds of the participants. It also refers to the person and style of the therapist. Finally, the principle of *professional discretion* states that within the broad parameters of for example, policy and best practice standards, professionals should use their clinical judgment when implementing interventions, thereby allowing flexibility. I would argue that these last two principles are complementary, and crucial to the ability of the therapist to be optimally responsive. Clinical judgment can therefore override the above principles if warranted (Ward & Eccleston, 2004; Ward et al., 2006).The RNR model assumes the best way to reduce recidivism rates and protect the community is to reduce or eliminate the dynamic risk factors through a combination of risk management and therapeutic interventions. These factors constitute clinical needs or problems (often referred to as *criminogenic needs*) that should be explicitly targeted in treatment; and risk assessment should drive the treatment process and offenders' assessed levels of risk should determine the intensity and duration of treatment (Ward et al., 2006).

The RNR Model has been very influential across treatment providers. Most providers would now always do a comprehensive assessment prior to accepting a person for treatment and this assessment would cover the variables that have been

identified by research as static and dynamic factors. The assessment would usually include risk assessment instruments designed specifically for that purpose. For example, on the treatment team I worked for in New Zealand, a risk assessment instrument called the Estimate of Risk of Adolescent Sexual Offense Recidivism Version 2.0 (ERASOR) played a central role in our assessments. The ERASOR has been constructed on the basis of research conducted by Worling & Langstrom (2003) which identified statistically relevant factors correlated with adolescent sexual offending. These were then classified as either static or dynamic risk factors. The history of offending is always a static risk factor, whereas factors such as impulse control, loneliness, affect regulation, oppositional defiance and family dynamics are all dynamic factors.

The RNR Model assumed that these dynamic risk factors could be primarily treated using a combination of cognitive behaviour therapy and educational interventions, primarily within a group therapy context. However, research into treatment effectiveness conducted by Marshall and colleagues (Ward & Marshall, 2004) has now begun to highlight the importance of non-specific treatment responsivity factors, such as the therapeutic relationship and the characteristics of the therapist and the participant. This research will be discussed in more detail below. Treatment responsivity is now seen as a key factor in treatment effectiveness, given as much importance as the risk and need principles (Ward & Eccleston, 2004). Responsivity theory refers to a number of related issues concerned with engaging the participant in the therapy process. Responsivity includes internal responsivity (characteristics of the person who offended) and external responsivity (characteristics of the treatment environment and the therapist) (Birgden, 2004). In particular it

relates to the personal qualities of the therapist, the style of the therapist, the process of therapy, including the qualities of the therapeutic relationship, and the tailoring of interventions to match the personal qualities, cognitive abilities, learning styles and interests of the participants. Contemporary theories of rehabilitation and treatment of adolescent sex offending have begun addressing issues of internal responsivity, such as specialist groups for intellectually disabled clients (Ayland & West, 2005). However, the topic of external responsivity is only now beginning to be addressed, such as the recent work on the role of the therapist, and using a positive approach to treatment (Drapeau, 2005; Marshall & Serran, 2004; Marshall et al., 2005; Ward et al., 2006).

Contemporary approaches to the rehabilitation of both adults and adolescents who have sexually offended are placing more emphasis on a more positive and reconstructive approach to treatment emphasising the centrality of enhancing the quality of life of people who have offended in order to reduce the risk of re-offending, rather than focusing solely on criminogenic needs or risk factors (Ward & Stewart, 2003). This movement is in line with constructive approaches to the rehabilitation of offenders in contradistinction to retributive approaches to offending (Ward et al., 2006). The movement towards a more positive approach to offender rehabilitation has been given impetus by developments in explanatory theory which trace the origins of both adult and adolescent sexual offending to poor quality childhood relationships with parents and the recognition that offenders have needs for a good life, like other members of the community. There has therefore been a new emphasis placed on client values, hopes, intentions, self-esteem, the personal qualities of the therapist and the creation of a collaborative therapeutic relationship (Marshall,

2005; Marshall et al., 2005). There is also an implicit recognition that we need to overcome "us and them" perceptions of offenders and break-down negative stereotypes of child sex offenders if we are going to improve the process of community re-integration. Given that many adolescent clients have experienced insecure parent-child attachment relationships and various degrees of abuse and trauma as children, the field is now adopting a developmental attachment-based approach to treatment to complement the more traditional cognitive-behavioural-educational interventions, in order to heal past trauma, develop the reflective function and to build healthy self esteem so that these young men *can* take responsibility for their past actions and go on to lead good lives, free from violence and abuse (Mann, 2004; Rich, 2006a; Schore, 2003b; Solomon & Siegel, 2003; Ward & Marshall, 2004).

One of the more interesting developments of the past few years has been the emergence in the field of strengths-based rehabilitation theory. This is not meant to replace but to complement and enhance the risk-needs-responsivity based framework. The strengths-based model is founded on the principles of positive psychology (Ward et al., 2006). The strengths-based approach to assessment and treatment has also been influential in social work (Saleebey, 1992). Ward et al. (2006) stress that the positive goal-setting approach to offender rehabilitation is going to be more effective in reducing recidivism than the more negative risk management relapse model. They argue that offenders will be more motivated to change if they can be given opportunities to participate in developing their own preferences for a good life. The authors have developed a treatment theory which they call the "good lives model" (GLM). They found their theory on a primary and secondary human needs model,

which assumes that people who commit sexual offences still share with all other human beings a predisposition or motivation towards what they call "primary goods". Primary goods are states of mind or forms of relating which are intrinsically satisfying and generate a sense of well-being. They include relatedness, health, autonomy, creativity and knowledge. These are distinct from instrumental or secondary goods which provide the means towards achieving the primary goods, such as the acquisition of language and income. It is argued that the key to rehabilitation and treatment theory is the assumption that sexual offending is a misguided attempt to achieve these primary goods. Pathways to meeting these primary goods are therefore mapped out, in collaboration with clients, into a good lives plan. Emphasis is also placed on identity issues and how clients conceptualise their own view of a good life:

> In our view, individuals' conceptions of themselves directly arise from their basic value commitments (human goods), which are expressed in their daily activities and lifestyle. People acquire a sense of who they are and what really matters from what they do; their actions are suffused with values. What this means for therapists is that it is not enough simply to equip individuals with skills to control or manage their risk factors; it is imperative that they are also given the opportunity to fashion a more adaptive personal identity, one that bestows a sense of meaning and fulfillment (Ward et al., 2006, p. 304).

Therefore, the authors conclude that the client's sense of well-being should play a "major role in determining the form and content of rehabilitation programmes,

alongside that of risk management" (p. 304). The strengths-based approach is therefore a positive reconstruction of the risk-need-responsivity model, and it would be hoped that outcome studies would show greater effectiveness through measuring retention rates and relapse percentages. The model makes intuitive sense and really opens up the field to create a more positive culture on treatment programmes than in the past. It promises not only to benefit the community and the clients of programmes but should also motivate clinicians and help to retain clinicians working in this often stressful field. I see my research in this thesis contributing to this work, by introducing the additional concept of optimal responsivity and by focusing on the therapeutic use of self.

2.9 Process issues in sexual offending treatment

As discussed above, it is only recently that research attention has been directed at process variables such as the person of the therapist and the therapeutic relationship and it has been suggested that treatment effectiveness might be improved by training therapists to enact the positive therapist behaviours that have been identified in the psychotherapy research literature (Marshall & Serran, 2000). Marshall also argued that treatment manuals needed to be revised to allow for therapist flexibility (2009). There has been a surge of research into therapist style and process issues covering areas such as engagement or readiness (Ward et al., 2004); the therapeutic alliance (Ward et al., 2008); the therapeutic climate (Beech & Fordham, 1997; Beech & Hamilton-Giachritis, 2005) and treatment manuals (Hollin, 2009; Mann, 2009; Marshall, 2009). This research has led to changes in the way treatment is practiced.

Marshall and his colleagues (Marshall, Fernandez et al.,2003; Serran, Fernandez et al., 2003) completed a comprehensive review of the literature on general psychotherapy which indicated that the therapist's style, the client's perceptions of the therapist, and the alliance between client and therapist, all influenced treatment effectiveness. On the basis of the literature the following therapist factors were found to enhance effectiveness: Empathy, genuiness, warmth, respect, support, confidence, emotional responsivity, self-disclosure, open-ended questioning, directiveness, flexibility, encouraging active participation, rewarding, & use of humour. Many of these factors are examples of the use of self. The following factors were found to impede change: Confrontation, lack of the above factors; low interest; expression of anger or hostility. Out of all these factors it was found that empathy was the most important (Marshall, Fernandez, et al, 2003).

It was also found that client's perceptions of the therapist and the therapeutic alliance had a significant impact on outcomes. The literature showed a positive correlation between a client's perceptions of the quality of the therapeutic relationship and their perception of positive outcome. This survey of the literature suggested that it is not only what the therapist says or does, but also the way the client perceives the therapist's behavior that determines treatment outcome. Client's perceptions of the therapist's confidence, involvement, focus, emotional engagement, and positive feelings for them, significantly influenced their view of the value of treatment and engagement. Typically, client's sense of improvement is correlated with positive views of their therapists (Marshall, et. al., 2003). Research into therapeutic outcomes has consistently shown that the therapeutic relationship is an important factor (Lampard & Barley, 2002) and according to these studies, this relationship is a

product of therapist's style and the client's perceptions of the therapist. Similarly, after a review of the literature on the client's experience of therapy, McLeod (1990a) determined that clients consider the therapeutic relationship as more important than the use of any specific treatment procedures. Marshall's research showed a consistent and positive relationship between the quality of the alliance and treatment outcome. It was also clear that therapist style helps the development of the alliance and that these findings re therapist style and relationship apply equally to all modalities.

After completing this comprehensive review of the general psychotherapy literature, Marshall and his colleagues (Marshall, *et al.*, 2002; Marshall, *et al.*, 2003) went on to conduct a series of studies aimed at elucidating the influence of the therapist's behaviour and style on treatment change with sexual offenders. They had access to data on treatment changes across a variety of treatment programs operated by the prison service in London as well as video-taped recordings of every session. The therapists were required to follow a detailed treatment manual. In this way the same treatment was standardised across all the programmes, plus they all used the same pre and post treatment outcome measures. The tapes were reviewed by the researchers to see if the therapist features identified in the general psychotherapy literature could be identified. These studies confirmed Marshall's argument that a collaborative psychotherapy style is more beneficial than a confrontational style.

This argument was also supported by the research conducted by Beech and colleagues (Beech & Fordham, 1997; Beech & Hamilton-Giachritsis, 2005). The first study examined the influence of group cohesiveness on behaviour changes in 12 different sexual offender treatment groups and found that the group with the highest cohesiveness scores correlated with the highest change and the group with the lowest

cohesiveness score displayed almost no changes. A helpful and supportive leadership style was found to be important whereas overcontrolling leaders were seen to have a detrimental effect upon group climate, thus supporting the research of Marshall that a collaborative over a confrontative style was preferred. In a subsequent study it was again found that group cohesiveness predicted treatment outcomes. They also reported that the degree of emotional expression during treatment was positively related to beneficial changes. They agreed with Marshall and colleagues (2003) that respect, support, confidence, emotional responsivity, self-disclosure, open-ended questioning, flexibility, positive reinforcement and the use of humour were correlated to good outcomes.

In another paper (2005) Marshall & Serran argue that although past practice under the guidance of the risk-needs-responsivity model dictates offender programmes should be based within a CBT orientation, little is known about the impact of the therapist in delivering program content, or how therapist behaviors can enhance the therapeutic process. The paper argues that therapists can use the therapeutic relationship to build trust and rapport, and that training should aim to enhance these relational skills such as the use of self. The authors in particular emphasised the importance of a non-judgmental approach to enhance trust. They also discuss the responsivity principle and argue that this implies the need for flexibility on the part of the therapist.

A series of studies by Drapeau (2005) combining qualitative and quantitative approaches also found that programme participants judged the role of the therapist to be crucial to any benefits they received from treatment. While some techniques were seen as valuable, the therapist was seen as the most important factor. Effective

therapists were seen as honest and respectful, caring, non-critical and non-judgmental. Therapists who were confrontational led to clients withdrawing from effective participation, while therapists who worked collaboratively with clients were successful in gaining full engagement.

2.10 The therapeutic alliance and sexual offending treatment

The therapeutic alliance has been consistently demonstrated in research to be one of the best predictors of outcome across all therapy models (Horvath & Symonds, 1991). According to Bordin (1979) the quality of the alliance is a function of the degree of agreement between therapist and client on the tasks and goals of therapy and the quality of the affective bond between them (Safran & Muran, 2000). The facilitative conditions and personal qualities of the therapist as perceived by the client contribute to the development and maintenance of the therapeutic bond. The therapist also contributes through negotiating tasks and goals and repairing ruptures to the alliance:

> Tasks are the behaviours and processes within the therapy session that constitute the actual work of therapy. Both the therapist and the client must view these tasks as important and relevant for a strong therapeutic alliance to exist. The goals of therapy are the objectives of the therapy process that both parties endorse and value. Bonds include the positive interpersonal attachment between therapist and client of mutual trust, confidence, and acceptance (Lambert & Barley, 2002, p. 24-25).

The relevance of the therapeutic alliance for sexual offending treatment has been recently investigated from the unique perspective of sexual offending therapy (Ross, Polaschek & Ward, 2008). The authors argue that in spite of the vast literature confirming a positive relationship between the therapeutic alliance and treatment outcome, there is little theoretical understanding of how the therapeutic alliance develops and is maintained. In this theoretical paper the authors set out to revise Bordin's theory of the therapeutic alliance to make it relevant for therapists who work to reduce the future risk of criminal behaviour. Although Bordin's description of the alliance as comprising an agreement on the goals and tasks of therapy and a therapeutic bond has been widely influential, Ross and colleagues argue that it fails to account for how the alliance develops in the first place. They identify a number of different factors that can hinder or enhance the development and maintenance of the therapeutic alliance in sexual offending therapy.

Following on from Marshall and colleagues' research, which identified a number of helpful therapist characteristics, Ross and colleagues argue firstly that therapist characteristics are important determinants of the successful development of an alliance: "therapists bring both who they are as a person and the effects of their professional training, to a therapeutic interaction" (p. 465). Therapist behaviours, including self-disclosure, can contribute to the alliance. Ross and colleagues also bring our attention to the influence of the bias and expectations of therapists who work with offenders. For example, before meeting the participant, on the basis of professional and court reports, the therapist may already have formed a schema of the client that is not going to be helpful in the long-run to the formation of a collaborative relationship. Secondly, apart from therapist characteristics, participant

characteristics, such as aggressive or withdrawn behaviours, must also play a part in the development of the alliance. For, as Marshall already argued, participants' perceptions of the therapist (empathic) and the relationship (supportive) will have an influence on the alliance. As with the therapist, the interpersonal schemas (internal working models) the participant brings to therapy, will also have an effect on the development of the alliance. For example, as mentioned previously, children with disorganised attachment who expect caregivers to hurt, are thought to be very difficult to engage in a therapeutic bond because of their fears of re-traumatisation. Thirdly, Ross and colleagues argue that participant motivation to change (treatment readiness) will be another characteristic that predicts the formation of an alliance. Fourthly, the quality of the therapist-participant interactions must also play a significant part in the formation of the alliance. For example, is the match of therapist to client characteristics more important than the individual characteristics themselves? Are the various attachment styles complementary? "Given the importance ascribed in psychotherapy to the relationship between participant and therapist, it is surprising that the way in which therapist and participant interactions affect its development has not been examined more often" (Ross et al., 2008, p. 468).

Finally, Ross and colleagues also highlight the often neglected concern of the practice setting, system and social-environmental factors and role conflicts. The ideal situation, of a comfortable office, tastefully decorated, with a motivated client who has a support network and clear goals is rarely encountered in sexual offending treatment. However, these setting and context factors also contribute to the alliance. Participants in the sexual offending field are often mandated and the settings are usually very basic. System factors such as the legal process prior to entering

treatment or the relationships clients have had with other practitioners from different agencies such as juvenile justice or child protection can also have an influence. The sexual offending therapist will be perceived through the schemas and narratives participants have developed from these experiences. The need for risk management and safety planning can also be difficult to negotiate through the vehicle of a "collaborative therapeutic" alliance. Participants are expected to trust their therapist and practice self-disclosure, but the therapist, because of limited confidentiality requirements, may have to report the information to someone else, thus undermining the client's trust, and potentially, the alliance. This can create role-conflicts for the therapist. Social-environmental factors include how environments such as jails and other correctional facilities may undermine the ability of the offender to engage in a collaborative therapeutic alliance. Similarly, for adolescents being treated in the community, their peer group or other family members may undermine the goals of therapy. The therapeutic alliance may also be undermined by program requirements which place priority on risk management. This could mean some goals are imposed upon clients rather than allowing clients to negotiate their own goals thereby undermining the collaborative relationship and hence participants will feel less ownership and hence commitment to the alliance.

On the basis of the above concerns, Ross and colleagues (2008) concluded their paper by proposing a revised theory of Bordin's therapeutic alliance, incorporating the above factors as outlined. This identification of the various factors that help to develop and maintain the therapeutic alliance, make the revised construct more relevant for the treatment of people who have sexually offended. The revised theory has a number of important clinical implications:

> Since part of a therapist's role is to monitor therapeutic processes, this theory has implications for how flexible, introspective and aware a therapist needs to be in interactions with an offender. In essence, the RTTA (revised theory of the therapeutic alliance) implies that therapists may need to be *more* aware of their own personal characteristics and the behaviour that results in a therapy session, and to acknowledge that professional training does not create an objective automaton who delivers therapy to any and all comers … we suggest that therapists are likely to make the best contribution to fostering and repairing a TA (therapeutic alliance), when they are able to take on an introspective role that has only quite recently begun to gain adequate recognition in the cognitive-behaviour therapy domain. They need to be especially sensitive to how their client reacts to them, and perhaps adjust – through the expression of behaviour – their style of relating and working to suit the client. Therapists also should be encouraged that repairing ruptures is likely to strengthen the TA, especially if it can involve a relatively open discussion of the cognitive and emotional responses of both parties (Ross et al., 2008, p. 477).

The research documented in this thesis seeks to build on this surge of interest in research into process issues, in particular how the therapeutic use of self helps to create and sustain the therapeutic alliance.

2.11 Conclusion

In this chapter I have discussed the relationship between explanatory and treatment theory and stated my position on how treatment theory can benefit from the insights of explanatory theory, but that the subjective experience of the therapist and the clinical judgment which is derived from this is what should be the optimal guide to clinical interventions. Following this, I reviewed the location of sexual offending therapy within the legal and social construction of sexual offending. I then reviewed attachment theories of sexual offending and gender theory explanations of sexual offending. I concluded that integrating both these levels of explanation is necessary in order to guide adolescent sexual offending therapists. Finally, I reviewed the research on process variables and the therapeutic alliance. This research clearly supports the move towards greater awareness of the role of the therapist and the therapeutic alliance in sexual offending therapy. In particular, the research suggests that the personal experiences and qualities of the therapist are just as important to therapy outcomes as are their professional training and techniques. The risk-need-responsivity rehabilitation model therefore needs to be revised in the light of these findings. For example, the therapeutic use of self can make a major contribution to the responsivity principle and also highlights the need for treatment programmes to acknowledge the place of professional discretion. I also suggested that the responsivity principle offers a useful guideline to treatment and can be enriched in practice by incorporating the relational psychoanalytic concept of optimal responsiveness. In chapter three I develop this argument further and theoretically locate the concept of optimal responsiveness within the history of relational psychoanalysis.

3.

RELATIONAL THERAPY AND OPTIMAL RESPONSIVENESS

The deeper and more trusting the client-worker relationship, the more the client reveals, and the easier it is for the practitioner to see the world through the client's eyes. (Freedberg, 2009).

3.1 Introduction

In chapter two, after giving an introduction to the relationship between explanatory and treatment theory and the legal and social construction of sexual offending behaviour, I discussed some of the major explanations of sexual offending, current research into process issues and the risk-need-responsivity (RNR) model of offender rehabilitation. The RNR model offered a useful bridge between explanatory theory and treatment theory and the responsivity principle was a useful guideline for evaluating treatment programmes. I argued that this model needed to be expanded beyond the implementation of CBT techniques to take into consideration therapy process factors such as the participant-therapist relationship and the personal and professional features of the therapist as well as the characteristics of the participant. I suggested that the concept of optimal responsivity could be a helpful way of thinking clinically on how to implement the principle of responsivity in practice. In this chapter, I locate the concept of optimal responsivity within a selected theoretical history of relational therapy. I begin my discussion of relational therapy with a consideration of the therapeutic relationship and how the experience of empathy can

be understood as one of the key factors in generating rapport. Empathy can be seen as the foundation of optimal responsivity, having both a receptive mode (listening stance) and a responsive mode (verbal and non-verbal responses). I then discuss the work of Heinz Kohut, a psychoanalyst, who was one of the key figures in the development of the relational approach. Kohut's work is considered along with that of the more well-known work of Carl Rogers. I then discuss self psychology, the particular relational approach that Kohut established. Following this I discuss the concept of *intersubjectivity*, which again expands upon the concept of empathy developed in self psychology to include the important dimension of subject-subject relatedness or other-centred relating. Intersubjectivity is discussed both as a developmental category and as a form of relational therapy. Finally, I conclude this introduction to relational therapy with a discussion of the relevance of the concept of *optimal responsivity* to sexual offending therapy. Optimal responsiveness is inclusive of both self-psychology and intersubjectivity theories of therapeutic change. In particular, I argue that the concept of optimal responsivity, first introduced in 1985 by the psychoanalyst Howard Bacal (Bacal, 1998b), can make a significant contribution to helping to implement the responsivity principle in practice. There are many therapists who have contributed to the development of what has come to be known as the relational approach and within the short space of this chapter I cannot effectively overview this history. I refer the reader to the work of Aron (1996), DeYoung (2003), Freedberg (2009), Safran & Muran (2000) and Wachtel (2008) for excellent overviews of the historical development of this approach.

3.2 The therapeutic relationship

Although I was initially trained in narrative therapy, like other narrative and systemic family therapists such as Bird (2000, 2004), Flaskas (1996, 2002), Flaskas & Perlesz (1996), Gibney (2003), Satir (2000) and Winslade, Crocket, and Monk (1997), I have come to the conclusion that family therapy, including narrative therapy, has sometimes overlooked how the participants' experience of the therapeutic relationship can be an important resource for enhancing self-awareness and facilitating therapeutic change. For example, I agree with Bird's (2000) comment that:

> Narrative and systemic family therapies commonly leave the therapist out of descriptions of the therapeutic relationship. A proliferation of articles on the technical application of ideas together with success stories has unwittingly created a context where trainees and experienced therapists ignore their own experiences in search of the 'right' question (p. 14).

One of the reasons for this may have been the need for narrative and systemic family therapists to distance themselves from the psychoanalytic tradition and concepts such as transference and countertransference. Indeed, White (1997) argued forcefully for the "decentring" of the therapist, in order to avoid privileging the "micro-world" of therapy over the "macro-world" of the lives and relationships of the participants. On this particular point I disagree with White and agree with other narrative therapists such as Bird (2000) and Winslade et al., (1997) that the "here and now" experience participants have within the micro-world of the therapeutic relationship are invaluable

resources for mutual discovery and collaborative meaning-making. In fact, if we wish to focus on the lived experience of the present moment in therapy (Stern, 2004a), we *have* to privilege the micro-world of therapy. To privilege the macro-world, as White seems to imply, means we miss the rich texture of the moment-to-moment lived experience of the therapy session. I also wish to join with other narrative therapists and relational psychoanalysts (Bird, 2000, 2004; Buirski, 2005; Buirski & Haglund, 2001; Orange, 1994; Polster & Polster, 1973; Winslade et al., 1997) in developing an alternative way of describing and understanding the therapeutic relationship from the one person psychological language of transference and countertransference as used in classical psychoanalysis. Although the understanding of these terms has changed considerably since the days of Freud, they still bring with them the connotation that the client's experience of past relationships is transferred onto the blank screen of the therapist, rather than recognising the unique mutual influential interactions taking place within the here and now of the therapeutic relationship.

Psychotherapy research has shown repeatedly that after client factors are taken into consideration the single most reliable predictor of successful outcomes is the quality of therapeutic relationship (Bohart & Greenberg, 1997a, 1997b). Lambert and Barley (2002) reviewed the literature on research into the therapeutic relationship and psychotherapy outcome, and found that psychotherapy outcome research has not supported the notion that specific therapy techniques are a major contributor to client progress, when compared with the contributions attributable to the therapeutic relationship (p. 17). After a detailed analysis of the research, they concluded that extra-therapeutic factors contributed 40% to client progress; common factors (the

therapeutic alliance and the person of the therapist) contributed 30%; expectancy (placebo effect) contributed 15% and techniques contributed 15%. (p. 18). In this thesis I am concerned with relationship or "common" factors, shared in common by all different therapy traditions. In particular the thesis inquires into the use of self and how this contributes to creating facilitative conditions and the therapeutic alliance. When summarising the research on outcomes and the therapeutic relationship, Lambert and Barley (2002, p. 21-22) found that, "… it is difficult conceptually to differentiate between therapist variables (interpersonal style, attributes), facilitative conditions (empathy, warmth, positive regard), and the client-therapist relationship (therapeutic alliance, working endeavour)." It can also be shown that "despite concerted efforts to suppress unique therapist effects (training, manuals, supervision) a considerable portion of the variance in outcome between patients is likely due to the particular therapist who provides treatment" (p. 22). Clients also appear to believe that "the personal qualities of the therapist were more important than specific technical factors of treatment" (p.22). As detailed in chapter two, several therapist variables have been consistently shown to have a positive effect on outcome. These include "therapist credibility, skill, empathic understanding, and affirmation of the patient, along with the ability to engage the patient, to focus on the patient's problems, and to direct the patient's attention to the patient's affective experience" (p. 22). The factors most frequently reported in the research summarised by Lambert & Barley (2002) are those proposed by Carl Rogers (1967/76): empathic understanding, warmth, care and respect (positive regard) and congruence (the client's perception that the therapist is real and genuine).

Both Rogers' work on relational conditions, and Kohut's developmental self psychology, propose that empathy is a key ingredient in developing the therapeutic bond and a principal agent for facilitating change (Elson, 1986; Meares, 1993; Wolf, 1988):

> The empathic process in which therapists steep themselves in the world of the other attempting to understand how others see and experience themselves and their worlds, putting this into words and checking their understanding, appears to us to be curative. Empathy is a process of co-constructing symbols for experience. Clients' process of symbolizing their experience appears to us to be a universal core ingredient of the therapeutic process. Being able to name an experience first makes the previously implicit explicit, thereby providing an improved sense of facilitation and comprehension of how one knows what one is experiencing. This in and of itself provides some clarity- and relief from earlier confusion. Once one has a handle on what is felt, one can then also begin to reflectively operate on what has been symbolized in awareness: reorganizing, explaining, and exploring further, thereby creating new meaning and new narrative constructions. This process of becoming aware of internal experience, putting it into words and reorganizing it once it has been symbolized, is healing and leads to greater self-understanding and improved self-organisation. Empathy thus helps us to make sense of our experience (Bohart & Greenberg, 1997b, p. 5-6).

However, although development of empathy for the victims of sexual abuse has long been recognised as one of the most commonly defined goals and hoped for outcomes in evaluating the progress of participants in treatment (Burke, 2001; Rich, 2003; Ryan, 1999; Ryan & Lane, 1997b) there has been less attention paid to it as an important element of the treatment *process*.

The practice of empathy is often taken for granted and the skills or approach to practice necessary to produce the experience of feeling understood is often overlooked in preference to more directive forms of intervention: "This neglect of the curative effects of relational empathic skills is occurring despite the fact that most of our psychological models of the genesis of psychopathology emphasise relationship deficits" (Bohart & Greenberg, 1997b, p. 4). A second wave of interest in empathy (after Rogers) is now occurring within the fields of psychotherapy generated by self-psychology, feminist relational self theory (Herman, 1992; Jordan, 1997) and the findings of contemporary neuroscience, attachment research and especially infant research (Bohart & Greenberg, 1997a; Schore, 2003a). These findings are also directly relevant to adolescent sexual offending treatment. Attachment theory, infant research and neuroscience have been influential in shaping the understanding of the importance of dyadic affect regulation (Schore, 2003a, 2003b; Schore & Schore, 2008; Siegel, 1999; Stern, 1985/2000). It has been particularly influential in helping us to understand how individuals with poor attachment histories are vulnerable to self esteem, intimacy and empathy disorders which are linked to relationship difficulties, conduct disorders and sexually abusive behaviours (Chorn & Parekh, 1997; Marshall & Marshall, 2000; Rich, 2006a; Smallbone, 2005). It is suggested that the intuitive empathically attuned therapist can repair this developmental deficit,

by reproducing in the therapeutic relationship, an analogous situation to the caregiver-child relationship, hence giving the child a developmental second chance (Buirski & Haglund, 2001; Schore, 2003a). This can be seen as the therapist facilitating a play space within which both participants create a shared, idiosyncratic form of "feeling language" which is productive of intimacy and an enriched sense of personal being (Hobson, 1985; Meares, 1993). Evidence suggests that attachment is produced through the primary care-giver providing affect regulation, by mirroring the positive, vitalizing affects and soothing the negative affects experienced by the child. The provision of affect regulation by an attuned caregiver produces an emergent preverbal self. For the infant, mutual affect regulation is provided through the pre-discursive interactions with caregivers; and for adolescents and adults in therapy, it is provided through the experience of feeling understood by an attuned empathic therapist (Lichtenberg et al., 1996; Schore, 2003a; Siegel, 1999; Sroufe, 1995; Stern, 1985/2000). Given that many of the participants in adolescent sexual offending programmes suffer from intimacy deficits and attachment disorders, it would therefore seem to be the case that all treatment interventions within adolescent sexual offending therapy should be grounded in an empathic and caring therapeutic relationship.

Empathy also has the effect of helping clients "become more compassionate and empathic to themselves" (Bohart & Greenberg, 1997b p. 6). This is considered to be a crucial component of therapeutic work with trauma survivors and has been developed into a therapeutic practice entitled "compassionate witnessing" by Kaethe Weingarten (2003 p. 203-206). The capacity to become more compassionate and empathic towards self can be seen as the first crucial step towards becoming empathic

towards others. One of the widely accepted goals in adolescent sexual offending treatment is the development of the ability of the participant to empathise with the person(s) who has been harmed by their offence (Ryan & Lane, 1997a). However, findings from developmental psychology would suggest that the ability to empathise with others is not an innate ability but a higher order function which is dependent on the development of the ability to self-reflect, which, in turn, is dependent upon the establishment of a secure attachment relationship with attuned caregivers (Fonagy, Gergely, Jurist, & Target, 2004; Schore, 2003a; Sroufe, 1995; Stern, 1985/2000). The ability to empathise with others, it seems, is dependent upon having the consistent experience of being empathised with. It is reasonable to suggest therefore, that children who have been raised in environments where there is abuse, neglect or consistent mis-attunement may grow up with an inability to express or receive empathy.

3.3 Rogers and Kohut

There is nothing new in the argument that the therapeutic relationship is the core of therapy and is more important than any particular model or intervention. Rogers (1957) argued that the therapeutic relationship was itself therapeutic and more important than specific techniques or theoretical orientation. He also argued that the establishment of the therapeutic relationship was conditional upon the personal qualities of the therapist, such as empathy, warmth, non-judgmental acceptance and genuineness. Before Rogers, psychoanalysts such as Ferenczi (1932) and Alexander & French (1946) argued that it was the patient's emotional experience of the therapeutic relationship rather than the transference interpretation, which was the key

to therapeutic change. It was the work of these analysts and the interpersonal school of psychiatry founded by Sullivan (1953), together with the work of Kohut, which led to the development of the contemporary relational approach to psychoanalysis which exists today (Aron, 1996).

Rogers claimed that it was the quality of the therapeutic relationship that was the single most important element in determining treatment effectiveness (Rogers, 1967/1976) . Rogers was one of the first treatment theorists to argue that the person of the therapist was a key factor, in that it was important for the therapist to meet the client on a person to person level. According to Rogers, this was accomplished through the attitudinal qualities expressed by the therapist and importantly *perceived* by the client. This is a key point. It doesn't matter how warm or empathic a therapist may experience themselves to be if the client is not *feeling* safe and understood by the therapist.

Rogers formulated this important insight into his three influential principles: *congruence*: the therapist is genuine, he or she, does not put up a professional front or façade but meets with the client as a person; *unconditional positive regard*: the therapist is accepting and non-judgmental; and *empathic understanding*: the therapist is accurately attuned to the client's inner life and expresses this in such a way that the client feels understood (Rogers, 1967/1976). Rogers defined empathy as the therapist's ability to understand the client's private inner world and communicate some of that understanding to the client: "To sense the client's inner world of private personal meanings as if it were your own, but without ever losing the 'as if' quality, this is empathy, and this seems essential to a growth-promoting relationship"(Rogers, 1967/1976, p. 92-93). In this sense, Rogers developed a phenomenological definition

of empathy (Warner, 1997). That is, staying as close as possible to the actual phenomena as subjectively perceived by another person.

I find it interesting that most counselling courses cover Rogers but very few cover Kohut (Kohut, 1971, 1977, 1984). Heinz Kohut was the founder of psychoanalytic self-psychology and his concept of the introspective-empathic stance had a significant influence on the development of relational psychoanalysis (Buirski & Haglund, 2001; Wolf, 1988). It was the work of Kohut in combination with British analysts such as Winnicott, Fairbairn and Balint that led to the break from the classic drive or desire paradigm to the relational paradigm in contemporary psychoanalysis (Lee & Martin, 1991). Kohut argued that psychoanalysis was a human science. Its subject matter therefore differed from the natural sciences in that it was concerned with understanding subjective experience and that subjective experience could only be understood subjectively. He argued that we cannot directly observe or gain direct access to another's subjective experience; therefore we have to rely upon what he described as "vicarious introspection". Kohut argued that psychoanalytic data were gathered through prolonged immersion in the patient's subjective experience via this process of vicarious introspection. He distinguished introspective data from extrospective data, arguing that only introspective data were psychoanalytic data. Extrospective data, such as the genogram, developmental and family history and professional theory could be helpful in orientating the therapist during the initial assessment stage but introspective data was essential in understanding the patient. Empathy, for Kohut, is therefore a form of observation or data gathering using an introspective lens through which we can think and feel ourselves into another person's subjective experience (Lee & Martin, 1991; Wolf, 1988).

Kohut used the example of a "tall" man to illustrate the process of empathy:

> Only when we think ourselves into his place, only when we, by vicarious introspection, begin to feel his unusual size as if it were our own and thus revive inner experiences in which we had been unusual or conspicuous, only then do we begin to appreciate the meaning that the unusual size may have for this person and only then have we observed a psychological fact (Kohut, 1959, pp. 207-208; quoted in Lee and Martin, 1991, p. 106).

This is a good illustration of the relationship between empathy and understanding of personal meaning. Like Rogers, it involves coming to an understanding of personal meaning by completely immersing oneself in the viewpoint of the other. One difference between Kohut and Rogers was that this phenomenological immersion in the subjective experience of the patient was only the first step toward empathic understanding according to Kohut, although Kohut thought this was the most important step and described it as "experience near". The second step, and this is where Kohut would differ from Rogers who did not make "interpretations" (Rogers,1967/1976), was to articulate explanations or interpretations to the patient based upon this prior experience near understanding in combination with theoretical knowledge. Kohut referred to this as "experience distant" empathy, because the language was more abstract and generalised. In a third, distinct definition, Kohut, following Rogers, also recognised empathy as being central to the formation of human bonding. Furthermore, like Rogers, Kohut saw the work of empathic understanding as being central to therapeutic transformation:

> . . . empathic immersion is not simply a new mode of data gathering. Empathy itself, Kohut claimed, "is a therapeutic action in its broadest sense, a beneficial action in the broadest sense of the word." In other words, empathy as a mode of observation is inextricably intertwined with empathy as a therapeutic agent in its own right. Our empathic inquiry results both in our better understanding of our patient and in our patient's *feeling understood*. Thus, the inquiry itself transforms the subjective state it inquires into (Magid, 2002, p. 15).

Also, in contrast to Rogers, Kohut's understanding of empathy (and therapy) was developmental. He saw the roots of empathy lying in the mutual responsiveness of the infant-caregiver dyad. Kohut's emphasis on the participation of the personal self of the therapist was also quite different to Rogers in the sense that it is often not under our conscious control, hence Kohut realised that the therapist can never always be totally congruent and in tune with the client. Aspects of the therapist's self will not always be totally known at any given moment in an interpersonal relationship. It is therefore expected that the therapist will make mistakes, cause ruptures and hence hopefully mend these ruptures.

Kohut distinguished a three phase pattern in what is now referred to as mutual dyadic affect regulation (Schore, 2003a): *attunement,* during which the therapist strives to be empathically attuned to the moment by moment affective states of the patient; *disruption,* when the patient perceives the analyst as being misattuned; and *repair,* when the analyst is able to pick up on the misattunement, acknowledge this

and repair the disruption through regaining the state of attunement. The outcome of this process is the development of an attachment bond and the internalising of the ability in the patient to self reflect and self-regulate leading to the building of resilience. This basic pattern that Kohut identified in his clinical work has since been demonstrated in the findings of infant research (Elson, 1986; Fonagy et al., 2004; Fosha, 2000; Lichtenberg et al., 1996; Schore, 2003a; Sroufe, 1995; Stern, 1985/2000), which suggests the infant's experience of misattunement being repaired by re-attunement is what creates the attachment bond. It has also been taken as a metaphor for understanding how to build and repair the therapeutic alliance (Safran & Muran, 2000). Kohut's experience of treating what are referred to as narcissistic disorders in psychiatric discourse led to his formulation of his developmental theory and his theory of self-objects.

3.4 Self Psychology

Kohut's theory of self psychology is a theory of human development based upon his clinical experience (Elson, 1986, 1987; Kohut, 1971, 1977, 1984). Kohut never gave an explicit definition of what he meant by the concept of self (Wolf, 1988). Current psychoanalytic developmental theory recognises that the self should not be reified; it is a function rather than a thing. It is an outcome of our developmental context. According to the work of Stern (1985/2000) the infant is born with an emergent self which by the end of the second month, given an optimal responsive caregiving milieu, develops into a "core sense of self"; whereas a vulnerable self, prone to fragmentation emerges from a less than optimal environment. Between the seventh and fifteenth month an "intersubjective self"

(1985/2000, pp. 124-161) emerges with a capacity for engaging in interpersonal relatedness such as the sharing of intentions and affective states with its caregiver. This includes the capacity to recognise minds – the ability to recognise other people have intentions and feelings separate to the self. Finally, between the ages of 15 to 18 months the infant develops a verbal self with the capacity to enter into symbolic play and to create narratives and experience an objective sense of self (1985/2000, pp. 162-184). This is sometimes referred to as the "mirror stage", when the infant is capable of recognising itself in the mirror (Jacoby, 1999).

Without the self there can be no subjective experience (Sroufe, 1995). The self functions to both evaluate interactions with the environment (emotions) and to regulate our emotional states in much the same way that our lungs and heart regulate the circulation of oxygen and blood. The core sense of self which emerges at approximately 2-3 months could be referred to as the "core affective self" or the "preverbal self" (Stern, 1985/2000). This self emerges from the attachment relationship and has developed its own centre of initiative or sense of purpose in the second half of the first year. At about 18 months the child develops the capacity of self-awareness, and hence experiences the so-called secondary or self-conscious emotions such as shame and guilt (Broucek, 1991; Tangney & Dearing, 2002). Midway through the second and third years the narrative self emerges (Stern, 1985/2000). This emerges at the same time as the child develops a theory of mind and the reflective function (Fonagy et al., 2004; Ward et al., 2006). The core affective self and the narrative self continue to function throughout the lifespan. Relational interventions, such as mirroring and affect attunement are aimed at the core affective self whereas narrative interventions such as reflexive questions are

aimed at the narrative self. This combination of interventions supports the functioning of the affective-narrative self in maintaining our sense of coherence, continuity and vitality.

Kohut also speaks metaphorically of a bi-polar self (Wolf, 1988), which develops from infancy onwards. On one end of the polarity we have the child's sense of healthy narcissism, taking delight in its own grandiosity. When the caregiver mirrors this delight in their facial expressions and vocal tones this side of the self develops into what in later life become our ambitions. On the other end of the polarity, the child identifies with an idealisation of the caregivers. In later life need for an idealising self-object becomes transformed into values and ideals. In between the two polarities Kohut speaks of a tension arc of skills and abilities which are the means by which these ambitions and ideals can be realised.

According to Kohut, the self grows and develops through a process he called *optimal frustration*. By this he means during infancy the needs of the infant expressed through vocal and facial cues are read by the responsive caregiver. Therefore, initially the physical and emotional needs of the infant are regulated by the caregiver. However, inevitably there will be times when the caregiver cannot be there right away and the infant becomes frustrated and has to fall back upon its own resources. For example, the infant may be able to soothe itself by cuddling on the blanket, with the blanket associated with the warmth and security of the caregiver, temporarily substituting for the caregiver. If the caregiver then arrives, the infant has begun the process of transmuting the functions of the caregiver into self-functions. However, if the caregiver does not return, then the experience becomes traumatic because the infant goes into a state of panic. Kohut began to call the function that is

performed by the caregiver, a self-object. In infant research this is usually referred to as the self-regulating other (Jacoby, 1999). When the infant begins to transmute the function previously performed by the self-object (optimal frustration), this is what Kohut called structure-building, that is building the self so that the self becomes self-regulating.

Kohut's theory of human development diverged from the dominant psychoanalytic theories at that time, such as Mahler (Mahler, Pine, & Bergman, 1975), which emphasised the developmental trajectory as moving from symbiosis to individuation and autonomy – a movement from dependency to independence. Kohut also rejected Freud's theories of narcissism (Freud, 1914/1957) and aggression (Freud, 1930/1973). Freud had argued that primary narcissism is eventually transformed into mature object love. Kohut, on the other hand, argued that narcissism has its own line of development that continues through the whole lifespan. This was Kohut's argument for a "healthy" narcissism. Kohut argued that healthy narcissism eventually matured into creativity, humour and wisdom. However, if a child was raised in an environment in which self-objects were unreliable or abusive, the child would receive narcissistic injuries. Kohut thought that destructive forms of interpersonal aggression were not primary drives but were secondary reactions to narcissistic injuries. These injuries to the self created a vulnerability that predisposed the child to various forms of narcissistic rage in reaction to various precipitating factors such as perceived criticism or ridicule. These children would then grow up into adults with unmet needs for mirroring and idealising self-object transferences (Wolf, 1988).

Kohut claimed that when a patient with a narcissistic injury met a therapist who responded empathically the unmet needs of childhood would be reactivated and eventually manifest in what he called the self-object transferences: the mirror transference, the idealising transference and the twinship transference (Wolf, 1988). Self-object experiences refer to "any experience that enhances the strength of the self or, in more 'experience-near' terms, any experience that enhances the feeling of well-being" (Bacal, 1998a p. 149). As with childhood, the process of analysis would parallel the infant-caregiver system. The self-object functions initially performed by the analyst would eventually, through the same process of optimal frustration, be transmuted into self-regulating functions.

> Selfobject relations, or more precisely, selfobject experiences, are the proper topic for psychoanalytic investigation. Selfobject experiences are not objectively observable from the outside, so to speak. They are not events in an interpersonal context and are not part of social psychology . . . Direct access to the selfobject experience is only by introspection and empathy (Wolf, 1988 p. 54-55).

Kohut developed the concept of "selfobjects" to make sense of what he experienced in the transferences and as a developmental concept (Lee & Martin, 1991; Wolf, 1988). In these relational experiences Kohut thought that the patient made use of the therapist as a "selfobject" in the same way that infants made use of their caregivers. What he meant by this was the patient came to depend on the therapist to provide experiences that were missing from his or her upbringing. Thus, mirror transference

referred to how the therapist would mirror back to the patient their positive affect in relation to an accomplishment they were proud of. The idealising transference referred to the way the patient may experience the therapist as someone to look up to and aspire towards. The twinship transference referred to a feeling of collegiality with the therapist. The crucial point for psychoanalysis was that in formulating these ideas about self-objects Kohut was actually moving away from the concept of the separate isolated self towards the concept of the relational self. After the death of Kohut, this idea was in turn expanded upon and developed by psychoanalysts who developed the contemporary schools of relational psychoanalysis (Aron, 1996). His ideas also fitted well into the attachment or dyadic affect regulation paradigm (Jacoby, 1999; Schore, 2003a; Stern, 1985/2000). It is this overlap with psychoanalytic developmental theory and infant research which makes the work of Kohut still relevant today. In the next section, I first of all summarise the relational school known as *intersubjective systems theory* which builds upon and expands the work of Kohut. I then introduce the work of Jessica Benjamin who developed a constructive critique of Kohut's work, which lacked a theorisation of the relation between inner experience and how this is mediated by the external sociocultural world (1988). This issue has been addressed by a number of relational theorists (Altman, 1995; Aron, 1996; Chodorow, 1999), however, the work of Benjamin is pertinent to the discussion of gender theory that was begun in the last chapter.

3.5 Intersubjectivity and gender relations

An intersubjective systems approach to therapy is an example of a relational psychoanalytic tradition which has built on the work of Kohut and the British object

relations school (Aron, 1996; Bacal, 1998b; DeYoung, 2003; Freedberg, 2009; Goldstein, 2001; Wachtel, 2008). Intersubjective systems theory is critical of diagnostic categories that pathologise individuals in a manner which does not take into account the relational context within which the "pathology" developed (Stolorow et al., 1994). Intersubjective systems therapy understands pathology or problems as inherently relational and contextual:

> … all selfhood – including enduring patterns of personality and pathology – develops and is maintained within, and as a function of, the interplay between subjectivities …Intersubjectivity theory sees pathologies, from phobias through psychoses, in these terms. In other words, it radically refuses to place the origins or the continuance of psychopathology solely within the patient (Orange, Atwood et al. 1997, p. 6).

The focus of therapy remains on subjective experience, but more emphasis is placed on the experience of mutuality. Intersubjective systems therapy moves beyond the limitations of liberal-humanist individualism and the isolated Cartesian self, and to replace this understanding with a notion of a relational or intersubjective self. There is no subjectivity without intersubjectivity. The therapist cannot stand outside the system and become a neutral or unbiased observer who is not affected or changed in some way by the relationship. In this sense, psychotherapy is not a science, in the sense of the natural sciences, but is rather a practice of arriving at an emotional and dialogic understanding with the person who presents for therapy. Intersubjective systems therapy eschews rules and techniques and prefers to think of therapy as a

practice in the tradition of Aristotle's concept of phronesis or practical wisdom (Orange et al., 1997). In the same spirit, each treatment is regarded as unique arising from the unique subjectivities of the participants. The person who comes for therapy would present differently for different therapists and the two of them together would create their own unique processes (Buirski, 2005).

The two key practices in intersubjective systems theory are the *empathic-introspective stance*, which is a form of listening and receiving and *affect attunement*, which is a form of response. The therapist seeks to communicate their empathic understanding through verbal and nonverbal, affectively attuned responses (Buirski & Haglund, 2001). Intersubjective systems therapy builds upon the findings of psychoanalytic developmental psychology and infant research (Lichtenberg et al., 1996; Schore, 2003a). The central organising thesis of contemporary developmental psychoanalysis is that the "self" emerges from the mutual affect regulation in the caregiver-infant dyad (Schore, 2003b; Stern, 1985/2000). The quality of affect regulation provided by the caregiver will determine the ability of the child to self-regulate. The therapeutic practice of affect attunement therefore seeks to replicate this process in therapy sessions. For example, the therapist may mirror the client's affects – their crescendos and decrescendos, in their face, tone of voice and rate of speech. Affect articulation occurs when the therapist puts into words the feelings that they interpret are going on within the participant. This is particularly important when working with traumatised children and adolescents who often do not have the verbal and narrative skills to name their feelings. This practice develops the coherence of the client's self narrative and helps them to regulate affects. In my work with adolescent boys, I often hear complaints from caregivers and other professionals about

aggressive and self-destructive behaviours directed towards others or towards themselves. This is often described as "acting out" (Fonagy et al., 2004, pp. 294-295) their emotions, such as anger or sadness, rather than putting them into words. Adolescent boys often experience difficulty in regulating their affects, forming intimate relationships, participating in intimate conversations and experiencing empathy (both for themselves and others) (Rich, 2006a; Saxe et al., 2007). The ability to articulate affect is understood to be an important skill of affect regulation (Fonagy et al., 2004). When the therapist tentatively articulates what the participant may be actually feeling and the person feels understood, their affect is co-regulated, with a positive soothing or calming feeling being the result.

There is a confusing array of meanings for the words feelings, emotions and affect. Damasio (2000) proposes that "the term *feeling* should be reserved for the private, mental experience of an emotion, while the term emotion should be used to designate the collection of responses, many of which are publicly observable. In practical terms, this means that you cannot observe a feeling in someone else, although you can observe a feeling in yourself when, as a conscious being, you perceive your emotional states" (p. 42). Although we cannot observe someone else's feelings we can observe the emotion expressed in facial gesture and tones of voice. The look of recognition and the reciprocal smiles on the face of the client and therapist signal a shared moment of understanding. These interactions follow a temporal contour (Stern, 2004b). As the old cliché says, a picture tells a thousand words. A smile only lasts for a brief moment but can be a deeply meaningful experience. If we do manage to respond with a well placed word, it is important that

the word resonates with the client's affective embodied state. As another cliché says it's not what you say, it's how you say it.

Relational therapy understands the mind to be created through the mutual interactions of subjects. The self is inherently relational. However, although the term selfobject as developed by Kohut expresses this understanding, it fails to adequately recognise the "other" as a separate centre of experience. The meaning of *intersubjectivity* has been defined in psychoanalysis as the unique psychological field created by the intersection between two subjectivities (Buirski & Haglund, 2001; Stolorow et al., 1994) and as the mutual recognition of two subjects (Benjamin, 1990, 2004). Intersubjectivity has also been described as a developmental achievement, starting with the infant and caregiver participating in shared intentional states (Stern, 1985/2000), culminating in the child recognising the mother as an independent "subject" (Benjamin, 1990). Intersubjectivity has been used by a number of relational psychoanalysts, and I do not have the space to cover the work of all the different nuances. In this section I therefore focus on the work of Jessica Benjamin (Benjamin, 1988, 1990, 1998, 2004), who focuses attention on subject-subject relatedness within the therapeutic relationship.

Benjamin's work differs from other relational psychoanalysts by focusing on the problem of domination as it is structured in the polarity of gender relations, and replicated by other dualisms such as male rationality/female irrationality; male subject/female object; and male autonomy/female dependence. The achievement of intersubjectivity, as the relation between equal subjects is argued by Benjamin to be the way forward out of domination and duality. She is critical of the work of Kohut and object relations theorists as failing to distinguish between using others as

"objects" or "selfobjects" without recognising the other as an outside subject. These intrapsychic models only focus on the relationship to an internal object and they disregard the developmental experience of a subject meeting another subject which she takes to be the essence of the intersubjective view. However, she does not seek to replace the intrapsychic model with the intersubjective position but sees them as complementary ways of understanding our experience of subjectivity (Benjamin, 1988).

Benjamin stresses the centrality of recognition by the other in order to develop agency and self-assertion, and also the need to simultaneously recognise the subjectivity of the other. Benjamin (2004) defines intersubjectivity "in terms of a relationship of mutual recognition---a relation in which each person experiences the other as a "like subject," another mind who can be "felt with" yet has a distinct, separate center of feeling and perception (p. 1)". Her work draws on contemporary infant research which shows that the relationship between the mother and infant is interactive, where both parties initiate the sharing of subjective experience (Stern, 1985/2000). Intersubjectivity is therefore a developmental achievement (capacity) with a separate trajectory to that of the internalization of object relations (Benjamin, 1988; Stern, 2004b).

In seeking to understand the relations of domination within both the interpersonal and social domains, Benjamin's work builds on Simone de Beauvoir's insight:

> … that woman functions as man's primary other, his opposite – playing nature to his reason, immanence to his transcendence, primordial oneness to

> his individuated separateness, and object to his subject. This analysis of gender domination as a complementarity of subject and object, each the mirror image of the other, offers a fresh perspective on the dualism that permeates Western culture. It shows how gender polarity underlies such familiar dualisms as autonomy and dependency, and thus establishes the coordinates for the positions of master and slave (Benjamin, 1988, p. 7).

In her book, *The Bonds of Love* (1988), Benjamin argues that the phallic representation of sexual desire was based upon the dominant masculine culture of subject-object relationships, in which the masculine subject dominates the feminine object. Benjamin "identifies this unequal complementarity not only as the basic pattern of domination, but also as a *masculine* mode of thought and practice that permeates all social organisation" (Greene, 1996, p. 3-4). For Benjamin the intrapsychic model misses the essence of differentiation: "the paradoxical balance between recognition of the other and assertion of self" (Benjamin, 1988, p. 46). Intrapsychic theory stressed only the differentiation from the state of merger or oneness to separation and autonomy, with the state of oneness being derogated as a form of narcissistic regression. This creates a domination duality where the other is always seen as the doer or the done to, the other is the breast and the self is the hunger. The experience of the intersubjective as formulated by Benjamin overcomes this domination duality by understanding that sameness and difference can exist simultaneously in mutual recognition:

Experiences of "being with" are predicated on a continually evolving awareness of difference, on a sense of intimacy felt as occurring between "the *two* of us"…

> To transcend the experience of duality, so that both partners are equal, requires a notion of mutuality and sharing. In the intersubjective interactions both partners are active; it is not a reversible union of opposites (a doer and a done-to). The identification with the other person occurs through the sharing of similar states, rather than through reversal. "Being with" breaks down the oppositions between powerful and helpless, active and passive; it counteracts the tendency to objectify and deny recognition to those weaker or different – to the other. It forms the basis of compassion, what Milan Kundera calls "co-feeling", the ability to share feelings and intentions without demanding control, to experience sameness without obliterating difference (Benjamin, 1988, p. 47-48).

According to Benjamin (1988) it is during this differentiation process that the male child goes through a process of disidentification with the mother and anything feminine thereby developing his gender and identity by establishing discontinuity and difference from the person he is most attached:

> The denial of identification with the mother also tends to cut the boy off from the intersubjective communication that was part of the primary bond between mother and infant. Emotional attunement, sharing states of mind, empathically

> assuming the other's position, and imaginatively perceiving the other's needs and feelings – these are now associated with cast-off femininity. Emotional attunement is now experienced as dangerously close to losing oneself in the other; affective imitation is now used negatively to tease and provoke (Benjamin, 1988, p. 170).

Benjamin's work can therefore be seen to be providing a bridge between domination experienced at the psychic, developmental and relational level and the domination of hegemonic masculinity at the social level.

Benjamin's model of the need for mutual recognition between the child and mother also applies to the relationship between therapist and participant. The therapist is experienced by the participant not only as a selfobject, but as a subject, with an independent experience of the world. This subtle shift in emphasis has implications for clinical practice, opening up possibility for a different kind of response from the therapist. In contrast to an empathic listening stance, where the therapist immerses themselves in the participant's experience, when a therapist listens from a subject-subject position, they are listening from an other-centred listener perspective (Fosshage, 1998), quite different to the kind of empathic listening recommended by Kohut. It also follows that the therapist's response would also be different, for example, respectfully challenging the viewpoint of the participant or presenting the therapist's opinion. This assumes that the participant is capable of and interested in listening to the opinion or point of view of the therapist and entering into a genuine dialogic interchange.

3.6 Optimal responsiveness, specificity, reflexivity and empathy

Howard Bacal, a relational self psychologist, introduced the term *optimal responsiveness* in 1985; since then he has continued to revise the concept and has identified *specificity theory* as the theoretical perspective that underpins it (Bacal & Herzog, 2003). The intention was to replace the concept of optimal frustration introduced by Kohut. Kohut had argued (consistent with traditional Freudian theory) that self structure was built through the process of the patient experiencing an optimal level of frustration in the therapy process thereby strengthening the self. Bacal also challenged the preeminence of interpretation as the key change agent. Kohut had described the change process as a two-step process of empathic immersion followed by interpretation (explanations). Bacal proposed that the concept of optimal responsivity replace that of interpretation:

> Empathy or vicarious introspection is the process by which the therapist comes to understand the patient by turning in to his inner world. Optimal responsiveness, on the other hand, refers to the therapist's acts of communicating his understanding to his patient (Bacal, 1998, p. 5).

Specificity, reflexivity and empathy are related but different concepts that refer to the ability of the therapist to become aware of both the subjective and intersubjective dimensions of the therapy process.

Specificity theory (Bacal & Herzog, 2003) claims that the therapist cannot know beforehand what kind of intervention is going to work for that particular participant. The intervention, verbal or nonverbal, must arise from the unique

configuration of the moment. Therapeutic change is inevitably a product of the unique personal characteristics of the therapist and the participant and the ability of the therapist to respond flexibly on a moment by moment basis to the needs of the participant. Therapy is understood as a unique personal encounter in which the subjectivity of both the therapist and the participant influences the ups and downs of the therapy process. Each therapy encounter is therefore unique to the parties involved. Specificity theory therefore fits well with the responsivity principle and helps us to understand what this may mean in practice.

Reflexivity is an important concept in both the systemic-narrative traditions and the relational tradition (Aron, 2000b; Hedges, 2005). Reflexivity has a wider meaning than empathy, and refers to the capacity to both observe and think about both the subjective and objective sense of ourselves while at the same time being aware of the subjective and objective self of the participant. It also refers to the ability to be aware of how both our professional theories and personal prejudices are constantly influencing our interactions in the therapy relationship.

Practising therapy in a forensic setting is always going to present some intrinsic difficulties, in particular the importance of balancing the social control functions of risk management with the goal of building a therapeutic alliance[2] with the participants (Ross et al., 2008). The therapeutic relationship is characterised by a power imbalance even in the best of circumstances. Working in an agency with legally mandated clients only increases the potential for therapists to inadvertently replicate abusive practices participants had previously experienced within their lives.

[2] I use the term therapeutic *alliance* (as distinct from therapeutic *relationship*) to describe the feeling or sense of working collaboratively together towards agreed upon goals and tasks (Safran & Muran, 2000)

In my experience, combining the twin goals of building a therapeutic alliance and managing risk were often difficult to hold together. Engaging participants in a therapeutic alliance and being able to repair any ruptures which may occur has been described as the *central task of therapy* (Safran & Muran, 2000). Without a functioning therapeutic alliance everything else falls apart. The reflexive use of self is essential to alerting us to any breakdowns to the relationship. I think of self-other reflexivity as the capacity to be intersubjectively mindful. My listening perspective is to attune myself to my here and now experience, the participant's here and now experience and the unique intersubjective space we are creating. An optimal intervention is expressed through my response. This can be either non-verbal or both verbal and non-verbal. In a practice founded upon the empathic use of self, we cannot, not respond. The other person's experience of our responsiveness will be partly determined by their habitual ways of organising their experience, sometimes referred to as transference (e.g., one more stupid therapist who sounds just like my father) and partly may be experienced as something new and unique.

The reflexive and empathic use of self was the foundation of my ability to both understand the programme participants and at the same time to be changed by my meetings with them. To be empathic, I believe we have to be open and vulnerable. I also feel that an empathic approach is crucial in the field of adolescent sexual offending. Empathy has not always been recognised as an important factor when working with adolescents who have abused. This is puzzling, given the large body of literature documenting findings of empirical research into infant-caregiver relationships and the effects of trauma on children's brain development (Schore, 2003a; Siegel, 1999). Similarly, the importance of empathy has also been

demonstrated by research into the socialisation of male children (Connell, 2000; Kindlon & Thompson, 1999; Wexler, 1999). Both these areas of research are now reinforcing the importance for children of receiving empathic understanding from caregivers and therapists as an essential precondition for the child developing empathy for others. This development of empathy can be understood through the lens of intersubjectivity theory. Indeed, achieving intersubjectivity can be seen as one of the most important developmental milestones. The child moves from a subject-object relational matrix to a subject-subject relational matrix, recognising the independent subjectivity of the other, starting with their mother (Benjamin, 1988, 1990; Stern, 1985/2000).

As well as aligning with the values of a positive approach and the personal qualities of warmth and empathy as described by Marshall and colleagues (2005), a responsive therapist will need to develop both a theoretical and skill-based experiential ability to implement forms of mutual regulation and emotional understanding. A responsive therapist will also be aware that therapy is a two-way process which often leads to a need to reflect on one's own life and attachment history (Ross, Polaschek, & Ward, 2008). Many of the young people who are referred to adolescent sexual offending treatment are suffering the legacy of poor attachment histories and have also been the victims of violence and abuse (Rich, 2006a; Ryan & Lane, 1997b; Wexler, 1999). Combined with the effects of hegemonic masculinity, one of the effects of this history is a reduced capacity to self regulate affects (Rich, 2006a; Schore, 2003a, 2003b; Schore & Schore, 2008). Or to put this in more simple terms, these young people, like the rest of us, want to avoid emotional pain at all costs. This experiential avoidance of pain is one way of understanding how the

offence process occurs at the micro-level. This needs to be addressed in treatment through the therapist becoming empathically attuned in order to help participants develop the capacity to tolerate negative affects and make meaning out of their emotional experience (Orange, 1995). In order to develop an emotional understanding of participants' personal and social history I draw on my relational skills to build an affectional bond and negotiate the therapeutic alliance with the participants throughout the course of therapy (Rich, 2006a). Of course, according to attachment theory, this is exactly what is often resisted by persons with a history of insecure attachment (Howe & Fearnley, 1999; Smallbone, 2005; Sroufe, 1995). The self and subjectivity of the therapist, including their gender and their own experience of adolescence, will inevitably shape this process. In my experience I have found that empathic attunement is a necessary precondition for persons to experience both feeling understood and to developing a strong and stable therapeutic alliance.

3.7 Conclusion

In this chapter I have discussed the centrality of the therapeutic relationship to relational therapy and located the concept of optimal responsivity within the tradition of relational psychoanalysis and argued that it can strengthen and enrich the responsivity principle as outlined in the risk-need-responsivity (RNR) model of offender rehabilitation. I also discussed the related concepts of specificity, reflexivity and empathy and how they function as key relational skills. In the next chapter I turn to a more detailed outline of autoethnography as a methodology or "strategy of inquiry" (Denzin & Lincoln, 2005b), the research method I utilised to generate the data, and the ethical dilemmas I encountered.

4.

METHODOLOGY

4.1 Introduction

In chapter one I introduced the research problem and identified the research questions: namely to investigate how the therapist can use his or her experience of self to be optimally responsive with participants. I also introduced autoethnography as my preferred research methodology to investigate the therapist's use of self. In this chapter I describe the methods I used to generate, story and analyse my data in order to answer my research questions. I introduce autoethnography as a strategy of inquiry that fits with a relational perspective. I argue that autoethnography is uniquely suited to be able to study the subjective experience of therapy. I also review the historical evolution of autoethnography, with a specific focus on narrative, reflexivity and the politics of representation, with reference to how offender rehabilitation has been saturated with an "us and them" culture. This chapter therefore links up with the research problem I discussed in chapter one. It is organised around six major topics: pluralism; epistemological considerations; ethical considerations; the research process; alternative justification procedures and evaluation criteria. The chapter begins with a critique of positivism and the positivist understanding of the scientist-practitioner model as the basis for evidence-based practice and an argument for a more inclusive model more suited to human science research.

4.2 A plurality of methods

Methodology is concerned with the application of *methods* for the generation and analysis of data. However, the concepts of methodology and methods are often

only understood through the lens of positivism, such as the distinction between theory and facts and observer neutrality. Positivism is a form of objective realism and seeks to delimit the methods in the human sciences to the *experimental* method as applied in the physical sciences, and assumes this to be the benchmark by which all research in the human sciences is to be evaluated. When it comes to qualitative research, however, methods of doing research and arriving at certain conclusions or findings do not have to follow the traditional methods of positivist or experimental research. Qualitative research is therefore not limited by experimental methodology (Denzin & Lincoln, 2005a; Howe, 2004). For example, writing itself can be understood as a method of inquiry (Richardson, 1994; Richardson & St. Pierre, 2005).

A qualitative inquiry implies an investigation into something. While agreeing that it is important to establish some criteria about how we are to evaluate the quality of the research, these criteria do not have to replicate the same criteria that are applied in the physical sciences. This is simply because we are dealing with different ontological realms: of human realities rather than physical realities. People can be treated as objects, but unless the subjective dimension of human experience is also taken into account we will never have a complete understanding of what it means to be human (Gadamer, 1975/1989; Goldstein, 1990). Like other forms of qualitative research, within the field of autoethnography there is no one agreed upon "method" that is followed to arrive at a certain result (Bochner & Ellis, 2002; Holman Jones, 2005). There is therefore a plurality of methods that can be employed in qualitative studies (Denzin & Lincoln, 2005b).

4.3 Evidence-based practice?

The question of how do we know what "works" or what constitutes good or effective therapeutic practice, is a contested terrain, with the scientist-practitioner model currently in the ascendant. The scientist-practitioner model is usually constructed on the basis of a positivist-experimental understanding of science. Similarly, adolescent (and adult) sexual offending treatment is usually located within the individualistic paradigm in psychology, which is founded on modernist and objectivist epistemological foundations, and seeks to promote the positivist scientist-practitioner model as the best form of practice. It is a one-person psychology in which the expert therapist seeks to rehabilitate the almost passive offender by applying evidence-based interventions or techniques. Change is therefore assumed to be a one-way process.

Evidence-based practice (EBP) is now an integral part of contemporary mental health and the understanding of what is to count as valid "evidence" has been almost entirely dominated by the positivist scientist-practitioner model as it was developed in psychology:

> The scientist-practitioner employs an empirical scientist approach to practice, designing interventions based on the best possible information, measuring the impact of the interventions, and then modifying the interventions in response to information about their impact.
>
> EBP operates from the premise that once an intervention has been demonstrated to be effective with a specific problem, it should be able to be

> implemented to good effect whenever that problem is present (King, Lloyd, & Meehan, 2007 p. 7).

Furthermore, there are established hierarchies of evidence with the single case report at the bottom of the hierarchy. This is because, it is argued, they are not generalisable – what works for one person might not work for another and is not replicable for other people or settings. According to this standard positivist view there has to be a demonstrable causal relationship between the intervention and the outcome. Near the top of the hierarchy are randomised controlled trials (RCTs). A common way of doing RCTs is to randomly allocate half of the sample research population with a common problem, such as depression, to a time-limited course of therapeutic interventions while the other half continues with care as usual or are given a placebo intervention. Any differences in outcomes are therefore attributed to the interventions. If a series of trials with different researchers yield similar outcomes then it is claimed that the evidence is persuasive and we can therefore assume that a causal connection between the intervention and the outcome has been established, and that the generalisability of the intervention has been demonstrated (King et al., 2007, p. 8).

I am not arguing against this specific form of research design, because I believe in a plurality of methodologies. However, I believe it is just as limited in its claims as any alternative qualitative methodology because it is based on a debatable assumption that a causal relationship can be demonstrated by controlling only selective variables when there are so many other variables involved that cannot be controlled:

> If only the therapy process lent itself to being studied by the experimental method, we might finally be able to resolve one of the questions that have nagged at therapists for the last one hundred years: whose way of working is most effective for which people? Unfortunately, the psychotherapy process does not lend itself to the systematic control of the variables that affect the process. This is, in large part, because the psychotherapy process involves an open system where many, if not most, of the variables affecting the process cannot be identified. Since the variables that impact the process come from the conscious and unconscious worlds of experience of both participants, the participants themselves may have no awareness of all the factors influencing their engagement. (Buirski, 2005, p. 39)

Rather than seek to demonstrate causal connections I believe the focus of research in the human sciences should be at the level of meaning. It is a question of developing richer understandings, rather than seeking casual explanations.

Unfortunately, it is still the case that some forms of qualitative inquiry, such as autoethnography, are viewed with suspicion by those who adhere to positivist understanding of human science and are therefore seen as lacking in legitimacy in university research because of what are ultimately political decisions about what constitutes scientific knowledge. Initially, qualitative methods tried to follow the same requirements of validity and reliability that had been laid down as the criteria to guide the production of quantitative research. However, since that time there has been a number of paradigm shifts in qualitative methods, at least eight different "historical

moments" according to Denzin (2005). One of the distinguishing features of these different shifts has been the move away from defining what is to count as valid and reliable knowledge based upon traditional standards of scientific methodology towards reclaiming the knowledge claims of the arts and humanities under the umbrella of qualitative studies. This is a political battle that is still being fought and autoethnography is one example of how many different qualitative methodologies are redefining the meaning of the scientist-practitioner.

I am opposed to attempts to impose an epistemology of hierarchy in the human sciences, with randomised controlled trials understood as being at the pinnacle of what constitutes the "gold standard" in psychotherapy research. I join with other therapists in opposition to the attempt to impose a very limited understanding of science and therapy onto the model of a scientific-practitioner (Etherington, 2004; Larner, 2004; McLeod, 1999; Speedy, 2008). I see this as an ideology which I call scientism. I define scientism as the attempt to impose the ideology of positivism onto the disciplines of counselling, psychotherapy and social work and into the political realm of public policy and programme funding. This attempt to promote neopositivist research design as the *most* valid form researching human subjects engaged in therapeutic practices is problematic on ethical and epistemological grounds (Denzin & Lincoln, 2005a) . Ethically, I believe it reproduces "us and them" dualities, reproducing the therapist as the expert who is more knowledgeable than the client. It also reproduces a neo-liberal position which individualises and internalises the problem in the "offender" rather than situating the problem contextually and relationally (Orange et al., 1997; White & Epston, 1990). On epistemological grounds, I am not against attempts to research effectiveness and outcomes; however, I

believe we need to tread carefully when trying to reduce a complicated human interactional process to the application of a reproducible intervention to a universal and abstract problem. Human relationships cannot be reduced to a simple linear cause and effect relationship and it is impossible to separate "interventions" from the people and context in which they are applied. All the various diagnostic categories are lists of general symptoms, whereas the actual lived experience of mental health problems is different for each person. This does not mean we have to walk away from evidence as to what counts for good, effective or helpful practice. I understand professions such as psychotherapy, counselling and social work to be dialogic practices aimed at developing mutual understanding that deal in ambiguity and uncertainty (Gray & Mcdonald, 2006; Orange et al., 1997; Parton & O'Byrne, 2000). People who work in these professions are required to respond to complex human situations that cannot be reduced to the simple application of pre-designed solution. From this perspective, I contend that the search for evidence-based "interventions" needs to be freed from the shackles of positivist hierarchy and opened up to include alternative methodologies that are based upon constructionist and contextualist epistemologies.

4.4 The autoethnographic case study and narrative analysis

I see autoethnography as a strategy of inquiry which is congruent with the ideas above, undermining social hierarchies and professional knowledge which reproduce "us and them" dualities and "one way accounts" of therapy which are so prevalent in professional accounts of the therapy process (Buirski & Haglund, 2001; White, 1997). Autoethnography can be defined as "a form of self-narrative that places the self within a social context" (Reed-Danahay, 1997a, p. 9). Autoethnography gave

me permission to write about my subjectivity as therapist, exposing the process whereby the personal intersects with the professional and vice versa. Interestingly, the more I got into the research process, the more aware I became of how the practice of autoethnography inevitably acts as a kind of self-therapy, in the sense of writing being a form of making sense of my own life and those of others (Richardson & St. Pierre, 2005) .

I think of the researcher as a story-teller. A good piece of research tells a good story. It then becomes important to ask, what is a good story? This is a question I will come back to later when I discuss the alternative ways autoethnographic research is evaluated. As the name implies, *auto* means self; *ethno* means people or culture; and *graphy* means writing or describing (Ellis, 2004). Debra Reed-Danahay (1997a) thought the term "has a double sense – referring either to the ethnography of one's own group or to autobiographic writing that has ethnographic interest" (p. 2). I view autoethnography as a form of reflexive writing about personal experiences in a way that links these personal experiences to social and cultural realities. It is a narrative form of inquiry (or research) into my own subjective experience of self and others which is informed by various disciplines and which draws upon fiction writing techniques to engage my audience in the project (Ellis & Bochner, 2000).

The origins of autoethnography can be traced to the growing turn towards narrative and reflexivity in the social sciences, particularly in sociology and anthropology (Denzin & Lincoln, 2005b). This includes the idea of writing vulnerably, as in *The vulnerable observer: Anthropology that breaks your heart* written by Ruth Behar (1996). In this book, Behar takes the idea suggested by

George Devereux (1967), an ethno-psychiatrist, that "*what happens within the observer* must be made known … if the nature of what has been observed is to be understood" (Behar, 1996, p. 6). The essays included in the book include self-disclosure stories of personal trauma and loss from her own life that are linked together with her ethnographic studies of the process of grieving in a northern Spanish rural village.

This is a very important organising principle for me. I think the idea of writing vulnerably is what links autoethnography and therapy together. As a therapist I hope to create an atmosphere of safety and trust that allows participants to expose their vulnerabilities. I expect the same of myself as an autoethnographer. Autoethnography is also linked to what Denzin (1997) refers to as the crisis of representation. I think Edward Bruner's 1986 paper entitled *Ethnography as Narrative* is a good place to start.

This was published in a book which Bruner edited along with the anthropologist Victor Turner called *The Anthropology of Experience.* It was a key text in the development of narrative therapy, which often gets lost in the emphasis that is placed on Foucault. Michael White took the "rite of passage" as an analogy to the process of therapy from that book, among other key ideas. For example, White also adopted the idea of dominant and alternative narratives. In this paper Bruner discussed the indigenous North American's construction of a "resistance" narrative as an alternative to the "assimilation" narrative that was previously dominant in the anthropological literature written by European-Americans. His paper can also be seen as an early form of autoethnography (Holman Jones, 2005; Smith, 2005). The

previous representation of the "native" was now seen as a form of colonial oppression (Bishop, 2005), bringing about a "crisis of representation". Bruner (1986) stated:

> … the present is given meaning in terms of that anticipated present we call the future and that former present we call the past (p. 142)

> … the narrative structures we construct are not secondary narratives about data but primary narratives that establish what is to count as data (p. 142-3)

> … life experience is richer than discourse. Narrative structures organise and give meaning to experience, but there are always feelings and lived experience not fully encompassed by the dominant story (p.143)… .

That last statement was quoted in full in *Narrative Means to Therapeutic Ends* (White & Epston, 1990), which I think illustrates clearly how influential it was to the formation of narrative therapy. However, of more relevance to my thesis is that Bruner also claimed in this paper that ethnography itself was a "genre of storytelling" (p. 139). Autoethnography was therefore made possible by this narrative turn and also by what has been called the "politics of representation" (Denzin, 1997; Denzin & Lincoln, 2005a). In fact, Bruner was already talking about the politics of representation in this same paper when he makes the point that "stories are not ideologically neutral"; they are structures of meaning but they are also "structures of power" (p. 144). It was primarily white anthropologists who told the story of how the Native North American peoples' culture was dying and being assimilated into

European culture. The alternative narrative of resistance and cultural resurgence had altogether different political implications.

The method used by anthropologists in the past was often called ethnography, the study of culture. The primary method of collecting data in ethnographic fieldwork was often called *participant observation*. The anthropologist went into the field and formed a relationship with the subjects they were observing. They lived alongside their participants and made their observations. Field notes (data) were taken and then written up through a theoretical lens. However, what was missing from this write-up was an analysis of the experience of the observer; how the observer could not step outside of their own horizon of understanding in formulating their descriptions of the "native" and how their presence changed the behaviour of the people they were purportedly describing in their "natural" environment (Tedlock, 2005). As philosophers of science have argued for a long time, observation is never value free – it is theory-laden (Popper, 1959). So anthropologists began to situate themselves. They could no longer understand themselves as neutral objective observers. This turning point in anthropology has parallels with the move towards reflexivity in family therapy, when it was also realised that therapists could not continue to see themselves as sitting outside the family system and the resulting creation of "reflecting teams" (Andersen, 1999). Parallel developments also occurred in psychoanalysis, in the relational psychoanalytic traditions where they argued against Freud's principle that the analyst must remain a neutral observer for exactly the same reasons (Orange et al., 1997; Stolorow et al., 1994).

This is where the work of the anthropologist, Ruth Behar, comes in again. Behar was writing ten years after Bruner's paper. The narrative turn had already been

well-established in the human sciences (Polkinghorne, 1988). Behar's book shone the light of reflexivity not just on the mind but also on the heart of the anthropological observer. For example, she writes an autobiographical story entitled *The Girl in the Cast*. The story tells how at nine years old she recovered from a car crash, only to find years later as a thirty-five year old the trauma resurfaces at an aerobics' class. She is immobilised by fear and hides away in her bedroom. Finally, through her own research, she comes to an understanding of her symptoms and allows the tears, which the girl could not shed, to come pouring out. In retelling this story Ruth Behar weaves the effects of a trauma caused by a road accident into stories which link her experiences to experiences of race, class and gender. The story becomes an autoethnography. Autoethnography is postmodern because it mixes the genres of autobiography and ethnography and is concerned with narrative truth (Ellis, 2004) rather than historical or representational truth. The work of Behar also demonstrated how writing autoethnographically could be understood as a form of therapeutic writing. The wounded story-teller heals herself.

Narrative truth is concerned with being true to your experience, whereas representational truth seeks a description which corresponds to the so-called objective facts – facts which are external to experience. For example, Freud used the metaphor of archaeology to describe the process of unearthing buried memories because he believed the historical past could be reconstructed. Of course, these memories were sometimes interpreted as "fantasies". Freud believed the process of analysis was about reconstructing the truth of the actual events that did happen. The narrative turn in the human sciences influenced psychoanalysts like Spence (1982), who "argued that psychoanalysis is not one of archeological reconstruction but is, rather, an active

construction of a narrative about the patient's life" (Aron, 1996 p. 37). Contemporary relational analysis now rejects the Freudian project of the reconstruction of historical truth, along with the attempt to remain neutral (Aron, 1996). These days, following Kohut (1959), analysts are more concerned to understand how the person undergoing therapy experiences their world, with the emphasis on *their*. Their experience does not have to correspond with the "facts" of what actually happened.

I found autoethnographic methodology to be congruent with the philosophical stance I was developing in my practice. I believed it was a methodology that could capture the therapist's subjective experience of therapy and the therapist's empathic understanding of the client's experience of therapy. I discovered in autoethnography a form of doing research that was closer to my heart, closer to describing the rich phenomena of the intersubjective dimensions of therapy. As previously argued, I have never identified with the traditional scientist- practitioner model as it is usually narrowly conceived. I prefer to think of myself as a reflexive-practitioner, taking into consideration matters of literary as well as clinical merit (Etherington, 2004; Speedy, 2008). I was drawn to therapy, as I have been to song-writing, because it engages audiences and practitioners alike on both an emotional and cognitive level. Autoethnography offered me the opportunity to write creatively, but with a theoretical and ethnographic perspective.

As far as I know, there have been no autoethnographic studies of adolescent sexual offending therapy, but the potential of autoethnography to research counselling, psychotherapy, social work and mental health nursing is now being recognised (Butler et al., 2007; Etherington, 2004; Foster et al., 2006; McLeod, 2003; Speedy, 2008). Before discovering autoethnography I had read the work of Yalom

(1991) and I enjoyed his collection of therapy tales reconstructed from work with actual patients. These tales read like short stories and were very revealing of the self of the therapist, including his anxieties and reflections on his mistakes. However, they were not written from a self-conscious autoethnographic perspective. They were written from the perspective of an existential therapist. After I had discovered autoethnography I became dimly aware of the possibility of writing autoethnographically about my experience of therapy. I then read both Luepnitz's (2002) and Orbach's (2002) stories about therapy. Orbach's characters were all fictional, whereas Luepnitz's characters, like Yalom's, were reconstructed from meetings with actual patients. Again, neither of these authors was conscious of using an autoethnographic perspective.

In regards to the fields of adult and adolescent sexual offending there is very little in-depth case study research, let alone autoethnographic writing. There is, however, a work by a New Zealand psychologist that is a kind of autobiographical account of how he started working with adult sexual offenders. In fact, he started working with the same agency I worked for in Auckland. It is called *Into the Darklands* (Latta, 2003). It is not an academic text, it is written more like a novel. Again, the author is not consciously using an autoethnographic perspective. He writes as a psychologist, with little disclosed about his personal life. The book is an example of what I call a "them and us" criminological discourse. For one, the sub-title is *unveiling the predators among us.* I find the "predator" metaphor to be in the same family as the monster metaphor. I believe this use of language is unhelpful; it dehumanises people and contributes to creating a climate of fear that encourages the

kind of vigilante reaction which happened in New Zealand in May 2005.[3] However, I was fortunate to discover the work of a Canadian researcher, Williams (2006), who has worked as a therapist in the field of adult sexual offending treatment.

Williams is the only other researcher in this field that I am aware of who uses autoethnography. He argues that autoethnography can help to overcome exactly these kinds of "us and them" barriers which separate criminals from the general public and treatment providers from inmates and clients. This "us and them" divide leads to dehumanisation and the objectification of the clients as the other. Williams argues that autoethnography has the potential to contribute to improving the quality of the therapeutic alliance and thus improve treatment outcomes. It does this by including stories about the person of the treatment provider in order to show that we are all vulnerable and sometimes capable of acting in ways that we may later be ashamed of:

> I believe it is critical for practitioners of all kinds to rediscover and embrace their own painful stories, which is the catalyst for the ability to empathise with others, including offenders, who have painful stories of their own. Indeed, much of offender rehabilitation seems to be mired in a one-person psychology

[3] During May 2005 there was a story in the media about a man who had convictions relating to sexual offenses against children who had moved to a village called Blackball in the South Island. The local residents found out and were led by the local mayor who warned the local police they were about to "take the law into their hands" unless something was done quickly. It was found out where the man was residing and rocks were thrown through the windows and the house was picketed. Needless to say, the man ended up moving elsewhere. On the 18 May the morning current affairs programme on national radio featured a debate between someone from the local community and a GP, followed by an interview with the Director of SAFE. The journalist also invited listeners to email their views. The radio journalist read out some of the emails and commented that this was a "large, complex and emotional issue" which divides the public between the view that these people are "animals" who should be locked up and those who express the view that this attitude will only make it more difficult for disclosures to occur.

> – that is, the dominant focus is on pathology (e.g., thinking errors) and risk of the offender, while little consideration is given to the therapist countertransference and intersubjectivity that is present within the entire correctional process.
>
> As therapists, often we keep our painful stories hidden from both ourselves and others. It can be difficult to admit that they are still a part of us and always will be – a raw, unrefined, but very real part that does not fit with revised accounts that are shaped by time and socialisation. Nevertheless, these are important to rehabilitation, both for practitioners and clients, and a refusal to acknowledge them does not mean they do not exist. Interestingly, offenders often do not want to acknowledge or share narratives exposing their crimes and weakness but we insist, in the name of healing, that they do. Yet are we prepared to do the same? Can we admit our humanness? Can we admit commonalities we share with those behind the prison bars? (Williams, 2006 p. 28-29).

Williams concluded that autoethnography contributes to offender rehabilitation by emphasising commonalities rather than differences – whereas the professional culture of evaluation promotes distancing because the purpose is to identify pathology or deviations from the "norm". Williams also argues that autoethnography "gives voice to multiple identities, which allows us to empathise and connect with others" (p.34); through telling stories we also learn about ourselves. In particular, autoethnography can expose the intersection between the personal and the professional, whereas traditional academic writing has expressly prohibited the personal from entering the

professional in the name of neutrality and objectivity. I agree with Williams, that it is our ordinary, experiential self that connects with participants:

> Indeed forensic psychotherapy, like psychology in general, has been quick to emphasise intervention techniques and theories and slow to pay careful attention to the therapeutic alliance – the positive cognitive-affective relationship between client and therapist. This general historical overemphasis on intervention techniques, while largely ignoring the personal influences that contribute to the therapeutic dyad, is likely to be at least partly the result of psychology's fierce determination, historically, to become a scientific discipline. As mentioned previously, science tends to view emotion as a contaminant to what is objectively real. This is interesting, because just as some scholars are adamant that autoethnography is not scholarship because it focuses on the human self (including personal emotionality and subjectivity) within research, psychology has been somewhat slow to acknowledge how the human element affects therapeutic outcome (Williams, 2006 p. 35).

One of the central critiques of autoethnography is that because it relies on the self as a source of data it can become self-indulgent, narcissistic and individualised (Atkinson, 1997). However, I believe autoethnography can contribute to sexual offending therapy by helping the practitioner researcher stay connected with and explore their personal issues and experiences that are triggered by working in this field or with a particular participant. This allows the researcher to develop self-

empathy and empathy for the participants in exactly the same way I would hope the participants would be able to move from self-empathy to empathy for others.

Polkinghorne (1995) makes a distinction between *the analysis of narratives* and *narrative analysis.* In the former case, the narrative is taken as data and is analysed using methods such as thematic analysis, conversational analysis, discourse analysis, in order to extract some findings. The narrative is analysed for the knowledge it contains. In the latter case, the creation of the story is seen as the act of analysis. The story is the knowledge, is the finding. In this thesis I present an autoethnographic case study based on an analysis of myself as the therapist and my work with four participants. The autoethnographic case study is a form of narrative analysis, which in the present study seeks to show how the subjectivity of the therapist enters into both the therapy and the research. Unfortunately case study research has been seen as having less legitimacy than systematic quantitative research. I agree with Hoffman (2009) who argues that the privileged status of systematic experimental research over in-depth case study research is unwarranted epistemologically and potentially damaging to our understanding of therapeutic process and the quality of our clinical work.

Hoffman's paper considers the scientific status of individual case reports as compared with systematic research. Hoffman's argument is that case studies "generate possibilities for practitioners to have in mind as they work with particular patients" (p. 1046) that may be helpful or not and that in reality this is all that systematic hypothesis testing research can do and therefore systematic research does not deserve a higher status than case study research. Hermeneutic critiques of evidence-based practice as usually presented, note its "abhorrence of ambiguity,

complexity, uncertainty, perplexity, mystery, imperfection, and individual variation in treatment" (Cushman & Gilford, 2000, p. 993). Many therapists who take a hermeneutic perspective consider therapy to be first and foremost a moral enterprise where questions such as "What is a good way to be in this moment?" and "What constitutes a good life?" are implicit in every response a therapist makes. These questions are outside the realm of science to answer. Hoffman also contends the whole person of the treatment provider is involved in engaging a person who is struggling with problems in living. Systematic quantitative studies cannot control for the "consequential uniqueness" of the therapist, the participant, their relationship and the moment, and this detracts substantially from their scientific and pragmatic value. Conversely, the fact that case studies *do* allow for consideration of the consequential uniqueness of the above factors, goes a long way toward contributing to their special scientific power, notwithstanding whatever limitations they may have (Hoffman, 2009). The question of bias is often thrown in as an example of the limitations of case study work, however, from a hermeneutic perspective "it is neither possible nor desirable to seek to view the object from 'nowhere'. Hermeneutic reflection always takes place within one's textured background and the situation always appears embedded in a particular context" (Polkinghorne, p. 166, 2004). The response to this charge is also to point to the trustworthiness of the data. The criteria of validity therefore need to be re-defined in order to evaluate the unique methodology of autoethnographic case study research (see below).

I thought an autoethnographic case study was an excellent strategy to inquire how I and the other participants experienced the therapeutic process. Writing the stories and reading them aloud allowed me to "feel my way" into emotionally

important events experienced within the session. It allowed me to show how my participation as a therapist-researcher transformed me on a personal level and how my professional practices as a therapist evolved through doing this work. That is, the stories show how I was challenged and changed on a personal and professional level. This included my reflections on theory and practice, consideration of the therapeutic effects of writing autoethnography, and what this tells us about the relationship between the professional and the personal. I wanted to provide relevant background knowledge on the personal life experience of the therapist, in particular his relationship with his father and his sons. This would enable the reader to see the relationship between the therapist's personal self and professional self. I also wanted to show how the therapist worked through his lived experience of guilt and shame, often in a parallel way to the participants on the program.

Guidelines for writing personal experience stories can be found in the works of ethnographer writers such as Ellis (2004) and Denzin (1997; 2003; 2006). I selected events from my personal life which showed critical, turning point events, which were rendered into scenes. Similarly, I chose to write up sessions from the therapy process which seemed to be significant in some way, either because they contained critical, turning point events or which captured special moments of meeting between the therapist and the client.

I think other therapists will be interested in this form of autoethnographic case study because the self of the therapist, though omni-present, is seldom explicitly attended to – the focus is usually on how clients are changed. I also think this kind of research has implications for how therapists are trained in both therapy and research methodologies. Autoethnography is still relatively new to the field of offender

rehabilitation, hence, if it can be shown to be helpful on a clinical level that would be an important finding.

Many nights I lay awake listening to the rain falling on my tin roof, wondering if it was going to be possible to complete my PhD with "a methodology of the heart" (Pelias, 2004). I liked the phrase, a methodology of the heart. It resonated with my Zen Buddhist practice, and I remembered how in Japanese Zen the word for mind was mind-heart. In that tradition, the two are inseparably connected, unlike in the West, when practically since Descartes and the Enlightenment, the mind and the heart have been radically torn apart.

4.5 The politics of representation

There is a vast literature on qualitative research and the politics of representation (Denzin, 1997; Denzin & Lincoln, 2005a; Holman Jones, 2005), which because of limitations of space I cannot do justice to here. I will therefore limit this discussion to the issues of representation that I was aware of while researching this thesis. Autoethnography presents us with ethical dilemmas about how we represent both ourselves and others. This takes me back to issues around *the politics of representation*, or what I might call, after Shotter (1994), the rhetorical aspects of constructionist theory. Written documents are extensively used in therapy, especially in assessment evaluation and progress report type formats. These written documents (including case notes) act as a form of accountability. However, these documents are often written for professional audiences without regard for the effect they may have on participant readers. The use of therapeutic documents in narrative therapy has opened up new ways of working with written documents with a larger participant

audience in mind (Freeman, Epston, & Lobovits, 1997; White & Epston, 1990). The autoethnographic stories I wrote about therapy sessions for the purpose of this thesis are another example of an alternative way of documenting work that can be shared with therapy participants. Participants could also be encouraged to write their own autoethnographies as part of the treatment process and share them in group therapy (Williams, 2006).

Autoethnography has the potential to be used as both a narrative way of researching the experience of therapy and as a way of improving the effectiveness of therapeutic practice. For example, when the therapist writes autoethnographies, either during the process of therapy or at the end of therapy, these stories can act as a form of self-supervision, or they can be taken along and discussed in individual or group supervision. When used to represent participants in research, these stories can be shared with participants either during or at the end of treatment and can potentially act as another form of therapeutic document. These stories can also be experienced by participants as validating of their therapeutic journey and can also provide participants with an opportunity to make a contribution, by participating in research, to improving the effectiveness of rehabilitation programmes. The therapist can also share these stories with participants as another example of what White (1997) refers to as a form of "taking it back practice"; that is acknowledging the contributions of the participants to the therapist, thus affirming therapy as a "two-way" process. Autoethnography is therefore both performative and participative.

Gergen and Gergen (2002, p. 12) have written about the "relational consequences of ethnographic representation". Autoethnography has been shown to contribute to the development of empathy with research participants (Berger, 2001).

I think this is even more the case when a therapist is writing. However, consideration also has to be given to the impact of reading the story on those people who are represented in the story. In the next section I address this ethical issue in more detail, including discussing the process of informed consent and how I shared my autoethnographic stories with participants at the conclusion of their treatment. Sharing autoethnographic stories with participants, like other forms of therapeutic documents, will potentially have positive or negative therapeutic effects on their lives and relationships, depending upon their experience of reading the stories. Hence, the stories were crafted with this consequence in mind. It was my hope that the use of autoethnographic stories would act to support the young person's preferences for living and to help them continue moving in preferred directions. As Gergen and Gergen (2002) wrote: "Our words constitute forms of action that invite others into certain forms of relationship as opposed to others" (p. 13). For the young people who volunteered to participate, I wanted the autoethnographic story about our clinical work together to act like a therapeutic intervention, supporting and consolidating the work they had done. I think they also saw the choice to participate in the research as an opportunity for them to give something back to the community. For other professionals, working in this field, I hope these stories stimulate self-reflection, discussion and debate on both clinical and policy issues. I also think there is potential to use autoethnographic stories as resources for training and education for therapists and caregivers, whether they be foster carers or residential care workers. I believe carers need to be seen as co-therapists, whose day to day interactions with these young people are sensitive and responsive to their therapeutic needs.

Finally, autoethnography can be a form of political practice, designed to bring about social change (Denzin, 2003, 2006; Holman Jones, 2005; Reed-Danahay, 1997b). I believe the stories documented in this thesis can be seen as a vehicle for giving expression to the unique voices of these boys that does not reduce them into the "other" of diagnostic categories or statistical probabilities. The stories hopefully open up the possibility for the audience (reader) to empathise with the participants, even though they have committed crimes. Autoethnographic stories could be usefully incorporated into government reports and green papers thereby increasing the audience and possibly changing the views of policy-makers, health and correctional professionals and the general public towards young people who commit sexual crimes. This is one of the ways in which research like autoethnography can be evaluated. It is not evaluated on standard positivist criteria, it is evaluated on its verisimilitude and its ability to move readers, and hopefully to have some impact on both legal and treatment policy. I agree with Denzin (2003) that autoethnography can be understood as a form of *performance ethnography* and performance ethnography is designed to move our minds *and* hearts. Autoethnographies are intended to be *performed*. I realised this first hand when I began reading my work to an audience. It was in the reading of the work, that is, the performance, that the heartfeltness of the writing was experienced in a visceral way. When I read the story aloud, I was more able to feel moved by the words I had written, whereas this would not have happened to the same extent if I had been reading silently to myself. So, in a way, reading the story aloud was one of the ways I could start to evaluate my draft stories. Academic writing is generally only evaluated on its capacity to move minds. This is why autoethnography is such a radical academic sea change. Whether read alone or read

out loud for others to hear, a good story is always a performance because "we" the reader/audience become involved on an emotional as well as cognitive level (Denzin, 2003). If the audience does not get involved on an emotional level then I'd say the author has not been successful at engaging the reader on that level and hence fails one of the key evaluative criteria I will discuss later in the chapter.

4.6 Ethical considerations

In this section I consider some of the ethical concerns encountered in autoethnographic research, such as the protection of participants' rights to privacy and confidentiality, including family members who I wrote about in the autobiographical parts of the thesis. It is now an established principle within university codes of ethics that the pedagogical good that may come from researching human subjects takes second place to the ethics of non-harm and the protection of privacy rights (McLeod, 1999; Waikato, 2007). Research on human subjects must not be undertaken if there is any possibility that it may cause harm to the people being researched or infringe their right to privacy. Within the general professional ethics literature, a set of core ethical principles have been established (McLeod, 1999): that the research will have beneficial outcomes; that the research will avoid doing harm to participants; that the research will respect the autonomy of participants and will treat everyone involved in a fair and just manner. In addition, the human rights to privacy and confidentiality are also essential considerations when conducting research with human subjects. Informed consent must therefore be obtained from research participants if their rights to privacy and confidentiality are to be diluted. However, when it comes to applying these principles in practice it is not

always so straight forward, especially when it comes to autoethnographic research which includes stories involving people who have not given any formal consent to be included in the research story (Ellis, 2004). For example, Frank (1995) in writing about the "wounded story teller" speaks about how "becoming a witness assumes a responsibility for telling what happened" (p. 137). In telling my story I act as a witness to my experience of being a secondary victim of sexual offending. I tell my story as part of my own process of recovery. I needed to tell my story but in order for me to tell my story I had to disclose my father's story. This created the ethical dilemma of finding a balance between my moral responsibility as a witness to tell my story and the rights of my family to respect their privacy.

According to McLeod (1999, p. 80) there are two unique ethical dilemmas that present themselves to therapists who research their own clients: firstly, because counsellors seek to go beyond not doing harm and also hope to enhance client well-being, then it is morally wrong to compromise client well-being for the sake of research; secondly, it creates dual roles, therapist and researcher, and it is therefore important to examine if the researcher role is going to interfere in non-beneficial ways with the therapeutic process. In addition to these general concerns that arise within practitioner research, I was also conducting qualitative research into one of the most sensitive topics possible. The rights to privacy and confidentiality in regards to sexual offences against children are crucial considerations given the extent of vilification people who have records of sexual offences against children are often subjected to, and the sense of shame already experienced both by the person who offended and their families.

As the project progressed the ethical dilemmas became clearer as did the possible solutions. One of the obvious risks to participants was the potential for embarrassment or shame if their identity was to become known. Participants' rights to privacy were therefore protected by disguising their identity and the agency identity and location. This was achieved by changing personal names and other identifying attributes and referring to "the agency". Any written publications or conference presentations based upon this research will also continue to disguise the identity of participants as above. Other dilemmas included: At what stage of the therapy process should participants be asked to give informed consent? Prior to commencing? Midway, after some trust has been established? Or, at the termination stage or even later? How consensual is the process of giving informed consent? How could I ensure the research did not intrude into the participants' private lives? At what stage of the process would the participants' read the story? I was also concerned about the length of the story, and how this would affect the participants' ability to read the story. Similar dilemmas have been discussed by narrative ethnographers who had chosen to fictionalise their accounts because of ethical concerns (Angrosino, 1998) and in the psychoanalytic literature about the ethics of writing case studies (Aron, 2000a; Kantrowitz, 2002a, 2002b; Levine & Stagno, 2001). Reading these papers convinced me to ask for informed consent at the time when the participants had formally graduated from the programme and to send them a copy of their stories to read a few months later thereby reducing the influence of the agency and the therapist on their ability to choose freely.

The formal process of ethics approval delineated these processes and the research proposal was approved by both the agency and the university. The plan was

to access participants who had already been allocated to me as key therapist through the normal agency referral process. I proposed to offer invitations to participate in the research only to these young men, and possibly their parents/caregivers. During the earlier phase, when I was still developing my research proposal, I had considered doing audio/visual recordings of therapy sessions, making a transcript and then doing some form of discourse analysis of the transcript. The decision not to go down this path and to explore the possibility of using autoethnography as an alternative methodology of researching the therapy process was prompted by the problem of researching a sensitive topic.

Sexual offending was not something that people felt comfortable talking about and even less being known for. The benefit of adopting autoethnography as my research methodology meant that I would not have to tape the therapy sessions, thereby allowing me to capture the feel of a therapy session without subjecting participants to the possible feelings of anxiety that may have arisen if sessions were being taped. I also could not risk the therapy process being hindered by the use of recording technology because it may have reduced the participants' safety to self-disclose. In most agencies (and in private practice) there is an expectation that counsellors will record some notes regarding what was discussed during a counselling session as a form of accountability (Ludbrook, 2003). Some counsellors choose to take notes within the actual session and some choose to write up the notes at the end of the session. Some therapists sometimes turn these notes into therapeutic documents of various kinds such as therapeutic letters. Other therapists use the notes to help them remember the various themes that are being discovered as the therapy progresses. I have tried both methods. Recording summary notes was a requirement

of the agency in which I worked. The notes were recorded on a common file which included both group and individual sessions and any other telephone calls in between so that all therapists involved could be kept up to date. However, prior to formal approval being given for my research from the University's Human Research Ethics Committee, I began taking more detailed process notes (Gabbard, 2004) of therapy sessions than I was required to do by the agency. These notes were written only after certain sessions, in which I felt something of significance had happened, that was either helpful or hindering to the therapy process. The notes were usually written on my laptop when I arrived home on the same day and I would use these notes as a resource for supervision. I first came across the idea of process notes in my psychotherapy training in Adelaide. In psychotherapy training the supervisee is encouraged to take very detailed notes of what happened during a session (Gabbard, 2004). Note taking during a session was discouraged so that I could be more present to the participants and at the same time mindful of my own feelings and thoughts and the intersubjective field (Anderson, 1997; Gabbard, 2004). This technique originated before the days of recording technology but has continued. At the end of the session (or sometime later) a written record is made of the most salient events during the session. This includes details of the dialogue, side by side with the therapist's internal thoughts and feelings, and details of the intervention. These notes are then used as a basis for a supervision session. I basically adopted this technique for some sessions (certainly not every session!) and to varying degrees. Gradually, I began to see this as being the equivalent of writing ethnographic field notes. I also found it was a good practice that supported my intention to remain mindful and attuned to my own internal states during therapy sessions, as well as attuning to the participant. The

personal information relating to participants, including my process notes were protected by either being stored in my lap-top, which requires a password, or in a locked filing cabinet in my home study. The only people who were allowed access to these notes apart from myself and the participants were my academic and clinical supervisors. Normally, when research is completed, the University of Waikato Human Research Regulations requires the indefinite archiving of data from published research but in this case the School of Education Ethics Committee endorsed my preference to destroy the process notes at the completion of the project.

As discussed above, the issue of informed consent was also a concern in regard to the different kinds of autoethnographic writing I was using in this project, which I eventually delineated into three different voices: the voice and story of the therapist, reconstructing stories from memory and process notes of the in-session therapeutic interactions; the autobiographical voice of my personal and professional stories, and the researcher's voice telling the theoretical story. It was clear that I needed informed consent for the participants' stories to be included, but this was not the case for the *fictional-composite* story involving the character named Billy. I felt at the time that taking process notes did not require the consent of the participants because these were related (as on a continuum) to the normal process of note-taking following a therapy session that all counsellors are required to do. I would argue that apart from the accountability or ethical reasons for note taking, note-taking is a form of on-going research (Bird, 2000). I therefore took the position that the process of informed consent was not necessary if the accounts of the therapy were to be fictionalised. To ask for consent to write fictionalised accounts would be unnecessary and unduly restrictive upon the imagination and creativity of the researcher/writer.

The decision about informed consent to write about family members in my *personal narratives* was another dilemma, which I return to later in this section. For the stories based upon the therapy sessions, (as stated above) I decided participants would be recruited when they had completed the treatment programme.

This decision was a solution to a primary ethical concern raised by the fact that I was playing two roles: researcher and individual therapist. I was concerned that this dual relationship would affect the process of giving consent. Therapeutic relationships are assumed to operate from a power imbalance. It is very important to participants and their families that they are seen to be cooperating with the therapist. Reports written by the therapist make recommendations to the authorities about such issues as family reunification and ultimately therapists determine when a participant graduates from the programme. I was concerned that my potential participants would therefore find it difficult to feel they had a choice to say no to participation in the research out of deference to the therapist. I proposed to counteract this possibility by making it as clear as I could that they were free to say no without prejudice. I hoped this would address the concerns that participants would only be consenting out of deference (or gratitude) to the therapist or fears that it might be seen as negative and hinder their graduation from the programme.

These concerns were also shared by the School of Education Ethics Committee who approved the project in February 2005 on the condition that the invitation to participants to participate in the research project invitation would first of all come from the manager of the regional agency where the research was to be conducted. It was thought potential participants would find it easier to say no to the manager rather than to me. The manager would explain the voluntary nature of their

participation. Following this conversation a letter of introduction from the manager (Appendix One) was given or posted to the potential participants with the information form attached (Appendix Two). It was hoped the letter would counteract any deference or sense of loyalty they felt to the therapist and give them a clear permission to decide not to participate. It would also emphasise that "Andrew intends to write stories about his experiences while working on the programme". The final step in the recruitment process would take place when the participants agreed to meet with me, once they had been informed of the date they would be graduating from the treatment programme. At this meeting I went through the informed consent form (Appendix Three) to ensure their understanding of the content and to answer any questions. These forms gave relevant details regarding such things as my identity; what the research would be used for; what was expected of participants; confidentiality; publication of papers and presentations at conferences based on the research; and opportunities to read all drafts of the autoethnographies and details clarifying acceptance or declining participation. In order to assist participants to understand what they were consenting to, I read through the information form with them and had a discussion with them about the research. The information form explained the research project and their right to decline consent. Participants therefore would have a sense of what they were committing themselves to.

It was also explained *this consent could be withdrawn at any time prior to the submission of the thesis for examination.* When a draft story was completed after the participant had graduated, the intention was to give the participant a copy of the story. They could then decline their consent, give consent on the basis of certain changes being made or continue to give consent for the story to be included in the PhD

without changes. Given that the consent could be withdrawn after the young man had graduated, I reasoned that participants therefore had no further need to defer to my interests as a researcher because of the power relation established by my dual role as a therapist.

The agency was very supportive of the research but they had been primarily used to positivist psychological research. Understandably they were cautious about what I was proposing. During August 2005 I attended a meeting with my chief supervisor and the agency management team in the city to discuss the research. Following this meeting the clinical manager of the agency in the city emailed the following understanding that had been reached in relation to the proposed autoethnographies:

- *Andrew will get consent from all participants at the commencement of his research (not the commencement of treatment).*

- *His research will be available for reading by the clients when they are at the end of treatment. This will hopefully mitigate the possibility of the therapy being contaminated by the self-disclosure of his therapeutic process contained in the writing.*

- *Should Andrew decide to include material about other therapists in his study, then their consent must be sought.*

- *Andrew will consult with Ratapu Rangiawha (cultural consultant) about any Maori clients he uses in his research.*

- *Andrew will keep the agency informed about his research as he goes along, particularly in regard to his presentation of the agency's policy, practice and related information.*

- *Andrew will present his research to the agency's Journal Club when he is ready to do so.*

I went ahead with this plan following the protocols agreed to with the School of Education Ethics Committee and the agency. In December 2005, three participants gave their consent just prior to their graduation from the programme and I agreed to contact them when I had finished a final draft of the story, send them a copy and then arrange to meet with them to discuss and clarify if they required any changes to be made. After meeting with the participants, I was able to discuss the effect reading the story had on them. One of the participants thought it was okay and I did not need to make any changes. The other two participants both told me they had found reading the story affirming of the changes they had made and they also felt it was another way in which they were giving something back to the community.

Autoethnographic research created many ethical dilemmas in relation both to my participants, team members and the agency, as well as the responsibilities I feel towards my family members. Autoethnographic methodology encourages the writer to be honest about his or her thoughts and feelings, guided by ethical concerns.

Given that I was committed to sharing these stories with my participants there were the concerns about inadvertently re-starting the therapeutic relationship or bringing up issues that were painful to the participant. It was of central importance to me that my research practices did not in any way harm or undermine the treatment gains already made. On the other hand, I believed I had a right and a moral obligation as someone who was an indirect victim of sexual offending to tell my story. My dilemma was to find the right balance between these competing claims, while at the same time telling my story.

I particularly struggled with how best to deal with my personal disclosures and my responsibility to family members. Would I meet with them and discuss it? Let them read the relevant story? Embargo the relevant chapter(s)? Use another name? Or just go ahead in the knowledge that family members are unlikely to read my thesis. I agreed with Ellis (2004) that "If we don't take our work back to those we write about, we better have very good reasons for not doing so" (p. 145). Therefore when I had completed a complete draft of the thesis I decided to visit my sister and allow her to read chapter 11 – the chapter within which I disclose most about my family. I knew my sister had struggled with these issues in her own way. She read the chapter and was visibly moved by it. I believe she found it honouring of our father. I contemplated letting my Mum also read the chapter. She asked me about it and I told her how I discussed my father's "illness". I asked Mum if she wanted to read it and she declined. In regards to references to my friend at university, well she is dead, but her memory lives on 32 years hence. In regards to my first wife and my three sons from that marriage, I decided that the story was more about me than them. I deleted any possible negative comments about my first wife, so that even

if she did read it, it could not be taken as a disparaging portrayal. However, I did want to leave some significant details in, so as to convey the experience of my own sense of loss following the end of my first marriage. Finally, I guess if I try to put all this into a nutshell - I wanted to be as clear as possible for my own peace of mind that I wasn't using these stories to promote myself – that I wasn't using or exploiting my participants or family members for self-gain.

Finally, I also decided to use a composite character to represent my work on the programme with participants who were placed in out-of-home care. In fact, I became interested in the idea of designing a composite character not only on the basis of my personal experience of adolescence and my therapy/research experience but also on the various typologies that have been developed in the literature to profile the kind of young person who might engage in harmful sexual behaviours (Lambie & Seymour, 2006). However, following the work of Angrosino (1998) I claim that my representations are grounded in lived experience as well as being creations of the imagination. Other therapists, such as Luepnitz (2002) and Yalom (1991), have written stories about their work with real people who have given consent on the basis that their identity would be disguised. Luepnitz (p. 10-12) states that she struggled with finding the balance between concerns for confidentiality and for writing about real people:

> My imperfect solution has been to write stories about real (but carefully disguised) patients who have graciously granted me permission to do so. I have tried to render faithfully the substance of the clinical work, while changing information that could identify actual people.

Although I have combined both solutions in this project, I believe the fictional autoethnographies describe characters and the process of therapy with the same level of verisimilitude as do the stories based on actual participants.

4.7 Participants and sampling procedures

For the purpose of this thesis I was the primary participant, studying myself as a therapist on an adolescent sexual offending programme. The other participants were recruited from the agency within which I worked as a contract therapist.[4] The sampling process was purposive and opportunistic, all participants coming from my own case load. The referral process was basically a random process where new referrals would be distributed at regular team meetings, depending on capacity. Three participants were invited to participate in the project and all three accepted. All participants were sixteen years or over at the time they were invited to participate. As described previously the participants received a letter from the manager of the clinical programme advising them about my project and stating clearly that they were under no obligation to participate (Appendix One). An information form about the research was also included in this letter (Appendix Two). I then arranged a meeting with the participants after they had graduated from the programme to discuss their thoughts about including their story in the research. Participants were invited to ask questions about the research and I endeavoured to clarify what was involved in the research and

[4] In respect to the personal and professional relationships that are represented in the stories, those who played a significant role, such as Dr Magid, and my sister and mother were consulted about their inclusion.

the potential benefits of the research. Voluntary consent forms were then signed (Appendix Three).

After the three participants had given their informed consent to participate, approximately one to six months later they were given a draft of the autoethnographic story based upon our work together. Participants read the story and had the opportunity to refuse consent or to suggest changes or amendments. They were also invited to write their own commentary on the story. As it turned out all three participants liked the stories and suggested only minor changes.

4.8 Data generation and analysis

Following consent being given by participants, my autoethnographic stories about therapy were drafted primarily on the basis of the detailed process notes that I had written following therapy sessions, including reflections on my own subjective experience and my empathic conjectures on the subjective experience of the participant. These process notes were kept separate from the personal files kept in the agency office. I saw this method of data generation as a variation of the use of process notes used in supervision (Gabbard, 2004; Lichtenberg et al., 1996). Part of this was an ongoing study of my own subjective experience of the therapy session:

> Presenting process notes of sessions is probably the preferred modality of supervision for individual long-term dynamic psychotherapy in most training centers. The reason for this preference has a lot to do with how "data" are defined in psychodynamic work. Psychodynamic therapists are interested in more than the dialogue between two parties. On the basis of the conceptual

> model that psychotherapy is essentially a two-person enterprise, supervisors in dynamic therapy want to know what is happening inside the therapist. When process notes are presented in supervision, supervisors want to know how the therapist felt about the patient, how the therapist thought about various interventions presented to the patient, and how the therapist experienced the patient's response to the interventions. Data, in this regard, are construed as involving the therapist's subjectivity and countertransference in all their various manifestations (Gabbard, 2004, p. 175)

Of course, I knew that details of my interactions with the other participants could only be included in the research following the process of informed consent. Therefore, I didn't know at the time of writing, if these particular detailed process notes would later be able to be used as material to be transformed into the stories to be included in the research report.

The primary data were therefore generated using a combination of these process notes based on past therapy sessions, autobiographical memories of relevant events from my own personal and professional life (Ellis, 2004), and observing and utilising my self as research tool. This also involved using my therapeutic imagination to create some of the fictionalised dialogue including my ability to attune myself to the participant through a process of vicarious introspection coming to an appreciation of how the participant experienced the world (Elson, 1986; Wolf, 1988). Writing the therapy stories positioned me as both a therapist in transformation and as a compassionate witness to others, helping to deepen my empathic connection with participants (Berger, 2001; Weingarten, 2003). It also allowed me to reflect on my

therapy practice and relations with therapy participants from a distance: for example, my feelings and concerns about their progress in therapy; my worries about risk management; the effect of the larger institutional context on my work; how this work impacted on my personal-professional life and how I coped with the demands of the work. I decided to write about my own subjective experience of therapy, my empathic understanding of the participants and our shared experience of the therapeutic relationship (intersubjective field) from my perspective as the therapist. I did consider collaborating with these young men on their own writing projects, to tell their own stories, but decided against this on the ethical grounds that I was imposing my research agenda on the therapy process.

Autoethnographers seek to write of personal experience in a way that represents lived experience as taking place within a sociocultural context (Denzin, 2003; Ellis, 1999). They use narrative techniques such as rich descriptions and dramatic dialogues in order to do this (Ellis, 2004). Like other attempts to represent the process of psychotherapy in a fictional form (Luepnitz, 2002; Orbach, 2002; Yalom, 1991), I wanted to convey some of the challenges of this work, including: mistakes I have made, the ethical dilemmas experienced by being positioned as an agent of social control and a caring and empathic therapist, as well as documenting how the work with the young men and their families has contributed to my professional development and identity as a therapist.

In reflecting on my practice through the lens of autoethnographic research, I was able to capture insights which arguably would not have been possible through more orthodox forms of qualitative research. For example, video/audio tapes of interviews do not allow us to observe the therapist's internal dialogue and feelings

(Balint et al., 1972). Of course, the reader is reliant on the degree of honesty I am able to bring to this work. Ethically, I believe this places the therapist in a more vulnerable position than research that focuses on the experience of the client or on the textual analysis of transcripts. It takes us up close and personal, revealing much that would have remained hidden to the camera or other methodological investigations. However, I did sometimes regret not having taped some of my work. It still could have been written-up in an autoethnographic style. But again, I was dealing with some sensitive issues and I don't regret my decision not to go down that path.

In the tradition of autoethnography, the act of writing the story itself is understood to be a form of narrative analysis (Polkinghorne, 1995); this is because the aim of autoethnography is to show, rather than tell (Ellis, 2004). However, the stories are analysed in the final two chapters from the perspective of both the systemic-narrative therapy traditions and the relational therapy tradition, which makes links between theory and practice. This is a highly selective process and I am sure that each reader will read the stories differently and will have different experiences and draw different meanings from the stories.

4.9 Two-way account of research

Traditional accounts of research are predominantly one-way accounts, in which the researcher, through the use of various methods extracts knowledge from the research subjects. The research subject is constructed as the 'other' that these methods act upon. White (1997 p. 130-32) describes a "two-way" account of therapy, whereby the therapist acknowledges the contribution the person who has been consulting them has made to the development of their skills and knowledge. In a

similar way, the term mutuality is used in relational therapy to convey the concept that in relational therapy both the therapist and the participant undergo a mutual process of transformation (Aron, 1996). In the same way, I thought a two-way account of research would discuss the effect on the researcher(s) of entering into a research relationship. Research subjects in two-way accounts of research are constructed as "participants" or "co-researchers" (Crocket, Drewery, McKenzie, Smith, & Winslade, 2004; Etherington, 2004; Speedy, 2008; Tootell, 2004) who act to influence or change the understandings of the principal researcher(s). A two-way account of research challenges the traditional power relations inherent in most research discourse and foregrounds the contributions of co-researchers to the professional development of the principal researcher (Crocket et al., 2004; Gaddis, 2004). It helps to clarify, refine and re-story the principal researcher's own way of thinking about and practising therapy and research. This will be evident throughout the thesis as I describe my research journey, but I will also return to this question at the end of the final chapter when I describe how participating in this research contributed to the enrichment of my own professional identity as a practitioner researcher.

Most journal articles give a sanitised picture of the research process in much the same way that presentations of therapy stories are "glossed" and "do not adequately represent the disorderly process of therapy"(White, 1993, p. 22). This form of academic writing is often encouraged by editorial requirements that "promote a distorted technical picture of scientific research as a logical, linear process – which is far from the continually changing actual research process with its surprises, design changes, and reformulations of concepts and hypotheses" (Kvale, 1996, p. 83). I

therefore wanted to write about my research in an experience-near narrative style to which autoethnography lends itself, rather than the experience-distant style of most paradigmatic research reports (Bruner, 1986). I was committed to personalising and telling the story of my research journey as part of my methodological commitment to reflexive research and writing. However, I discovered that the writing process was not just about *telling* a story, *the writing process itself* was a path of discovery:

> … I consider writing as a *method of inquiry*, a way of finding out about yourself and your topic. Although we usually think about writing as a mode of "telling" about the social world, writing is not just a mopping-up activity at the end of a research project. Writing is also a way of "knowing" – a method of discovery and analysis. By writing in different ways, we discover new aspects of our topic and our relationship to it. Form and content are inseparable (Richardson, 1994, p. 516).

In writing about myself I transformed myself.

Reflexive research is, by definition, inclusive of the self of the researcher(s) in the final write-up of the research report (Ellis & Bochner, 2000). Following the principle that form and content are inseparable, the style in which I chose to write this thesis was therefore both a political and methodological act, aimed at making my subjectivity visible, unlike traditional academic writing which aims to render the subjectivity of the researcher invisible. This commitment to reflexive writing seemed to fit with my relational approach to therapy in that it supported my commitment to

rendering my prejudices visible while at the same time embodying a dialogic approach to meaning making.

4.10 Redefining validity: Alternative principles

Validity is a contingent concept; its definition is dependent on the particular research methodology it is located in; however our understanding of the nature of truth is central to any theorisation of validity (Winter, 2000). In order to simplify this discussion, I am going to discuss the difference between the objectivist-realist epistemology which underpins most quantitative research and the hermeneutic (perspectival-realist) paradigm which underpins various qualitative methodologies. The hermeneutic paradigm does not abandon realism for relativism but embraces a moderate or perspectival realism, allowing therapy to take into account the findings of other disciplines, (in this instance, neurobiology, infant research and attachment research). However, in the hermeneutic paradigm therapy is a moral enterprise where the self-understanding that arises is dependent on dialogue, and involves our awareness of both our emotional and cognitive responses to the other and our awareness of their responses to us. Because understanding is specific to the particular individual (in contrast to explanations which are universal) therapy needs to be reinvented anew at each encounter. Understanding is also inevitably partial and often mistaken. In this paradigm, then, our understanding is fallible (Orange, 2005).

Within the objectivist-realist paradigm, validity is often defined according to the correspondence theory of truth. This understanding argues that a statement is true, if it in some ways accurately represents, approximates or predicts events which occur in the world (Winter, 2000). It is assumed that we have access to this world,

and that is it an objective world. Validity within this paradigm is also often associated with the word reliability. Reliability also has numerous definitions, however it does seem to refer more to the instruments which are used to measure or quantify reality. Hence, reliability refers to whether the instruments which are used in fact measure what they purport to measure. This suggests that if the investigation is repeated exactly as before it will yield the same results. Hence we have the twin concepts of reliability and accuracy. This is how validity is most often understood in quantitative research. This can also be the case in qualitative research, when instruments such as questionnaires are used to measure constructs such as intelligence or depression or anxiety. Such research goes to great lengths to demonstrate that the instrument gives an accurate and reliable assessment of the object being studied.

In contrast to objectivist research is the hermeneutic tradition. Hermeneutic philosophy has its origins in the interpretation of biblical texts. This was then extended to include historical and literary texts. Historians such as Dilthey (1961) argued that because human beings have intentions and are therefore actors, in order to understand history we have to understand the subjectivity of these historical agents. Hence, the concept of "verstehen" or understanding became central to the hermeneutic project. Dilthey argued that the human sciences were concerned with meaningful relationships, not causal relationships. Explanation is therefore replaced by understanding. What Dilthey means by understanding is insight into the working of a human mind, or, as Dilthey himself says, "the rediscovery of the I in the Thou" (Dilthey, 1961, p. 39). Gadamer (1975/1989) developed the tradition of philosophical hermeneutics where he argued that the meaning of truth did not have to be confined to the narrow definitions of objectivist epistemology. Human truth is

ontologically different to natural truth because we are historical beings who can enter into dialogue. The truth of the orbits of the planets is the not the same truth that is captured in Van Gogh's painting of the wheat field the day before he died. The planets do not have a subjective experience and hence are not conscious of the passage of time. They can be studied as objects and reduced to mathematical dimensions in a way which is congruent with their being. But the truth expressed in a Van Gogh painting cannot be reduced to mathematics it can only be experienced by someone who is seeing or indeed reading the text. This truth is the truth of human experience and it is represented in visual art and literary art forms. And, Gadamer argues, we can enter into a dialogue with these texts in the same way in which we enter dialogue with another human being. By entering into dialogue we are potentially open to being changed or moved by the experience. Or to use Gadamer's own metaphor, our horizon of understanding is expanded. Research founded in the hermeneutic tradition acknowledges that our knowledge is relative to the historical period and cultural world we inhabit. Hence the concepts of validity and the related concept of reliability are re-interpreted.

Gadamer argued that there is a reality but that we only ever understand that reality from a particular perspective. Hermeneutics is concerned with understanding, as opposed to knowing. Hermeneutics starts with the text and then the text is seen as a metaphor for the person. We seek to understand a text in the same way we seek to understand a person. Before we engage a text we bring with us our horizon of understanding, all the background preconceptions and prejudices which form our worldview. When we read a text the text may challenge our background knowledge. If we enter fully into the text and seek to understand what the text is trying to say we

may be changed in the process. Similarly when we try and understand what our conversational partner wants to communicate we seek to understand her perspective, which may be different to our own. Understanding is therefore not concerned with correspondence with some objective reality that can be pointed towards as the ultimate arbitrator; understanding is concerned with understanding perspectives only. Although there is only one reality, there are only perspectives when it comes to understanding.

When these concepts are applied to therapy, self-understanding becomes the principle goal of the therapy process. Because understanding is essentially a contextual and relational process, requiring two or more people engaged in a conversation, the true locus of hermeneutics is this "in-between"; therefore "no method, technique, or procedure will yield understanding" (Orange, 1995, p. 16). Autoethnography is located in this hermeneutic tradition, along with other forms of reflexive research which are concerned to highlight the subjective presence and experience of the researcher (Etherington, 2004). In autoethnographic research, personal narrative and fictional writing techniques are used to evocatively represent a scene from life as lived by the autoethnographer. There is no neutral outside observer who can witness the tale and tell us if it was truth. So is validity a concept that can be defined for autoethnography? Also, how does reflexive research deal with the challenge of bias?

Etherington (2004) argues that we need to feel we can *trust* the researcher. Does he tell us enough to give us the confidence that what he said he did he actually did? This is related to researcher *transparency*. Does the researcher disclose enough about his personal and professional history for us to understand how they bias his

research interventions? Therefore, in reflexive research the problem of bias is dealt with by acknowledging that the research will be inevitably biased but this is balanced by the researcher's attempt to expose this bias through the use of self-reflexivity:

> I understand researcher reflexivity as the capacity of the researcher to acknowledge how their own experiences and contexts (which might be fluid and changing) inform the process and outcomes of inquiry. If we can be aware of how our own thoughts, feelings, culture, environment and social and personal history inform us as we dialogue with participants, transcribe their conversations with us and write our representations of the work, then perhaps we can come close to the rigour that is required of good qualitative research (Etherington, 2004, p. 31-32).

Secondly, we have to allow ourselves to trust our curiosity for stories and to trust our experience of the story. Was it believable? Did it ring true? In other words, we allow ourselves to immerse ourselves in the story – do we identify with any character, do we become emotionally involved? In many ways, the reader of an autoethnography is called upon to do the same as the researcher, to judge the story, among other criteria, by the extent to which he or she is emotionally moved by the story (Etherington, 2004).

According to McLeod (1997), who has published widely on research into counselling and psychotherapy, practitioner researchers into therapy will always have trouble *validating* their findings, when validity is defined according to positivist criteria. Therefore, McLeod believes it is important to develop alternative criteria

that are applicable to all practitioner research projects regardless of the specific methodology they have developed or chosen for their study. These criteria can then be used to validate the findings from qualitative studies carried out by practitioners. He states:

> It has already been suggested that to be able to develop knowledge that enriches practice, it is necessary to be as explicit as possible about the organisational and personal context within which the research was carried out. This principle leads to the following criteria for practitioner research:
>
> - A good practitioner research study will provide sufficient descriptive detail of clients, counsellors, the counselling approach, setting, social and political context, etc., for readers to be able to make informed judgements regarding the similarity and applicability of the study to their own practice;
>
> - A good practitioner research study will provide sufficient information on the personal engagement of the researcher(s) in the study, and their heuristic process, for the reader to be able to make a judgement concerning authenticity, 'ownership' and personal integrity (1999, p.18).

However, I believe these general criteria need to be supplemented by *redefining* validity in a way that makes it more suitable to assess the type of findings produced by autoethnography.

In contrast to positivist research, where findings are understood to be the end result of the application of a procedural method, autoethnographers " turn to criteria for judging the processes and outcomes of research projects rather than the methods by which outcomes are produced**"** (Ellis, 2004, p. 124). Autoethnographic productions are designed to be read, viewed or performed. It is in the reading, viewing and performing and the impact that this has on the reader, viewer or audience that the validity of autoethnographic research is to be found. I think it is helpful therefore, to develop some specific criteria for evaluating the findings of autoethnographic research, without implying that these are the only possible criteria.

I have identified the following six principles for evaluating autoethnographic findings from the literature (Denzin, 1997; 2003; Ellis, 2004; Etherington, 2004; Lietz, Langer, & Furman, 2006; Polkinghorne, 1995; Richardson, 2000). The first principle is emotional evocativeness. Do the stories touch our hearts in some way? Do they engender tears and laughter? Secondly, do the stories "hold" the readers/audience? Do they engage the reader/audience in some form of self-reflection on their own experience? Thirdly, do the stories show how autoethnographic writing can also be a therapeutic act, a process of self-transformation? Fourthly, do the stories achieve a sense of verisimilitude? Are they convincing? Do they ring true? Fifthly, do the stories demonstrate political relevance? Do they have the potential to generate debate and policy change? Finally, are the stories trustworthy? Do they

faithfully represent my relationships with the other participants, family members and other professionals?

The first and second principles reminded me of the way in which I would evaluate my song-writing or a novel I had read. A song only works for me if it moves or touches me in some way. A good song generally evokes emotions, such as laughter or sadness. Or it may make us want to get up and dance or become active politically! A song has to engage me on an emotional level for me to want to perform it. If I cannot feel my way into a song then it is certain that the audience also will not feel the song. Similarly, with good fictional writing, the reader is absorbed in the text:

> This is because the authors of these novels exercise an array of options in fostering dramatic engagement in the reading of the text. This provides readers with many invitations to contribute to the development of the story-line and to live out the drama of it. For example, well-structured novels have many gaps in the storyline that must be filled in by the reader. Good writers do not spell everything out, and the reader is required to participate in putting two and two together to make four, in bringing together specific events into sequences unfolding across time in the revealing of the plot, and in reconciling this with the underlying theme of the story. (White, 2007, p. 77)

In this interpretation of active rather than passive reading, the reader literally performs the text. Thus, I evaluated my autoethnographic writings in the same way – did they engage and move me in some way when I read them? This could also be

amplified, when I would test out the stories by reading them aloud to myself. In reading the stories I would be able to feel the emotion in a more visceral way. I think another criterion of good autoethnography is that it is always both an expression of the writer's genuine emotional experience – the ideas may not be unique, but the emotional experience is always unique and at the same time resonant with many other people's experience.

My experience of writing autoethnography helped me to also relate to the third principle: autoethnography can be understood as a form of therapeutic writing (Ellis, 2004). This worked on both the personal and professional level. On a professional level it contributed to an empathic understanding of all the participants including raising awareness of the state of the therapeutic alliance. I think practitioner autoethnographic research into therapy can be used in individual supervision in much the same way as other forms of recording such as process notes, audio and video recordings. It can also be understood as a form of self-supervision. On a personal level, the stories contributed to helping me work through deeply personal emotions in relationship to my father. In this way the writing can also be understood as a form of therapeutic writing or self-therapy.

I could also relate to the fourth and fifth principles. I hoped that autoethnography would help me to challenge the tendency to duality in our professional, public and family culture towards seeing everyone and everything in terms of us and them, inner and outer, subjective and objective, victim and perpetrator. I wanted to show an understanding based upon inclusivity rather than exclusivity, where a person can be both a victim and perpetrator. The world we inhabit is historical and cultural; we are also embodied. The emotions we experience

are therefore a mix of the universal primary emotions experienced by all human beings, such as anger, joy and sadness and how these emotions are expressed (or not expressed) according to culturally determined prescriptions. We are born into unique historical, cultural and family constellations and we develop idiosyncratic sexual fantasies, dreams, aspirations and ambitions which are still however shaped by our historical and cultural horizons. My thoughts and feelings come and go, but there are repetitions, patterns, recurrent themes. My sense of self from the very beginning is created in non-verbal and then verbal conversations and by the process of identification with feelings and personal and cultural narratives leading to a sense of continuity.

I think of writing autoethnography as a way of integrating my interest in biographical history, the relational self and its historical and cultural context. It can be understood as a postmodern alternative to the modernist case study, situating the therapist-autoethnographer in the text as both an empathic observer and engaged participant. In the same way that disclosing aspects of the researcher's own stories in ethnographic interviews can help the development of rapport (Berger, 2001), I came to see autoethnographic observation and writing as a pathway towards therapeutic empathy by introspectively reflecting on my own personal history and imaginatively entering into the world of the young person I was working with. Choosing autoethnography as my research method allowed me to consider the social and cultural context of adolescent sexual offending, while also keeping a focus on my own introspective-empathic experience of therapy practice. As well as observing and interacting with my participants, I also had the freedom to include my observations and reflections on the larger institutional context of my work, my own attachment

history (Holmes, 2001), and how this work impacted on my personal-professional life.

Finally, I was concerned that my research participants and the people from my personal and professional life (including Dr. Magid and family members) were represented in a respectful and trustworthy way. The representation of the participants and Dr. Magid were validated by sending each participant and Dr. Magid a copy of the relevant story. They were invited to edit the story if they did not feel the story was a trustworthy representation. Similarly, my sister read the relevant sections relating to our parents and I invited my mother to read the same sections but she declined. This idea does share a family resemblance to the concept of member validation often used in qualitative research. Member validation is used to validate the *analyst's* findings by "demonstrating a correspondence" (Bloor, 1997, p 41) with the research subject's own understandings of what happened.

4.11 Conclusion

In this chapter I have covered the research process involved in producing this thesis on a practical level and I have also discussed some of the philosophical issues and ethical dilemmas involved in conducting autoethnographic research with its grounding in subjective experience. I believe I have demonstrated my personal commitment to finding a balance between protecting the programme participants and other family members from unintended harm arising out of the research processes and my own right and moral obligation to tell my own story. I have also made a clear distinction between validity, as understood in positivist research and the alternative validity criteria that I have developed from my readings of the literature.

PART TWO

5.

MY STORY, PART I

In 1975 I graduated from Keira Boys High School in Wollongong, New South Wales, Australia, with a passion for music, literature and philosophy. These passions lead me to place a high value on freedom to express individual difference and to follow one's own path. I was also introduced to the politics of social justice by the lyrics and music of Bob Dylan and John Lennon. However, in graduating from high school I had little interest in or knowledge of political organisations and collective action to bring about social change. I had been too young to appreciate the excitement and energy generated by the election of the Whitlam Labour government in Australia in 1972. However, it didn't take me long to begin my political education.

In the 1970s, although situated between rainforest covered mountains and the sparkling blue Pacific Ocean, Wollongong could still be described as an industrial city with a large port designed to export coal and steel products. Many migrants from Europe had settled in Wollongong following the end of the Second World War, and were eagerly swallowed up by the local steelworks and coal mines, owned by BHP. During these years Wollongong developed a strong militant trade union movement. While studying for a BA degree at Wollongong University (1978-1981) I came under the influence of a charismatic sociology lecturer who was also a committed Marxist. It wasn't long before he had recruited me into the Communist Party of Australia where I met many influential trade union leaders. This was in the late seventies,

when it was still possible to dream of a future socialist utopia. I became involved with the local trade union movement as a research assistant, with the possibility of becoming a future trade union leader. However, I found the relational politics within the party and the union movement to be contradictory to the kind of world I was hoping to create. I remember at the time learning from another sociology lecturer, who described herself as an “ecofeminist”, that the personal is political; the ends can never justify the means and that patriarchal power relations were just as entrenched in left-wing socialist parties as they were in the wider society. I witnessed small factions within the party seemingly more concerned with their own territorial battles for power than the wider issues of social injustice we were supposed to be addressing. After a few years I eventually grew disillusioned and left the party.

Following this I began working in Sydney as a consultant in both Commonwealth and then State Industrial Relations Departments, where I specialised in employee participation and industrial democracy projects. These projects were designed to facilitate the production of local knowledge and expertise from the workforce to improve both jobs and production efficiency. During the 1980s when the Hawke Labour government was in power in Australia I enjoyed this work very much. However, when the Work Advisory Unit I was working in was abolished following a change of State government, I resigned from the public service and began doing a law degree with the intention of becoming a self-employed industrial relations consultant; this coincided with the birth of my son, and also wanting to work closer to home. However, when I commenced studying family law as part of my law

degree, I became more interested in family counselling (than family law) and did my research essay on this topic (which involved interviewing the local counsellor employed by the court). At the same time my first marriage was coming to an end and I had participated with my wife and my adolescent step-sons in some family counselling sessions. I hadn't studied family violence and abuse at university; however, I knew from experience something about its effects.

After separating from my wife in 1993 I enrolled in a social work degree at Sydney University. I was 37 years old and eager to revise my personal and professional identity! I enjoyed completing this degree, and the major essay at the end of first year asked us to write about the practice and theory of social work and its relationship to biography and empowerment. In many ways this PhD is another attempt to answer this question that has stayed with me through my 13 years of practice since graduating in 1995. In this essay we were encouraged to find social work theory that resonated with our biography and personal style. Building on my knowledge from studying sociology in my previous degree, I incorporated my understanding of the critical theorist Habermas (1971), who argued that the sciences can be divided into the technical interests of the "empirical-analytic" and the practical and emancipatory interests of the "historical-hermeneutic" (McCarthy, 1978 p. 56). The former are concerned with the technical mastery of nature and society, with explanation and prediction. The latter are concerned with "securing and expanding possibilities of mutual and self-understanding in the conduct of life" or the "reflection-in-action mode" of practice (Jones, 1990). I

identified with the argument that social work is a practical-moral activity with closer affinities to the arts and humanities than the positivist sciences concerned with explanation and prediction (Gray, 2002; Gray & Mcdonald, 2006; Jones, 1990; Lovat & Gray, 2007; Parton & O'Byrne, 2000). I was attracted to this account of practice as a form of reflection-in-action because it was "fitting to situations of instability and uncertainty (most of social work)". This form of practice required a "reflective conversation between enquirer and subject in attaining resolution" of problems. According to Jones (1990), in the technical rationality mode, "seen as possibly appropriate in situations of stability and certainty (rare in social work), the enquirer applies a pre-determined procedure to the object in order to solve the problem." In contrast, "reflection-in-action requires openness, mutuality, receptivity, self-adjustment, on the spot creativity – qualities understood as the 'artistic', when this is portrayed as polar to the 'scientific'" (p. 189).

Also in this essay, I wrote about my understanding of spirituality and its relationship to social work practice. I saw that spiritual contemplation and spiritual engagement in the world were complementary aspects of the same process (Howe, 1987). I saw that in seeking to understand ourselves we understood others better; and in seeking to understand others we understood ourselves better. For example, to be with and understand the suffering of someone bereaved I turned to my own experience of loss and pain. According to Rothberg (1993): "the intention of such spirituality is simultaneously to inquire into and to transform self and society, self and world, not to have to choose to transform only self or only world" (p. 112).

I first came across narrative therapy while I was still studying at Sydney University, while in the final year of my social work degree in 1995. I had successfully gained a placement with a Centacare agency in Sydney that specialised in working with people who had been the victims of sexual abuse. My agency supervisor at that time was also experienced in working with men who had perpetrated abuse, so she introduced me not only to literature in relation to the victims of sexual abuse (Durrant & White, 1990) but also to the literature on working with men who had sexually abused children (Jenkins, 1990). At the time I was already familiar with various schools of family therapy, from an optional subject I had taken as part of my social work degree. In fact, I had chosen this placement because the supervisor had described a preference for narrative therapy, as being one of the therapy models she mostly used in her work. For the duration of this placement I saw one client in weekly therapy over a 12 week period. He was my first ever therapy client: a 14 year old boy who had experienced neglect, physical and sexual abuse for most of his life up to the age of 10 when he had been removed from his mother's care. His foster father had reached the end of his tether because of this young person's erratic and often violent temper. While working with this young person and his foster father, we externalised the problem of his rage and over the weeks that followed he was able to see a connection between the rage and the abuse that had been perpetrated on him. Therefore, in the following year, after successfully completing my social work degree, I moved down to Adelaide, South Australia, with my new

partner, Annie, to study narrative therapy at the Dulwich Centre and to start a new life.

Narrative therapy, as developed by White and Epston, seemed to me to offer a form of political therapy, and a form of political practice that I could relate to more on a personal level, than in my previous experiences in union and party politics. I liked how narrative therapy drew on the work of the French philosopher and historian of ideas, Michel Foucault, to understand how power also produced the possibility of resistance to power. Narrative therapy seemed to offer a way of working politically on a personal level. White and Epston (1990) had brought my attention to how what we as counsellors see, hear and describe to others is primarily determined by the professional training we have been indoctrinated in. I also learned in my narrative therapy training how I could use therapy conversations to bring forth the values, skills and local knowledge of participants. These ideas were similar to the vision of the industrial democracy projects I had previously been involved with.

In 1996 I was employed as a project officer by the Northern Metropolitan Community Health Service of South Australia for one year to write a manual for group workers working with men who wanted to stop being violent in their relationships with women and their families. The agency wanted the manual to be written from the position of pro-feminist and narrative therapy practice principles. Rather than taking an educational approach (such as the Duluth model), the manual broke new ground by encouraging group leaders to take an “experience-near” (White, 1995)

position in their work with group members. It was argued this would be a better way of engaging men in the work and was also consistent with narrative therapy practice (Tootell et al., 1997).

After completing the manual I gained employment in child and adolescent community mental health. I worked with children who had been victims of abuse and neglect and many children who had witnessed domestic violence, but I had little experience in working with boys and young men who had sexually abused younger children. However, I never forgot the experience of doing group therapy with boys in Murray Bridge (one hour north of Adelaide) who had been suspended from school because of violent and abusive behaviours towards peers. It came as no surprise to me to discover that these boys had themselves been the victims of violence and abuse, both at home and at school. I saw how these boys would soon be the men I had been working with earlier. Reflective dialogue was a cultural practice few of these boys were familiar with. I found it difficult to engage them in narrative therapy style conversations without them jumping out the window and escaping from the community health centre where I worked at the time.

These experiences had a significant impact on me and led to my interest in the centrality of the use of self in therapy (Baldwin, 2000), and to the psychoanalytic tradition and eventually to self psychology (Wolf, 1988), contemporary relational psychoanalysis (Aron, 1996) and contemporary attachment-affect regulation theory (Schore & Schore, 2008). Self psychology and attachment theory helped me to understand that traumatised, insecurely attached children often lacked the capacity for “mentalization or reflective

function", thereby limiting their capacity to engage in narrative retellings of their lives (Fonagy et al., 2004). I responded by paying more attention to feelings and the non-verbal aspects of the therapeutic relationship. This included taking therapy outside the consulting room and into community parklands and fast food outlets. I also placed more emphasis on developing a sense of safety, playfulness and trust in an attempt to engage the child in a therapeutic alliance.

In 2000 I enrolled in a part-time research masters degree in the Department of Psychiatry at Adelaide University. I completed a Masters Research Thesis entitled: *Decentring research: Reflecting on reflecting teams* (Tootell, 2003). For this thesis I interviewed members of a solution-focused family therapy reflecting team and their clients in the agency in which I worked at the time. A key finding to emerge from this study was the importance of the therapeutic relationship and for "therapists to be there as persons not just as professionals" (p. iii). Therefore even with solution-focused therapy, the person of the therapist and the quality of the relationship were what the participants remembered more than any particular intervention. This fitted with a large body of research evidence that more than any model or technique it is the qualities of the therapeutic relationship and the individual therapist that account for successful treatment outcomes (Horvath & Symonds, 1991; Hubble et al., 1999; Luborsky, McLellan, Diguer, Woody, & Seligman, 1997). My research findings also highlighted the experience of therapy as being a two-way process, and that the therapist was open to change just as much as the client (Tootell, 2003). The degree also included a

four-year seminar programme on psychoanalytic theory and treatment provided by the members of the South Australian Institute for Psychoanalysis. This seminar series introduced me to psychoanalytic developmental theory, especially self psychology and attachment theory, and helped me to make sense of my work with the disaffiliated boys I was doing therapy with at Murray Bridge. This programme also introduced me to contemporary relational psychoanalysis and intersubjectivity theory (Aron, 1996; Benjamin, 1990; Stolorow et al., 1994) and contemporary infant research (Sroufe, 1995; Stern, 1985/2000). At this time I also engaged in weekly personal psychoanalytic therapy with Dr. Ric Curnow and fortnightly psychoanalytic supervision with Dr. Elizabeth Heath.

At the end of 2002, I obtained a senior social work position in child and adolescent mental health at the Innisfail hospital in Northern Queensland. While working there I suffered from a sense of professional isolation. It was then that I started up an email correspondence with a psychoanalyst and Zen teacher named Dr. Barry Magid. Barry, who is based in Manhattan, practices in the self psychology tradition, and my personal and professional relationship with Barry continues to enrich my understanding of therapy and Zen practice today.

During 2003, while working in Northern Queensland, I completed my master's thesis on research into family therapy in a child and adolescent mental health agency in South Australia. I approached the Dulwich Centre in Adelaide, with my friend and colleague, Dr. Steven Gaddis, to generate interest in producing a journal on narrative forms of research. Cheryl White,

one of the directors of the Dulwich Centre, encouraged us to make contact with the staff members of the Department of Human Development and Counselling at the University of Waikato, New Zealand. I therefore began an email correspondence with Assoc. Prof. Wendy Drewery and Dr. Kathie Crocket. When in March 2004 I landed in New Zealand, Wendy was the first person I visited and we began a conversation about the possibility of doing a PhD. Shortly after that I gained employment as a contract therapist on an adolescent sexual offending programme, and the idea of this thesis began to form.

The agency in which I worked had grown since the early 1990s into a busy non-governmental agency specialising in both adult and adolescent sexual offending assessment and treatment programmes. The regional office in which I worked had previously been used as a medical centre. It consisted of a staff room and kitchen, four counselling rooms and one group room. The floors were carpeted, and one of the counselling rooms had a sand tray and lots of figurines for sandplay therapy. When I arrived, the agency staff consisted of a full-time clinical manager and a team of contract therapists, who provided an assessment and treatment service to boys and young men[5] who had either acknowledged or had allegedly acted in sexually abusive ways. The full adolescent treatment programme involved individual, family and group therapy plus an annual wilderness camp. The agency received referrals from Child Youth and Family Services (child protection and juvenile

[5] According to legislation constituting the Youth Court of New Zealand people under 14 years of age are defined as "children" and people aged 14, 15 and 16 are defined as "young persons". For the duration of this dissertation I will adopt this definition.

justice) for youth aged 12-17. Before being offered the position, I had met with the clinical manager who had then introduced me to all the members of the treatment team. They were all experienced therapists with a broad range of trainings and expertise, ranging from cognitive-behaviour therapy, to gestalt therapy and narrative therapy. They worked within a common framework of professional standards which had been developed over the years by the agency, and the Australian and New Zealand Association for the Treatment of Sexual Abusers (ANZATSA). As a team, they met once a week to discuss new referrals, comprehensive assessment reports and other clinical issues.

Prior to me starting work the agency had organised a powhiri, a traditional Maori ceremony, associated with the welcoming and hosting of visitors onto the marae[6] (Barlow, 1991). These traditions had been adapted into many aspects of Pakeha New Zealand culture and in this case the powhiri was to welcome both Annie and me to the agency and also to New Zealand. It was a moving experience, culminating in each participant naming their river and mountain that marks their place of home. At the end of the ceremony, the guests who had been welcomed were required to sing a song. Annie stood next to me and although we were both nervous, we proudly sang a song in Gaelic from our own collection of Australian-Celtic songs we had written and recorded in the Adelaide Hills in 1996. It felt right, honouring the

[6] A marae (or community house) is where members of whanau (family community) who belong to a geographically located hapu (section of an iwi or tribe/people) meet for celebrating family events, mediating conflict and welcoming visitors. The marae also house the ancestors, whose photographs are displayed on the walls of the marae.

indigenous culture in New Zealand, still vibrant and alive, along with the distant indigenous culture of our own ancestry, long since lost.

Ten years had now passed since I had started my social work-therapy journey. It has been suggested that “the first decade of our professional life is spent imitating the master clinicians before we ever consider what we really believe in our hearts” (Kottler, 1986, p. 15). My first master was Michael White. However, I was now searching to find a way to express my own unique way of doing therapy. However, the enduring legacy of Michael’s teaching on my work was not his model of narrative therapy, but his personal qualities: his attention to detail; his warmth, empathy, respect and humility and perhaps more than anything else, the sense of never giving up, the hope that there was always some sparkling event, some unique outcome or initiative, no matter how small, that was there waiting to be discovered.

6.

Billy's Story

Billy was brought to his first assessment session by his foster mother, Kate Smith; he was a small fourteen year old boy with fair hair, freckles and an engaging smile, when he smiled, which was not often. Kate had previous experience as a nurse and was an experienced foster carer. Kate explained that Billy had been living with her for about three months; at first on a trial basis and now on a permanent basis. She said it had been a difficult period of adjustment for them both. Billy's previous placements had broken down due to his challenging behaviours.

Prior to the meeting I had learned from the referral information that Billy was taken into foster care when he was 6 years old along with his siblings. As so often happens, the siblings had been separated and placed with different families. Both his father and mother had drinking problems when he had lived at home and his father was violent towards his mother. His father was now in jail. His mother had apparently given up drinking and was currently looking after two young grandchildren because they had been removed from the care of her oldest daughter.

At this initial meeting (as it was to be in future meetings) Billy found it hard to talk about his birth mother. As Billy narrated to me this brief chronicle of his life I thought about the emotional pain of rejection that must have underlain much of Billy's external behaviours, which Billy needed to dissociate from in order to maintain his hope for some future reconciliation. Unfortunately, the longer a child

has been in foster care the more difficult it is to facilitate reunification with birth parents, leaving caseworkers and therapists with the only other alternative of trying to facilitate developmental attachment to foster carers.

At this first meeting we talked about what Billy could remember about his family of origin, which was not much. It felt like his life story was full of blank pages. I learned he had three brothers and two sisters. He had sexually offended against his younger sister during one of the previous foster placements. There had been a lot of sexualized behaviour occurring among all the siblings. There had been conjectures among the professionals involved that Billy had been sexually abused by his father and/or possibly an older brother. The older brother was himself up for sexual assault charges. Billy did not have much contact with his siblings. He told us he would like to see them and his birth mother more often, but he realised his birth Mum was really busy and didn't have that much time, so he attempted to reconcile himself to the situation.

I changed the subject and talked about school and his social interests. Billy said he had plenty of friends, but I knew from the referral information that he really didn't have any friends.

Children who suffer from relational trauma often have difficulty forming intimate relationships, first with peers and later with adults. Relationships tend to be superficial and shallow. One person or object can easily replace another one. One way of understanding this is that they have not experienced an attachment relationship of any depth. Another way of understanding this is that it is a protective mechanism – you don't allow yourself to get too close to anyone – it hurts too much

when you get let down! I sensed Billy's loneliness and simultaneously his fear of getting close in case he was rejected again.

He told me he enjoyed cricket, rugby and basketball. Kate told me he won 1st place in the school cross country race and then came third in the inter-school event. Kate thought he was a "neat kid" and with some help with his school work she thought he would "go a long way". I was heartened by the ability of Kate to see a positive future ahead, but I also knew that it wouldn't all be smooth sailing with Billy. And I knew that Billy himself found it difficult to envision a positive future for himself. There would probably be some storms ahead I thought, but I hoped the placement would survive and not sink, as so many in the past had done.

"How long do you think you'll be staying with Kate, Billy?" I asked matter of factly. Billy looked at Kate and said with a big charming smile "as long as I like". I continued, "Have you ever felt like you had a home before?"

Billy lowered his head and said "No."

"So this must be very important to you, knowing that you can stay with Kate?"

"Yeah. I don't want to move again".

I asked Billy about how many times he had moved and he named all the different foster homes he had been in. He detailed about seven different places. Then he said emphatically:

"I want to stay with Kate till I die."

"That's great Billy."

He then turned towards Kate and said, "I have found a home for the first time."

* * * * * *

Billy attended the programme once per week, having the whole day off school in order to this. He would arrive early in the morning for his group session, which would be followed by his individual session with me. The weeks went by and then the months. Progress was slow and Billy was difficult to engage. Today he didn't look happy. I invited him into the counselling room. He sat down glumly and glared up at me.

"I've got a new uniform, thanks to you," he said, tartly. The tone of voice indicated to me that he was not necessarily pleased.

"I smell, do I?" he said, looking daggers at me and folding his arms in an aggressive posture.

Last week I had noticed that his grey shirt looked as if it hadn't been washed for a few days. Then I received a complaint from Billy's group leaders saying the same thing and also saying the aroma left behind in the room from Billy was not very pleasant. I therefore contacted his caregiver, Kate, and left a message informing her about the hygiene issue and also about his school shirt.

"It looks really good Billy - new shorts as well?" I said, trying hard to sound upbeat.

"Yeah."

He did look good. I thought he was a handsome young man. But today he did not look happy. Billy seemed to me to vacillate between a cheerful willing to please mood and an aggressive "it's not fair" mood. However, in his short life he probably had good reason to feel life was not fair.

"Look Billy, it wasn't just me you know. I received a complaint from the group leaders last week."

"Yeah, but it was you who told her."

I knew that Billy knew that this was not just about the hygiene issue. He had previously told me that he was playing unsupervised with some of the neighbourhood children and I had recently informed his social worker and caregiver about this being a concern.

"Look, we talked last week about supervision. How it's a shared responsibility, not just mine. We agreed that you had to take responsibility for keeping safe. So, how did you go on the weekend with the neighbourhood children?"

"Yeah, and I'm pissed off with that too."

"Why?"

"Well it's not fair. She's old enough to be my friend."

"How old?"

"Eleven."

"And how old are you?"

"She could beat me up."

"Look Billy, don't take it so personally. It's the contract that you signed when you came on the programme. It's not just you; the rules apply to all the guys on the programme. It clearly states that you are not allowed to be alone with children unless it is with an informed adult." I sounded like a lawyer, I thought, distant and somewhat aloof.

"It's just a fuckin stupid piece of paper."

"There's no need to swear."

"You're ruining my life. There are no other kids my age to play with."

"The rules are there to keep you safe. You don't want to put yourself in a situation where you're alone with a child."

"She's not a child. She's eleven years old."

"And you are about to turn fifteen."

"So, I told you, she could beat me up."

"Well that's a bit different from what you told me last week. You said that you enjoyed being 'the master'."

"Well, they like to follow me. I like to be in control."

"Don't you see Billy? That's another reason why it is a safety issue. Remember the discussions we have had about power and control and sexual abuse?"

"No".

"Look, you are putting yourself in a seriously risky situation. However, we could inform her father about your past offending." I immediately regretted this response. It felt like an indirect threat, expressing my irritation and the power imbalance in our relationship.

"No way!"

"Well then, you'll just need to follow the rules." I felt I was colliding into Billy, rather than working collaboratively.

"What else am I going to do? It's really boring!"

"Are there any clubs you could join so that you could make friends your own age?"

"No. There's nothing to do. At least at Ed's place (previous foster carer) I had my playstation."

"You know why that was confiscated."

"No I don't."

"For playing R rated games."

"They weren't R rated."

Billy's previous foster carer and guidance officer had been alarmed at what they perceived as Billy's obsession with violent video games, which Billy himself would see as harmless; hence, another injustice.

"My friend lets me play on her playstation."

"Well, you are not to play with her anymore."

"It stinks. Why can't I have my playstation back?"

"Well, maybe I could bring it up at the next review meeting."

I wished I hadn't said that. I didn't have a clue what happened to it after Billy's social worker had taken it.

I noticed that Billy had been picking at a scab on his knee with a sharp metal object he'd found in the room. Billy had a bad habit of "picking" at his scabs. At the same time I felt heavy hearted; tired. I noted a familiar negative thought passing through my mind: You are not helping this boy - You are a lousy therapist.

I knew this voice well, the voice of self-criticism, aiming to expose me as an incompetent, fake therapist. I knew it well because it was often around. It complained, this is a hopeless therapeutic conversation. You can't even ask one decent question!

"Billy can you stop doing that – look, it's starting to bleed."

Sure enough a blob of red blood had formed on his knee.

"Can you get me a plaster Andrew?"

"Sure, hold on, while I get the first aid kit."

I went into the office and fetched the kit. I searched in the tin container for plasters. Fortunately we had some. I put one across the sore, and then Billy said:

"It'll fall off if you don't put some extra tape around it."

I found some tape and Billy instructed me how to do it. The heaviness I was feeling a moment ago was replaced by a feeling of tenderness. Billy also softened. He was being cared for. I sensed the lack of human warmth and tenderness in his life. I knew that Kate felt uneasy about close physical contact with Billy. I wondered when the last time was that someone had genuinely given him a loving cuddle …

"Would you like to go for a walk and I'll get you a bottle of ginger beer?"

"Yeah."

He smiled. We were friends again. We walked down the street laughing and making small talk and we headed for the bakery which also had a fast-food take-away section. He looked hungrily at the sausages.

"Look Andrew, they're only a dollar, like in the shop near my place."

I bought him a sausage. He appreciated this and it seemed to cement a bond between us.

The next session, before sitting down in the counselling room, we went for another walk and I bought him another sausage and before I knew it, we had created the sausage buying ritual. But I didn't mind, after all, they only cost a dollar.

One week later, I was sitting with Billy in the sand-tray room. He wandered over to the sandtray and pondered the complicated world created by another child. I remembered Billy's previous sandtray pictures in our earlier sessions - they

illustrated a consistent theme of attack and defence, soldiers, police – his life as one long war.

"Billy, would you like to come and join me. I feel lonely sitting here all by myself."

He came over and sat down facing me.

"You were angry with me last week."

"Was I," he half smiled. "I've forgotten."

He probably had forgotten, I thought.

"I think you probably experienced me as questioning you like a policeman or something." He smiled. "I'm sorry about that, but that's part of my job," I continue, "to ask you about the safety plan and stuff. To make sure you and others are safe. You understand that don't you?"

"Yeah, I guess so."

"I'm sorry I missed your talk in group about your grandmother's blanket though."

"I showed it to you."

"Yes, but I didn't hear you talking about it. How was it made?"

"She knitted it."

"Wow. She must love you a lot."

Billy nodded his head, sadly.

We decided to go for a walk. It was good to get out into the fresh air.

"I haven't had lunch yet," I said to Billy.

"Me neither" said Billy.

"You must have been disappointed about your birth Mum not being here today?"

"Yeah, I am."

Billy started to play his usual game of picking up the walking pace and leaving

me behind. He turned around and smiled.

"Hang on" I said. "Remember, I'm an old man."

We arrived at the bakery.

"Would you like a pie or a sausage?"

"Pie."

I grabbed a sandwich.

"Can I have one of those Andrew?" Billy pointed to a chocolate milk drink.

"Yeah, sure."

We walked back to the clinic and into the counselling room. I was wondering, how do I start? Can we hold a conversation for a little while? I wanted to say something about his birth Mum, something about how important she was and how important the hope of reunification had been to him. But was this hope of reunification helpful to Billy in the long-run and did it stop him bonding with Kate, or for that matter, any other caregiver?

"Billy, I'm sorry I didn't realise how precious your hope is to be reunited again with your birth Mum."

Silence. Then, almost impatiently, as if waiting for more, he said, catching me by surprise:

"Yeah, go on …" His tone implied, is that all you've got to say?

"How did you manage to keep alive that hope all the time? There must have been times when you felt angry at your Mum for not being there for you?"

Silence. I continued, stumbling along in the dark.

"You must really miss your Mum?"

"Yeah, I do."

I was not sure where to go next. I turned to the whiteboard.

"Remember when we used to draw?" I said.

"Yeah, squiggles." He remembered the name of the game I took from the British paediatrician and psychoanalyst, Donald Winnicott (Phillips, 1988). He drew a squiggle on the board and I started to create a picture. I drew a sad face peaking out from behind some clouds. Free associative drawing. I drew a baby in a pram. The mother was absent, or was the mother the sad face peaking through the clouds? The drawing was then erased - the transience of the therapeutic moment. An opportunity missed? Billy said nothing about the content. I squiggled some more lines and he began to draw.

"There," he said with a sense of satisfaction: "A two-headed shark." He drew a balloon from the mouth and in the balloon he wrote the words: "I want to eat you up."

"Who is the shark and who does the shark want to eat Billy?"

"I dunno."

"And why two heads, do you think?"

"I dunno."

When Billy had finished the drawing he said, "Can we play ball now?"

I replied, "I think you are changing the topic. What are you feeling right now?"

"I dunno."

"I know. How about we play a little game? How about you pretend to be the shark and I ask you some questions. Is that okay?"

"Alright."

"Hello Mr Shark, what big teeth you have!"

"All the better to eat you up with!"

We both laughed.

"Mr Shark, I would like to be your friend, but I feel you want to chase me away whenever I get close."

"Go away!"

"Okay, okay." I decided not to push too much – in my experience Billy would only withdraw even more if I tried to push too far.

"You sound angry Mr Shark. Are you feeling angry?"

"Yes!"

"Let's play some more then. Maybe that way you will trust me better and then you might change into a playful dolphin!"

So I suggested we play hand-football. He enjoyed this game, especially when he was winning. Near the end of the game, he started to gesture like a gorilla. I joined in the game, down on my hands and knees. He laughed at me beating my hands on my chest, imitating a gorilla. Then he started to beat his chest with his fist and again I joined him. Before long we were both laughing and enjoying ourselves immensely.

Finally, I reminded him gently that it was time to finish and asked for his help in tidying up the room. When we had finished tidying he moved off freely and without hesitation to his group session. Billy was back and re-engaged again with the therapy, but how long would it last, I wondered, and would his birth Mum come next week?

It was another blue sky autumn day. The ritual was now firmly established and Billy followed me out the door onto the street. We walked towards the bakery, turned the corner and crossed the road. I said, "Be careful crossing the road," but it was already too late, he had run across, just in front of a car; "Billy how many times do I have to tell you?"

"Hey, Andrew, can we play the car racing video game after the bakery?"

"No."

"Oh, why not?"

"Because I want to be with you - I'd rather play football than watch you play the video game. I like to look at you, face to face. We only get to be with each other one hour per week and I want to make the most of it. Besides you can play those computer games at home."

"No I can't, I don't have a playstation."

"Well, the answer is still no."

We entered the bakery.

"Can I have a drink Andrew?"

"Sure,"

Billy picked out his usual coke with no sugar.

"That's my third drink today", he said with a smile." He then went over to the glass display tray where the pies were displayed.

"Look", he said excitedly, "they've got my favourite pie.'

I went up close to have a look.

"Oh, pizza pie" I said. Then I started to sing:

"When the moon hits the sky

Like a big pizza pie that's amore …"

Billy gave me a funny look, imploring me to stop singing. We went to pay and at the counter he eyed the strawberry and chocolate tarts.

"They look nice," he said.

"We'll have one of those as well," I said to the shop girl.

"Six dollars thanks."

We walked back to the agency building, saying hello to some of the other boys from the group who were also sitting outside the shop. On the way back, I gave Billy one of my new business cards. Billy looked pleased to receive it.

"Thank you," he said. "I'll put your number on my cell phone."

"I didn't know you had a phone. How long have you had it?"

"Couple of days."

"Did your social worker give it to you?"

"Yeah."

We arrived back at the clinic.

"Which room shall we go in?" Billy chose the group room, because it was the room we played football in. He sat down at the table and we finished eating our lunch together.

"Okay, let's talk", I said.

"Okay, but I don't know what to talk about."

"Well, it can be helpful to talk about the past. I know you don't want to go there because it's too painful but at some stage it's going to be important for your healing to talk." Here I go again. This was a big assumption on my part. I didn't have the right to push anyone to talk about the past if they didn't want to talk about it.

"At some stage, but not now," he said. "Can't we talk about the present?"

"Fine, let's talk about the present."

There was a long silence.

"Well, how's your week been," I said.

"Good."

"Do you have any news?" He threw a small hand made object on the table.

"That's a scoopy doo. A girl made it for me."

"Oh, that's nice. Why do you think she gave it to you?"

"Because at the time she liked me and wanted to go out with me."

"Yeah, and she must have given that to you to remind you of her. Why did she stop liking you?"

"I don't want to talk about that."

"Well, can we talk about girls in general?"

He smiles: "No".

'Well, how about we talk about sexuality then. After all, that's why you're here."

"Nope."

I shook my head. Billy was successfully controlling the session and I felt stuck - another impasse.

"Okay, then. Come over here." I lay down on the carpet. "Let's have a hand wrestle."

Billy came down and joined me.

"Now be careful, because I broke my right arm and it's not as strong as it used to be".

Billy nodded his head in agreement. We started to hand wrestle and Billy's arm gradually forced mine down to the ground.

"I'm not hurting you, am I?" he said.

"No, I'm okay." I let Billy force my arm down. I was touched by this gesture of expressed concern for my well-being; the first that I could remember receiving from him. We wrestled with the other arm and Billy was triumphant again. We did it one more time and Billy was established as the champion arm wrestler.

"Can we play soccer now?" asked Billy. I went to get the ball while Billy set up the room. We each had our own goals at each end of the room. We played for about 15 minutes. He enjoyed the game but I quickly tired. "Okay", I said, "let's go for another walk and play that racing car game."

Back outside again we walked along in the sunshine. I wanted so much to connect on an emotional level with Billy, but he consistently seemed to resist any

form of closeness other than play. But at least when we played there was a closeness. Well then, if that's where he's at, I thought, that's where I have to be at.

"Billy, I do care about you, you know. I know it's easy for me to say that – I mean I only see you for one hour a week. But I do care."

He smiled.

"Well at least you know I respect your boundaries. I'm not going to force you to talk about anything you don't want to talk about." But then I wondered, was that allowing him to manipulate and control the sessions too much?

We entered the shopping centre. They were playing Cat Steven's song Father and Son on the music system as we entered. I started to sing along …

"It's not time to make a change
Just relax take it easy, you're still young
That's your fault, there's so much you have to go through …"

I remembered lying on my bed when I was Billy's age, or maybe just a little older, listening to that song and thinking about my Dad …

"All the times that I tried to be all the things I knew inside
But it's always been the same, the same old story,
From the moment I was born I was ordered to listen now there's a way,
That I know, and I have to go away, you know, I have to go …"

Billy gave me another funny look and tugged on my shirt to say stop singing.

We arrived at the machine.

"Do you want to play, Andrew?"

"Yeah."

We had two or three races. The graphics were amazing and I kept on crashing my car. I thought of the movie, Crash, which I had just seen. The movie is set in LA, and the cars which crash into one another are metaphors of the isolated person, alienated and afraid. They only connect when they crash into one another – and maybe, just maybe, there are times when they touch – like the father's love for the child … We got back just in time for Billy to go into his group.

A few months later we were sitting in the group room again finishing our lunch.

"Let's talk", I said.

"I don't want to talk," said Billy.

"The World Cup starts on the weekend. Are you going to watch some of the games?"

"I don't care about that."

"Billy, what do you care about?" I said softly.

"I dunno."

"Billy, how do you think you are going to graduate from the programme if you don't talk?"

"I dunno."

"How's the placement going?"

"What do you mean?"

"How's things been with Kate?"

"The same. I don't want to be there but I have no choice."

"Yes, I agree there's not many options. But has Kate been more understanding?"

"I dunno. Can we play now?"

"Billy, how do you think I feel when you refuse to talk all the time?"

"I dunno."

"I feel like you don't want to be with me."

Billy lowered his head and looked serious. He seemed to be listening. I was immediately struck by what I had just said and I continued, "I know that's how you must feel some of the time – that people don't want to be with you - but you're going to have to let yourself get close to someone one day. You can't keep shutting people out all the time because you are frightened they are going to hurt you. You are a good person and I like you but you won't let me in. I thought you would have been able to trust me by now. It's been almost two years now since our first meeting. If you don't let someone get close you are always going to be lonely and I don't want that. I care about you …"

Billy's head remained bowed.

"Billy, when do you think you are going to be ready to graduate? At the end of this year? Next year? What do you think?"

"Well, I won't be ready at the end of this year."

"Really? Why is that?"

"I dunno. I just won't."

A few weeks later Billy finished his group session and we followed the usual routine walking down to the bakery to buy some lunch.

"Some good news Billy – your social worker is coming today to take you shopping for your new bike. Are you feeling excited?" Billy had been expecting Amelia, his social worker, to take him shopping for the last two weeks.

"Sure, I'll believe it when I see it."

"No really. I just talked to her on the phone this morning."

"We'll see."

At the bakery he had a sausage and chips and I got my salad sandwich and we sat down to have lunch together. We then walked back to the clinic and into our usual counselling room. I would normally let Billy start the conversation, but this time I began:

"Billy, Kate rang me this morning. She told me you had some issues you wanted to talk about today?" She didn't really expect Billy to raise the issues. She wanted me to, but I thought I would just give Billy a chance to see what he would say. Billy shrugged his shoulders and said:

"I can't remember anything."

"You sure?" I gave him another chance.

"Yeah."

"Well she told me that last Friday when she came home she found a condom full of urine tied to the front steps."

"What? She's a liar!"

"Billy!"

"Well she's just such a bitch."

"Remember, I prefer you to speak respectfully of people here, even if you're angry with them. She says you got the condom from the agency."

"What?"

"Well, I said we don't have any condoms here."

"That's right. That's what I told her."

"So where did you get it from then?"

"I found it on the street."

"Right. Well thanks for being honest with me. You must have been really angry with her."

"Yeah. I felt like putting a dead bird on her bed."

"Billy!"

"Well I hate her!"

"Maybe the hate stops you from feeling close and maybe it's easier that way?"

"I suppose so. I'm never going to get close to anyone again because you always get moved on."

I paused for a minute, taking in how Billy had managed to understand some of the issues we had been talking about and repeat them in a way that made sense to himself. "Billy, you just said something really important. Maybe you don't want to get too close to Kate in case you get taken away."

"Maybe," said Billy, but I could see he was thinking about what I had said.

"Billy, there is one other issue that Kate wanted me to discuss with you. Remember Amanda? The girl in the special needs class at your school?"

"Yeah?"

"Well, Kate says she has complained to the Deputy Principal about you punching and slapping her again."

"What? I didn't punch her! I slapped her. If I'd have punched her she would have known it."

"So you admit to slapping her?"

"Yeah – well, she scratched me first! What do you expect me to do?"

"Well, maybe you could walk away and tell a teacher."

"Sure, they don't care – they don't listen to me."

"How come you didn't punch her?"

"I dunno."

"Well, you made a choice not to punch her. Why?"

"I don't know."

"I think it was because you didn't want to hurt her. Is that possible?"

"Hmm. Maybe."

"Billy, you know that Amanda has an intellectual disability. What if it had been a three or four year old who scratched you? Would you have still hit them?"

"Sure."

"What about if it had been your own son who scratched you? What would you do?"

"I'd hit him real good"

"Really? Billy, is that what happened to you?" Billy lowered his head. I continued, "Billy, who used to hit you?"

"My Dad did."

"I thought so."

"I use to get kicked up the arse and punched in the face for not looking after my brothers properly." Billy was beginning to disclose about his own victimisation. While Billy had been talking he had picked up a small bird from the shelf. The toy bird had feathers but its wings had come off. He tried to fix them back on without any success.

"Do you have any sticky tape?" he asked

"Sure, I'll go and get some". When I came back I handed him the tape and he fixed the wings on the bird.

"Now it can fly again" – I said, "just like you." Billy smiled.

"I'll give it some eyes as well," he said.

Billy picked up the white board marker and made two dots representing eyes.

"Now it can see and fly," I said.

"Yeah."

"Hey, Billy would you like a hot Milo drink?"

He nodded his head, "thanks."

He drank his Milo and then we waited outside. Finally, after a few minutes wait, sure enough, the social worker arrived to take Billy shopping for his new bicycle.

7.

MY STORY, PART II

As part of the requirements of my final year of training at the Dulwich Centre in 1998, trainees were invited to choose a topic they would like to explore in a narrative therapy conversation with the teacher, Michael White. I chose to focus on my relationships to my parents and to the children in my life, and how they had contributed to preferred developments in my professional work. I began the interview by saying I didn't think it was an accident that I was working with children. Contact with my own children had been difficult and sporadic both during and after my social work training because of the problems I had in my relationship with my first wife, Nadia.[7] I had started living with her when I was 19, just after finishing high school. She was 5 years older and she had two small children: Phillip who was five years old and Sam who was two years old. I remember Sam was still in his high chair when he had his feeds. In some ways Nadia was a safe harbour, a retreat from the three rejections I had received from young women my own age. I had just dropped out of university at the time, after a young woman I had been having a relationship with at university had veered off the road in a traffic accident and died. This left me feeling both grief-torn and guilty.

I had met Mandy at a party when I first arrived at university. She was living in an adjacent college to mine. I had approached her at the party because she was sitting by herself looking drunk and depressed. I managed

[7] All the names have been changed.

to engage her in conversation about existentialism and the limits of freedom and I walked her home to her room at the college and said goodnight. The following morning I was surprised to hear a knock on my door. I was still in bed, so I said “come-in”. The door opened and Mandy came in and joined me together in my bed. Our “affair” continued for a few weeks until I heard from college gossip that I wasn’t the only young man she was sleeping with. This may or may not have been true, but I experienced a kind of jealous resentment which I hid from her. This eventually came out one night and I expressed my underlying feelings of jealousy by putting Mandy down in a typical patriarchal way for sleeping around like a “whore”. She neither confirmed nor denied the rumours, she just sat on the bed and her eyes filled with tears. Understandably, she asked me to leave. That was the last time I saw her alive. I went away for the Easter holidays back to my parents’ place and when I returned a guy ran up to me saying the university had been trying to contact me. Mandy had died in a car crash and they thought I might have been in the car with her. I was in a state of disbelief and I remember feeling numb. I retired to my little room and kept playing the song “Nancy” by Leonard Cohen, over and over again. It’s another sad but beautiful song about a woman who committed suicide, who “wore blue stockings and slept with everyone”. At the time I thought Mandy took her own life. Now, I’m not so sure, I don’t think we can ever know – maybe she had been driving too fast and spun off the road.

Following Mandy’s funeral, at which I gave a heartfelt speech about the loneliness of university colleges, I dropped out of university and moved

back to my parents' place in Wollongong. I took a labouring job at the BHP steelworks in Port Kembla and Mum helped me find a flat. At the time I had big plans to save money from the job and go to Paris to live my fantasy of being a writer, like Henry Miller and Ernest Hemingway, or go to a Greek island like Alexander Durrell and Leonard Cohen. It was during this time that I began the relationship with Nadia. I had known Nadia from my circle of friends before I left Wollongong to go to university in Canberra. We met up again at the local folk club and began a relationship. Nadia was quite persistent in her affections, and after a short time I was eventually spending more and more time at her place until eventually I decided to let go of my flat and move in. But there was another side to Nadia that I was to meet. Near the end of her short-lived first marriage with a manic musician called Tony, who was prone to fits of violence, she had ended up in the inpatient psychiatric unit after what she called a "nervous breakdown". At first this history added a somewhat romantic sheen to her character and appealed to my sense of being the heroic knight on the white horse. Phillip and Sam enjoyed playing with me and it wasn't long before little Sam would toddle up the driveway to greet me when I came home from work. It wasn't long before I became fond of both the children and an affectional bond grew between us.

Two years later we were married at the local registry office. My parents could not hide their disappointment at my choice, but they did their best to be part of the celebrations. The marriage lasted precariously for 15 years. I found Nadia had a histrionic personality which was hard to bear, moving from clingy dependency one moment to outright verbal abuse, rage

and violence the next. I am sure I contributed to this by my ambivalence right from the start about marrying her, and this never changed. I am sure this only fueled her insecurity and distress. I couldn't cope with these extreme swings of moods and behaviours but I also lacked an understanding of trauma and abuse. During this time I had separated from her a number of times, but came back, pulled by my love for the children and my own insecurities. On the 26 December 1988, my son Justin was born, much to my joy and the delight of my parents. This kept the marriage going for another four years, but it didn't last. Then, one day when I was on the brink of despair, a new woman walked into my life, Annie, and I fell in love. The relationship with Annie commenced while I was still living with Nadia and then I moved out. This had devastating consequences, which I never could have foreseen, for my son Justin. Unfortunately Nadia found out about the affair, and she became hostile, making it impossible for me to see my son. She also left threats written on paper on Annie's car, which was traumatising for Annie. We therefore moved inter-state for peace of mind, but it was a struggle for me to see my son for many years without torrents of verbal abuse being unleashed upon me. I decided not to contest custody, because, in my experience, motivated by the rage of betrayal and the fear of losing Justin, Nadia was capable of doing anything. So I had infrequent contact with Justin, Phillip and Sam and the relationship between the three boys and I was never quite the same again.

I don't think I would have coped as well as I did, if it hadn't been for my work as a therapist in child and adolescent mental health. I guess the

boys I worked with helped me just as much if not more than I was able to help them. When I started to work with children therapeutically, I guess you could say I experienced a closer connection to the kids I saw in therapy than I did with my own children. At time of the interview with Michael White I stated to him that I had a sense of them fading out of my life and I guessed that they must have experienced a similar sense of me fading out of their life. The only exception to this scenario was that Justin and I did keep in contact through writing letters to begin with, and emails later on. Some of these letters were quite precious to me and maintained my hope that maybe one day things might be different.

Michael began the interview by asking me, “What are some of the good memories of your connection with Phillip and Sam?” I remembered backwards, starting with their teenage years. We had had some good in-depth discussions with each other about philosophical issues and they used to enjoy staying up late when my friends came round who also enjoyed philosophical discussion, ranging from politics to Buddhism. Then the memories of taking them out to movies and musicals and restaurants; taking pleasure when they did some good work at school; and we had some great games of table tennis together; watching sport on TV; reading stories to them like the Dr Seuss book, *The Lorax* (Seuss & Seuss Geisel, 1971):

> At the far end of town
> Where the Grickle-grass grows
> And the wind smells slow-and-sour when it blows

And no birds ever sing excepting old crows …

Is the Street of the Lifted Lorax.

And deep in the Grickle-grass, some people say,

If you look deep enough you can still see, today,

Where the Lorax once stood

Just as long as it could

Before somebody lifted the Lorax away

What *was* the Lorax?

And why was it there?

And why was it lifted and taken somewhere

From the far end of town where the Grickle-grass grows?

The old Once-ler still lives here.

Ask him, *He* knows.

At this point in the interview I began to sob. Michael asked me, "What are you thinking about – what are the feelings that go with those tears?" And I replied, "The years I've missed out on with Justin". Remembering all these activities only made it clear that I would miss out on all those experiences with Justin. He was only four and a half when we separated …I was never going to be able to experience these special moments with him, I thought, compounding my sense of loss. I let my mind wander back again, remembering playing games with them, bringing back memories of playing games with my own parents: Monopoly, Risk and even before that card

games and party games like “Old Maid”. Dad was good at those games, good at birthday parties playing “Simon Says”. I realised that the games I played with the children who consulted me at work had a lot in common with these experiences. I’d realised that the best way to connect with children before attempting any real talking therapy, especially if these children had a history of traumatic experiences, was to play with them.

Then Michael asked me, “What’s your sense of what these boys experienced with you?” He was referring to my own children. I said, “Care and love – someone who wanted them, who took pleasure and delight in being with them. I also shared my values with them – they would have developed a good sense of what I stood for – but I think that’s probably all shattered now…”

Michael continued, this time exploring the other side of the equation, parenting. Parenting, like therapy, like all intimate human relationships, is a two-way process. “What did they bring to your life, being a parent-figure to Phillip and Sam and a father to Justin? How are you different from having been their parent? How would you be now if you hadn’t been their parent?” I replied if it hadn’t been for them I would never have experienced what it is like being a parent. I told a story about meeting Phillip in a pub about three years earlier. He won the pool competition while I witnessed it – it was one of those rare occasions when I got to experience a sense of pride – like, “that’s my boy!” As I reflected more on Michael’s questions I realised how they had given me the opportunity to participate in a child’s world again – the world of the imagination – remembering my own childhood – the child’s sense of

wonder, adventure and play. I remembered Justin as a baby – the beautiful sense of stillness and oneness with the universe when he began sitting upright for the first time. I remembered how at his birth when I first held him in my arms thinking what a perfect being, wanting to be an equally perfect parent myself – to protect him from the world of suffering. Then I began to sob again, knowing that I had unintentionally introduced him to traumatic emotional pain before he even turned five….

Michael continued, "So they brought lots of things to your life, connections with your own history of being parented and the love that they gave to you?" Yes, my own experience of being a parent helped me to appreciate my parents. "How come?" asked Michael. "To appreciate the commitment it takes to be a parent," I replied, "the time that they gave to me, playing with me, and the way that they always stuck by me."

"How is all this expressed in your work?" he asked.

"I often find myself in awe of the parents I meet with," I replied.

"What does this make possible in your work?"

"I hope I've never had a parent who felt they weren't being heard or listened to. There is such a dominant culture of parent blame in our mental health system. I'm no expert on parenting (laughing) so there is a certain humility I think I bring to this work – I certainly don't come across as the expert in how they should parent!"

(Laughing together) "How do you think your children's contribution to you – the pride and the pleasure – their invitation for you to participate with

them in their world – how does this continue to get played out in your work, do you think?"

"I think children have magical capacities to change. They also put me back in touch with my own childhood. I remembered how my work with a young man called Dylan and his struggles with youthful embarrassment and shyness had helped me to remember my own struggles with these issues as an eleven-year-old:[8]

> I too had freckles, felt uncomfortable undressing and going to the pool for swimming lessons, and would never ask a girl to dance! But, more importantly, I'd like to thank Dylan for putting me in touch with some of the special qualities and abilities of the eleven-year-old Andrew, which will now be more present for me in my counselling work with children and families (Tootell, 1999, p. 28)

Also, a lot of the children and young people I work with, and they are mainly boys and young men, come with the labels ADHD and Oppositional Defiant Disorder (ODD). So I need to find alternative ways of talking about these problems without resorting to these labels. I often find that the effects of *trauma and abuse* are a much fairer and exact way of talking about these challenging behaviours. I also have to find ways of connecting with each child – because each one will be different and I agree with Irvin Yalom

[8] Dylan was a boy I had seen while I was studying at the Dulwich Centre. I wrote about our therapy work together as part of the course requirements and it was subsequently published (Tootell, 1999)

(Yalom, 2001) that we have to reinvent therapy for each new client we start to work with.

I think I owe a large legacy to my relationship with the boys I have worked with and how that continues to influence my work. I believe I am more able to connect, to get in touch with and appreciate the children who consult with me because of the legacy of my relationship with Phillip, Sam and Justin. In this way, they are present in my work. I feel more attuned and spontaneous – going with whatever arises in the moment.

This interview with Michael White certainly helped me to continue coping with the difficult constraints placed around my contacts with Phillip, Sam and Justin. Acknowledging their presence in my work helped to alleviate the sadness. There will always be a sadness that we don't have a closer connection and I can deal with that, but the sadness that is like an invitation to self-blame had been lifted from my life. It also put me more in touch with the contribution my parents had made to my life. Much more appreciation and a growing fondness – they had always been with me. I felt more in touch with my father's gentleness. Being in this line of work helps me cope with the sadness, because they too are present always in this work – the work itself evokes them – always bringing back memories – of my children and my childhood that are sustaining of my present self and the work that I do.

8.

Peter's story

I began working with Peter in individual sessions when he was fifteen. He had been adopted as a baby, but his adoptive parents separated and divorced when he was about ten years old. He was living with his adoptive mother (who he called "Mum") and stepfather at the time we began working together.

It was a cold day in early June. Peter was now nine months into the programme. He was dressed in a smart blue tracksuit jacket, pressed blue jeans and brown slippers. He had been wearing those slippers now for quite a few weeks, even though we were now approaching middle winter. I had always assumed it to be a fashion statement, vaguely remembering reading somewhere of a rapper in the USA wearing slippers.

"So, what would you like to talk about today?"

Peter looked down at the carpet then looked up briefly, smiled, made eye contact and then lowered his head again. There was a period of silence, and then I said: "Do you remember what we were talking about last week, when your Mum was here? I enjoyed that session. Do you remember? We talked about the anger problem, shyness and your relationship with your stepfather, Brian. Oh, and the concentration problem. We discussed some practices you could try out, like self-observation. I talked about just practising being aware and noticing if anger was present, by paying attention to your body and mind."

"I was angry this morning."

"Yeah, what happened?"

"Mum slept in and she never bothered to give me the money for my shoes."

"Do you need new shoes?" I realised suddenly that the slippers were not a fashion statement!

"Yeah, I get sore feet from the wet socks. These are the only shoes I've got. I've got two other pairs but they don't fit."

"Peter, I always thought you wore those slippers as a fashion statement. I would never have guessed … Is that what the guys in the group think as well? That they are a fashion statement?"

Peter smiled.

"Mum's been promising me shoes now for six weeks."

"So you were hoping to get them today?"

"Yeah. They're on lay-by. We've paid $60 and still owe a $100." He paused, and then said: "Mum does that heaps."

"What?"

"Gets my hopes up. She always lets me down."

The words, "lets me down", resonated in my mind. I wondered how many times in his short life had Peter experienced this feeling. "What do you remember feeling first, the let down feeling or the angry feeling?" I asked.

"Probably the let down feeling."

"Can you say a bit more what the let down feeling feels like?"

"Makes you feel like shit."

"Can you remember other times in the past when you have felt like shit?"

"When Dad said he was going to stay and see me and didn't."

"What kind of thinking does let down feelings encourage?"

"Feeling shit."

"If feeling like shit could speak what would it say?"

"Nobody cares about me."

I felt his sense of isolation and said: "It sometimes feels like neither your Mum nor your Dad care about you."

"Yeah."

"Anything else?"

"I wish this hadn't happened."

"Yeah, your expectations have been disappointed." I wanted to help Peter contain this feeling of disappointment. No caregiver is perfect. So I responded with "What do you think you have learnt about life and about yourself from being let down?"

"There's no point worrying about what you can't change."

"That's great, Peter". I got up and wrote his words onto the white board. "Anything else?"

"Not to get my hopes up."

I wrote that down as well.

"Yes. Anything else?"

"People don't always do what they say." Sad, but true I thought to myself. I wrote that down and as I was writing I wondered if we could identify or put some names to some of the coping skills that Peter was teaching me about.

"So, when you look back with the benefit of hindsight, what are some of the skills you have used to get you through the times when you were feeling like shit?"

"Sometimes I would cry it all out."

"Yeah, you were able to do that? Have you ever told anybody about that?"

"No."

"It takes strength to sit and feel the pain and cry."

Peter nods his head in confirmation and smiles.

* * * * * * *

"Hi Peter, what would you like to talk about today?"

"I'm not sure."

"Would you like me to suggest some options?"

"Sure."

"Well, we could talk about relationships. Like your relationship with your girlfriend, or your Mum and step-Father or your Dad or your brother and sisters. Or, we could talk about what kind of work you would like to do; or we could review some of the sexual offence specific work that we've done?"

"Relationships."

"Okay, which one?"

"My girlfriend."

"Just remind me, what's your girlfriend called again?"

"Sarah."

"Sarah, yeah."

"I'm really looking forward to seeing her tonight."

"Great. Do you think she is really looking forward to seeing you?"

"Yeah."

"That's even better."

"I'm staying at her place tonight."

"Tell me, what is she like as a person. What are some of the things she likes to do?"

"She's really happy and loud."

"Kind of like the opposite to you?"

"Yeah."

"Yeah, that's like me and my wife. She is more outgoing and I am the quieter one. What are some of the things she likes to do?"

"She likes dancing."

"Hip hop?"

"Yeah."

"Do you dance much Peter?"

"No."

"Would Sarah like you to dance?"

"Yeah."

"Would you like to dance?"

"Yeah."

"What do you think stops you?"

"Dunno."

"Do you think it has anything to do with shyness?"

"Yeah, definitely."

"Peter, when was the last time you got up and danced?"

"It was ages ago."

"Try and remember when."

"About February this year."

"This year? Was it at a party?"

"Yeah."

"Had you been drinking?"

"Yeah, I was pretty drunk."

"And the shyness went away?"

"Yeah."

"Interesting isn't it? The relationship between alcohol and shyness. Did you know that alcohol acts as a dis-inhibiter? Do you know what that means?

"No."

"When you drink alcohol the chemical affects that part of your brain which acts as an inhibitor. To exhibit means to show. To inhibit means to hide."

"I wasn't always a shy person. When I was a boy my Mum tells me I was a show-off"

"Right, can you remember any of those times?"

"No."

"But we do know there was a time when you didn't worry too much about what other people thought about you. Because when you think about it, there is a relationship between shyness and self-consciousness, or even worse, self-criticism. Like with me, I have always worried about not being good enough in many areas of my life, especially in music. For most of my life I have found it difficult to perform in public when singing songs and playing my guitar. My hands would shake and my body would be frozen in tension. It's only been over the last few years that I have

relaxed more when playing in front of people informally but put me on a stage and it's still the same. I think that's because I'm so critical of my playing that I can't just let myself go into the song. So, coming back to alcohol then, do you think alcohol is the solution to the problem of shyness?"

"No."

"Why not?"

"Because you get drunk?"

"Yeah. On the one hand, alcohol acts as a disinhibiter and you feel free to dance because you don't care what people think. But the problem with that is it can also disinhibit you in other ways. For example, you might say things you'll regret in the morning. Have you ever experienced that?"

"Yeah."

"Or you might start kicking a car that doesn't belong to you."

Peter smiles.

"So what is the answer to this problem of shyness?"

"I'm not sure."

"Do you think knowing Sarah has helped you to reduce the influence shyness has in your life, or has shyness increased its influence or is it just the same?"

"It's reduced the influence. When I first started to see Sarah at her place, if her parents asked me if I wanted something to eat I would say no even though I was really hungry. When they spoke to me I would usually look down at the ground. Now I say yes and look them in the eye."

"So it's helped getting to know them, they don't feel like strangers anymore. I remember you have expressed this knowledge before. That shyness has more

influence over you when you are with strangers but when you get to know them shyness has less influence. Is that right?"

"Yes."

"Are there any other ways that your relationship with Sarah has helped you to reduce the influence of shyness?"

"Yes, I would be really shy of eating in front of girls. Now I'm not."

"Hmm, that's interesting."

"When I was a boy", Peter continued, "my father was always critical of the way I used to eat. He would say things like 'stop eating like a pig' and he would make me eat things I didn't like and stuff like that."

"Right. Can you think of any other areas of your life in which the influence of shyness has been reduced?"

"Hmm …"

"I can think of one. It's an obvious one, what about sex?"

"Yeah, I was really shy to begin with."

"And now?"

"No, I'm not so shy anymore."

"So, knowing Sarah has really helped you to reduce the influence of shyness hasn't it?"

"Yeah."

9.

MY STORY, PART III

Every morning I set my alarm for 6.00am and I rise from bed and make myself a cup of tea. When I have finished my tea I go into my counselling room, light some incense and set the timer for thirty minutes. I then sit down on my zafu (meditation cushion), cross my legs in front of me in the "Burmese" posture, straighten my spine, take a deep breath and begin my daily morning meditation. As I sit I simply observe my physical sensations, returning often to the sensations of breathing; I also simply listen to the different sounds of the bird calls; at the same time, I observe my mental state, in particular, the array of feelings-thoughts that parade through my awareness field during the time period. The idea is not to try and stop the thought process, which is impossible; but rather to non-judgmentally observe the thoughts without getting caught up in the internal conversation. In order to do this, I practice a form of thought labeling, that is, when a thought arises in my awareness field I will either find a label to name it, such as "planning", or simply say to myself "having the thought - I need to ring the real estate agent today". This is a form of contemporary Zen meditation, the practice of non-judgmental awareness. This quality of mindfulness, or non-judgmental awareness which is developed in a consistent meditation practice, is also a form of acceptance of what is. One of my hopes is that I can re-enter this form of awareness when I am doing therapy, hence bringing forth this sense of self-acceptance as a core process of my practice.

I had read about Buddhism when I was an adolescent, but I didn't start practising meditation until after the birth of my son Justin. I found the books of the Zen teacher Charlotte Joko Beck particularly inspiring (Beck, 1989, 1993). I think it was her ability to make Zen sound relevant to everyday life, in particular, to working with emotions and relationships that made her books so appealing. As I previously discussed, my first marriage was very stressful, and I thought Zen practice could help me deal with my situation and keep me sane! I also liked the way Joko placed a lot of emphasis on fully experiencing this moment, on a physical level, even if at that moment we were sad, elated or depressed it didn't matter. I learnt from Joko, and much later from Barry, that *this is it*. There is not another time or place we can live – only here and now. Now, I had heard that expression before, it was very popular in the sixties and seventies and it sounded romantic but the actual practice was not at all romantic! Sitting still without moving when your leg has gone numb and the pain is starting to rise is not a pleasant experience, but it taught me perseverance and patience. I would also like to think I have become a little less self-centred over the last twenty years but I'm not so sure about that!

I had first come across the link between mindfulness and therapy in the social work literature (Brandon, 1979), but it was actually Dr. Barry Magid who helped me to see the link between mindfulness, empathy, affect regulation and psychotherapy (Magid, 2002). In fact over the past fifteen years there has been an explosion of interest in integrating mindfulness and psychotherapy in both the cognitive-behaviour traditions and the psychoanalytic traditions (Brazier, 1995; Epstein, 1995; Harris, 2007; Hayes &

Strosahl, 2004; Hayes, Strosahl, & Wilson, 2003; Safran, 2003; Siegel, 2007; Young-Eisendrath, 2004). There has also been a paper produced on narrative therapy and mindfulness, arguing how social constructionist thought has much in common with Buddhism and how externalising conversations can be understood as a form of mindfulness practice (Gaddis, 2004; Lax, 1996). The popularity of mindfulness as a therapeutic intervention continues to grow in Western psychotherapy and it is also being seen as a key intervention for trauma-informed therapy (Saxe et al., 2007).

There are basically three ways in which I believe mindfulness practice is relevant to the mental health professions. Firstly, it has beneficial outcomes for the practitioners themselves, acting as a form of self-attunement (Siegel, 2007) . Secondly, a daily practice of half an hour to one hour of meditation prepares the practitioner in being able to keep focused on their subjectivity as well as at the same time entering empathically into the world of the participant and being aware of the intersubjective dimension of the relationship (Hughes, 2007; Lax, 1996; Magid, 2002; Siegel, 2007). Thirdly, mindfulness practice helps to keep the therapist focused on the experiential "here and now" and to engage in collaborative reflection on this experience in therapy, which strengthens the reflective function of all participants (Fonagy et al., 2004; Siegel, 2007). The reflective function is when a child is able to both reflect on the contents of their own mind and those of others. Empathy would not be possible without the development of this function.

Mindfulness is a transpersonal *awareness* practice, in the sense that our tendency to identify with our linguistic "I" arises from the fact that the

culture we live and breathe in is saturated in subject-object duality and binary thinking: us and them; men and women; therapist and client. By practising everyday and going on intensive retreats we can learn to disidentify from our conditioned dualistic reactions and just stay with the basic non-dual reality of what is.

* * * * * *

In 2003 I was living with my wife Annie at Mission Beach, Northern Queensland, a literal tropical paradise. Only, I wasn't happy. I was missing friends and the stimulation of colleagues from my narrative and psychoanalytic networks in Adelaide. I read Barry's book on the relationship between Zen Buddhism and psychotherapy and I sent him an email:

April 7, 2003

Dear Barry

I live in a remote region of Northern Queensland opposite a beautiful beach. I work as a therapist in a child and adolescent mental health service. I have tried to maintain a fairly solitary Zen practice for 15 years. I have always been attracted to the work of Joko (Beck) and I have a shared interest in self psychology, intersubjectivity theory. I have done a limited amount of (personal) therapy with a psychoanalyst in Adelaide. I have also trained in narrative family therapy with Michael White.

I really enjoyed how you grappled with the ideas from the two traditions in your recent book and felt a close affinity with you. I don't know if this is possible, but could I become a student via the internet? I have never worked outside of a retreat with a teacher and now feel like it's time.

However, if not possible, thank you for your clear expression of the ordinary mind way and its connection with contemporary ideas.

Regards, Andrew

Much to my surprise, 12 hours later I received the following reply:

7 April, 2003

Andrew – I'd be happy to work with you whatever way we can via e-mail. Write whenever/whatever you like. Just please be patient if I cannot always respond immediately.

I hope I can be of some use,

Barry.

One week later I wrote back:

13 April, 2003

Dear Barry

Thank you for your kind and generous offer. I guess maybe you may become like a selfobject. Maybe also a replacement for the analyst I use to

see in Adelaide weekly for about a couple of years. So once again, thank you for being there.

Regards Andrew

Again to my surprise, the following reply arrived 24 hours later:

14 April, 2003

Andrew – I'm happy to serve as a cyber-selfobject (or would Kohut want me to drop that hyphen)?

If you practice on your own, I'd say make non-avoidance the centre of your practice – which means paying attention to the edge of avoidance we all have someplace in our daily life. When I talk about leaving everything alone, I mean especially watching what we don't want to leave alone, where our efforts at control, self-improvement, denial kick-in. Take a look at what you're trying to do as a therapist – how much helping/fixing intrudes …

Best, Barry.

So I had found myself an on-line analyst and Zen master all rolled into one! Over the months and years that followed I learned a great deal from Barry, not only about Zen practice but also about therapy. In particular, I liked how Barry emphasised the importance of not trying to "fix" people and to have trust in the healing powers of empathy. After selling our apartment at Mission Beach and moving to New Zealand I was fortunate enough to be able to go to New York and visit Barry to attend a Zen retreat.

* * * * * *

In April 2006 I travelled to New York to attend a weekend retreat with Barry and his Zen group at the Garrison Institute in New York. Prior to attending the retreat, I had arranged to stay with my friend, Steven Gaddis, another therapist, who lived in Salem, Massachusetts. Steven drove me down to New York and I stayed overnight with his family who lived on the Hudson River. On the following day, I managed to find my way to Grand Central Station and caught the metro along the Hudson River line along to Garrison. The Garrison Institute was a converted monastery that now functions as a retreat centre for various spiritual organisations, including a number of Zen Buddhist groups. The Institute was situated right on the river with well-appointed dormitory style rooms and good clean bathroom facilities. On the other side of the river, directly opposite, was the United States Military Academy, West Point.

We rose at 5.00am (quite luxurious by comparison to some other Zen retreats I had been on) and began the day with morning zazen (seated meditation) and chanting from 5.30 to 7.00am. This was followed by breakfast and then more zazen until lunch. Following lunch was more zazen and then in the afternoon Barry would give what is called in Buddhism a "Dharma" talk. This talk is meant to encourage students in their practice and can range from formal commentaries on Zen koans (teaching stories) to more informal talks about relationships and modern life. Barry gave a talk entitled

“Sameness and Difference”. The focus of the talk was on the relationship between the experience of “oneness” or “nonduality” and difference. Many spiritual traditions only focus on realising the oneness of reality and the Zen tradition is quite unique in its emphasis on working with both sides of the same coin, so to speak. So although Zen practice begins with the intention to unite with the whole universe, this can only be done with one object or one activity – whatever it is we are doing at this very moment, we do it with full mindfulness, washing one spoon, then one fork at a time. If you are cleaning the oven, just cleaning the oven; if you are bowing you are, just bowing; if you’re sitting, you’re just sitting. Then Barry brought our attention to the resistance that arises in just being the moment – if we are feeling blissful, then that’s easy to just sit and be that; but if the pain is sharp, we don’t want to be that – we want to escape that; or if boredom and restlessness are strong, we don’t want to be that, we want to escape into some kind of day dream. Barry then told us to pay attention to that desire to avoid the moment, because we are conditioned to only pay attention to things that we think are worthwhile or that are “ours”. We might be meticulous about keeping “our” house clean, but walk down the street and we ignore the litter that is lying all around us. So oneness or sameness practice means to value everything equally. Applying that to all people is hard; we usually place value on our small circle, our family and friends, and then our attention gets diluted the further and further we go out. Barry drew an analogy between sameness practice in Zen and the practice of empathy in therapy:

> One of the ways we engage people, analogous to the way we engage ritual objects in a Soto temple, is through empathy. Empathy means fully entering into the subjective experience of another person. Just totally letting yourself be in their world. And while you're doing that, that world is all there is. You see everything through their eyes. You let yourself enter into their reality rather than having a separate reality of your own that's bumping into theirs. And once again we practice looking at what kinds of experiences, what kind of worlds are we willing to enter into and where do we draw the line. There's a nice quote from Goethe that says, “I've never heard of a crime I couldn't imagine myself committing.” That was Goethe expressing his sense of his common humanity with everybody. Empathy is based on the fundamental belief, or the trust, that understanding is possible. That when you enter into another person's worldview what you're going to find in there is going to be basically recognizable and intelligible - that everyone has a shared form of life that includes things like love and attachment and loss and pain and hunger and dying. It's this common, shared form of life that makes it possible to enter into another person's worldview and have it make sense (Magid, 2008b).

Barry’s favourite philosopher is Wittgenstein, who makes the point that the reason why we can understand each other is that there is no such thing as private experience. This is very close to the social constructionist position,

especially the work of the Russian developmentalist psychologist Vygotsky (1962). For example:

> The reason we can understand each other is that everything about who we are, and what's going on inside of us, is something that we've taken in from the outside, from others, from our shared existence. Our inner world is made up of the things we've brought in from the outer world. For Wittgenstein this happens primarily through language. By language, he meant a whole system of interaction. It's not how we go about sending reports from our private inner world out into the outer world where you then take the message into your inner world and try to decipher it. Instead it's about how we exist together in this big soup of life and language and there is no boundary between inside and outside. That's what makes empathy possible, that we're all living in the midst of the same life. But at an emotional level we always bump up against personal barriers of empathy. What we recoil from, when we want to say, “that's not me, I could never do that.” We all do that at some point (Magid, 2008).

Barry went on to say that his teacher’s style of practice “was always to pay attention to that boundary of resistance, the place where you are inclined to say, “That's not me, I'm not like that!”” The experience of anxiety or anger can be an indication that we are experiencing that boundary of resistance.

We want to believe we are “a different kind of person”, but Goethe's point is we're all exactly that kind of person. Barry asked all the students to consider:

> What kind of empathy and courage does it take to allow yourself to be everything? That's the real psychological problem of oneness, it means letting everything in, letting yourself be everybody. It means not dividing the world into good guys and bad guys and us and them. It's like the old Pogo cartoon “We've met the enemy and he is us.” You have to be willing to identify with everything, even the things that we want to keep at arms length (Magid, 2008b).

Barry then went on to talk about the other side of the coin – difference; to allow and respect difference. We allow people to be different to us; we don’t expect them to be the same. We are willing to be with them in their difference without judgment, as “separate centers of agency and subjectivity”. We no longer ask, is this person meeting my needs or expectations – this constant evaluation of others from our own spectrum of interests – what are they doing for me? The same applies to stereotypes, the habit we easily fall into of reducing individual difference to sameness:

> And even if we're not personally related to them we categorize them or give them a stereotype or a role where we immediately know they're one of those. You know, “They're Republican.” End of story, right. How many versions of that do you know, that as soon as you get people in

to one or another narrative pigeon-hole, it's the end of the story. You don't have to know anything else about them. You've understood them so well that they're obliterated. That kind of understanding negates the other person's real subjective existence and genuine otherness. There's a quality of otherness or differentiation that we only appreciate when we don't understand them, when we acknowledge that they are too complex to sum up. Some times we can allow that, very rarely I think, in personal relationships: when we really feel that the other person has so many quirks and depths and qualities and talents that we'll never get to the bottom of them. They've had all these life experiences and I can see them in analysis 5 times a week, or be married to them for 20 years and I'll never get to the end of who they are. Very rarely are we able to treat people as that different, that new without sort of quickly saying, “Oh, I know her; I know all about her.” We understand them so well and so quickly that there's nothing new to learn. In that way we obliterate difference, we obliterate otherness. So there's a big resistance that we have to watch out for on this side too. The resistance to letting ourselves be impacted by the difference of other people without immediately sweeping them up into an agenda, into a story, who they are to me, who they are in my narrative world.

So sameness and difference each offer their own challenge: the challenge of letting ourselves be the same as everyone else; the challenge of allowing everyone else to be different from us.

> We have to learn to put those two sides together and see that what we have in common is that we're all different (Magid, 2008b).

As I listened to Barry's talk, I thought of how this problem of "sameness and difference" captured the intersection between spirituality and politics or the personal and the political. Essentially, the inability to recognise sameness and accept difference seemed to be the source of conflict within the world, at all levels, whether it is class, race, ethnicity, religion, family or nation state. We needed to see the oneness or equality of all people and at the same time respect their unique difference. It is also reminded me of some articles I had recently read on hospitality towards strangers, as the foundation for human sociality (Sampson, 2003). The talk also triggered thoughts about my work as a sexual offending therapist. I particularly liked the way in which Barry's emphasis on sameness and difference undermined the usual labels and subtle and not so subtle "us and them" distinctions that I was so used to coming across in the attitudes of some of the professionals I worked with in this area.

10.

Adrian's story

Adrian made himself comfortable in the lounge chair. He looked relaxed and thoughtful. I remembered the first time I met Adrian during the assessment sessions a couple of months ago. I had been struck by his good looks and thin wraith-like frame: tall and lanky, slightly feminine, almost elfin in appearance. His eyes were clear blue,

intense and intelligent. He reminded me of the young James Dean from the film 'Rebel without a Cause'.

When Adrian first started the programme he was preoccupied with the question, why did I do it? This is a common question, one that usually preoccupies the mind of family members as well. Adrian's auntie had taken an interest in his welfare and education. She had grown concerned that Adrian's Mum and Dad, who both lived independently with intellectual disability, were neglecting his hygiene and his education. She offered for Adrian to come and live with her and her husband. Adrian moved from the city to a town in the country where his auntie and uncle were dairy farmers. His auntie's daughter, Margaret, took a liking to Adrian and treated him like a younger brother. Margaret had a five year old son and Adrian would sometimes play with him. Sometimes he would also be left to baby-sit and that's when he began to engage in sexual offending. He was about twelve years old at the time. It had taken the form of a game in dark places.

After starting to experience nightmares, the child told his Mother and Adrian was removed from the care of his auntie by Child, Youth and Family Services

Department. He was then placed with a caregiver. Later, he would be moved into boarding college at a private Catholic school with the financial support of his auntie and uncle. He would stay with his parents on weekends. Margaret had been so traumatised when she found out about the offending she couldn't work for a number of months. Adrian attended a Family Group Conference organised by the Department where he had to face up to Margaret and the rest of his family. He was remorseful for what he had done and agreed to pay compensation to Margaret from his wages. He also agreed to attend the programme.

At our first individual session together we had discussed the question, what is counselling? Adrian had said "you talk about what you've done." I asked if he had any other ideas and he thought for a while before replying, "You try and put things in the right place". This fitted well with my own understanding of therapy – a collaborative process of making sense together. I had been enjoying my sessions with Adrian. He was easy to talk with and he was comfortable initiating conversations, which made my job easier. Many of my young male clients found it hard to talk freely. Not Adrian. He talked about family, school, computers, especially computers, work and girls. He worked hard at a part-time sales assistant job, which he maintained while still attending high school. School was not his favourite place. He found the teachers condescending at times, but he was making the best of it.

I knew that personal freedom was important to Adrian. Given his parents' limitations, he had grown up with a strong sense of independence and was quite mature for his years. Adrian's freedom of movement was constrained by his safety plan. Initially he was allowed no contact with friends outside of work and school and no contact with his victim. Over time, as Adrian moved through the programme, he

would gain more personal freedom. Eventually this would culminate in his graduation and reincorporation back into the community as a trusted citizen.

We started to talk about his parents. We hadn't talked about them that much. When I met with them for the first time at the assessment they were cooperative and likeable in a child-like way.

"What was it like growing up with your parents?" I said.

"I remember I was left alone a lot with nothing much to do."

"It must have felt lonely at times?"

"Yeah, but I had one of those computer games I would play on all the time. Dad sometimes played with me."

"Oh? What kind of games did Dad play with you?"

"I remember this toy train set. I think we had fun playing with that together."

"Adrian, when do you think you first realised your parents were a bit different?"

"I can't really say I've thought about it that much. I guess when I started visiting friends I began to realise my parents were a bit different from my friends' parents."

"You care a lot about your parents don't you?"

"Yeah, they're the only ones I've got!"

"Almost protective at times?"

"I guess so."

"How would you describe your relationship with your Mum?"

"Tense."

"Why is that?"

"She annoys me at times. I enjoy my Dad's company more."

"Tell me more about your parents."

"My parents fight about how much running around they do for me. Dad can sometimes get angry with me. He sometimes says things like 'as far as I am concerned you can spend the rest of your Christmas holidays in the cell'. That hurt me a lot."

There was a pause. I noticed a small tear forming and slowly rolling down the side of Adrian's pale and drawn face. He continued, "Sometimes I hear Dad say, 'I wish I was dead' when he feels frustrated with Mum. Dad says that a lot. He feels like he is being ruled by or dictated by Mum. They need each other – they can't really function without each other – Dad is good at talking and explaining things and Mum is good at sometimes being a fun person - she doesn't worry about big things but little things and she does all the financial stuff – my Dad can work but Mum is restricted from working by arthritis."

"What's it like when you go round and live with them on weekends?"

"The problem I find when I go on weekends is that they have no one to share their problems with so they talk to me about it - such as petrol money - but I've got my own problems so it gets annoying when they tell me all their problems."

"A bit like you being the parent to them?"

"Yeah. I think I spend too much time with them – I start to worry about their fighting and I need my time to be around people my own age."

"Yeah, that must be pretty hard – with all the other things you have to worry about."

"Yeah. I was talking to Mary last night …"

"Who's Mary?"

"My caregiver."

"That's right. Sorry."

"... about staying with her once a fortnight on weekends to give me a break from Mum and Dad – they fight and I become the parent – they can fight all night and I try and stop it then it gets sour between me and Mum because she thinks I am trying to manipulate her and sometimes she thinks I side with Dad."

"Do you?"

"Maybe. I say, 'shut up - stop fighting' and she'll say, 'stop swearing' and Dad will say 'well he's right' and she'll say, 'you don't back me up' and then Dad sits in his chair and sulks and it's horrible to see that ..."

"It's horrible to see the way they hurt each other."

"Yeah. My auntie tells me to ignore it but she doesn't understand how bad the fighting is, it is hard to ignore it. I would like to tape it for her."

"Yeah, I guess it's hard to know what it's like unless you've lived with them."

"Exactly. The fighting problem is getting worse. Mum used to join in playing games like monopoly but now she doesn't - she just turns the TV up."

"Oh, no."

"It seems worse because I have seen the difference between living with my auntie and uncle – Dad also thinks the family thinks he is lazy because he doesn't work – low self esteem – he goes for jobs then feels rejected when he doesn't get the job, then Mum says, 'I told you, you wouldn't get it!' Then Dad feels hurt and it just goes on and on ..."

A couple of weeks later his parents attended a family therapy session. Adrian's Dad broke down in tears when he talked about how other family members didn't really respect him and judged him unfairly that he was lazy. I saw the look of pain and embarrassment on Adrian's face when he witnessed this. I wondered how witnessing these breakdowns had affected Adrian's own sense of self-esteem, and how this motivated Adrian to do well at work. We were able to discuss in this session the effects of the arguments on Adrian and this did lead to some lessoning of tension. Later, Adrian's Dad was successful at gaining full-time employment and this seemed to help him consolidate his fragile sense of his own self-worth and dignity.

Although the content is different, Adrian's descriptions of his parent's relationship remind me of my own parents after my Dad had lost his teaching job because of the offending. I re-remembered the sense that my Dad had been disgraced in the eyes of my Mum. Although my Mum never mentioned the offending, her feelings of resentment came out in the tone of her voice, in the way she used to sometimes criticize Dad. This shared experience enabled me to get some sense of what it must have been like for Adrian to witness these parental fights.

Adrian's sense of shame or embarrassment about his father reminded me of my own struggle to come to terms with my own sense of shame regarding my father. I felt this was something we had in common, something that helped me to understand him. The association with James Dean from Rebel without a Cause came into my mind. I recalled how the son in the movie perceived his father as weak, symbolised by his wearing the apron – symbol of the

subjugated feminine. Our fathers didn't measure up to hegemonic masculinity – they had fallen from the status of hero and their vulnerabilities had been revealed.

Over the next few weeks we explored Adrian's experience of the culture of masculinity on his journey towards manhood. I started by inquiring into Adrian's experience of sport. He told me he had never really enjoyed sport much. It didn't surprise me to learn that his Mum and Dad didn't play sport either. He had started playing rugby just before he turned nine, just before he moved to his auntie's place. Adrian didn't like it because he didn't think he was any good and he was teased by the other guys. He remembered a time when he messed up by dropping the ball and he could remember being told "you've let us all down – it was your fault – you can't play for shit". He also remembered being called a "faggot". This was a humiliating experience for Adrian, one that he never forgot. Adrian's experience of school work was not much better. He told me how he had never really achieved at school and that he would get into "heaps of trouble" at school when he still lived with Mum and Dad. He remembered his best friend, Jason, who also didn't like sport. They used to crawl under the school into what Adrian described as a "bomb shelter". They took food with them and they would spend the whole day hiding out down there or hiding in a shed at the school. He remembered that as being fun. Adrian said "everyone saw me as being a rebel at school – but most of the time I really wanted to be like everyone else". However, Adrian still remembered a couple of teachers who had taken a liking to him. Maybe they had also been attracted to his thin Oliver Twist-like face. I think

Adrian had that quality which would call forth nurture in people. When Adrian went to live with his auntie he had to say goodbye to his best friend and lost contact with him. He found the transition to the new High School difficult. He made friends with Daniel, another boy who was an outsider with a reputation for being "gay". They eventually became "enemies" because Adrian was worried about being seen as "gay" as he was sometimes called "A Anal Stretch" and Daniel was called "Danny de homo". The guys at the school would also say things like "God you're ugly –girls would never go near you." Adrian was so convinced that he was ugly that if a girl said something different he wouldn't believe them.

Adrian talked about "proving he wasn't gay" when he went out with a girl in fourth form. The girl liked wearing glitter on her face so Adrian was given another name: "glitter-boy". Adrian described himself as "cracking up" at this point and he attacked four boys who had been teasing him. After that, they never teased him again. Adrian concluded, "I knew I wasn't gay". When reflecting back on the sexual offending, Adrian thought he had initiated the sexual abuse with his victim because other guys his age were talking about having sex and he desperately wanted to be seen as a man. Adrian said the other guys bragged about having done this or that and he felt jealous. He wanted to be one of those who'd "done it". This feeling of "missing out" is something that is often reported by young men who are insecure about their masculinity status.

It wasn't long after Adrian turned 16 that he had a new girlfriend, also aged 16, and they were going steady and having regular safe sex. This new relationship definitely helped Adrian move towards maturity. However, my wonderings about

Adrian needing his entry into manhood acknowledged by his peers was verified when he finally moved into the boarding college.

He came into the next session with a smile on his face and something about him felt different. He began to tell me all about how he had survived the "gauntlet", an "ordeal of pain", a male initiation rite that the older boys made the younger boys endure. A gauntlet is formed by a group of boys lining up on both sides of a hall, who punch and hit the initiate as he runs up and then down the gauntlet. (The rule is that they are not supposed to hit the runner in the face, but sometimes it happens.) Adrian was proud and transformed by his accomplishment. Everyone was shaking his hands and patting him on the back. Although I felt concerned that this form of coercive ritual was allowed at the college I didn't want to take anything away from how surviving this trial had boosted Adrian's self-esteem. It was heartening to me that Adrian did feel sorry for another boy who had been too frightened to attempt the gauntlet and was now suffering the consequences for his so-called "cowardice". Adrian was able to understand how this boy was actually a victim of this kind of initiation rite.

I asked Adrian what he thought running the gauntlet was all about and he said it was about being able to "withstand pain". He said the older boys had told him, "Tonight you go from being a boy to being a man". Adrian felt that he had finally been accepted into the tribe of men, at last. He said "once you've done it, you are accepted as a mate". Adrian reported that he felt really respected once he got through it. He said the first few steps are the hardest. I asked him, what gains the respect? He said, because you've shown you can take the pain without crying, that you didn't let the fear of being hurt stop you. He said he had taken at least fifty

punches and that "if someone explains something in words it's not that important, but if you go through the gauntlet you don't forget it – it's punched into you. Nothing else compares to that in my life as a learning experience." Adrian concluded, "It was definitely an experience I will never forget and that I will one day tell my kids".

A few months later I found Adrian waiting for me outside the office. He was having trouble lighting his roll-your-own cigarette with a small flint lighter that had run out of fluid. It sparked repeatedly but didn't light.

"Looks like you'll just have to go without for a while," I said and smiled. Adrian was dressed in his Catholic college uniform, long trousers hanging round his ankles. He looked tall and gawky still. However, his face was now changing from a boy's to a man's face.

We entered the building and walked through to the familiar counselling room where Adrian collapsed on the comfortable lounge chair, one leg hanging over the side.

"What would be helpful to talk about today?" I said. Adrian paused and contemplated before replying.

"I told my girlfriend about my past offending after our session last week." I remembered that Adrian talked about doing this last week. Another of the group members, Peter, had disclosed in the group, after he had told me in an individual session, that he had disclosed to his girlfriend and that she had appreciated it. This had inspired Adrian to do the same. I took a few deep breaths and continued:

"How did she respond?" I asked. There was a pause. It is a risky business, I thought to myself. I hope that it hasn't backfired on him.

"She was shocked at first but she said she didn't want our relationship to change."

"If you don't mind me asking, I'm curious what you said to her?"

"I said about a year ago I sexually abused my second cousin. She asked me how old he was and I told her."

"Did she ask why?"

"No, but I said when the offending first started I was having trouble getting a girlfriend."

"Right"

"I think she appreciated my honesty because she thought about it and decided she was going to be honest too. One day later she told her Mum that her Father had been sexually abusing her the last two years."

"Oh, my god!"

I was astounded by this turn of events. I was proud of Adrian's courage and responsibility in confiding with his girlfriend and what this had now brought out into the open.

"What do you think was the effect on your girlfriend after you had disclosed your offending to her?"

"She thanked me for telling her rather than hearing from someone else."

"Do you think she respected you?"

"Yeah, she appreciated my honesty."

"What effect did your honesty have on her?"

"It made her honest."

"And was that a good thing?"

"Yeah."

"Why?"

"Because she was being sexually abused since she was thirteen. She was able to tell her Mum."

"Did her Mum believe her?"

"Yes she did. They said to her father on the Saturday that if he did it again they would go to the police. Then he did it again on Monday and she texted me to tell me about it. I said you've got to tell. She said she was too scared. I said do you want me to do it? She said yes."

"What do you think she was scared of?"

"She was scared that her father might hurt her."

"So what did you do next?"

"I rang the CYFS emergency number."

"Did you find it in the telephone directory?"

"Yeah, it took me ages to find it."

"What happened?'

"I spoke to the worker and told her what my girlfriend had told me. After that she said I needed to get my girlfriend to ring."

"And did you?"

"After I spoke to her she did ring. On Tuesday she went to the school counsellor's office in the morning and the CYFS worker came and they went back to her place and packed her things."

"Where is she living now?"

"She is with her grandparents."

"So how is she coping with all that has happened?"

"She's doing really well. She's talking a lot more than she used to. She always looked worried, kind of withdrawn before."

"Yes, the power of conversation is amazing." I thought of the ripple effects. This was how therapy flowed into community work. Conversations created possibilities for action. The world was changed.

"Adrian, I was just thinking … by choosing to disclose about your past offending how do you think you were standing against the effects of abuse?"

"Well, by being honest I was going against secrecy."

"Yeah, and we know that secrecy is one of the tactics used by people who abuse. What else have you learned?"

"Well because of my work on the programme I understand how victims are often held in the grip of secrecy because of fear."

"Right. Has anyone else acknowledged this action that you took?"

"Yeah, my social worker spoke to my auntie about it and also the guys in the group all think it was amazing. Jamie said that the guys who had disclosed to their girlfriends were 'legends'."

"What was it that prepared you for that step of disclosing to your girlfriend?"

"It was practising disclosure in the group."

"What was the hardest disclosure you made?"

"Probably the first one I made to the group. And the time I disclosed to my family, when Margaret was there, at the review meeting."

"How did it affect you after you had told your girlfriend?"

"I felt relief that I had told her. You feel better about getting it out."

There was a short pause. I wondered how to respond next. I wanted to link this with other themes and alternative stories of self that we had touched on in previous sessions.

"Remember how last week we were talking about your plans about joining the army. I gave you a question to think about during the week. I asked you to be really clear that you weren't joining the army to prove you were a man?"

"Yeah."

"Remember when you talked about that initiation ritual? About running the gauntlet? You said it was an experience you would never forget? You felt that you had become a man that day? Well, I was just wondering, what do you think was the most important step you took towards being a man – disclosing to your girlfriend or running the gauntlet?"

"Disclosing to my girlfriend. Definitely!"

As the session ended and we got up to leave, I walked over and shook his hand like I always did. I said on parting, "See you next week Adrian. You know, I really respect what you did. Well done!"

Whether it was running the gauntlet or entering into a relationship with a girl he cared for deeply, Adrian never seemed to look back, and went from strength to strength in treatment. I admired the way he worked hard at his job and managed to stay at school, even though he didn't enjoy it. At the end of the year he graduated from the programme surrounded by the other group participants and invited guests including his girlfriend, his parents and his auntie and uncle. I remember how proud I felt and when he broke down in tears midway through a fine speech I felt myself crying as well.

The following year he was successful at gaining full-time employment, with plans to attend further education and training in the computer industry in the future. He was no longer a rebel without a cause.

11.

MY STORY, PART IV [9]

"In writing from the heart, we learn how to love, to forgive, to heal, and to move forward." (Denzin, 2006 p. 334)

Prior to attending the Zen retreat in New York, I had organised with Barry to do a couple of therapy sessions. So one beautiful spring morning I found myself walking down Columbus Ave, in "up-town" Manhattan, in the direction of Barry's consulting room, just down the road from Central Park. Earlier in the morning I had walked around Greenwich Village, through a snowfall, seeking out the ghost of Bob Dylan. He was nowhere to be found. I wondered, what ghosts was I likely to find with Barry?

I turned down 82nd street and continued walking along past the rows of terraced houses and flower shops and finally I found the golden name plaque on the outside of the building and pressed the buzzer. The door opened and I walked down the red carpeted corridor through another door and into the waiting room with copies of the *New Yorker* magazine lying on the side table. It was not long before Barry came out to greet me and showed me into his room.

I settled into a comfortable leather armchair, next to the obligatory chaise lounge opposite Barry. Barry's face was kind and his eyes had a Zen

[9] This is a fictionalised reconstruction of the therapy session and should not be seen as an accurate representation of how Barry actually works as an analyst.

twinkle which indicated a dry sense of humour. He had a long oval shaped face, clean shaven with a receding hair line and small round glasses that sat on top of a long aquiline nose. Unlike Zen masters seen in shop windows with big pot-bellies, he was lean and well-dressed. He wore a tweed jacket, a waist coat and a tie, befitting of a middle-aged Manhattan analyst. I looked around the room briefly. On one side of the room, was an original painting by the modernist landscape painter Albert York; on the other side was a book shelf with glass doors. On the other wall, next to each other, were a faded black and white photograph of Dr. Heinz Kohut and a colour photograph of Joko Beck, Barry's Zen teacher. I turned back to face Barry and we looked at each other in silence and smiled. I thought to myself, ah, I know this routine. He is waiting for me to say the first words. I waited a few more seconds and then obliged, saying:

"Well, I finally made it. It's good to be here."

"And it's good to see you again Andrew. You have traveled a long way. What have you found?"

Ah, I thought to myself, this must be a Zen-style koan question. I thought for a moment and then replied, "My self".

Barry laughed, "Yes, wherever you go, there you are!" We both laughed some more and then Barry said, "What would you like to talk about today?"

"Well, I have thought a lot about this on the plane coming over. Time is short, and I do not want to waste it. I do want to talk about my father, but before we do that, I would like to talk about my work."

“Feel free to talk about whatever you wish – this is your time.”

“As you know, I work as a therapist on an adolescent sexual offending programme and I am interested in writing about therapeutic change as a mutual two-way process as experienced by all participants, therapist and client. Unfortunately, the relevance of the self and subjectivity of the therapist has, until recently, tended to be ignored in the sexual offending field. This is because the field has been dominated by behaviorist and then cognitive behaviorist therapy, which have traditionally ignored the importance of the therapeutic relationship, though this is now changing. However, this resulted in an emphasis being placed on technical interventions and treatment outcomes, which could be observed and measured. Therapist techniques were seen as being the only factor to deliver outcomes and hence the attempt was made to identify these factors and record them in treatment manuals. Therapists could all then be trained in these techniques. The therapist was therefore seen as a technologist and the self and subjectivity of the therapist were all but ignored as irrelevant to treatment outcomes.”

“Yes, I am aware of the evidence-based practice movement – it is not very kind to psychoanalysis.”

“Yes, exactly; fortunately, some practitioner researchers are now seeing that outcomes and techniques are only one side of the coin, so to speak; and to only focus on research into techniques is one-sided, as research into therapy has demonstrated the client’s perception of the personal qualities of the therapist, the therapeutic relationship, and the personal qualities of the client, can also account for treatment effectiveness

or outcomes (Hubble et al., 1999; Marshall & Serran, 2004). Therapy techniques only account for 15% of therapeutic effectiveness according to these research studies (equal to the placebo effect). As a result of this, clinicians and researchers in the sexual offending field have belatedly come to the realisation that therapist, client and process variables also need to be acknowledged and researched. So with the growing recognition of attachment and trauma problems, increasing attention is now being given to therapist responsivity. For example, issues of transference and countertransference are now being discussed in the field. However, these are often framed in negative terms."

"Yes, and that was the case when Freud originally formulated his idea of the countertransference. He saw it as contaminating the therapy process (Aron, 1996). However, over time analysts came to realise that countertransference was about paying attention to the therapist's beliefs and assumptions about the world and secondly how the therapist is in turn influenced by the patient. This is why some analysts now prefer to speak of co-transference, rather than transference and countertransference (Orange, 1994)."

"Yeah, that fits for me. Take my work for example. The ability of the therapist to be appropriately responsive to the client is going to be influenced by their attitudes to offending in general and sexual offending in particular. This is going to be even more relevant if the therapist has been touched in a more personal way by offending, whether as a direct victim, a secondary

victim (family and close friends of the person who offended) or as a member of the community (all women are tertiary victims of the crime of rape)."

"Yes, and this attitude is inevitably going to be communicated either verbally or non-verbally to the client. In fact, more and more contemporary analysts are coming to the conclusion that perfect anonymity and neutrality are both questionable as ideals and, in any case, unattainable in practice (Magid, 2002; Orange et al., 1997). Our race, patterns of speech, gender, style of dressing, office decoration and location all inevitably speak volumes about who we are. Our goal as analysts, therefore, must be not to strive to eliminate the impact of these inevitable latent communications, but to acknowledge their existence and strive to make explicit their impact on our patients' perceptions and fantasies. An intersubjective approach assumes that the analyst's personality, her actions and inactions, always continually shape the course of the treatment (Magid, 2002 p. 147-148)."

"An intersubjective approach also assumes that the relationship will also be transformative of the therapist. Would you agree with that?"

"Yes, I think that is a good description of the therapy process."

"Michael White has also developed a consistent critique of what he refers to as the "one way account of therapy" (White, 1997). He argued that the context of therapy cannot be separated off from the politics of relationships, gender, culture, ethnicity and the hierarchies of knowledge. He was persistently critical of the attempt by professional associations to demarcate professional expertise and knowledge from what may be called folk knowledge. White believed this was degrading of the people who

consulted professionals and also created a responsibility overload for professionals rendering them subject to self doubt and burn-out. He argued that by redefining therapy as a two-way process, therapists would be able to participate equally in the transformative process of therapy."

"Hmm, yes I can see there is a family resemblance. However, I don't know enough about White's work to comment."

I stopped talking and paused for a minute. Then I said, "I guess this brings me to the real topic I wanted to discuss today – my father."

"Good."

"I found out my father had died when I received a phone call from my brother in Australia, early on Sunday morning the 27th of June 2004; I remember it quite clearly. We had only been in New Zealand a few months and I had just enrolled in the PhD. The previous weekend I had spoken to my Dad on the phone about the European Soccer championship game where England had just been beaten by Portugal. He died peacefully in his sleep. He probably would have hung on longer if England had won, but now he could let go. I knew he wanted to go because he had more or less told me so. Mum told me later how the night before he died he had really enjoyed his last supper, so to speak. Almost like his body knew. I could hear Mum sobbing in the background while my brother talked. Riveting, heartfelt sobs that I'd never heard from her before. My father had slipped away silently into the night. No more would my mother hear his gasping breaths, his snoring restless nights and his mumbling protestations about his deteriorating body. His last, final out breath had come and gone. He was free, at last. Mum

woke up to find his still, cold body, soulless and stranded on the bed. How she must have wept that morning. Still in shock the reality still dawning. Her soul mate was gone. I guess we all have to face that moment one day with our partner – who will go first and who will be left behind?"

"When was the last time you saw him?"

"The last time I saw my Dad alive was on the ANZAC day weekend 2004. I had flown over from New Zealand especially to be there. He was eighty-five years old and his body was weakened from fighting bowel cancer and now he had a heart condition. I watched the parade with my Mum and sister beside me. ANZAC day had always been a special day for Dad. He could no longer walk so he was chauffeur-driven in a limousine. I could see his pale and drawn face inside the car. He was smiling and waving at the cheering crowds that lined the street. I could see the twinkle of pride and self-respect in his eyes. I too felt pride. After the funeral my mother sent me a duplicate set of medals that I now wear with pride every ANZAC day in honour of my father. But it wasn't always that way. Back in the seventies, the young people of my generation, outraged by the Vietnam War, saw ANZAC day as a glorification of war. I even remember the angry words from one of my very first songs about my Dad after I learnt to play basic guitar:

You've got six shining medals on your chest
But that doesn't make you better than the rest
Just cause you've got six medals on your chest.

This song expressed a relatively recent change of heart, brought on by the upheavals of adolescence and the discovery of injustice. Round about sixteen I began to rebel against war and patriarchal authority, wearing glitter and a caftan to school as a form of protest against hegemonic masculinity. My primary school years in contrast, had been quite different."

"Where did you grow up?"

"My boyhood years were lived in the suburbs of the Lancashire cotton mill town of Oldham. My mother and father's family came from Bolton. Dad was in a tank regiment during the Second World War and when he came home he studied short hand and typing and became a clerical worker. His father had worked in the cotton mills and had been a strong "Labour" man. Dad was the first "white collar" worker in the family, and he proudly wore a tie. Eventually he went back to evening school and became a teacher himself, at a technical college in Oldham."

"Tell me more about your Dad."

"My father was a gentle man. He was never violent towards me nor did I witness him being violent to others. Yet, as a boy the image of my father that made the biggest impact upon me was that of a soldier. I use to love sitting with my mother and looking at the old faded black and white photos of Dad in his khaki uniform posing in front of the Egyptian pyramids. I loved to draw pictures of tanks and planes and bombs. I loved to make model tanks and model warships. I also loved my mother to read to me from *The Wonder Book of Daring Deeds,* a book which had previously belonged to my older brother. My brother had married and left home before I was born. These

stories were all about male heroics such as the young man who stood by his gun on the battleship while all around him perished; the story of Scott of the Antarctic; Lawrence of Arabia and the real Robinson Crusoe. I would play act some of these stories with my friends. During winter when the snow drifts piled up on the fields, I would be Scott of the Antarctic taking his final tragic walk into the snow.

Dad also loved football and cricket. He told me that his Dad could have played professional football but he decided to stay home with his mates in the mill. I dreamed of being a footballer or a cricketer. I would go and watch Oldham Athletics' home games every second Saturday afternoon during winter. Dad was often working on Saturdays but sometimes, every blue moon, he would take me to Old Trafford to watch Manchester United play. That was magical. It was the era of Bobby Charlton, Dennis Law and Georgie Best, legends in their own lifetimes. The stadium was called "Old Trafford"; they now call it "the theatre of dreams". It holds 75,000 people. I loved the atmosphere and the chanting of the crowd at the Stratford end:

Oh when the reds, go marching in
Oh when the reds go marching in
I'm gonna be in that number
When the reds go marching in

United! United! United!

Yeah, those were the days!"

"What else do you remember about those days Andrew?"

"I hated going to school and from almost my first day I had to fight. I fought many fights in that first year until the kids stopped picking fights with me. I hated the cold milk we were forced to drink, the lessons we were forced to learn. But I loved football, cricket and athletics."

"What else?"

"It was the 1960s", I said, smiling in nostalgia. "My sister had a good collection of Beatles records. I liked my sister, she use to play with me when I was little. On Saturday mornings I would jump into her bed and wake her up! When I was older we would sometimes fight over what programmes to watch on TV. She liked music and had some classical records like Swan Lake that I also listened to in secret. It was through my sister that I grew to love the Beatles. I bought my first "single" at Oldham markets. It was the Beatle's "I am the Walrus" and "Strawberry Fields". When my sister married and decided to migrate to Australia my mother missed her so much that when my sister became pregnant two years later we decided to follow. I had just started first year high school in England, it was called a "Comprehensive" school to distinguish it from "Grammar" school. My sister had gone to grammar school but I had "failed" my eleven plus exam, not that I worried about that at the time. In my first week at high school I was in a big fight. This time with a boy who came from a different primary school. We were both regarded as the best fighters from our respective primary schools and we were surrounded by a host of cheering boys. Unlike the other boys I had fought, this boy wouldn't

give in, even though I had my arm around him in a neck lock and I was punching and punching him in the face, he still wouldn't give in. Finally, my mother arrived on the scene and stopped the fight. One of the neighbourhood girls had told her and Mum had walked from the house to stop the fight. That would have taken her at least 10 minutes, so the fight must have been going for about half-an-hour. I didn't want to stop because I was winning and felt embarrassed that it had been my mother who came. I cried in frustration all the way home."

"Two cocks fighting to the death!"

"Exactly! It was the winter of 1969. We watched *I Love Lucy* and the *Dick Van Dyke* show on TV. My favourite was *The Saint* and *Dr Who*. The Americans had just walked on the moon, which I had stayed up all night to watch. Russian tanks had rolled into Czechoslovakia. Not that I really understood the politics of the situation. That would take a few more years. United had just won the European Cup. My parents sold our house that had been our home for eight years and we gave away my pet poodle, Cindy, who we all loved. We moved into a guest house while waiting for the big day to arrive when we would board the ocean liner to sail away to Australia. The promised land!

I had just turned 13. Not long before I had accidentally discovered the pleasures of masturbation, lying down on my back in the toilet with the door locked. One day I was quite surprised to notice some clear liquid coming out of my penis after I had reached climax. It wasn't long before it turned into a thicker milky kind of stuff. I didn't even know at the time it was called sperm.

It was over two years later that my parents gave me a copy of the “little red book”, a sex education manual for teenagers. Round about the same time I became fascinated by cigarettes and the illicit pleasure they afforded and the joys of reading. I devoured books like *Tom Sawyer*, *Treasure Island* and *King Solomon’s Mines*.

Then the big day arrived: December 17, 1969, the day we were destined to sail away. When the ship we had boarded, called the Fairstar, had disembarked from the docks at Southampton I looked backwards and imagined my old life disappearing under the horizon. I turned towards the future and felt happy. I didn’t know it at the time, but this early migratory experience was going to become an integral part of my future identity. I was excited about the journey and the migration process. It was like an initiation rite, crossing the equator between what had been and what was to be. It was interesting that it coincided with my passage into puberty. It was the first time in my life, but not the last, that I would take it as an opportunity to reinvent myself. For one thing, I had made a commitment to myself to stay out of fights. I was never again involved in a fight, well, at least not until my first marriage. I also decided to start wearing my glasses all the time. I guess that was when I began to resist the prescriptions of hegemonic masculinity.

Australia was not a disappointment. As the Fairstar sailed along the coast I saw my first flying fish and dolphins following the ship in its wake. We docked at Circular Quay, Sydney, and travelled by car to stay with my sister and her husband in Canberra. They had just had their first child. We spent Christmas with them. It was a long happy holiday for me. Then we traveled

back up to Wollongong where Dad was going to teach and we rented a home unit. The unit was close to the best surfing beach, a picturesque harbour with fishing boats, and an old light house facing out to sea. It was January, it was hot and I was excited by my first experience of the Australian surf. I enjoyed that long hot summer very much, between innocence and experience, the mountains and the sea.

School started and it was decided that I would repeat first year again. It was like being given a second chance. At the end of that first year I walked out in front of the assembly to receive my first ever academic prize. I had done exceedingly well in all my subjects. I discovered I did have a brain after all!

The migration experience turned out well for me, but not so for Dad. He was terribly homesick and depressed. I remember one day Mum spoke to me saying that we had to go back to England because Dad was not very well. I cried and protested. I couldn't bear the thought of returning. However, we didn't leave and I continued to thrive. I played soccer and cricket and made new friends. My best friend at the time had Greek parents and I invited him back to my place to see my collection of plastic toy soldiers and my fish tank.

My father was still "not well". Mum told me there was something wrong with his brain. Mum would drive up to Sydney to visit Dad who was in a hospital and I would be her navigator. I didn't realise at the time he was staying in the psychiatric ward and I wouldn't have understood the meaning of this at the time. I guess Mum made a decision she wanted to protect me from knowing the full-story about what was happening. At night we would listen to

music, like the Nutcracker Suite and sometimes Mum would tickle me on my back. It was soothing.

Dad came out of hospital and things returned to normal. However, he was no longer working in his teaching job and was now working at the accountancy department at BHP Steelworks in a clerical capacity. Funny, I don't think I wondered much about why this was the case. I was so involved in my own world.

Slowly I began to develop an alternative identity. Although never quite letting go of soccer and cricket, I began to get more and more into literature and philosophy and music. At sixteen I was reading the Penguin modern classics, lots of poetry and learning how to play guitar. Although I couldn't have said it at the time, Dad radiated disillusionment. Symbolically, he had become a fallen hero and had been replaced by my new heroes, Bob Dylan and Leonard Cohen.

Just before I turned seventeen I had my first heterosexual sexual experience with a lovely sixteen year old girl who had German parents. I had "fallen in love" with her at a party. It all happened in the dark and it was pretty rushed and I didn't really know what I was doing but after that night I was literally walking on air! This was the ultimate initiation into manhood. Unfortunately, she had a boyfriend and although I beat him in the Regional 1500 metres athletics final, she still went back to him.

After I had successfully completed High School, my parents had decided to take a holiday back to England to visit my sister who had returned with her husband and two children the year before. Dad gave me a lot of

money and I left first on my own. I met a young Australian woman who had just completed her teaching diploma on the bus from Heathrow to London. We spent some nights together and journeyed by train to Stratford on Avon. I bought a long suede overcoat with a fur collar and a wide brimmed hat. I had decided I was going to study literature and become a writer and therefore it was a requirement to dress like one. We said goodbye and I went on to Manchester to meet up with my parents at my sister's place for Christmas. I was reading Sylvia Plath at the time.

It was the night before Christmas, 1975, that I learned the truth about Dad's "illness". I was having a get-to-know each other session with my sister and brother-in-law, aided by lots of drinks. I received the whole story about how Dad had exposed himself, both on the street where we lived and at the Technical College where he worked. The news sank in deep under the anesthetic of the alcohol. The conversation triggered a memory – it unwound in my mind like I was sitting back observing it pass before me like a movie …

It is a bright sunny Sunday afternoon in October 1970. I am almost fourteen at the time, and looking forward with excitement to traveling up to Sydney to see a movie called Napoleon, starring Rod Stieger. I am looking for Dad but can't find him anywhere.

"Where's Dad, Mum?"

"I don't know love. I thought he was out on the verandah?"

"No, he's not Mum".

"That's strange."

"We're going to be late Mum."

"Don't worry. He must have just popped out to the shop."

Half-an-hour goes by. Mum is now starting to look anxious. Dad had disappeared. I am fuming. I go upstairs to my bedroom to read. I think I am reading War of the Worlds by HG Wells. Then I hear Mum's voice downstairs.

"Where have you been Tom?"

Dad mumbles something I can't hear. I race down stairs.

"Dad we're late for Napoleon".

There is a look of seriousness on their faces, I haven't seen before. I can't remember if Mum had been crying but I think her eyes were red and swollen.

"Andrew, go back to your bedroom, we're talking."

"But what about the movie?"

"We're not going now."

"But you promised!" I run upstairs, crying in anger and bang the door behind me. I can hear them talking in the kitchen.

"But don't you realize this is serious?" Dad says.

"It doesn't matter. We promised we'll take him and we are going to take him." About five minutes later I hear a knock on my door. Dad comes in.

"Do you still want to see the movie?" He tries his best to sound cheerful.

"Yeah."

"Well, we can still go."

I am happy again. We drive to Sydney. I remember Mum is unusually quiet and the atmosphere in the car is charged with tension. I put it down to the anxiety of driving to Sydney. Something that dad doesn't like to do. I enjoy the movie, especially the battle scenes, the colorful uniforms, the cavalry charge. Napoleon lost the battle of Waterloo. We drive home through the darkness in silence. Something else had been lost that day, but only later was I able to identify the sadness in my chest as belonging to my father.

On Christmas Day, 1975, my brother and his wife and their parents came for Christmas dinner at my sister's place. My paternal Aunty and her husband also came. It was supposed to be a happy reunion until I made a scene, acting out my pain and anger at the news I had just received. I was restrained by the code of secrecy and did not speak about the real reason behind what I was doing. My theme for the night was hypocrisy. I focused on the rift between my sister and sister-in-law but that was only the smokescreen. I was drunk on scotch whiskey. My brother almost punched me. In the morning it was all explained away as adolescent immaturity and drunkenness. I joined in the conspiracy of silence and went on my way. I wandered the streets of London for a few days before flying back to Australia. All I could see were William Blake's "Marks of weakness, marks of woe." Then a woman approached me, she said:

"Do you want a woman, love?"

I had never met a prostitute before. Her breath smelt of alcohol and she wasn't even pretty. She asked for some money and I naively gave it to her

and she asked me to follow her. She quickly disappeared into the dense Soho crowd, and I never saw her again.

After that I bought my first book on psychotherapy, written by Anthony Storr, entitled “Human Aggression”. My parents met me at Sydney airport with the Higher School Certificate results. I had done well and decided to leave Wollongong and move to Canberra to study a Bachelor of Arts Degree at the Australian National University.”

I fell into silent reverie. I could hear cars driving past in the background and I was vaguely aware of Barry’s presence. I had been so wrapped up in the telling of the story; I had almost forgotten he was there. I made eye contact and Barry said: “So did you ever get round to talking about this secret with your Dad?”

“Well, a few years later, in my early thirties, I found myself as a successful public servant, in a well paid position in the Department of Industrial Relations, wearing my new grey suit and tie with self-conscious pride and enthusiasm. I had reinvented myself again. During this time, I attended an expensive personal development course called “The Forum”. It involved attending from Friday night through the weekend finishing late on Sunday night. We were asked to return on Wednesday evening with people we cared for. An excellent marketing technique – we were to bring in the new customers. However, for all my retrospective criticisms of this programme, it was intense and powerful. On the Monday evening, following the weekend, I drove down the coast to visit my Mum and Dad. We had never spoken about the shameful family secret. It was my intention to confront this head on.

I began by telling them about The Forum and the projects I was going to undertake. Then I got down on my knees in front of my Dad and with tears in my eyes held both his hands and said, Dad, I know what happened – why you went to hospital. I wanted to let you know that it's okay – I forgive you.

After that I think we cuddled for the first time, a practice which we continued until the day he died. I felt better even though Dad didn't talk about it and we never mentioned the topic again."

"What about your Mum?"

"Funny you should ask, I've been doing some writing about that. Two years after Dad's death Mum came over for a visit to New Zealand with my sister. I remember it well because she brought up the subject of Dad's "illness" with me for the first time. We were visiting the snow-capped volcano, Mount Ruapehu, which towers over the little town of Ohakune. My sister also came and two of her adult children. We were going to share a meal together in honour of the second anniversary of Dad's death. I can still see in my mind's eye the vision of the mountain shining in the moonlight through the window.

During the afternoon I had gone with Mum to the travel agency to sort out some problems with her entry visa back into Australia. The last time she had traveled overseas had been to England and she hadn't had the passport stamped. When we arrived back at the chalet we found ourselves alone. Everyone else had gone up the mountain to have a go at ski-ing. I asked Mum how come they had never become Australian citizens and she said they did get the forms once, but when Dad looked at them he said "I'm not going to

tell them what I did" so they never did. I assumed Dad may have had a criminal record and he didn't want to disclose that but Mum said she didn't know. I said to Mum, "It took a lot of courage, strength and loyalty to get through all those years" and she said, "Oh, you always praise me." Mum has never been comfortable with praise, even to this day.

Then I asked her what she thought caused Dad's nervous breakdown and she said "I don't know …. It just came out of the blue!" She thought some more and said "I think maybe coming here at 50. He was depressed with home-sickness." I asked her what did the doctors say and she said "They just interrogated you … and they asked me if I wanted to leave him." I asked her why she didn't tell me, and she said, "I just wanted to protect you". She asked the doctors and the solicitors to keep it out of the papers and they did. She looked at me with tears in her eyes and said, "We came through all right didn't we?" I said, "Yes, we did Mum, we did," then I reached over and held her hand. Mum told me that even now she still gets scared when she bumps into one of Dad's ex-students and they say they studied short-hand and typing. She said, "You haven't got any idea how it felt when someone said, 'Oh, my daughter was in your husband's class'.

I could only imagine the pain and embarrassment and humiliation Mum must have felt, especially at those moments. And she never received any help, although she said the counsellors helped him to get an office job at the steelworks – which he couldn't stand – she said it bored him to tears. I said to Mum "Do you know how I found out?" and she said "Was it your sister's ex-husband?" and I said "Yeah." Mum acknowledged, "He was good to me at

the time." Then Mum said, "You know we never talked about it?" I couldn't believe it. I said "Really?" Mum said "Your Dad never spoke of it again after he came out of hospital," and I said "Just like the war, Mum?" and she said "Yes, just like the war."

I fell silent again. I felt the old sadness that had been there in the background for so many years, rising again in my chest.

"My father and my mother never talked to me about my father's "illness". It was shameful and had to be hidden away. My father exposing himself in class did not fit with the professional image. I guess I've always worried that I might one day do something bad because if my Dad was capable, then why not me? After all, am I not similar to my Dad in many ways?"

"Are you not also different to your Dad in many ways?"

"Yes, I guess so. Though, I had a dream last night."

"I'm listening" said Barry.

"I dreamt about a dog which had some kind of disease. In the dream I was naked and I was hitchhiking back to my parents' place and I was given a lift by a woman in a white van. When she dropped me off she gave me some clothes to wear. I then saw this dog with a foaming mouth showing its teeth at the end of the road and I felt afraid. I was worried that if the dog bit me I would become contaminated, and I felt dirty, ashamed. The woman in the car saw the dog, and so to keep me safe, she drove me further down the road."

"Rabies."

"What?"

"The dog had rabies – a contagious disease."

"But who does the dog symbolize?"

"Maybe your father's illness?"

"Ahh …"

"You were on your way back to your parents' place – your place of origin. But there is something that is poisoned in the land. Your father is wounded and you are also afraid the wound might be contagious. Are you bound to repeat the past? Would you develop a similar problem?"

"Yes, now that we are talking about it, that interpretation does seem to make sense. The fear I could barely articulate ever since I had heard the story about Dad - I used to worry there might be something wrong with me - if my Dad could do it, then why not me?"

"It is important to pay attention to everything that shows up, including those thoughts, memories, feelings that make us uncomfortable. Jung use to talk of the shadow self – Freud talked about repression – all these ideas these days can be talked about as forms of experiential avoidance – Joko talked about the edge of resistance – these are all aspects of ourselves that we want to deny, split off, forget about – our practice is about facing up and letting these experiences be without pushing them away."

"Yes, I can see that. You know, I once asked my father, just before he died, if he had his life over again, what would he have liked to have done as a career? He answered without hesitation, a professional ball-room dancer."

"Right."

“You know, it’s like he had to repress that side of himself – like I did all the things that he never allowed himself to do.”

“Yes.”

“He loved dancing but it was not possible given the circumstances, his class background and the historical period that he could ever consider doing something like that professionally. He sacrificed all that for what realistically I guess he thought was the best way to support his family.”

“It’s also possible his parents did not recognise or value that side of him.”

“Barry, how much do you know about exhibitionism?”

“Well according to the DSM-IV, ‘Exhibitionism’ can be classified as one of the many different varieties of ‘Sexual and Gender Identity Disorders’. Specifically, it is characterised as one of the ‘paraphilias’, which include any aberration of either the sexual act or the sexual object, for example, exhibitionism, as well as frotteurism, sexual masochism, sexual sadism or voyeurism.”

“How common is it?”

“Indecent exposure is a very large problem, being the most common sexual offence. I think it constitutes approximately one third of all sexual offences committed (Kahr, 2001 p. 19). I don’t know if you know this, but even Dr Heinz Kohut, while perilously ill from pneumonia at the age of 67, exposed his penis every morning to the nurses at the University of Chicago Billings Hospital (Kahr, 2001 p. 32-33).”

“That’s amazing! No, I didn’t know that!”

“Yes, so your Dad wasn’t the only one.”

“Well, what is commonly understood to be the cause?”

“When your father was ill, I’d say the dominant psychiatric theory would have been some form of neurological abnormality.”

“What about psychoanalysis?”

“Well, Freud helped us to understand that every human being possesses strong exhibitionistic urges from infancy onwards. Children frequently delight in exhibiting their naked bodies. Although most of us adults never expose our private parts in public, we nevertheless find ways of exhibiting ourselves, and of being recognised (Kahr, 2001 p. 40). Some analysts talk about the desire to know the other and the desire to be known by the other. Classical analysts would reduce these desires to the component drives of scoptophilia (voyeurism) and exhibitionism. They might talk about the wish to reveal oneself to the other as well as the longing to know the other. In some families, this wish may be expressed concretely, through sexually exhibitionistic or voyeuristic fantasies or behaviours (Aron, 1996 p. 234).”

“So Dad was metaphorically saying, look at me.”

“Some more contemporary theorists argue that exhibitionism (in males) functions as a means of affirming their sense of masculinity. It has also been suggested that the male exhibitionist may have endured a difficult relationship with his mother, possibly neglect or overly intrusive behaviour showing a lack of respect for personal privacy, leading to depression later in life. It has been suggested that the act of indecent exposure not only affirms the man’s

sense of masculinity but also functions to stave off depressive affects as well (Kahr, 2001 p. 50-51)."

"You know Barry that makes sense. I remember my sister telling me a story about how when Dad returned from the war he would go over to his mother's place for a bath and she would wash him. He was also certainly depressed in Australia at the time the offending began."

We finished the session and I thanked Barry for all his help, promising to come back again. As I was about to leave I stood at the door and turned around.

"Barry, why do you think is it so important to feel known and understood?"

"Because when we feel known and understood, we no longer feel so all alone. What was previously unbearable when we were alone is now bearable within the context of feeling understood by an empathic other."

I smiled and said goodbye.

I stepped outside. A cold wind was blowing through the trees. I wrapped my overcoat around me and walked towards Central Park. I realised I could never know for sure why my father had sexually offended all those years ago, but I did know that I loved him and he loved me. It was a knowledge I could bear, it was something I could speak about in public and no longer feel ashamed about. What he did was wrong, but he was still the father who cared for me all those years and took me to the football and cricket. He was a good man, and I was proud of him.

Like so many of his generation, not only had Dad gone to war for five years, but he had also devoted himself to learning and teaching secretarial skills, while all the time what he would rather have been doing was ballroom dancing! This was his sacrifice towards giving his family a better life.

I was like my Dad in some ways, but different in others. I followed my dreams and I took risks. I didn't always put my children first.

I walked into Central Park, and sat down on a bench near the John Lennon memorial. A young man was playing guitar and singing "I wish you were here", by Pink Floyd. I thought of John Lennon and of Dad, and I thought of all the victims and perpetrators of sexual abuse everywhere in the world and I felt compassion for them all. A feeling of peace and acceptance came over me. I looked up into the darkening sky and saw the evening star. I smiled at the pigeons, content just being in the moment, and I watched the sun setting behind the trees. It was time to move on.

12.

Jamie's story

Jamie had been separated from his family as part of his safety plan and was living in residential accommodation for adults because there was no adolescent accommodation in the town where he lived. The House was owned and managed by an evangelical Christian church. Jamie described to me how he shared a room with a 22 year old guy who was the chef of the house. Jamie was not allowed to go out much, apart from going to church. The manager would share his passion for the Bible with him, but Jamie was not sure if he wanted to identify as Christian. He talked to me in the early sessions about feeling confused about his identity, stating that "I try to please people all the time. I'm not sure who is the real me any more, because I try to impress people all the time". I found Jamie to be more articulate than I might expect of an average fifteen year old. He liked to read and he had a good vocabulary. After a few weeks of working together the following conversation occurred.

Jamie looked hesitant, as if deciding whether or not to speak about something that was on his mind. Then he said: "Andrew, horrific memories came back after talking with you last session."

This caught me off guard and I replied: "Do you feel okay about talking about them?"

"I have been trying to suppress them," he continued.

"Do you think it would helpful to talk about them?"

Jamie then proceeded to tell me in detail about how he had been sexually assaulted in a park a number of years ago by two older teenage boys.

"I'm really sorry that happened to you Jamie. That's awful. Do your Mum and Dad know?"

"No. The guys threatened me. They said. 'If you ever tell anyone, remember, we know where you live.' When I got home my parents noticed I was upset and I told them some older boys beat me up. My parents reported it to the police as a physical assault."

"Have you told anyone?"

"Yeah, after my sister disclosed, my aunt and uncle confronted me. They said I would end up in prison and get raped … then they asked me if anyone had abused me. I broke down and told them. It was the embarrassment that stopped me from telling. I didn't want to admit to myself that it had happened. But talking about what has happened took a big load off my shoulders. Now I can't hide from it."

"It felt like a huge burden was lifted?"

"Yeah. I felt I had to suppress my anger a lot, being so young I couldn't fight back and also I had to stay quiet. I feel the anger is still bottled up inside. In my dreams I used to want to kick the shit out of them."

"Yeah, so you've been walking around with all this rage bottled up inside but with nowhere to turn."

"That's right. I hate those bastards!"

"How else do you think it might have affected you?

"I became more secretive – I'd keep many secrets. I tried to block it out – sometimes I'd have nightmares, flashbacks. Since I've admitted it, it has become more real and I am dreaming about it more."

"In what ways may it have affected how you think about your self?"

"I wanted to prove to myself that I was still straight, not gay. I would have done anything to prove I was straight."

"Jamie, I have worked with a lot of young men who have also been afraid of being called gay. Why do you think that is so?"

"Because it is a big put down."

"Yeah. It's a common form of ridicule which is demeaning to men who are sexually attracted to other men. It is sometimes called homophobia – fear of homosexuality."

"It says in the Bible that it is a sin."

"Well, some Christians choose to read the Bible in that way. There has been often a strong prejudice within various cultures, but not all cultures, against homosexuality. How do you think it affects young men who are attracted sexually to other men?"

"It must be hard for them – they would try and keep it a secret."

"Yeah. Jamie, how do you think your life would have been different, if the rape hadn't happened and if homophobia wasn't so influential?"

"I don't think I would have done some of the things I did … I'm positive I wouldn't have done what I did to my sisters. I would have been more respectful to people. I wouldn't be so confused about who I am. It's like the rape separated me

from reasoning … thinking things through and the homophobia made me keep the rape a secret."

Not long after Jamie had disclosed the traumatic event of his own abuse, the following conversation ensued.

"When we were coming up in the car today my Dad told me that he had been sexually abused when he was younger by an uncle. I wished I'd known that before," he said thoughtfully.

"How did it affect your Dad?"

"He let it out in different ways, whereas I wanted to prove to myself I wasn't gay."

"Has knowing this changed your relationship with your Dad in any way?"

"Yeah, I think we are a lot closer now. We talk a lot more because he drives me here every week."

We began talking about school and about Jamie's ambitions. He played down his academic abilities saying, "It's not cool to be seen as brainy". He told me most of his friends were "goodie goods" in his "pack". He talked about the importance of being seen as "being cool". He said he would like to have bigger muscles, because "it signals to other guys I'm tough." Jamie thought being seen as "tough" gained you more respect than being seen as intelligent.

"What do they call brainy kids?" I asked.

"Geeks! Kids beat up people who are good geeks or faggots."

"Do you think there is some connection between you wanting to be seen as tough and your own sexual abuse?"

"Yeah. When I was abused I was eight. I was still short. Prior to the abuse I used to get picked on. I remember I got a hiding – a huge black eye – when I told this dude to stop teasing me about Mum. But I didn't make a connection between being gay and the abuse until I was about ten or eleven. That's when I learnt about homosexuality. I was scared I might be gay – even to this day I haven't told my mates about the abuse. Now I fear homosexuality less because I know I'm attracted to women."

"Do you have a girlfriend?"

"Not yet. It's the rich little white boys get the chicks, not the outsiders."

After a few months in the programme, Jamie began to notice how he was feeling differently, how he was experiencing a new sense of self. He also talked about friendships with a number of girlfriends. He was now comparing the "old self" with the "new self". He was clear that he preferred his "new self" to the "old self":

"I use to go out of my way to make female teachers life a hell – playing to the audience of other guys. I didn't know who the real me was. I didn't want the other guys to see me as soft and when I was around other guys I was a dickhead."

"What changes have you noticed since coming to therapy?"

"Since coming to therapy my mates have noticed I am becoming more polite – I have been standing against dissing people."

"Have you made any other commitments?"

"I'm no longer going to play I'm dumber than I am. I am going to be my own person now."

For Jamie's last session I took him to the café to celebrate. He'd been on the programme for eighteen months.

"Jamie, I've been asking you a lot of questions since we've been meeting. Are there any questions you'd like to ask me?"

Jamie took a long pause, thought and then asked: "What advice would you give about telling someone about why I come here every week?"

"Well, every person and situation is going to be unique. I don't think you need to feel obliged to tell anyone – lots of people have skeletons in their closets so to speak – there are no perfect people walking around out there – but on the other hand, if you trust this person, then it might be okay …

"What if you were going to marry someone, would you tell them then?"

"Again, it's really your own judgment call – if you love a person and they love you, then usually people will disclose more about events from the past that they might sometimes be ashamed of because they know the other person is judging them on the person they are today, not what they might have done in the past."

"Yeah, but what if you don't tell and then they find out about what I did from someone else?"

"I guess there is always a slight possibility that might happen, but it is unlikely. But I understand your concerns. I am sure it would be better if the person heard it directly from you rather than indirectly from someone else."

"Well, I've told Vicky."

"You have?"

"Yeah."

"What was her response?"

"She kind of looked a bit shocked for a few seconds but then she said it was alright and gave me a big hug."

"Why did you decide to tell her?"

"She asked me why I was at The House. She said, she had a friend once who had stabbed somebody and she kept on being their friend."

"Do you think she cares about you?"

"Yeah, I think so. I said I wish I had stabbed somebody rather than living with the shame about what I did."

"Jamie, I am going to tell you something in confidence; I haven't told many people. My father was a "sex offender". I don't like that language. He was not abusive towards children but he exposed himself to young women more than once. It happened when I was going through my adolescence. I found out about it when I was nineteen from another family member. In retrospect I wish my Dad had been able to tell me himself. It disturbed me for many years but I didn't talk about it much. Sometimes it would come out when I was very drunk. Eventually, I told my Dad I forgave him and that my knowledge of what he had done didn't affect my love for him. You see, that's why I do this work Jamie. My Dad was a decent, honorable, gentle and loving man yet he did some stuff he was so ashamed of he could never speak about it to anyone." I feel tears forming in my eyes as I tell this story. Jamie is very quiet, and then he says:

"I don't know what to say."

"That's okay."

"I feel honoured."

I notice my watch and its five minutes past two.

"Oh, we're running late."

We walk quickly back. I hope my disclosure is helpful to him in some way. My Dad could never overcome the shame barrier and disclose to me.

"I've really enjoyed meeting with you every week Jamie. I have admired your courage and commitment to talk through all that you've been through."

We shook hands and I said, "See you next week at the Graduation."

PART THREE

13.

THE USE OF SELF IN THERAPY:

A META-ANALYSIS OF THE STORIES

13.1 Introduction

In narrative research, including autoethnography, there are two basic forms of analysis: the analysis of narratives and narrative analysis (Polkinghorne, 1995; Etherington, 2004; Ellis, 2004). In the analysis of narratives, the narrative itself becomes the data to be analysed. The narrative could be anything ranging from a short story to a film to a transcript of a conversation. Analysis can be based on concepts derived from previously known theories which are applied to the data or concepts derived from the data (Etherington, 2004, p. 80), or, I would suggest, a combination of both. Specific methods such as conversational analysis, thematic analysis, grounded theory and discourse analysis have been developed and refined in order to carry out these tasks. Alternatively, the concept of narrative analysis recognises that the story itself is a form of analysis, as told by the researcher. The story is not just raw data to be analysed but is actually constitutive of the life of the researcher who is telling the story. In autoethnography the telling of a coherent story which engages the reader on both an intellectual and emotional level *is* the analysis (Etherington, 2004; Ellis, 2004). Therefore for autoethnography, narrative analysis is, by definition, essential; whereas the analysis of narrative is therefore optional. When an analysis is done of a piece of autoethnographic writing it is therefore a meta-analysis.

In this chapter I have chosen to include an analysis of the stories from part two of the thesis based upon my reading of the stories from the perspective of both the systemic-narrative therapy traditions and the relational psychotherapy tradition and to show how the use of self links together these two traditions. In particular, I identify and describe how the use of self becomes involved in the intersubjective and interactive processes of dyadic therapy. This is just one reading, and I am sure each reader would have a different interpretation and understanding of the stories. The cyclical interactive pattern that stood out for me in dyadic therapy involved an action or a response from the participant followed by an action or response from the therapist and so on. I refer to this as the action-response (A-R) cycle. Viewed from an intersubjective perspective, the use of self is sometimes an intentional act; and at other times it is an improvised spontaneous response, often outside of conscious awareness, such as the subtle emotions communicated non-verbally through facial expressions, voice prosody, gesture and posture (Schore, 2005).

Both the systemic-narrative traditions and the relational traditions recognise the importance of the use of self; however, as discussed in chapter three, they differ in the amount of attention given to this aspect of the therapy process and their understanding of what constitutes the main mechanism of change. In systemic-narrative therapies, the therapist primarily uses questions as the main form of intervention, to generate new meanings; whereas relational therapies generate new meanings through the use of interpretations. Relational therapies also recognise the importance of non-verbal implicit communications and work on the assumption that the therapeutic relationship has the potential to provide the context for the participant to undergo change through experiencing a corrective emotional experience with the

therapist. Although the importance of a respectful collaborative relationship is acknowledged in the systemic-narrative traditions, with some exceptions, the use of self, implicit non-verbal communications and the transformational potential of the relationship between therapist and client is given less weight (Bird, 2004; Flaskas & Perlesz, 1996; Flaskas,2002).

I begin the chapter with a discussion of the tradition of judgment-based practice. This sets the scene for my analysis of the moment-to-moment process of interactions. I begin with how I used both a combination of reflexive questions and interpretations in order to facilitate the creation of meaning. These were intentional interventions, in which I took the lead in initiating the interactional cycle. This is followed by a discussion of position calls and optimal responsiveness, two alternative ways of analysing therapeutic interactions. I then analyse the use of intentional self-disclosure and the facilitation of critical reflections on hegemonic masculinity. This is followed by a discussion of how a sense of relatedness and intimacy is created through various types of playful interactions. In particular, I focus on the need to find creative and flexible ways of emotionally engaging participants who are significantly affected by abuse related trauma. Finally, I finish this chapter with a discussion of how therapist self-reflexivity (or intersubjective mindfulness) is central to the therapy process and an analysis of how self-and-other reflexivity is constantly being used by the therapist as a means of attuning to the here and now of the intersubjective context of the interactional cycles.

13.2 Judgment-based practice

Both therapist and participant are unique individuals who develop a unique relationship which cannot be replicated. The notion of developing therapy anew for each participant fits with the ideas of optimal responsiveness and specificity theory, as discussed in chapter three. These ideas can be seen to belong to a much older tradition known as judgment-based practice (Polkinghorne, 2004). Unlike the scientist-practitioner model, a judgment-based practice approach argues that interventions cannot be separated off (and studied as independent variables) from the unique configuration of subjectivities involved in the therapy process. I have argued in chapter three, that the related ideas of optimal responsiveness and specificity theory can enrich the principle of treatment responsivity as discussed in chapter two. However, the practice of professional discretion or the art of clinical judgment has not been researched in sexual offending therapy. I argue that a better understanding of the role of clinical judgment in therapy practice can make a significant contribution to the critique developed by Marshall, Ward and colleagues (Marshall et al., 2003; Ross et al., 2008; Ward & Marshall, 2004; Ward, Melser, & Yates, 2007) of the failure of the risk-need-responsivity rehabilitation model to adequately theorise the importance of the person of the therapist and the therapeutic alliance to treatment effectiveness.

Polkinghorne (2004) traces his version of judgment-based practice to the philosophy of Aristotle, who distinguished between what we would now call the physical sciences, the technological applications of the physical sciences, and the moral or human sciences. Polkinghorne presents the case for a "judgment-based approach as against the technological approach, for the practices of care". I contend

that the dominant understanding of evidence-based practice is analogous to a technological approach to the practice of care. The technological version of evidence-based practice argues that it is possible to define and isolate the procedures that are applied in the practices of care, and through experimental research, (ideally the randomised controlled trial), establish evidence for what "works" in practice. The problem with this technological interpretation of evidence-based practice is that it assumes it is possible to isolate the procedure from the people involved in implementing the procedure, without acknowledging how this is removed from the reality of clinical practice (Hoffman, 2009; Orange, Atwood & Stolorow, 1997; Strupp, 2001). This assumption is also contradicted by research into psychotherapy outcome research which has shown that techniques only account for 15% of client progress (Lambert & Barley, 2002). Polkinghorne (2004) argues that it is the practitioner themselves that is more important than any procedure or technique:

> On the basis of a practitioner's self-knowledge, experience and training, he or she is expected to make judgments about what actions will accomplish a goal with a specific person, in a specific situation, at a specific time. Judgment-based practice focuses on the practitioner as the factor that produces change. It argues that practitioners can take into account the needs of particular individuals and respond to situational differences (p. 3).

Polkinghorne argues accountability should therefore be focused on the outcomes produced in a particular situation, not just on the prior selection of a validated

program or procedure. I therefore became curious about how clinical judgment actually works in practice.

I began to see a connection between the use of self and judgment-based practice. Judgment-based practice is founded on the ability of the therapist to learn from the participant and to be able to respond flexibly on a moment by moment basis. The skill of reflexive self awareness or the analogous concept of intersubjective mindfulness captured for me the primary receptive stance of the therapist. This included my ability to be aware of my embodied affective and cognitive experience as well as being attuned to nonverbal and verbal communications of the participant in the here and now of the therapy session. From this open posture of intersubjective mindfulness I would then be called upon to respond with an action of some kind or initiate an intentional intervention. Intentional interventions, which involve elements of deliberation and choice, are carefully crafted responses to the atmosphere of the encounter as interpreted by the therapist in that moment. However, at the same time, there is a more subtle emotional communication happening at the non-verbal level, often taking place outside the conscious awareness of the therapist and participant (Schore, 2003a; 2005). If the intentional intervention is incongruent with the emotional context of the interaction, it is unlikely to be experienced by the participant as an optimal response, and therefore more likely to have a negative effect.

Polkinghorne (2004) defines judgment-based practice as a form of practical knowledge or practical wisdom which comes from Aristotle's theory of knowledge. Aristotle classified knowledge into three categories: "episteme", "techne" and "phronesis". Episteme refers to certain knowledge that we would describe as deductive or mathematical. Techne refers to the use of knowledge to produce objects

of practical value such as building a house. Phronesis refers to the realm of morality, it concerns the good life:

> A phronetic perspective on being with others reveals their needs and pains and calls forth a human caring response. *Phronesis* unconceals the moral dimension of human existence and seeks to promote the good and avoid causing harm to others (p. 45).

The concept of phronesis, or practical wisdom, is central to the idea of a human science (Gadamer, 1975/1989), and it is inclusive of "all our human sensitivities, including our emotions" (Polkinghorne, 2004, p.107):

> Because of the unique, emerged characteristics of human beings, successful practice with them requires improvisation and ongoing adjustments informed by situated practitioner judgment. Such a practice was taught by Aristotle for use in human interactions. He spelled out the characteristics of this nontechnical practice and termed the deliberation employed in it to determine actions 'phronesis' (p. 95).

The human sciences study the subjectivity of human actors who have intentions and goals. The question of what constitutes a good life and the path towards living a good life are ultimately questions of morality rather than science. In contrast to the methodologies of the physical sciences, which seek to identify empirically valid propositions that are universal in their application, the human sciences study the

particular and unpredictable realm of human practice. The findings of a human science cannot instruct us as to how we should proceed to reach the end we are seeking but rather provide us with "useful descriptions of what has worked in other situations and might work in the present one" (p. 94). This is exactly the way in which case studies are therefore judged as useful.

Polkinghorne argues (2004, p. 110) that human choice is guided by values, specificity of the situation, and emotions and imagination (emotional understanding). Our emotional response can be a better guide to a situation than an intellectual response. We therefore need to remain present and open to responding with our whole being. It is often the case that an improvised response will be the best response. Practitioners of care such as therapists are often responding to the perceived response of the client to their actions. "The interaction between the caregiver and the other person, whose responses are not scripted, is like musical improvisation in which each player is attuned to and responsive to the other's performance" (p. 119).

Phronetic knowledge is therefore a form of embodied rationality. When engaged in it, practitioners "draw on their values, feelings and imagination; they incorporate their cultural understandings, personal experiences, training, and applicable scientific findings. It is deliberative processing that occurs both within and outside their conscious awareness" (Polkinghorne, 2004, p.131). Similarly, Damasio's (2000) " view of practical decision making is that it is experientially based, drawing on images from a person's past encounters and enactments in the world … Images are not merely visual but include all manner of internal and external sensing; for example, sounds, taste, smell, and touch" (p.147).

Phronesis is also related to the concept of reflective understanding. For example, Polkinghorne (2004) states: "The ability to ask the right questions about the topic under investigation is something of an art, an art which above all requires insight and good judgment (or better, *phronesis)* as a condition of its possibility. Framing questions that lead to an enlarged understanding is a creative process that cannot be reduced to a set of rules" (p. 165). Reflective understanding results in action:

> Schon believed that a substantial part of practitioner expertise, and probably the most important part, comes in the form of 'knowledge-in-action' which can be distinguished from 'knowledge-for-action' …Validity is determined by its effectiveness in a particular situation at a particular time … Practitioners of care must monitor the effect of their judgments continuously (Polkinghorne, 2004, p.169-171).

Practitioners therefore both monitor and model the interactive process by the use of reflexive self-awareness.

13.3 The creation of meaning: Reflexive questions and interpretations

The stories revealed to me how much I used questions as well as interpretations. I understood this to be a consequence of my initial training in narrative therapy. Narrative therapy grew out of strategic and systemic family therapy. It was the Milan Associates who introduced so-called "circular questions" in 1980 into the therapy world (Palazzoli et al., 1980). These questions were called

circular because each family member was asked in turn questions about the behaviour of two or more family members. These questions were initially designed to generate information about difference. This news of difference in turn changed both client and therapist. The questions were also circular in the sense that the feedback observed by the therapist changed the therapist's response. Circular questions became the most important intervention in systemic therapy (Boscolo & Bertrando, 1996). In congruence with their systemic epistemology, the Milan school used circular questions, initially as a means of developing an hypothesis about the family system but they gradually came to the conclusion that the questions themselves where enough to bring forth new meanings and hence change. Karl Tomm called this style of practice "interventive interviewing". Tomm divided circular questions initially into two categories: informative and reflexive. Informative questions generated information and reflexive questions facilitated change (Boscolo & Bertrando, 1996, p. 107; Tomm, 1987a, 1987b, 1988).

Narrative therapists also used questions as primary interventions to create new meanings. White & Epston (1990) introduced what they called "relative influence" questions. These questions built on the innovation of circular questions, and created news of difference in relation to the influence of an externalised problem on the client and the influence of the client over the problem. The use of questions in both systemic and narrative therapy worked in very similar ways because these types of questions positioned the client as a reflective observer on the behaviours, feelings and thoughts of themselves and others, often in relation to a problem or a solution. They were designed specifically to facilitate the client's ability to generate new meanings and alternate stories about their lives and relationships:

> Considered from a linguistic point of view, therapy is a subtle game of hermeneutics and rhetoric … in analytic therapies the client is a rhetorician and the therapist is a hermeneutist (the client speaks and the therapist interprets the client's words), in systemic therapy the relationship is turned upside down: the therapist is the rhetorician (the one who asks questions) and the client is the hermeneutist, the one who furnishes meaning. The questions of the therapist implicitly delegate the responsibility of interpretation, i.e. the attribution of meaning, to the client (Boscolo & Bertrando, 1996, p. 136).

The questions that I used in the stories are derived from these traditions. I call them reflexive questions, not only because they facilitate change through the generation of new meanings, but to try and confer how these kinds of questions facilitate the participant's development of reflexive self-awareness or mentalisation, the ability to hold in mind other people's minds as well as one's own. These questions were my dominant mode of intentional intervention in the stories, except in my work with Billy.

Billy as a composite character was representative of my work with children in out-of-home care, who have often suffered abuse related trauma. These children often experience difficulty in "mentalising" that is, reflecting on the internal states of themselves and others. I found in my work with young people in out-of-home care that because of the effects of abuse related trauma, they were not yet at an appropriate stage in their maturational process to respond to these questions, and I learned, therefore, they were not an optimal response. However, in my work with the

participants who had a secure attachment to at least one parent, they responded positively to well-timed reflexive questions.

For example, the following excerpt illustrates how reflexive questions were less than optimal with Billy, and how I picked up on Billy's cues and communications, such as the response "I dunno" and his associated non-verbal communications such as lowering of the head. I therefore responded by using alternative intentional interventions such as communicating empathy through interpretations and using intentional self-disclosure as a form of metacommunication:

"Billy, what do you care about?" I said softly.

"I dunno."

"Billy, how do you think you are going to graduate from the programme if you don't talk?"

"I dunno."

"How's the placement going?"

"What do you mean?"

"How's things been with Kate?"

"The same. I don't want to be there but I have no choice."

"Yes, I agree there are not many options. But has Kate been more understanding?"

"I dunno. Can we play now?"

"Billy, how do you think I feel when you refuse to talk all the time?"

"I dunno."

"I feel like you don't want to be with me."

This move to respond by an intentional self-disclosure is a turning point. Billy was withdrawing from my questions, following the disclosure Billy seems to listen again:

> *Billy lowered his head and looked serious. He seemed to be listening. I was immediately struck by what I had just said and I continued, "I know that's how you must feel some of the time – that people don't want to be with you - but you're going to have to let yourself get close to someone one day. You can't keep shutting people out all the time because you are frightened they are going to hurt you. You are a good person and I like you but you won't let me in. I thought you would have been able to trust me by now. It's been almost two years now since our first meeting. If you don't let someone get close you are always going to be lonely and I don't want that. I care about you …"*
>
> *Billy's head remained bowed.*
>
> *"Billy, when do you think you are going to be ready to graduate? At the end of this year? Next year? What do you think?"*
>
> *"Well, I won't be ready at the end of this year."*
>
> *"Really? Why is that?"*
>
> *"I dunno. I just won't."*

In contrast to how the reflexive questions fell flat with Billy, there are many examples to show how the questions generated meanings for the other participants. For example, this following excerpt is from my session with Peter:

The words, "lets me down", resonated in my mind. I wondered how many times in his short life had Peter experienced this feeling. "What do you remember feeling first, the let down feeling or the angry feeling?" I asked.

"Probably the let down feeling."

"Can you say a bit more what the let down feeling feels like?"

"Makes you feel like shit."

"Can you remember other times in the past when you have felt like shit?"

"When Dad said he was going to stay and see me and didn't."

"What kind of thinking does let down feelings encourage?"

"Feeling shit."

"If feeling like shit could speak what would it say?"

"Nobody cares about me."

In contrast to Billy, Peter is able to respond to the invitation to reflect on his feelings, and therefore he is able to clearly articulate his sense that "nobody cares about me". By putting these feelings into words (symbolising), Peter is on his way to being able to self-regulate these feelings of let down and disappointment, whereas for much of the time Billy can only enact his feelings that nobody cares about me. This also creates the potential for a future dialogue with Peter's mother about these feelings and an opportunity for Peter's mother to respond to his feelings and repair the rupture in their relationship. The conversational interactions have a feeling of flow, which communicated to me that the intervention was optimal.

13.4 Optimal responsiveness and position calls

I slowly began to see how the use of self mediated the action-response (A-R) cycle that I had identified in the stories. This idea resonated with ideas found in both the systemic-narrative traditions and in the relational traditions. In the first, I found the work of Drewery (2005) to provide one way of thinking about this A-R pattern through the lens of positioning theory (Harre & Langenhove, 1999). This understanding is based in the paradigm of discursive theory and practice. In the relational tradition, as discussed at length in chapter three, I found the concept of optimal responsiveness (Bacal, 1998 a,b,c), which builds on the work of Kohut, to be another, equally engaging way of conceptualising this interaction pattern. It was a genuine insight for me to discover how the systemic-narrative tradition focused on the *rhetorical* skills of the therapist to *initiate* interactions, especially the skillful use of interventive interviewing (Tomm, 1987a; 1987b; 1988), wherein the skillful use of questions invites the participant into the agentive position of meaning making; and how the relational tradition focused on the *hermeneutic* skills of the therapist to respond with well-timed, empathic interpretations with the participant being positioned as the rhetorician (Boscolo & Bertrando, 1996).

I agree with Drewery (2005) that:

> The professional practice of teachers of counselling requires among other things close analysis of what is therapeutic about conversations: we need to distinguish, and thus teach our students to distinguish, between different kinds of responses and different kinds of conversational moves. We need to be able

> to say clearly why one way of speaking is more therapeutic than another (p 306).

In order to do this Drewery turns to positioning theory, "a body of writing that centres on the use of positioning as a conceptual tool." Positioning theory can be used to understand how subjectivities are produced through conversations and how preferred identities are taken up. Drewery is particularly interested in "the production of relationships of respect" and the ways in which language can be used to call people into "agentive subject positions". She refers to "position calls" to describe the micropolitics of everyday conversations in which people routinely accept or decline being positioned within discourses. Drewery suggests that therapists are "discourse users whose sensitivity to language is brought into service to invite their clients into an agentive position in relation to the problem with which they are concerned" (p. 318). From a relational perspective, therapists also need to be sensitive to the rhythm and music of nonverbal communications and to hold in mind the subjective experience of the participant (Schore, 2005). As discussed by Bacal (1998c) in relation to his concept of optimal responsiveness, everything a therapist does or says (or does not do or say) is a form of communication. Similarly, everything a participant does or says (or does not do or say) is a form of communication. In this sense, contrary to Freud, therapy is not the talking cure, but the *communicating* cure (Schore, 2005). The therapist communicates acceptance or respect non-verbally and verbally, through actions as well as through words. The therapist also needs to be sensitive to affects, both to her own experience and the affects as expressed by the participant. In a similar way, if conversation is taken in this more inclusive sense, to

include both the verbal and non-verbal components of interactions, then it may be also possible to apply positioning theory to the many different A-R patterns I have identified in the stories. For example, Billy's call, "Can you get me a plaster Andrew?" calls forth a nurturing response. The participant initiates and I respond. It is an optimal response because it repairs the rupture in the relationship and moves the therapy process along. Similarly, a reflexive question invites people into "mentalising" positions, helping them to identify their intentions, desires, dreams or wishes. Or, when a participant lowers their head and sighs, this calls for some kind of empathic response.

In summary, there are two ways of analysing these interactions on the basis of who is doing the calling, or the invite. In the systemic and narrative therapies it is often the therapist who takes the lead, inviting a response from the client. In this form of practice the therapist is positioned as the rhetorician, the one who asks the question and the client is positioned as the hermeneutist, the one who provides the response, the making of meaning. When this process is reversed, it is the client who is doing the calling and the therapist is positioned as the one who provides a response. This response can be a natural, spontaneous response such as "would you like a cup of tea"? Or, it could be a well-crafted interpretation, such as "you feel as if no one wants you". To add an extra layer of complexity, it is also possible for the therapist to be mindful of calls coming from within, that is, internal cues, such as a physical sense of tightness in the chest and shoulders, and in this case the therapist plays interpreter to her own internal cues and might say silently or out loud, "I am feeling anxious".

13.5 Intentional self-disclosure and hegemonic masculinity

Although adolescent treatment literature is now emphasising the importance of creating psychologically safe relationships through creating a trusting therapeutic relationship with an empathic therapist and providing a new or corrective emotional experience for the young person (Ryan & Lane, 1997a), the place of therapist self-disclosure in adolescent sexual offending treatment is rarely researched or discussed in any detailed or meaningful way. I have previously discussed how our subjectivity always enters the therapy relationship, whether we like it or not; we will always be communicating certain aspects of our personal self all the time, from the clothes we wear, the accent we speak in, to the inner thoughts that flow through our mind that are not usually disclosed. All this will be expressed through our non-verbal communications (Schore, 2003a; Winslade et al., 1997). The stories show how *self-disclosure* was ubiquitous to the therapy process, in the sense that the therapist cannot *not*, self-disclose. However, in this section the focus of my discussion will be on *intentional* self-disclosure. The stories suggest that intentional self-disclosure can deepen the connection experienced in the therapeutic relationship, and give the participants in the therapy process the experience of being treated as equal partners. It can also model the use of self-reflection, by communicating the therapist's subjective experience in the here and now, or telling a story about the therapist's experience when he was a young man. I also found that the judicious use of intentional self-disclosure can be a way of facilitating reflection on cultural discourse, especially in relation to the effects of hegemonic masculinity on the participants. Because of my personal experience of male culture and my personal experience of being a son and a father, I often found myself resonating in response to the stories

being told by the participants. For example, the fact that my father had sexually offended was a factor that enhanced my ability to identify with the participants non-judgmentally. It also aided my ability to empathise with the participants' own sense of shame. I also drew on my own experience of male culture and my experience of being a boy, a son and a father, to respond to what the participants were disclosing.

I used intentional self-disclosure in a number of the sessions. For example, when talking with Peter about shyness, I make a fairly lengthy self-disclosure as preparation for inviting him to make a link between his use of alcohol and his experience of shyness:

> *"But we do know there was a time when you didn't worry too much about what other people thought about you. Because when you think about it, there is a relationship between shyness and self-consciousness, or even worse, self-criticism. Like with me, I have always worried about not being good enough in many areas of my life, especially in music. For most of my life I have found it difficult to perform in public when singing songs and playing my guitar. My hands would shake and my body would be frozen in tension. It's only been over the last few years that I have relaxed more when playing in front of people informally but put me on a stage and it's still the same. I think that's because I'm so critical of my playing that I can't just let myself go into the song. So, coming back to alcohol then, do you think alcohol is the solution to the problem of shyness?"*

Peter's story also illustrates how sharing my story about self-consciousness in relation to performing also helps to consolidate our relational bond. The intentional use of self disclosure can also help to facilitate the experience of mutual empathy and encourage greater levels of self-disclosure by the participant. For example, Jamie's story concludes with an intentional self-disclosure regarding my father's offending. I think the disclosure was well-timed and gave Jamie a sense of acknowledgement, as somebody whom I considered trustworthy to share such information and also to provide him with an opportunity to be empathic towards me. The story suggests that empathy can be a mutual experience and illustrates how the sharing of personal stories transforms both participants.

The stories often touched on issues of male culture, in particular the effect of gender hierarchies, in particular homophobia (Connell, 2000), on the participant's experience of self. The concept of "hegemonic masculinity" (Connell, 1995, 2002) was a useful way of understanding how gender relations shaped the subjectivity of participants and therefore the meanings that participants made from their own experience of victimisation and how this may have contributed to their own offending behaviour. The sociocultural concept of hegemonic masculinity also complemented the neurobiological and developmental-psychological concepts of abuse related trauma, insecure attachment and Benjamin's (1988; 1990) theory of intersubjectivity as discussed in chapter three. The effects of hegemonic masculinity provides a complementary understanding, alongside the effects of abuse related trauma and insecure attachment, of why some of the boys and young men on the programme found it difficult to contact and express their feelings and to show empathy towards others. According to Benjamin (1990), intersubjectivity is a developmental

achievement which involves a relationship based upon mutual recognition, not domination. These theories helped me to understand how many of the participants found the expression of vulnerable emotions, commonly referred to as feminine, a difficult challenge. Adolescent sexual offending could therefore be understood as a reactionary act of self-formation, intended to define one's place in the hierarchical order of masculinity and a form of domination over the weaker feminised other. My interventions in the stories were influenced by these different theoretical perspectives. The construction of masculinity as strong and active and femininity as weak and passive, reinforced by such cultural institutions as religion, sport, Hollywood and the family, can be seen being reenacted in the stories told by Adrian, Peter and Jamie. Jamie and Adrian's fear of being seen as "gay" and Adrian's sense of accomplishment in running the gauntlet are examples of the force of hegemonic masculinity to shape the adolescent's fragile sense of identity.

In Adrian's narrative I was emotionally touched when he began to tell the story of his parent's relationship with each other and his relationship with them. In particular, I was touched by Adrian's identification with his father, which reminded me of my own relationship with my father. This scene brought forth my associations with the film *Rebel without a cause.* In this movie the son perceives his father's "weakness" through the lens of hegemonic masculinity. Adrian both identifies with his father and, at the same time, wishes to destroy that identification. The conflict builds both at home and at school. At school he is subjected to homophobic teasing and at home he witnesses how others view his father as weak and lazy. Hence he experiences running the gauntlet, that traditional masculinist (abusive?) initiation ritual, as a positive and validating experience. Rather than challenging this directly,

which would have been misattuned to his subjective experience, I waited until Adrian retells in therapy how he discloses his offending behaviour to his girlfriend which leads to his girlfriend disclosing details of her own sexual abuse. Adrian tells how he supports her in this. Near the end of the story I respond by inviting Adrian to reflect on his actions and compare them to running the gauntlet, and he states that disclosing to his girlfriend was a more important step towards becoming a man than running the gauntlet. This provides a foundation for developing a different story of what it means to be a man than that provided by the gauntlet. This positive outcome was contributed to by the way I was able to empathise with how important the gauntlet experience had been for Adrian. It would have been easy to explicitly question his enthusiasm for the experience. However, this would have been I think, a less than optimal response. However, waiting till another moment arises, later in the session, and juxtaposing these two affirming experiences, allows Adrian's values of care and compassion to be more richly articulated.

Similarly, Peter's story illustrates how he was able to acknowledge experiences and skills that are usually expressly prohibited for boys by the dictates of hegemonic masculinity. He is able to speak about his vulnerable feelings of being "let-down". He also shares how "crying it all out" has helped him to cope with the let-down feeling. I provide a mirroring response and name this practice as a skill and an expression of strength, helping to build Peter's self-esteem. My intentional self-disclosure shows that, like Peter, I also struggled with social inhibition when asking girls to dance when I was a boy, and how I also saw myself as a "shy" person. This is an example of how the effects of hegemonic masculinity (it is "sissy" or "gay" to like

ballroom dancing or ballet) are internalised as psychological deficits.[10] Peter's story also illustrates how consuming alcohol, a practice which is congruent with hegemonic masculinity, also enables the overcoming of social inhibition. However, in considering the effects of alcohol, such as disinhibiting the social restraints around violence, Peter was able to resist hegemonic masculinity. Also, the conversation highlights how the experience of a mutually respectful, intimate relationship with his girlfriend Sarah, was also an antidote to feelings of shyness and shame. Interestingly, the reference to feeling inhibited around eating evokes associations of his relationship with his father, who could at times be violent and shaming, demonstrating how attachment relationships, as well as sociocultural discourse, are formative of our sense of self.

Finally, Jamie's story shows how the impact of sexual abuse on boys and men is complicated by the culture of hegemonic masculinity. For boys who are sexually assaulted, apart from the initial trauma of the event, the meaning of the event is filtered through the lens of hegemonic masculinity and this affects the way they come to view their masculinity and their sexuality. Most boys in our culture would view their masculinity as having been diminished, and they fear they are now destined to become homosexual. Sexually abusive behaviours then become understood as misguided attempts by adolescent boys to re-affirm their lost sense of power and control or in some cases to "prove" to themselves they are not homosexual. For a boy who is already insecure, being a victim of sexual assault only thickens a negative story of self such as personal failure, by comparing himself to the

[10] It would be interesting to research contemporary dance forms, such as "rap" or "hip hop" and to explore their relationship with hegemonic masculinity.

specifications of hegemonic masculinity. It is unlikely that Jamie would have been able to disclose these feelings and make these links, without the level of trust he experienced with me as a male therapist. It is not easy for a man to disclose he has been a victim of rape. Jamie was also able to respond to my intentional interventions, so that when I asked him in what ways the rape had "affected how you think about yourself?" he was able to articulate how he wanted to prove that he was still straight and not gay. This then enabled us to externalise homophobia and hence helped Jamie to develop the capacity to critically reflect on male culture.

13.6 Playful improvisations and the experience of intimacy

Meares (2005) argues that one of the signs of progress in therapy is the feeling of flow, the sense of "inner aliveness", and how this is communicated through the quality of the therapeutic conversation (p. 18). Abuse related trauma, in this account, takes away an ability to reflect inwardly. Reflection is a higher function, easily lost. The ability to connect is also lost because an awareness of inner life allows others to connect with us (p. 89). It was very hard going sometimes to feel a sense of connection with Billy, because of this lack of awareness of an inner life. According to Meares, restoration of a healthy sense of self is often signaled by an ability to play and this is reflected in the quality of the therapeutic conversation:

> Therapy is a means of enabling a play-like mental activity to begin again. Therapy, ideally, establishes a play space in which can be generated an experience of selfhood which Jane Goodall believes may be unique to the human primate. It depends upon the exchange of that which is most 'inward,'

> the meaning of 'intimate.' Intimacy is an interplay between people who know the experience of self. The play, in this case, is with symbols which we use in our ordinary conversations without noticing what we are doing. Such interplay is necessary to the maintenance and growth of self (p. 163)

Mears argues that people who have been damaged by the early circumstances of their lives have often not reached the maturational level of symbolic play. An earlier stage of maturation must be activated first. Therapy can provide a form of relatedness equivalent to the non-verbal proto-conversation experienced during infancy (p. 170), however this cannot be modeled on the mother-infant interaction.

Meares believes the parent's responsiveness (as with the therapist's responsivity) can be described as a three phase process of *coupling* (joining in with the positive affect), *amplification* (amplifying the positive affect) and *representation* (starting with facial expressions representing emotions):

> Coupling is a conversational linking to the most 'personal' aspect or element of what has just been offered … the therapist must also be unfocused and aware of a series of themes of sensations, perceptions, feelings, imaginings, and memories. This state includes the capacity to notice changes in one's self as the patient's story is being told and, as it were, to become a spectator to those experiences (p. 176-177).

Meares encourages therapists to stay with the client's experience and to use the client's words, perhaps elaborating on them. "Amplification typically includes the

enhancement of positive affect, which is very often muted … A principal feature of amplification is that it gives value." (p. 179). Representation refers to the attempt to empathise, to portray through the use of metaphors, the emerging inner world of the client. Meares argues that "the therapist's capacity for empathy is the principal agent of beneficial change in the patient" (p. 181). The attention of the therapist shifts to representing the inner life of the client (equivalent to the symbolic play space). The use of metaphor is a crucial part of this process of the transformation of thoughts into visual images:

> Metaphor is necessary to the empathic process since the intangible movements of inner life can only be conveyed by means of things that can be seen and touched. Emotions, at the bottom, are always expressed in terms of metaphor (p. 182).

Early pretend play in children is significantly related to the development of the reflective function, an understanding of other people's feelings and beliefs. People affected by abuse related trauma are often lacking in empathy for self and others. Meares argues that the communication of feeling tone is more important therapeutically than the construction of meaning.

The trauma is dissolved through the process of creating a play space within the therapeutic conversation in which the client can reconnect with previously compartmentalised parts of the self. The on-going effects of traumatic memory can be inferred from the quality of the conversation:

> When traumatic experience underlies the conversation, the language becomes a limited form of 'social speech' taking the form of 'chronicles' or 'scripts'. The consciousness, as Janet put it, is constricted. A second major difference, of course, involves reflective awareness, which is lacking in the traumatic state …
>
> Traumatic memory … remains sequestered, unable to mingle with the experience of self …The traumatic memory system must change in its form so that it becomes more like reflective or dualistic consciousness, allowing it to mingle, or, as it were, to dissolve in it. In order to allow the dissolution of the traumatic material into the consciousness of self, it is necessary to have a self present in the first place, into which the destabilizing and diminishing memory system can be integrated. The establishment of self must be a priority. Self is not a fixed state. It comes and goes … a particular form of relatedness with others is necessary to the generation and maintenance of self. That kind of relationship has the quality of empathy (p. 194- 195).

In summary, Meares argues that the experience of self arises in the context of a particular form of relatedness. This particular form of relatedness is mediated by an empathically attuned conversation. This way of talking together, and the relationship from which it emerges is, therefore, the transformational element.

In my work with Billy, it was difficult to experience a verbal therapeutic conversation in which intimacy could be mutually experienced because of the effects of abuse related trauma. I therefore had to find more optimally responsive ways of engaging him, working on a more bodily and intuitive level, mediated by the right

hemisphere of the brain, which is responsible for our emotional experience in intimate attachment relationships (Schore, 2003, 2008; Siegel, 1999, 2003). One of the ways I made use of myself to create an experience of intimacy was through the spontaneous expression of acceptance and care and the spontaneous engagement in playful improvisations. My subjective experience of acceptance and care helped to facilitate a similar experience of self-acceptance and self-care for the participant.

The stories show how my subjective experience of *acceptance and care* or *compassion* was foundational to practice, especially when I experienced a *mutual experience of caring* to be present. This occurred when I knew, that the participant knew, that I was experiencing and expressing care. This captures the experience of the intersubjective, of "being with" the participant through the sharing of similar subjective states (Benjamin, 1988; Stern, 1985/2000). The stories also showed how the experience of mutual care was a key relational experience that indicated to me that my responses had been optimal and therefore a process of mutual transformation was underway.

Generally speaking a caring holding environment is the responsibility of the therapist to create. Care cannot be turned on like a tap; it has to be genuinely experienced. The experience of care is usually initiated by the therapist, and the participant responds when they experience the therapist's expressions of care and emotional understanding to be genuine. Care and emotional understanding are expressed in a variety of ways: through the process of self-disclosure, ranging from facial gaze, tone of voice and attentive listening through to the expression of various forms of mutual understanding, including the sharing of personal and professional stories.

I was aware of the importance of practicing care on a foundation of non-judgmental acceptance and unconditional positive regard (Rogers, 1957). This is, of course, not always possible to sustain, given that the therapist, like the participant, is subject to emotional reactions based upon past experience. Spontaneous responsiveness was also central to my practice (Bacal, 1998c). Planned agendas would be set aside in order to allow myself to respond, as appropriate, in a more flexible manner. I quickly realised that trying to force a predetermined agenda was often not optimally responsive, and instead began attuning to the participant in the here and now. As the therapy progressed I also experienced the development of an affectional bond with the participant (Holmes, 2001) and became curious as to how the participant was experiencing their relationship with me, both over time, and in the here and now of the therapeutic session. In order to facilitate this process I also began sharing some of my experience of the relationship with the participant. This kind of intervention has been described as a form of "metacommunication" (Safran & Muran, 2000), that is, communicating about the therapist's own subjective experience of the verbal and non-verbal communicative process, hoping to open up these experiences in an accessible way to the participants for discussion. It could also be described as a form of intentional self-disclosure, as discussed in the previous section, as, for example, when I acknowledged to Billy that I was experiencing a feeling of being unwanted and wondering if this was how Billy often felt. I was also aware of the importance of expressing non-verbal or affective communications – with the professional knowledge that it was crucial that the participants could see that I cared (Fosha, 2000; Schore, 2003a). I understood that it didn't really matter how much I believed I genuinely cared, if the participants could not see or feel that I cared. It is

doubtful that therapists can be of much help unless the participants have a conscious experience of being cared for or a sense of being liked and validated by the therapist (Bird, 2000; Rogers, 1957).

This sense of *caring for* and the experience of being *cared for* were therefore at the centre of the therapy process. Similarly, in my work with participants who were in out-of-home care, summarised in the composite character of Billy, I struggled to forge a connection. One possible explanation was that they found it much harder to allow themselves to experience being cared for. Given the personal and family history of many participants it was understandable that it would have been hard to trust the therapist. Many of the participants began the programme isolated and alienated from themselves and others. Some of them had closed the door, especially those participants like Billy who had multiple experiences of abuse, rejection, abandonment and shame. Rarely in their lives had they experienced sharing an intimate space with family members or friends. They were uncertain as to how to form close relationships with others, and possibly reluctant to form close bonds with others. Hence, a feeling state of aloneness was often pervasive. Facilitating connection was not always an easy task, having to overcome not only age and cultural barriers but also the participants' own protective strategies against feeling close to someone again.

I tried different ways of responding to find a way of connecting with Billy; for example, I engaged a number of times in playful improvisations. Billy was often lacking the capacity to engage in conversations generated by reflexive questions, hence I had to engage him in other more direct ways, involving sensorimotor skills such as ball games and other forms of physical play. However, Billy also responded

well to visual games, such as the game of "squiggles", which generated the sharing of positive affect. However, whenever I attempted to switch from embodied affective responses to reflexive questions Billy would again respond by withdrawing, as illustrated in the following excerpt:

> *"There," he said with a sense of satisfaction: "A two-headed shark." He drew a balloon from the mouth and in the balloon he wrote the words: "I want to eat you up."*
>
> *"Who is the shark and who does the shark want to eat Billy?"*
>
> *"I dunno."*
>
> *"And why two heads, do you think?"*
>
> *"I dunno."*
>
> *When Billy had finished the drawing he said, "Can we play ball now?"*
>
> *I replied, "I think you are changing the topic. What are you feeling right now?"*
>
> *"I dunno."*

In this series of A-R interactions, my attempt to introduce reflexive questions was not optimal, as can be witnessed by the participant's blunt responses. I would probably have done better to have tried an empathic communication such as "maybe you are afraid someone is going to hurt you". However, I picked up on the participants cue and tried a playful improvised response instead, which created a feeling of safety:

"I know. How about we play a little game? How about you pretend to be the shark and I ask you some questions. Is that okay?"

"Alright."

"Hello Mr. Shark, what big teeth you have!"

"All the better to eat you up with!"

We both laughed.

"Mr. Shark, I would like to be your friend, but I feel you want to chase me away whenever I get close."

"Go away!"

"Okay, okay." I decided not to push too much – in my experience Billy would only withdraw even more if I tried to push too far.

"You sound angry Mr. Shark. Are you feeling angry?"

"Yes!"

"Let's play some more then. Maybe that way you will trust me better and then you might change into a playful dolphin!"

So I suggested we play hand-football. He enjoyed this game, especially when he was winning. Near the end of the game, he started to gesture like a gorilla. I joined in the game, down on my hands and knees. He laughed at me beating my hands on my chest, imitating a gorilla. Then he started to beat his chest with his fist and again I joined him. Before long we were both laughing and enjoying ourselves immensely.

In the above excerpt, I succeeded in engaging Billy in a playful conversation but when I tried to engage Billy in reflecting on his feelings, again, he pulled away. So I

returned to engaging Billy in a playful improvisation involving gorillas, resulting in a mutually enjoyable experience.

I therefore tried many ways to form a connection. For example, in Billy's story, when I was feeling disconnected, I went to get a plaster at Billy's request from the First Aid Kit. Looking back at this scene, my actions can be understood as expressing my emotional understanding – an embodied affective communication – the spontaneous expression of care. Billy was able to communicate his need for this kind of nurturing action, which was exactly the kind of response he had not been receiving from his foster carer. My experience of acceptance and care seemed to arise together. Perhaps these are both elements of compassion - without acceptance we cannot care. Without care for the other there can be no acceptance. I think this also involves an ability to be self-accepting on the part of the therapist (Safran & Muran, 2000). Billy's story shows how my ability to practice acceptance (and tolerate Billy's anger) creates a context for the participant to begin the process of accepting themselves (Safran & Muran, 2000). This can be complicated by a resistance to being cared for and accepted, because of previous ambivalent experiences with caregivers. If the experience of being supposedly "cared for" was also associated with the experience of being hurt, then to surrender to someone else's care was not always an easy option for some participants.

So I learned about the importance of practicing *with* care and acceptance. It was not an "intervention" that could be learnt. It had to begin with my acceptance of my own uncertainties and insecurities; the fact that I did not have *the* answer, or *the* intervention to fix the problem (Magid, 2008a). Partly, it was about creating intersubjective spaces of acceptance and spontaneous play, a transitional space where

therapist and participant could find a way to connect (Meares, 1993). Playfulness often generated the possibility of sharing positive affect, the pleasure, the excitement of entering a play world together. Laughing together and enjoying each other's company. Knowing with the participant that the experience of enjoyment or intimacy was a genuine, mutually *shared experience* involving a process of *joint actions*, had a powerful therapeutic effect. Spontaneous unstructured play activity helped to create the attachment bond. This could also be understood as a form of *mutual responsivity* (Katz & Shotter, 2004). If the participant enjoys the session, he looks forward to the next session; hence he begins to miss the therapist or to look forward to seeing him again. A genuine relationship is created.

These spontaneous expressions of acceptance and care and playful improvisations laid the ground for new relational experiences, in which I had the felt sense that something significant had been communicated that was mutually connecting and moved the therapy process on in a positive direction. These interactions may be entirely non-verbal and can sometimes happen outside of the conscious awareness of both the participant and the therapist. Spontaneous expressions of emotional understanding, such as the plaster story, demonstrated key turning points in the sessions and possibly in the therapy. The first challenge therefore, when I met with a participant for the first time, was to move from the feeling of being the "other", of being strangers to each other, to experiencing what Martin Buber called a genuine meeting (Orange, 1995 p. 20-21) and what Benjamin (1988) refers to as the intersubjective sense of "being with" the participant.

13.7 Self-reflexivity and re-membering

Aron (2000) reviewed the literature on self-reflexivity in the psychoanalytic tradition. He views therapist self-reflexivity as a significant contributor to therapeutic action; also for Aron, the final and most important outcome for a client is the development and maintenance of self-reflexivity. Self-reflexivity involves a "meeting of minds". It involves the embodied self and the verbal self; the self as subject and the self as object; the other as subject and the other as object; the intra-psychic and the intersubjective dimensions of consciousness. Aron uses the terms *intrapsychic* and *intersubjective* as Benjamin (1995) defined them, " to refer to two types of relationships to the self and to the other, two complementary modes of experience, in which individuals relate both to the self and to the other as both subject and as object" (p. 668). He links this conceptualisation of the self to William James. James viewed the "me" as referring to the sense of the self-as-object and the "I", as the sense of the self-as-subject. The sense of the self-as-object, is what is known (and how we may feel others know us), and the sense of the self-as-subject is the knower and the doer:

> Reflexive self-awareness, or self-reflexivity, is the capacity to move smoothly between subjective and objective perspectives on the self … To love, one must be able to experience oneself and the other as separate yet related and similar subjects, whereas to lust, one must be able to experience the other as an object of one's desire and one must also be able to "let go" of one's own self-as-agent, in charge and in control … (p. 673-675).

Self-reflexive *awareness* refers to the ability to hold in mind both the sense of the self as subject and the self as object and the other as subject and object. Following Winnicott, Benjamin (1988) argues that a child learns to reflect on her mind (and her mother's mind) because another person regards her as having a mind to reflect on. Self-reflexive awareness can be interpreted as intersubjective or relational mindfulness: a key skill in therapeutic practice (Safran & Muran, 2000; Hughes, 2007).

Self-reflexivity therefore refers to the ability of the therapist to be mindful of both his own internal cues, thoughts and feelings and the participant's subjectivity, expressed through his responses and cues on a moment by moment basis. This can be understood as the practice of intersubjective mindfulness:

> What I am describing is intersubjective mindfulness. The therapist is fully in the present moment, accepting whatever presents itself, being curious about what she is being aware of, having compassion for self and other. In contrast to the more traditional centers of awareness in mindfulness (breathing, sounds, a tree), in this situation the subjectivity of the present other is the center of awareness, along with one's own subjective response to his or her subjectivity, and the other's subjective response to one's own subjective response. (Hughes, 2007, p. 97).

This flow of sensation, feeling and inner conversation is available to the conscious awareness of the therapist prior to making an intentional intervention (there may also be processes occurring simultaneously that the therapist is not aware of). In this section I identify and discuss in relation to the stories the practice of intersubjective mindfulness, specifically my

awareness of my own flow of thoughts and feelings, including drawing upon a stock of background knowledge relevant to the interactional sequence.

I was struck by how my feeling of self-worth and competence as a therapist was directly linked to the responsiveness of the participant I was working with. In this way, when I experienced the participant as a positive self-object, it helped to facilitate the flow of the therapy process; when I experienced the participant as a negative or critical self-object, it impeded the flow of therapy. It was also my awareness of the quality of the responsiveness of the participant that indicated to me if I was being optimally responsive or not. I became aware of how the non-responsiveness, or the hostile responsiveness of the participant, had an impact on my self-confidence in my ability to be therapeutic , illustrating how responsiveness is a two-way street and how the therapist also depends upon a certain amount of positive responsiveness from the participant (Bacal & Thomson, 1998). For example, in the following interaction with Billy I am aware of my self-state becoming increasingly disillusioned in response to Billy's aggressive and dismissive self-state:

> *"Look Billy, don't take it so personally. It's the contract that you signed when you came on the programme. It's not just you; the rules apply to all the guys on the programme. It clearly states that you are not allowed to be alone with children unless it is with an informed adult." I sounded like a lawyer, I thought, distant and somewhat aloof.*

I am also aware of how my own communications have a frustrated tone, exacerbating the disjunction:

> *"Look, you are putting yourself in a seriously risky situation. However, we could inform her father about your past offending." I immediately regretted this response. It felt like an indirect threat, expressing my irritation and the power imbalance in our relationship.*
>
> *"No way!"*
>
> *"Well then, you'll just need to follow the rules." I felt I was colliding into Billy, rather than working collaboratively.*

At the same time I am aware of the subjectivity of the participant I am also simultaneously aware of my own disillusioned self-state:

> *I noticed that Billy had been picking at a scab on his knee with a sharp metal object he'd found in the room. Billy had a bad habit of "picking" at his scabs. At the same time I felt heavy hearted; tired. I noted a familiar negative thought passing through my mind: You are not helping this boy - You are a lousy therapist.*
>
> *I knew this voice well, the voice of self-criticism, aiming to expose me as an incompetent, fake therapist. I knew it well because it was often around. It complained, this is a hopeless therapeutic conversation. You can't even ask one decent question!*

The participant's non-responsiveness, or hostile responsiveness, was often experienced as a form of disruption to the relationship or profound sense of disconnection from self and others (Meares, 2000). This led me to identify this experience as being part of the *disruption and restoration cycle* that has been noted by a number of relational therapists (Safran & Muran, 2000; Wolf, 1988, 1998). My sense of professional failure is related to the degree to which the participant is experienced as being non-responsive; however, when I am able to facilitate restoration of the therapeutic alliance, the sense of well-being also returns and I no longer feel like a failure:

> *I found some tape and Billy instructed me how to do it. The heaviness I was feeling a moment ago was replaced by a feeling of tenderness. Billy also softened. He was being cared for. I sensed the lack of human warmth and tenderness in his life. I knew that Kate felt uneasy about close physical contact with Billy. I wondered when the last time was that someone had genuinely given him a loving cuddle …*
> *"Would you like to go for a walk and I'll get you a bottle of ginger beer?"*
> *"Yeah."*
>
> *He smiled. We were friends again. We walked down the street laughing and making small talk and we headed for the bakery which also had a fast-food take-away section. He looked hungrily at the sausages.*

In the above excerpt, I am able to let go of my own preoccupations and doubts and follow the lead of the participant. I notice how my inner landscape of feelings is

changing in response to how Billy's self-state is also changing. I also intuit Billy's need for affection and nurture. I know on a feeling level that my response is now hitting the mark, "resonating" with the client's feelings in a positive cycle of relationship repair. The rupture is mended and a feeling of aliveness emerges (Meares, 2005).

This example illustrates how the participants in therapy can send cues to the therapist as to what might be a more appropriate response. If the therapist is alert and aware enough to pick these cues up it can often produce rich therapeutic moments. When the participant was unresponsive to my interventions I felt at times hopeless, incompetent and self-critical. Before placing the plaster I was feeling disconnected, dis-empowered and irritable, and I had started to resort to using power over tactics. I was also caught up in my own professional self-doubt and criticism. The plaster transformed this back into a sense of being connected again. A feeling of professional competence and well-being returned. In this case it happened to be a nurturing interaction. I then cemented the bond with the sausage buying ritual.

How do we explain this from a relational perspective? I think the interaction with the plaster takes me out of my professional self (*thinking* about what to do or say) and I just respond without deliberation. Maybe I was attuning and responding to Billy's communications outside of my conscious awareness. However, I would also like to consider why Billy was so angry at the beginning of the story. I think he probably felt betrayed. In some of his sandtray work Billy had consistently used soldiers to depict two forces at war. He often experienced Child, Youth and Family Services as one of the enemies. He wanted me to be on his side. He was therefore hurt. To be reminded about the hygiene issues must also have been humiliating for

him. Billy's trust in me had therefore been seriously compromised. This highlights the fine line therapists working in this specialised field have to walk, wanting to be seen as aligned both with the participant and the community. It is our accountability to victims and to community safety that takes precedence in the final instance – hence the need to help Billy see this also. My internal voice of self-criticism is triggered in Billy's story when I begin to understand Billy's feelings of betrayal. My sense of despair and failure was also triggered when I experienced Billy as withdrawing behind his defensive wall. In the story Billy has become defensive and some would say resistant. He is resisting my invitation to work in collaboration. Collaboration is one of the goals of most therapies, no matter who the participant is. It is crucial that the participant is engaged in the therapeutic process. My attempts to engage Billy in taking responsibility to monitor his own situation and to make sure he doesn't put himself (and therefore, someone else) at risk only serves to alienate him. I feel his pain, his isolation. Part of me feels that Billy can be trusted, that his relationship with the neighbourhood kids is healthy. Yet the part of me that wears the risk management hat cannot risk this – it is still too early. I feel divided and disillusioned. I try hard to invite Billy to collaborate with me – to be on the same team – to share the responsibility of supervising his relationships with children, but my invitations are declined.

I think the story also illustrates how quickly I became aware that there has been a rupture in the relationship and I need to mend it, but I can't seem to find a way to do that with words. Hence I also become vulnerable to narcissistic wounding – I have failed as a therapist. I start to get caught up in thoughts that I am not making a

difference. I start to blame myself. The thoughts weigh heavy on my body – I feel like giving up.

Then by luck, or chance, or by the subtle movements that occur within the intersubjective space, there is a turning point experience - we have an opening into compassion and the nurturing act. Billy is picking at a scab, trying to distract himself, maybe, from the emotional pain of experiencing rejection and exclusion once again. He then shows me how to re-connect to him by the simple request of a plaster. This one simple act of attending to his wound creates an emotional experience for us both. It is a tender "moment of meeting" (Stern, 2004b). Billy visibly softens; the bitterness and the hardness dissolve in this simple act of kindness. This shared experience, experienced by Billy as a new experience, outside of what he would have predicted, mends the rupture and the therapeutic alliance is back on track. I believe this one act not only restored the relationship, but actually delivered a turning point in the therapy process. I showed that I did care and the participant recognised this care. Again this is reinforced by the regular walk to buy sausages, which begins a ritual that is repeated again and again in future sessions. This illustrates how actions sometimes speak louder than words, especially joint actions, doing things together often communicate more than any word.

The stories also illuminated how I would draw upon my awareness of background knowledge to guide my response. This could be professional knowledge, such as developmental theory or wisdom that I had inherited from previous clients or personal experience knowledge gained from my life. For example, in the following excerpt, I am drawing on my professional knowledge:

At this initial meeting (as it was to be in future meetings) Billy found it hard to talk about his birth mother. As Billy narrated to me this brief chronicle of his life I thought about the emotional pain of rejection that must have underlain much of Billy's external behaviours, which Billy needed to dissociate from in order to maintain his hope for some future reconciliation. Unfortunately, the longer a child has been in foster care the more difficult it is to facilitate reunification with birth parents, leaving caseworkers and therapists with the only other alternative of trying to facilitate developmental attachment to foster carers.

Children who suffer from relational trauma often have difficulty forming intimate relationships, first with peers and later with adults. Relationships tend to be superficial and shallow. One person or object can easily replace another one. One way of understanding this is that they have not experienced an attachment relationship of any depth. Another way of understanding this is that it is a protective mechanism – you don't allow yourself to get too close to anyone – it hurts too much when you get let down! I sensed Billy's loneliness and simultaneously his fear of getting close in case he was rejected again.

I also often found myself in a position of recalling memories from my own family history and using this personal knowledge to help guide my responsiveness. This can be referred to as a form of "re-membering", both for the therapist as well as the participant (White, 1997). For example, when I was being interviewed by Michael

White in chapter five, I spoke about how I was able to re-member my experience of play with my parents and my own children in my work with the participants:

> I let my mind wander back again, remembering playing games with them, bringing back memories of playing games with my own parents: Monopoly, Risk and even before that card games and party games like "Old Maid". Dad was good at those games, good at birthday parties playing "Simon Says". I realised that the games I played with the children who consulted me at work had a lot in common with these experiences. I'd realised that the best way to connect with children before attempting any real talking therapy, especially if these children had a history of traumatic experiences, was to play with them.

The stories also illustrate how I drew on my memories of family troubles and shame to empathise with the participants:

> Although the content is different, Adrian's descriptions of his parent's relationship remind me of my own parents after my Dad had lost his teaching job because of the offending. I re-remembered the sense that my Dad had been disgraced in the eyes of my Mum. Although my Mum never mentioned the offending, her feelings of resentment came out in the tone of her voice, in the way she used to sometimes criticise Dad. This shared experience enabled me to get some sense of what it must have been like for Adrian to witness these parental fights.

> Adrian's sense of shame or embarrassment about his father reminded me of my own struggle to come to terms with my own sense of shame regarding my father. I felt this was something we had in common, something that helped me to understand him. The association with James Dean from Rebel without a Cause came into my mind. I recalled how the son in the movie perceived his father as weak, symbolised by his wearing the apron – symbol of the subjugated feminine. Our fathers didn't measure up to hegemonic masculinity – they had fallen from the status of hero and their vulnerabilities had been revealed.

My background knowledge therefore covers an enormous range of prior experience and learning, ranging from professional training and reading, to prior work with clients in similar situations and the full extent of my relevant explicit autobiographical memories as well as my implicit procedural memories (relational templates) of how to engage in playful interactions with children.

13.8 Conclusion

In this chapter I have argued that the use of self intersects both the systemic-narrative and relational psychotherapy traditions, and enables the therapist to move flexibly between these two traditions to provide an optimal therapeutic response based upon the unique circumstances of the here and now moment. All interventions are required to be introduced with sensitivity to the relational context and the timing

must be appropriate to the moment. Interventions can be taught, but the *relational knowing* (Smith, 2004) that is involved in when and how to introduce an intervention, is a form of practice wisdom. I have therefore located the use of self in the judgment-based practice tradition and related it to the concept of phronesis. I have shown how the use of self mediates the action-response (A-R) cycles within which the therapist both initiates interventions and responds to the initiatives or responses of participants. I have analysed how this works with intentional interventions, such as reflexive questions or interpretations. I have suggested that both the concept of position calls and optimal responsiveness offer principles to help therapists to distinguish between positive and negative therapeutic interventions. I have also shown how the intentional act of self-disclosure not only helps to build safety and trust in the therapeutic relationship, but can also offer a pathway into conversations which invite participants to critically evaluate the effects of hegemonic masculinity on their sense of personal identity. The use of self was also intimately involved in helping me relate to the participants through playful improvisations, often re-membering my own memories of playful interactions with my father and my sons. Finally, I have identified self-reflexivity and the capacity for intersubjective mindfulness to lie at the heart of this process.

14.

DISCUSSION AND IMPLICATIONS

14.1 Introduction

In the previous chapter, a meta-analysis of the autoethnographic stories illustrated how my use of self in adolescent sexual offending therapy enhanced my ability to be optimally responsive. The stories showed how I became emotionally engaged in the therapeutic relationship with the participants in order to generate intersubjective experiences which were possibly transformative of both the therapist and the participant. I also discovered as an outcome of this research how the therapist is influenced by the responsivity of the participant as the participant is influenced by the responsivity of the therapist. This is in contrast to the earlier tendency in sexual offending rehabilitation literature to conceptualise therapy as a one-way process where the therapist applies certain procedures or techniques (cognitive restructuring) to change, correct or "fix" the participant (offender) in some way. The stories presented in this thesis show how the subjectivity of the therapist enters into the therapy process and how therapy works as a mutual process of change. I have included stories of events from my personal life, in order to provide an autobiographical context for understanding some of the influences on my use of self as a therapist, and to directly show the impact of my professional life as a therapist on my personal self. However, the act of writing these stories also worked as a form of self-therapy for me, helping me resolve the original trauma of discovering that my father had been a "sexual offender". This PhD has completed putting this trauma into the larger context of my personal and family history. In this way the trauma is

gradually dissolved (Meares, 2005) by becoming one of the chapters in my personal story. This personal journey models and parallels the process of therapy that the participants also had to go through. The autoethnographic research therefore deconstructs the conceptualisation of therapy as a "them and us" process, exposing the therapist to the same level of vulnerability as the participant. The therapist, like the participant, is human, all too human. This thesis therefore stands as a case study of a therapist's experience of being changed by therapy and by research and how my research into the use of self contributed to the ongoing integration of my professional and personal self.

In this final chapter, I will discuss the findings of my research in response to the second research question:

> *How might research into the therapist's experience of their use of self in therapy contribute to the integration of the personal and professional self of the therapist?*

As far as I am aware, this is the first time that autoethnographic methodology has been applied in the field of adolescent sexual offending therapy to investigate this kind of question. My stories show the process of the integration of the professional and personal self of the therapist and how this interweaves with the use of self in therapy as described in chapter 13. I then discuss the implications of the research for policy and practice in the area of sexual offending therapy. I emphasise, on the basis of the research, the need for therapists who work in this field to develop their capacity for self-reflexivity in order to develop self-knowledge and skills for the use of self in

therapy. Finally, I conclude with a discussion about the limitations of this kind of research and the need for further research on this topic.

14.2 The autoethnographic journey

In recent years, with the growing acceptance of feminist, narrative, reflexive and autoethnographic research, interest has grown in the use of self in research, including research into psychotherapy and mental health practice (Etherington, 2004; Foster et al., 2006; Holman Jones, 2005; Speedy, 2008; Wolsket, 1999). Engaging in this research project enabled me to clarify not only the importance of the person and subjectivity of the therapist to the therapy process, but also to revise my professional identity as a therapist/researcher.

Professional development, practitioner research and supervision can be seen as a process of continually revising and refining the story of one's professional identity (Crocket, 2004a, 2004b; McKenzie & Monk, 1997; Winslade, 2002). The process of writing this thesis is one example of practitioner research in action and shows how the writing of autoethnographic stories was constitutive of my professional identity as a therapist/researcher and also how this writing also made a significant contribution to helping me work through my personal story in relation to my own family.

I found that writing is itself a method of inquiry, that leads to the discovery of new meanings and the development of ethical and reflexive selves (Etherington, 2004; Richardson, 1994; Richardson & St. Pierre, 2005). Autoethnography is a research method that calls for self-reflexivity; however, practicing autoethnography also develops the skills of self-reflexivity. For example, the findings of this research

(the autoethnographic stories) have enabled me to story myself as a therapist who works from within and between different traditions and perspective. I also discovered that when autoethnography is used to research the relationship between the personal and professional self of the therapist, it can function as a form of self-supervision (Lowe, 2000). For example, autoethnography increased my awareness of the relationship between my personal life and my professional life. There are numerous examples of how I drew from my personal experience when interacting with the participants, as detailed in chapter 13. Autoethnography allowed me to articulate my experience of therapy as a "two-way" change process: firstly, by describing the relationship between my personal life and my professional experience as a therapist; secondly, by giving detailed description of therapy interactions within the framework of a first person narrative account; and thirdly, by giving expression to the unique voice of the young people I worked with, thereby challenging the dominant cultural practice of dividing people into "us and them" categories in which the "other", seen through the lens of deficit, is understood as being very different to ourselves.

My participation in the adolescent sexual offending therapy programme, along with my research project, were significant chapters in my personal and professional development as a therapist, helping me to integrate and acknowledge how both the systemic-narrative and the relational tradition continue to inform my practice as a therapist. As demonstrated in chapter 13, autoethnography contributed to my ability to work on this integration process over the six year period I have been involved in this project. During this period I have found that my personal and professional selves are intimately related (Edwards & Bess, 1998 p. 99). If this is the case, it is therefore not possible to evaluate therapeutic processes without taking into account the person

and subjectivity of the therapist. Good practice therefore needs to be founded upon the competent and ethical use of self. As my analysis in chapter 13 shows, this required me to engage in an ongoing self-reflexive process, both of my own emotional and cognitive experiences, of cultural discourses, of professional knowledge and of the emotional and cognitive experiences of the participants, as well as their own knowledge of themselves, their families and their cultures. It was my intention to create a context in which the other participants in the therapy process experienced themselves as equal if not senior partners in this process (Winslade et. al., 1999).

The development of an ethical and self-reflexive professional self requires ongoing practice, commonly referred to as professional development. Therapy becomes a means towards caring for the self (and by implication, the other), albeit a particular, professional form of caring, in the same way that Zazen practice can be described as another means of caring for the self or cultivating one's attention to *this moment*, which is complementary to the practice of therapy. Or, to use the language of Habermas, therapy, undertaken as a practical and moral activity, can be described as an emancipatory dialogue characterised by the practice of reflection on self in relation to others (Habermas, 1971). Therapy is therefore positioned within an ethical and political discourse. Within an ethical-political discourse, the participants are invited into a position of equal partnership (or even senior partnership) in the relationship, giving them the freedom to be the author(ity) on their lives and relationships (Winslade et al., 1997). The effective use of self must therefore be founded upon an ethics of emancipation.

Therapy is therefore founded upon a competent and ethical use of self and the development of a collaborative therapeutic relationship. The therapeutic relationship provides a context for the growth of self-awareness and self-reflexivity for both the therapist and the participants. The therapist, through their own reflexive use of self, demonstrates a practice of self-awareness and self-acceptance which is communicated to the participant. This is why I conclude that all good practice which relies upon interpersonal communication has to be founded upon the competent use of self and the ability to enter into ethical-professional relationship. Practice techniques can be taught but we need to be careful that they do not become disembodied, reified and de-contextualised (Bird, 2000; Safran & Muran, 2000). For example, the choice to self-disclose is always dependent upon the relational context existing at that moment in time. At its core, it is a response, coming from our emotional understanding of that particular moment, as discussed in chapter 13.

The practice of autoethnography, (writing and reading the stories), confirmed for me my preference for understanding therapy as a practical-moral activity, situated within an ethical-political discourse rather than a scientific discourse. (This does not mean that therapy cannot be researched scientifically using different methodologies or that therapists cannot draw upon scientific research, such as neurobiology and attachment research). This understanding of therapy was initially a legacy of the work of my first teacher, Michael White (1995; 1997; 2007). For example, it was important to me that the therapeutic relationship did not replicate other professional relationships in which the participant was subjected to the knowledge and expertise of the professional. I wanted to create a context for collaborative conversations that

would facilitate the ability of the participants to reflect ethically on their actions while at the same time I was conscious of not wanting to "impose" ideas on them.

Autoethnography was also an important form of clinical supervision, whether as a form of self-supervision, group supervision or in consultations with an individual supervisor. The development of self-awareness through writing and reflecting on this writing was both a form of self-supervision and a preparation for discussion of my work with my clinical supervisor. Reading the stories helped me to re-experience what I felt during the sessions. When I read some of these stories out loud to an audience I realised how much they touched me and moved me. Sometimes, when I felt hopelessly overwhelmed by my inability to make a difference to their situation, writing the stories helped me to contain these feelings. Discussing the stories in clinical supervision also helped, as did my Zen practice.

Zen is a practice that makes no distinctions between work and life. Working with my teacher enabled me to see the connection between empathy and ethics; how resisting cultural barriers to objectify otherness begins with the practice of empathy; how Zen itself has been described as a practice of "no gain"; and how this practice of no-gain can help me to step back from powerful invitations to try and "fix" people. For example, Dr Magid would often encourage me to bring my Zen practice into my work. For example, he would often ask me what my edge was. That is, what did I want to avoid in my work? One example I gave was the feeling that the help I was trying to provide wasn't helping. I was regularly witnessing people suffering and was feeling that whatever help I was offering was not making a difference. How to keep going under those circumstances? Dr Magid suggested I try disclosing my feelings of helplessness and failure with the participant. These feelings were possibly telling me

something about how the participants might be feeling, and I could share this with them. I also came to see this as part of my Zen practice, to be aware of these feelings when they arose and name them and fully experience them in the body, accept them rather than push them away. If I could not bear to hold these feelings, then how could I possibly expect the participants to be able to get in touch with those feelings, and slowly be able to acknowledge them and place them into a narrative about their life? Invariably, when I disclosed concerns that I was not being of help, the participants responded that I was being of help in ways that were unique to themselves and also with the understanding that they didn't expect me to be able to fix everything with my magic box of tricks.

As I discussed in chapter four, autoethnography is a form of self-inquiry that can also be a form of self-therapy; as Laurel Richardson argued: "the self that is writing the story is changed by the process of writing it". In writing about my self I constitute myself (Foucault, 1997, p. 207-222). By writing in first person narrative form I became a witness to my own work. I also became a witness to the lives of the other participants, including documenting some of their stories. This served the same purpose as video work, but unlike video work, an autoethnography reveals the inner life of the therapist and the relationship of the work to the therapist's personal history. Writing in this way helped me to attune and empathise with both myself and with the young person I was working with. By reflecting on my practice in this way, I began to shape the way I theorised and practiced therapy.

One of the major themes demonstrated by autoethnography was the extent to which experiences and stories from the "macro-world" of my personal and family life entered into the "micro-world" of therapy; and how my personal narratives from the

"macro-world" of my personal and family life were also transformed by the research. Autoethnography enhanced my practice by helping me become more self-aware of the presence of these stories and the effects of these stories on how I related to myself and other participants.

The task of integrating the professional self with the personal self is a life-long process, similar in many ways to self-analysis. This ability, to integrate or meld the professional and personal selves, is described by Dewane as a "hallmark of skilled practice" (2006, p. 543). It is also argued that the "development of congruity between personal and professional identities" through the "dynamic process of self-narration" is the hallmark of the experienced practitioner (Butler et al., 2007, p. 293-295). It has been previously recognised that autoethnographic practice can act like a form of self-therapy (Bochner & Ellis, 2002). I think by now it is clear how much the therapy process triggered associated memories from my personal life and all the corresponding stories and feelings associated with those memories. One example of this was that working with participants with attachment-trauma experiences brought up my own attachment-trauma experiences associated with my sons and with my father. This of course included re-telling the story of my disconnection from my sons and witnessing the story of my father's offending in a public forum. The story of my father and how our relationship was affected by sexual offending is one of the dominant plots of the thesis. It can be seen as a form of redemption or atonement story. In the same way that children are affected by the insecure attachment relationship their parents experienced, my relationship with my father was affected by his family and war experiences. After being told about the history of my father's offending, the family's secret shame story was passed along to me, and I wanted to

survive and recover from this burden. Rather than continue to not speak of it, as my father had done, I chose to speak about it to trusted friends and professional confidants. I became a "witness" to my father's "illness":

> Becoming a witness assumes a responsibility for telling what happened. The witness offers testimony to a truth that is generally unrecognised or suppressed. People who tell stories of illness are witnesses, turning illness into a moral responsibility (Frank, 1995, p. 137).

Writing this thesis has taken my witnessing one step further, by placing it in the public domain. In this way I have stood up against the power and oppression of the secret shame story and used this experience to hopefully contribute something to adolescent sexual offending rehabilitation as discussed above.

Re-working and integrating these personal memories was an important part of the autoethnographic process and involved me writing therapeutically and vulnerably (Ellis, 2004). I was able to use my personal experience of loss or shame to connect with participants emotionally and use self-disclosure therapeutically (Butler et al., 2007). I also believe this is a form of ethical practice, equivalent to what Rogers (1957) would have described as genuineness. A therapist is not neutral when it comes to all the issues he or she works with. In doing this research I demonstrated how a therapist, informed by both systemic-narrative and relational perspectives, experiences therapy as a bi-directional intersubjective process (Aron, 1996; White, 1997). As a therapist, I may learn just as much about myself from the process of therapy as will the other participants. The fact that I have lived through the shameful

after-effects of my father's sexual offending, means I will always have a uniquely personal viewpoint of sexual offending. In my case, I think I was able to use this experience in a way which enabled me to empathise with both people who were victims of sexual offending and the people who were responsible for offending.

In the same way, the therapy process evoked memories of my relationship with my sons, and it became clear to me how the boys and young men I have worked with in therapy have given me so much back, and have helped me so much to overcome the personal pain involved in this area of my life. Research has shown that therapists often become therapists from a desire to heal themselves, hence the metaphor of the "wounded healer" (Sedgwick, 1994; Sussman, 2007). As more clinicians confront "the fact that they bring as many unresolved difficulties to the therapeutic encounter as their patients do, they have been more willing to view the healing process as one where both parties wish to grow" (Strean, 1999 p. 128). For example, I speak in this thesis about an episode in my life in which I acted harmfully based upon sexual jealousy. Although this wasn't a sexual offence, it was an act of disrespect based upon notions of male entitlement. These personal disclosures carry with them an element of professional risk, but I decided to include them because it shows how we are all "more human than otherwise"(Sullivan, 1953), and by appropriately acknowledging our human frailties and vulnerabilities, we are less likely to reproduce a "them and us" professional culture (Butler et al., 2007; Williams, 2006). Ultimately, the process of integrating our professional and personal selves is a life-long project. For me, it is at the "heart" of professional development.

14.3 Implications for agency policy and practice

This thesis provides qualitative support for the argument that the use of self is a crucial factor in developing and maintaining the therapeutic alliance and enhancing the effectiveness of our interventions. The capacity of the therapist (or caregiver) to provide attuned and flexible responses is also crucial to the recovery process of children and young people who have experienced abuse related trauma (Tucci, Mitchell & Goddard, 2010). Although the findings of this kind of case study research cannot be generalised, they suggest possibilities for practitioners to have in mind as they work with particular clients (Hoffman, 2009). They also suggest that evidence-based procedures or techniques depend upon the reflexive use of self if they are going to be implemented in an optimally responsive way. In order to conform to the requirements of "objective" science, randomised controlled trials distort the complex reality of clinical practice. However, there is no reason why these complexities cannot be acknowledged. These complexities, I suggest, are best studied through qualitative methodologies, such as case studies and discourse analysis.

Therefore, perhaps it is now time for reconciliation between the evidence-based practice tradition and the tradition of judgment based practice. That evidence-based practice needs to pay closer attention to relational skills and indeed the subjectivities of the participants and the unique intersubjective field that is created within each therapeutic dyad. In this way, even though therapy is invented anew for each participant, it would be possible to develop principles and guidelines for therapists and others who are interested in the systemic-narrative and relational-non-verbal aspects of the therapy process. Indeed, when it comes to the questions of

manuals, as discussed in chapter two, this is exactly the argument that is put forward by practitioners (Safran & Muran, 2000; Marshall, 2010).

I believe the implications of the findings of this research for the specialist field of adolescent sexual offending are that the emphasis on risk management needs to be balanced by agency responsiveness to the therapeutic needs of participants, the majority of whom have experienced abuse related trauma. For example, residential and community treatment programmes and the out-of-home care services, should all be alert to ensuring all staff and processes as well as referring agencies such as child safety agencies do their best to provide an empathic service that takes into account the attachment needs of clients, including their needs for security and containment. I therefore agree with Ward and Brown (2004) when they argue that risk management is a necessary but not sufficient condition for the rehabilitation of people who have offended; treatment approaches must also take into account the needs and preferences of persons who have offended to live more fulfilling and worthwhile lives. As discussed in chapter two, many of the vulnerabilities experienced by adolescents who sexually offend originate in problematic childhoods characterized by the lack of empathic attunement and care (Chorn & Parekh, 1997; Marshall & Marshall, 2000; Rich, 2006a). Although therapists can never become parents to vulnerable young clients, I do believe that they can provide a treatment experience that creates the preconditions for young people to develop resilience and go on to lead fulfilling and worthwhile lives. Ideally this needs to be complemented by placing young people into environments that provide a caring and empathic response on a day by day basis (Rich, 2006a). This can involve assisting young people develop an attachment relationship with foster carers or repair the rupture in the relationship with their

family of origin. Indeed, in contrast with the emphasis on group work in the adult programmes, it can be argued that an attachment focused family therapy approach (Hughes, 2007) should be the core intervention in adolescent programmes.

I believe the first goal in the treatment process is for the therapist to create the preconditions for the formation of a therapeutic alliance, with the young person and also with the caregiver/s, if there is someone available. The way to go about doing this is for the young person and caregiver/s to experience the therapist as someone who is consistently empathically attuned and responsive to their lived experience of the world on a session by session basis. However, it is not always an easy task to balance empathic attunement with risk management responsibilities. While acknowledging the potential pitfalls involved, I believe the art of balancing empathy with risk management lies in the stability and strength of the therapeutic alliance. If the alliance lacks these qualities, then it is unlikely the mutually supportive goals of risk management and empathy will be met.

The research also alerts therapists to the importance of paying attention to integrating their professional and personal selves as part of their ongoing professional development. I suggest that, at a practice level, attention is given to encouraging self-reflexivity by practitioners on the relationship between their personal and professional selves with a view to integrating autobiographical knowledge with professional knowledge of theory and technique (Edwards & Bess, 1998). For example, this includes paying attention to their experience of being parented and their personal experience of cultural contexts such as class, race and gender. The research highlights the relevance of the subjective experience of gender identity, an area that often goes under-represented in the delivery of adolescent sexual offending

programmes. This research supports the inclusion of gender specific interventions in these programmes. The findings also support the argument that the experience of caring for and being cared for is central to treatment, and that self reflexivity can be both a process and an outcome goal for all therapy participants, both client and therapist. Therefore, in keeping with the move towards holistic approaches to treatment (Ryan, 1999; Rich, 2006a), as well as focusing on sexual offending specifics (such as offence cycles) the research suggests that treatment would be enhanced by focusing on the psychological-developmental context (effects of abuse related trauma) and the sociocultural context (hegemonic masculinity).

My research demonstrates how the practice of honest introspection by the therapist can lead to a more humble and genuine response to young people who have offended. This mitigates against the temptation (which is always there) to get caught up in viewing the person who committed an offence as the "other". These realisations therefore have significant implications for policy and practice.

At a practice level, both during training, supervision and ongoing therapy, therapists can be encouraged to pay more attention to their own subjectivity and their own moment-by-moment experiences of the therapy process. In this way, the therapist will learn about themselves as well as about the person they are working with. This also means encouraging all therapists who work in this area to see self-therapy as an ongoing inquiry that never ends, in the classical psychoanalytic tradition. This does not mean that a therapist has to go into analysis for a lifetime but it does mean that a therapist can (and I would argue should) use supervision and other forms of self-inquiry (such as personal therapy, meditation or autoethnography) to be constantly self-reflective and vigilant.

I would also suggest that agencies need to be careful that the emphasis on risk management does not overshadow the principle of responsivity. The problem in highlighting the story of the "risky child" (Brownlie, 2001) is that it can tend to render invisible the effects of abuse related trauma on the children and young people referred to the programme. This problem was illustrated in the belief held by some clinicians whom I have encountered, that offender treatment should not be confused with victim treatment. This dilemma, of finding an appropriate balance between treatment which is sexual offence specific, and treatment which considers the "whole" child, is currently being discussed and debated within the field (Rich, 2003; Ryan & Lane, 1997b). It constituted much of my external and internal dialogue in this work. This led me to question the inclusion of adolescent programmes within specialist agencies that also provide programmes for adults. I consider that this inclusion tends to tar adolescents with the same offender stigma as adults, leading to ongoing suspicion and to a rigorous supervision of these adolescents while they were on the programme, when they could be seen as young people who are in need of nurture, and appropriate space in which to mature. In my view, practices driven by an overemphasis on risk management to the diminishment of personal healing and the development of hope for a better life in the future, run the risk of not only undermining the therapeutic alliance but of re-traumatising the young person.

On a policy level, what counts as evidence-based practice needs to be expanded so that policy makers come to understand the importance of clinical judgment, responsivity and professional discretion. I believe the traditional definitions of the scientist-practitioner can and must be challenged to allow for a diversity of research traditions to find their place within public policy debates and

ultimately for the judgment-based practice tradition to enter into dialogue with the evidence-based tradition. I am concerned that at the moment in the health and justice policy arenas, the only understanding of evidence-based practice is based on the medical model characterized by the randomised control trial of drugs. This has been able to successfully give the impression that therapies such as cognitive behaviour therapy (CBT) can be administered to clients in the same way as a medication. The person and subjectivity of the therapist have been totally excluded. This is in contrast to most advocates of CBT who do argue that the therapeutic alliance is foundational to the successful implementation of CBT interventions, and it also forgets the historical origins of CBT in Hellenistic ethics, which was centrally concerned with the care or government of the self (Nussbaum, 1994; Rabinow, 1997).

Finally, although the focus of this work is on the practice of adolescent sexual offending therapy, it was my intention that this research is honouring of all victims of sexual abuse and makes a contribution to understanding how people can change and make choices that are consistent with respectful ways of relating to other people. I think the research is significant to others (professionals and consumers) because the clinical implications of this study present a challenge to the current ways in which adolescent sexual offending therapy is sometimes conceptualised and practised. I would hope that other therapists who work in this area would be encouraged to question the relationship between the personal and the professional in their own practice and to question the binaries built within conventional English language which operates to set ourselves up as the "good" therapist and the participants as the "bad" other (Bird, 2004). I also hope my work contributes to improving the rehabilitation of young people who have sexually offended. I believe

autoethnography has the potential to do this by helping professionals improve their ability to develop a therapeutic alliance with programme participants, thereby helping participants to reach a place within themselves of authentic realisation of empathy towards the people they have harmed (including themselves), leading to a healthy experience of guilt and the arising of the genuine need to make reparations (Jenkins, 2006).

14.4 Limitations of the study

The qualitative evidence presented in this study for the various possible ways in which adolescent sexual offending therapists may use self-reflexivity in their practice is based upon what could be called a singular case study of one therapist's work with a small number of participants. I think it is important to note that the stories were never meant to be read as "transcripts" – autoethnographies deliberately set out to "capture" a broader range of emotive engagement, as conveyed in the literary aspects of story-telling, than is possible in a recording or a transcript. The ability to draw general conclusions from the evidence presented is therefore limited in a number of ways. Firstly, the evidence is filtered through my subjectivity and what I selected to include in the stories. The main strength of the study, which can be characterized as experience-near research, is therefore also its major limitation - it is based primarily on data based on one therapist's self-observation and the therapist's observation of others. Secondly, the data generated for this study was based upon the recollections of the therapist writing detailed process notes of the sessions following the completion of the session. With some exceptions (see chapter four), notes were usually completed after the sessions. Recall from memory is not as reliable as

recordings. When the descriptions of therapy are based exclusively on the therapist's descriptions it misses some of the nuances that take place in the clinical exchange that other methodologies using audio or video technology would have picked up (Safran & Muran, 2000, p. 215). These observations cannot therefore be validated by external observers; however, the stories were read and confirmed for their accuracy of the observations by the three participants who volunteered to be a part of the study; the stories can also be evaluated by my peers as to their verisimilitude, which is one of the criteria commonly used for evaluating autoethnography (Richardson, 2000).

Although the ability to draw general conclusions is limited by the above concerns, case study research provides opportunities for other practitioners to explore the kinds of therapist responses detailed in the case study and encourages other practitioners to reflect on their own work in the light of the findings of this case study. The stories present possibilities for other practitioners to hold in mind (Hoffman, 2009). Advances in the theory and practice of psychotherapy have often been inspired by research using single case study observations by the therapist practitioner (Balint et al., 1972; Freud, 1909/1955; McLeod, 1999). Case study research also provides a substantial base for the development of principles and guidelines for practitioners. I also believe evidence based upon personal experience is legitimate and can be used to support claims about the effectiveness of therapeutic interventions. I believe the method of recording used in this study allows the clear emergence of the characters of the participants to unfold on a session by session basis along with the nature of the therapeutic interventions employed, which otherwise would have needed to be laboriously extracted from thousands of pages of transcript material (Balint et al., 1972). Although the research cannot demonstrate the

effectiveness of the treatment sessions discussed when measured according to the criteria demanded by neopositivist evidence-based research, it will be up to the reader to decide if the research as presented lives up to the six criteria for evaluating autoethnographic research as discussed in chapter four. The first principle is emotional evocativeness. Do the stories touch our hearts in some way? Do they engender tears and laughter? Secondly, do the stories "hold" the readers/audience? Do they engage the reader/audience in some form of self-reflection on their own experience? Thirdly, do the stories show how autoethnographic writing can also be a therapeutic act, a process of self-transformation? Fourthly, do the stories achieve a sense of verisimilitude? Are they convincing? Do they ring true? Fifthly, do the stories demonstrate political relevance? Do they have the potential to generate debate and policy change? Finally, are the stories trustworthy? Do they faithfully represent my relationships with the other participants, family members and other professionals?

In conclusion, the findings of this case study of one therapist cannot be generalised to the population of all therapists working in this field. Additional studies are needed to explore these findings further. Nevertheless, these limitations are balanced by the potential appeal of these stories to clinicians working in the field. Some of these stories may resonate with other therapists, some may not. It is to be hoped that for those therapists who identify with the stories discussed in this thesis that this will provide validation of their experience and hopefully inspire them to research and publish their own research in relation to therapist responsivity and the therapeutic alliance in adolescent sexual offending therapy.

14.5 Further research

Further autoethnographic case study research, into the subjective and intersubjective experience of both therapists and participants involved in sexual offending rehabilitation programmes, would develop these ideas further and give us the opportunity to compare autoethnographic case studies. I believe autoethnography can make substantial contributions to the accumulated research into therapist responsivity and the therapeutic relationship and hence our understanding of the processes involved in being optimally responsive. Finally, I would also like to think that this research will provide an example for other therapists who may be interested in finding an appropriate research methodology to explore their own experience of the integration of their personal and professional selves.

APPENDIX ONE

AGENCY LETTER

Re: Andrew Tootell's PhD Research

Dear (Programme Participants)

As discussed on the phone, Andrew will soon be contacting you to see if you are interested in meeting to discuss participating in his PhD research. In this study Andrew intends to write stories about his therapeutic practice while working on the programme. I am attaching an Information Form to this letter which explains the proposed research project.

I wish to again emphasise, in order to successfully complete the programme it is *not* a requirement that you participate in Andrew's research. You are free to participate or to decline – it is your decision.

The agency has always placed a great deal of importance on supporting on-going research into our services. We are supportive of Andrew's research project as detailed on your information form. We also support the collaborative nature of Andrew's project, sharing his work with you and asking for your feedback.

We have no hesitation in encouraging you to participate in this project, however once again I want to underline that this is entirely voluntary and we respect your choice either way. If you agree, Andrew will discuss the project with you all at a convenient time and will ask you to sign some written consent forms. Andrew will be able to answer any questions you have about the project at this time.

Best wishes

Agency Manager

APPENDIX TWO

RESEARCH PROJECT INFORMATION FORM

Dear Parent/Caregiver/Young Person

I am currently enrolled as a student at The University of Waikato, in the Department of Human Development and Counselling. I am conducting research into my own therapeutic practice while working as a therapist on the programme for the purpose of my PhD in Counselling. I am asking for your assistance and cooperation in writing about my practice. I would like for you to give your consent for me to possibly include one or more stories about some of the therapy sessions we have had together. Your son is under no obligation to participate and is free to decline.

I would like to include a story about our therapeutic work together, in individual and/or family therapy in my PhD.

The therapy story will be written from my perspective. It is likely that I will have a different perspective to your own. However, I am hoping that whatever I write you will find to be respectful. Copies of relevant draft stories will be given to you for comment when the treatment programme has been completed. I will be happy to include any comments you may have at the end of the story. Also, I will be happy to incorporate any changes that you would like to make. In writing up this research I will take great care to ensure your identity is hidden and cannot be recognised. No stories will be published in the PhD involving reference to our work together without your consent. If at any stage of my research prior to my submitting my PhD for examination, you wish to withdraw your consent for me to include your story in my PhD, you are free to do so.

Thank you for your time and help in making this study possible. My chief research supervisor is Prof. Wendy Drewery, Assistant Dean of Graduate Studies, University of Waikato. Her address and contact numbers are listed above. If you have any queries regarding ethical concerns, please contact my Supervisor in the first instance.

Alternatively you could contact:
The Chairperson,
School of Education Ethics Committee,
University of Waikato,
Private Bag 3105
Hamilton.

I will be contacting you soon to confirm if you are willing to meet to discuss your participation in this project. If so, I will arrange a meeting to answer any questions you may have and to sign the formal consent forms if you agree to participate.

Yours Sincerely

Andrew Tootell.

APPENDIX THREE

RESEARCH PROJECT CONSENT FORM
(Young Person)

1. I, ……(*please print name)* consent to be included in the above named research project.
2. I acknowledge that I have read the Information Form.
3. I have had the project, so far as it affects me, explained to my satisfaction by Andrew and I understand that my participation may not be of any benefit to me.
4. My consent is given freely.
5. I understand that the purpose of the research is for Andrew to write stories about the work he is doing on the programme and how it affects both himself and the people he works with.
6. I have been informed the stories written by Andrew are to be included in his dissertation to be published as a PhD qualification.
7. I also give my consent for the same stories to be included in a book or academic paper that Andrew may write based upon his research.
8. I have also been informed that any personal identifying characteristics relating to myself or my parents/caregivers will not be included in the stories to be published.
9. I understand that I am free to withdraw my consent for my inclusion in the project *at any time prior* to Andrew submitting his PhD for examination and that this will not influence in any way the continuing therapeutic service that I receive from the agency.
10. I have also been informed that I will receive a draft copy of the story that relates to me when I have finished the programme and that I will be able to make comments and suggest changes.
11. I am aware that I should retain a copy of this consent form when completed.

……
….
YOUNG PERSON'S SIGNATURE DATE

I have described to ……. (*name of participant*) the nature of the research in which I am asking them to be involved. In my opinion he understood the explanation.

Status in Project: *Sole researcher and candidate for PhD.*

Name: Andrew Tootell, BA; BSW (Hons); Grad. Dip. Law; MCS)

……
……
RESEARCHER'S SIGNATURE DATE

REFERENCES

Alexander, F., & French, T. M. (1946). *Psychoanalytic therapy*. New York: Ronald Press.

Altman, N. (1995). *The analyst in the inner city: Race, class, and culture through a psychoanalytic lens*. New York: The Analytic Press.

Andersen, T. (1999). The reversal of light and sound. *Gecko: a journal of deconstruction and narrative ideas in therapeutic practice*(2), 5-9.

Anderson, H. (1997). *Conversation, language, and possibilities: A postmodern approach to therapy*. New York: Basic.

Andrews, D. A., & Bonta, J. (2003). *The psychology of criminal conduct*. Cincinnati, OH: Anderson.

Angrosino, M. V. (1998). *Opportunity House: Ethnographic stories of mental retardation*. Walnut Creek: Altamira.

Aron, L. (1996). *A meeting of minds: mutuality in psychoanalysis*. Hillsdale, NJ: The Analytic Press.

Aron, L. (2000a). Ethical considerations in the writing of psychoanalytic case histories. *Psychoanalytic Dialogues, 10*(2), 231-245.

Aron, L. (2000b). Self-reflexivity and the therapeutic action of psychoanalysis. *Psychoanalytic Psychology, 17*(4), 667-689.

Atkinson, P. (1997). Narrative turn or blind alley? *Qualitative Health Research, 7*, 325-324.

Ayland, L., & West, B. (2005). *The good way model: A strengths based approach for working with young people, especially those with intellectual difficulties, who have sexually abusive behaviour*. Wellington STOP Inc.

Bacal, H. A. (1998a). Optimal responsiveness and the specificity of self-object experience. In H. A. Bacal (Ed.), *Optimal responsiveness: How therapists heal their patients*. Northvale, New Jersey: Jason Aronson Inc.

Bacal, H. A. (1998b). Optimal responsiveness and the therapeutic process. In H. A. Bacal (Ed.), *Optimal responsiveness: How therapists heal their patients*. Northvale, New Jersey: Jason Aronson Inc.

Bacal, H. A. (1998c). *Optimal responsiveness: How therapists heal their patients*. Northvale, NJ: Jason Aronson.

Bacal, H. A., & Herzog, B. (2003). Specificity theory and optimal responsiveness. *Psychoanalytic Psychology, 20*(4), 635-648.

Bacal, H. A., & Thomson, P. G. (1998). Optimal responsiveness and the therapist's reaction to the patient's unresponsiveness. In H. A. Bacal (Ed.), *Optimal responsiveness: How therapists heal their patients*. Northvale, New Jersey: Jason Aronson Inc.

Baldwin Jr, D. C. (2000). Some philosophical and psychological contributions to the use of self in therapy. In M. Baldwin (Ed.), *The use of self in therapy (second edition)* (pp. 39-60). New York: The Haworth Press.

Baldwin, M. E. (2000). *The use of self in therapy (second edition)*. New York: The Haworth Press.

Balint, M., Ornstein, P. H., & Balint, E. (1972). *Focal psychotherapy: An example of applied psychoanalysis*. London: Tavistock.

Barbaree, H. E., & Marshall, W. L. (Eds.). (2006). *The juvenile sex offender (second edition)*. New York: Guilford.

Barlow, C. (1991). *Tikanga Whakaaro: Key concepts in Maori culture*. South Melbourne: Oxford University Press.

Bateman, J., & White, N. (2008). The use of narrative therapy to allow the emergence of engagement. *The International Journal of Narrative Therapy and Community Work*(2), 17-28.

Beck, C. J. (1989). *Everyday Zen: Love & work*. New York: HarperSanFrancisco.

Beck, C. J. (1993). *Nothing special: Living Zen*. New York: HarperSanFrancisco.

Beech, A. & Fordham, A. S. (1997). Therapeutic climate of sexual offender treatment programs. *Sexual Abuse: A Journal of Research and Treatment,* 9(3), 219-237.

Beech, A. R. & Hamilton-Giachritsis, C. E. (2005). Relationship between therapeutic climate and treatment outcome in group-based sexual offender treatment programs. *Sexual Abuse: A Journal of Research and Treatment,* 17(2), 127-140.

Behar, R. (1996). *The vulnerable observer: Anthropology that breaks your heart*. Boston: Beacon.

Benjamin, J. (1988). *The bonds of love: Psychoanalysis, feminism, and the problem of domination*. New York: Pantheon Books.

Benjamin, J. (1990). An outline of intersubjectivity: The development of recognition. *Psychoanalytic Psychology, 7*(S), 33-46.

Benjamin, J. (1995). *Like subjects, love objects.* New Haven, CT: Yale University Press.

Benjamin, J. (1998). *Shadow of the other: Intersubjectivity and gender in psychoanalysis*. New York: Routledge.

Benjamin, J. (2004). Beyond doer and done to: An intersubjective view of thirdness. *Psychoanalytic Quarterly, 73*, 5-46.

Berger, L. (2001). Inside out: Narrative autoethnography as a path toward rapport. *Qualitative Inquiry, 7*(4), 504-518.

Bird, J. (2000). *The heart's narrative: Therapy and navigating life's contradictions*. Auckland: Edge Press.

Bird, J. (2004). *Talk that sings: Therapy in a new linguistic key*. Auckland: Edge Press.

Birgden, A. (2004). Therapeutic jurisprudence and responsivity: Finding the will and the way in offender rehabilitation. *Psychology, Crime & Law, 10*(3), 283-295.

Bishop, R. (2005). Freeing ourselves from neocolonial domination in research: A Kaupapa Maori approach to creating knowledge. In N. K. Denzin & Y. S. Lincoln (Eds.), *The sage handbook of qualitative research (third edition)* (pp. 109-138). Thousand Oaks: Sage.

Bochner, A. P., & Ellis, C. (Eds.). (2002). *Ethnographically speaking: Autoethnography, literature, and aesthetics*. Walnut Creek: Altamira.

Bohart, A. C., & Greenberg, L. S. (1997a). Empathy and psychotherapy: An introductory overview. In A. C. Bohart & L. S. Greenberg (Eds.), *Empathy reconsidered: New directions in psychotherapy* (pp. 3-31). Washington, DC: American Psychological Association.

Bohart, A. C., & Greenberg, L. S. (1997b). Empathy and psychotherapy: An introductory overview. In A. C. Bohart & L. S. Greenberg (Eds.), *Empathy reconsidered: New directions in psychotherapy* (pp. 3-31). Washington, DC: American Psychological Association.

Bohart, A. C., & Greenberg, L. S. (Eds.). (1997b). *Empathy reconsidered: New directions in psychotherapy*. Washington, DC: American Psychological Association.

Bordin, E. (1979): The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice,* 16, 252-260.

Boscolo, L. & Bertrando, P. (1996). *Systemic therapy with individuals.* London: Karnac

Bowlby, J. (1953/1965). *Child care and the growth of love (second edition)*. Harmondsworth: Penguin.

Bowlby, J. (1969). *Attachment and loss: Vol. I. Attachment*. New York: Basic Books.

Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation, anxiety, and anger.* New York: Basic Books.

Bowlby, J. (1980). *Attachment and loss: Vol. 3. Loss: Sadness and depression*. New York: Basic Books.

Bowlby, J. (1988). *A secure base*. New York: Basic Books.

Brandon, D. (1979). Zen practice in social work. In D. B. M. Jordon (Ed.), *Creative social work.* Oxford: Basil Blackwell.

Brazier, D. (1995). *Zen therapy: A Buddhist approach to psychotherapy*. London: Robinson.

Bromberg, P. M. (2006). *Awakening the dreamer: Clinical journeys*. Mahwah, NJ: The Analytic Press.

Broucek, F. J. (1991). *Shame and the self*. New York: Guilford.

Brownlie, J. (2001). The 'being-risky' child: Governing childhood and sexual risk. *Sociology, 35*(2), 519-537.

Bruner, J. (1986). *Actual minds, possible worlds*. Cambridge: Harvard University Press.

Bruner, J. (1990). *Acts of meaning*. Cambridge, Massachusetts: Harvard University Press.

Buirski, P. (2005). *Practicing intersubjectively*. Lanham, Maryland: Jason Aronson.

Buirski, P., & Haglund, P. (2001). *Making sense together: The intersubjective approach to psychotherapy*. Northvale, New Jersey: Jason Aronson Inc.

Burke, D. M. (2001). Empathy in sexually offending and non-offending adolescent males. *Journal of interpersonal violence, 16*(3), 222-233.

Butler, A., Ford, D., & Tregaskis, C. (2007). Who do we think we are? Self and reflexivity in social work practice. *Qualitative Social Work, 6*(3), 281-299.

Cantwell, P., & Stagoll, B. (1996). The therapeutic moment: A double-sided drama. In C. Flaskas & A. Perlesz (Eds.), *The therapeutic relationship in systemic therapy*. London: Karnac Books.

Casement, P. J. (1991). *Learning from the patient*. New York: Guilford.

Cassidy, J., & Shaver, P. R. (Eds.). (1999). *Handbook of attachment: Theory, research, and clinical applications*. New York: Guildford.

Chase, S. E. (2005). Narrative inquiry: Multiple lenses, approaches, voices. In N. K. Denzin & Y. S. Lincoln (Eds.), *The sage handbook of qualitative research (third edition)* (pp. 651-680). Thousand Oaks: Sage.

Chodorow, N. J. (1999). *The power of feelings*. New Haven: Yale University Press.

Chorn, R., & Parekh, A. (1997). Adolescent sexual offenders: A self-psychology perspective. *American Journal of Psychotherapy, 51*(2), 210-228.

Connell, R. W. (1995). *Masculinties*. Berkeley: University of California Press.

Connell, R. W. (2000). *The men and the boys*. Berkeley: University of California.

Connell, R. W. (2002). On hegemonic masculinity and violence: Response to Jefferson and Hall. *Theoretical Criminology, 6*(1), 89-99.

Crocket, K. (2004a). From narrative practice in counselling to narrative practice in research: A professional identity story. *The International Journal of Narrative Therapy and Community Work*(2), 63-67.

Crocket, K. (2004b). Storying counselors: Producing professional selves in supervision. In D. A. Pare & G. Larner (Eds.), *Collaborative practice in psychology and therapy*. New York: The Haworth Clinical Practice Press.

Crocket, K., Drewery, W., McKenzie, W., Smith, L., & Winslade, J. (2004). Working for ethical research in practice. *The International Journal of Narrative Therapy and Community Work*(3), 61-66.

Cushman, P. (1995). *Constructing the self, constructing America: A cultural history of psychotherapy.* New York: Addison-Wesley.

Cushman, P. & Gilford, P. (2000). Will managed care change our way of being? *American psychologist,* 55, 985-996.

Dallos, R. (2006). *Attachment narrative therapy: Integrating narrative, systemic and attachment therapies*. Maidenhead: Open University Press.

Daly, K. (2002). Sexual assault and restorative justice. In H. Strang & J. Braithwaite (Eds.), *Restorative justice and family violence*. Cambridge: Cambridge University Press.

Damasio, A. (2000). *The feeling of what happens*. London: Vintage.

Denzin, N. K. (1997). *Interpretive Ethnography: Ethnographic Practices for the 21st Century*. Thousand Oaks: Sage Publications.

Denzin, N. K. (2003). *Performance ethnography: Critical pedagogy and the politics of culture*. Thousand Oaks: Sage Publications.

Denzin, N. K. (2006). Pedagogy, performance, and autoethnography. *Text and Performance Quarterly, 26*(4), 333-338.

Denzin, N. K., & Lincoln, Y. S. (2005a). Introduction: The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research (third edition)* (pp. 1-32). Thousand Oaks: Sage.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2005b). *The Sage handbook of qualitative research (third edition)*. Thousand Oaks: Sage.

Denzin, N. K. L., Yvonna S. (2005). The Discipline and Practice of Qualitative Research. In N. K. L. DEnzin, Yvonna S. (Ed.), *The Sage Handbook of Qualitative Research (Third Edition)* (pp. 1-32). Thousand Oaks: Sage Publications.

Devereux, G. (1967). *From anxiety to method in the behavioral sciences*. The Hague: Mouton.

Dewane, C. J. (2006). Use of self: A primer revisited. *Clinical Social Work Journal, 34*(4), 543-558.

Dilthey, W. (1961). *Pattern and meaning in history*. New York: Harper Torchbooks.

DeYoung, P. A. (2003). *Relational psychotherapy*. New York: Routledge.

Donald, R. R. (2001). Masculinity and machismo in Hollywood's war films. In S. M. Whitehead & F. J. Barrett (Eds.), *The masculinity reader*. Cambridge: Polity.

Drapeau, M. (2005). Research on the processes involved in treating sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 17*(2), 117-125.

Drewery, W. (2005). Why we should watch what we say: Position calls, everyday speech and the production of relational subjectivity. *Theory and Psychology, 15*(3): 305-324.

Drury, N. (2006). The delicate scientist practitioner. *ANZJFT, 27*(4), 177-186.

Durrant, M., & White, C. E. (1990). *Ideas for therapy with sexual abuse*. Adelaide: Dulwich Centre Publications.

Edwards, J. K., & Bess, J. M. (1998). Developing effectiveness in the therapeutic use of self. *Clinical Social Work Journal, 26*(1), 89-105.

Ellis, C. (1999). Heartful autoethnography. *Qualitative Health Research, 9*(5), 669-683.

Ellis, C. (2004). *The ethnographic I: A methodological novel about autoethnograhy*. Walnut Creek: Altamira.

Ellis, C., & Bochner, A. P. (2000). Autoethnography, personal narrative, reflexivity. In N. K. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research (second edition)* (pp. 733-768). Thousand Oaks: Sage.

Elson, M. (1986). *Self psychology in clinical social work*. New York: W.W. Norton & Company.

Elson, M. (Ed.). (1987). *The Kohut seminars on self-psychology and psychotherapy with adolescents and young adults*. New York: W. W. Norton.

Epstein, M. (1995). *Thoughts without a thinker: Psychotherapy from a Buddhist perspective*. New York: BasicBooks.

Etherington, K. (2004). *Becoming a reflexive researcher: using our selves in research*. London: Jessica Kingsley Publishers.

Euromonitor-Archive. (2006). Metrosexuality - the male shopping giant awakes. *Euromonitor International*.

Ferenczi, S. (1932). *The clinical diary of Sandor Ferenczi* (M. Balint & N. Z. Jackson, Trans.). Cambridge, MA: Harvard University Press.

Flaskas, C. (1996). Understanding the therapeutic relationship: using psychoanalytic ideas in a systemic context. In C. Flaskas & A. Perlesz (Eds.), *The therapeutic relationship in systemic therapy*. London: Karnac.

Flaskas, C. (2002). *Family therapy beyond postmodernism: Practice challenges theory*. Hove and New York: Brunner-Routledge.

Flaskas, C., & Perlesz, A. (Eds.). (1996). *The therapeutic relationship in systemic therapy*. London: Karnac Books.

Fonagy, P. (2001). *Attachment theory and psychoanalysis*. New York: Other Press.

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2004). *Affect regulation, mentalization, and the development of the self*. London: Karnac.

Fosha, D. (2000). *The transforming power of affect: A model for accelerated change*. New York: Basic Books.

Fosha, D. (2003). Dyadic regulation and experiential work with emotion and relatedness in trauma and disorganized attachment. In M. F. Solomon & D. J. Siegel (Eds.), *Healing trauma: Attachment, mind, body, and brain*. New York: W.W. Norton.

Fosshage, J. I. (1998). Optimal responsiveness and listening/experiencing perspective. In H. A. Bacal (Ed.), *Optimal responsiveness: How therapists heal their patients* (pp. 117-139). Northvale, New Jersey: Jason Aronson Inc.

Foster, K., McAllister, M., & O'Brien, L. (2006). Extending the boundaries: Autoethnography as an emergent method in mental health nursing research. *International Journal of Mental Health Nursing, 15*, 44-53.

Foucault, M. (1997). The ethics of the concern for self as a practice of freedom. In P. Rabinow (Ed.), *Ethics: Subjectivity and truth* (Vol. 1, pp. 281-301). London: Penguin Books.

Frank, A. W. (1995). *The wounded story-teller: Body, illness and ethics*. Chicago: The University of Chicago Press.

Freedberg, S. (2009). *Relational theory for social work practice: A feminist perspective*. New York: Routledge.

Freeman, J., Epston, D., & Lobovits, D. (1997). *Playful approaches to serious problems: Narrative therapy with children and their families*. New York: W. W. Norton.

Freud, S. (1909/1955). *Two case histories ('Little Hans" and the 'Rat Man'*. London: The Hogarth Press.

Freud, S. (1914/1957). *On narcissism*. London: Hogarth Press.

Freud, S. (1930/1973). *Civilization and its discontents*. London: Hogarth Press.

Friedrich, W. N. (2007). *Children with sexual behavior problems*. New York: W. W. Norton.

Gabbard, G. O. (2004). *Long-term psychodynamic psychotherapy: A basic text*. Washington, DC: American Psychiatric Publishing.

Gadamer, H. (1975/1989). *Truth and method (second edition)*. London: Sheed & Ward.

Gaddis, S. (2004). Repositioning traditional research: Centring clients' accounts in the construction of professional therapy knowledges. *The International Journal of Narrative Therapy and Community Work*(2), 37-48.

Ganzer, C. (2007). The use of self from a relational perspective. *Clinical Social Work Journal, 35*, 117-123.

Gergen, M. M., & Gergen, K. J. (2002). Ethnographic representation as relationship. In A. P. Bochner & C. Ellis (Eds.), *Ethnographically speaking: Autoethnography, literature, and aesthetics*. Walnut Creek: Altamira Press.

Gerson, B. E. (1996). *The therapist as a person: Life crises, life choices, life experiences, and their effects on treatment*. Hillsdale, NJ: The Analytic Press.

Gibney, P. (2003). *The pragmatics of therapeutic practice*. Melbourne: Psychoz.

Goldner, V. (2004). When love hurts: Treating abusive relationships. *Psychoanalytic Inquiry, 24*(3), 346-372.

Goldstein, H. (1990). The knowledge base of social work practice: theory, wisdom, analogue, or art? *Families in society: The journal of contemporary human services*, 32-43.

Goldstein, H. (2001). *Object relations theory and self psychology in social work practice*. New York: The Free Press.

Grafanaki, S., & McLeod, J. (1999). Narrative processes in the construction of helpful and hindering events in experiential psychotherapy. *Psychotherapy Research, 9*(3), 298-303.

Gray, M. (2002). Art, irony and ambiguity: Howard Goldstein and his contribution to social work. *Qualitative Social Work, 1*(4), 413-433.

Gray, M., & Mcdonald, C. (2006). Pursuing good practice? The limits of evidence-based practice. *Journal of social work, 6*(1), 7-20.

Greene, E. (1996). Sappho, Foucault, and women's erotics. *Arethusa, 29*, 1-14.

Habermas, J. (1971). *Knowledge and human interests*. Boston

Beacon Press.

Hacking, I. (1991). The making and molding of child abuse. *Critical Inquiry, 17*(Winter), 253-288.

Harker, T. (1997). Therapy with male sexual abuse survivors: Contesting oppressive life stories. In G. Monk & J. Winslade & K. Crocket & D. Epston (Eds.), *Narrative therapy in practice: The archaelogy of hope* (pp. 193-214). San Francisco: Jossey-Bass.

Harré, R. & Van Langenhove, L. (Eds.) (1999). Positioning theory: Moral contexts of intentional action. Oxford ; Malden, Mass : Blackwell.

Harris, R. (2007). *The happiness trap: Stop struggling, start living*. Wollombi: Exisle.

Hayes, S. C., & Strosahl, K. D. (Eds.). (2004). *A practical guide to acceptance and commitment therapy*. New York: Springer.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2003). *Acceptance and commitment therapy: An experiential approach to behaviour change*. New York: Guildford.

Hedges, F. (2005). *An introduction to systemic therapy with individuals: a social constructionist approach.* London: Palgrave Macmillan.

Herman, J. L. (1981). *Father-daughter incest*. Cambridge, Mass: Harvard University Press.

Herman, J. L. (1990). Sex offenders: A feminist perspective. In W. L. Marshall & D. R. Laws & H. E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories and treatment of the offender* (pp. 177-193). New York: Plenum.

Herman, J. L. (1992). *Trauma and recovery: From domestic abuse to political terror*. London: HarperCollins.

Hesse, E. (1999). The adult attachment interview: Historical and current perspectives. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 395-433). New York: Guilford.

Hobson, R. F. (1985). *Forms of feeling: The heart of psychotherapy*. London: Routledge.

Hoffman, I. Z. (2009). Doublethinking our way to "scientific legitimacy: The desiccstion of human experience. *Journal of the American Psychoanalytic Association,* 57, 1043-1069.

Hollway, W., & Jefferson, T. (2000). *Doing qualitative research differently*. London: Sage.

Holman Jones, S. (2005). Autoethnography: Making the personal political. In N. K. Denzin & Y. S. Lincoln (Eds.), *The sage handbook of qualitative research (third edition)* (pp. 763-792). Thousand Oaks: Sage.

Holmes, J. (2001). *The search for the secure base: Attachment theory and psychotherapy*. Hove: Brunner-Routledge.

hooks, B. (1984/2000). *Feminist theory: From margin to centre (second edition)*. Cambridge, MA: South End Press.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38,* 139-149.

Howe, D. (1987). *An introduction to social work theory*. Aldershot: Wildwood House.

Howe, D., & Fearnley, S. (1999). Disorders of attachment and attachment therapy. *Adoption & Fostering, 23*(2), 19-30.

Howe, K. R. (2004). A critique of experimentalism. *Qualitative Inquiry, 10,* 42-61.

Hoffman, I. Z. (2009). Doublethinking our way to "scientific" legitimacy: The desiccation of human experience. *Journal of the American Psychoanalytic Association,* 57 (5), 1043-1069.

Hubble, M. A., Duncan, B. L., & Miller, S. D. (Eds.). (1999). *The heart & soul of change: What works in therapy*. Washington: American Psychological Association.

Hughes, D. A. (2007). *Attachment-focused family therapy*. New York: W.W. Norton.

Hughes, D. A. (2009).*Attachment-focused parenting.* New York: W. W. Norton.

Jacoby, M. (1999). *Jungian psychotherapy & contemporary infant research*. London: Routledge.

Jenkins, A. (1990). *Invitations to responsibility*. Adelaide: Dulwich Centre.

Jenkins, A. (1994). Therapy for abuse or therapy as abuse? *Dulwich Centre Newsletter*(1), 11-19.

Jenkins, A. (1998). Invitations to responsibility: Engaging adolescents and young men who have sexually abused. In W. L. Marshall & Y. M. Fernandez & S.

M. Hudson (Eds.), *Sourcebook of treatment programs for sexual offenders*. New York: Plenum.

Jenkins, A. (2006). Shame, realisation and restitution: The ethics of restorative practice. *ANZJFT, 27*(3), 153-162.

Jones, M. (1990). Understanding social work: A matter of interpretation? *British Journal of Social Work, 20,* 181-196.

Jordan, J. V. (1997). Relational development through mutual empathy. In A. C. Bohart & L. S. Greenberg (Eds.), *Empathy reconsidered: New Directions in psychotherapy* (pp. 343-551). Washington, DC: American Psychological Association.

Kahr, B. (2001). *Exhibitionism*. Cambridge: Icon Books.

Kamsler, A. (1990). Her-story in the making: Therapy with women who were sexually abused in childhood. In M. Durrant & C. White (Eds.), *Ideas for therapy with sexual abuse*. Adelaide: Dulwich Centre.

Kantrowitz, J. L. (2002a). Writing about patients: I. Ways of protecting confidentiality and analysts' conflicts over choice of method. *Journal of the American Psychoanalytic Association, 52*(1), 69-99.

Kantrowitz, J. L. (2002b). Writing about patients: II. Patients' reading about themselves and their analysts' perceptions of its effect. *Journal of the American Psychoanalytic Association, 52*(1), 101-123.

Katz, A., & Shotter, J. (2004). On the way to "presence": Methods of a "social poetics". In D. A. Pare & G. Larner (Eds.), *Collaborative practice in psychology and therapy* (pp. 69-82). New York: The Haworth Clinical Practice Press.

Keenan, T., & Ward, T. (2000). A theory of mind perspective on cognitive, affective, and intimacy deficits in child sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 12*(1), 49-60.

Kindlon, D., & Thompson, M. (1999). *Raising Cain: Protecting the emotional life of boys*. London: Michael Joseph.

King, R., Lloyd, C., & Meehan, T. (2007). Key concepts and definitions. In R. King & C. Lloyd & T. Meehan (Eds.), *Handbook of psychosocial rehabilitation* (pp. 1-11). Oxford: Blackwell Publishing.

Klein, M. (1988). *Love, guilt and reparation and other works 1921-1945*. London: Virago Press.

Kogan, S. M., & Gale, J. E. (1997). Decentring therapy: A textual analysis of a narrative. *Family Process, 36*, 101-126.

Kohut, H. (1959). Introspection, empathy and psychoanalysis. *J. Amer. Psychoanal. Assn, 7*, 459-483.

Kohut, H. (1971). *The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissitic personality disorders*. New York: International Universities Press.

Kohut, H. (1977). *The restoration of the self*. New York: International Universities Press.

Kohut, H. (1984). *How does analysis cure?* Chicago: University of Chicago Press.

Kottler, J. A. (1986). *On being a therapist*. San Francisco: Jossey-Bass.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. Thousand Oaks: Sage Publications.

Laclau, E., & Mouffe, C. (1985). *Hegemony and socialist strategy: Towards a radical democratic politics*. London: Verso.

Lambie, I., & Seymour, F. (2006). One size does not fit all: Future directions for the treatment of sexually abusive youth in New Zealand. *Journal of Sexual Aggression, 12*(2), 175-187.

Lambert, M. J. & Barley, D.E. (2002). Research summary on the therapeutic relationship and psychotherapy outcome. In J.C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 17-32).Oxford: Oxford University Press.

Lane, S. (1997). The sexual abuse cycle. In G. Ryan & S. Lane (Eds.), *Juvenile sexual offending: Causes, consequences, and correction*. San Francisco: Jossey-Bass.

Larner, G. (2004). Family therapy and the politics of evidence. *Journal of family therapy*(26), 17-39.

Latta, N. (2003). *Into the darklands: Unveiling the predators among us*. Auckland: HarperCollins.

Law, I. (1999). A discursive approach to therapy with men. In I. Parker (Ed.), *Deconstructing psychotherapy* (pp. 115-131). London: Sage.

Lax, W. D. (1996). Narrative, constructionism, and Buddhism. In H. R. K. Kuehlwein (Ed.), *Constructing realities: Meaning-making perspectives for psychotherapies*. New York: Jossie-Bass.

Lee, R. R., & Martin, J. C. (1991). *Psychotherapy after Kohut: A textbook of self psychology*. Hillsdale, NJ: The Analytic Press.

Levine, S. B., & Stagno, S. J. (2001). Informed consent for case reports: The ethical dilemma of right to privacy versus pedagogical freedom. *J Psychotherapy Pract Res, 10*(3), 193-201.

Lichtenberg, J. D., Lachmann, F. M., & Fosshage, J. I. (1996). *The clinical exchange: Techniques derived from self and motivational systems*. Hillsdale, NJ: The Analytic Press.

Lietz, C. A., Langer, C. L., & Furman, R. (2006). Establishing trustworhiness in qualitative research in social work: Implications from a study regarding spirituality. *Qualitative Social Work, 5*, 441-458.

Lovat, T., & Gray, M. (2007). Towards a proportionist social work ethics: A Habermasian perspective. *British Journal of Social Work*(March), 1-15.

Lowe, R. (2000). Supervising self-supervision: Constructive inquiry and embedded narratives in case consultation. *Journal of Marital and Family Therapy, 26*(4), 511-521.

Luborsky, L., McLellan, A. T., Diguer, L., Woody, G., & Seligman, D. A. (1997). The psychotherapist matters: comparison of outcomes across twenty-two therapists and seven patient samples. *Clinical Psychology: Science and Practice, 4*(53-65).

Ludbrook, R. (2003). *Counselling and the law*. Hamilton: New Zealand Association of Counsellors.

Luepnitz, D. A. (1988). *The family interpreted: Psychoanalysis, feminism and family therapy*. New York: BasicBooks.

Luepnitz, D. A. (2002). *Schopenhauer's porcupines: Intimacy and its dilemmas*. New York: Basic.

Madison, G. (1990). *The hermeneutics of postmodernity*. New York: Indiana Press.

Magid, B. (2002). *Ordinary Mind: Exploring the Common Ground of Zen and Psychotherapy*. Boston: Wisdom Publications.

Magid, B. (2008a). *Ending the pusuit of happiness: A Zen guide*. Boston: Wisdom Publications.

Magid, B. (2008b). *Samness and difference*, [Ordinarymind.com]. Ordinarymind.com.

Magid, B. (2010). Personal communication, June.

Mahler, M. S., Pine, F., & Bergman, A. (1975). *The psychological birth of the human infant*. New York: Basic Books.

Mahoney, M. J., & Norcross, J. C. (1993). Relationship styles and therapeutic choices: A commentary. *Psychotherapy: Theory, Research and Practice, 30*, 423-426.

Mann, R. E. (2004). Innovations in sex offender treatment. *Journal of Sexual Aggression, 10*(2), 141-152.

Marshall, W. L. (2005). Therapist style in sexual offender treatment: Influence on indices of change. *Sexual Abuse: A Journal of Research and Treatment, 17*(2), 109-116.

Marshall, W. L. (2009). Manualization: A blessing or a curse? *Journal of Sexual Aggression*, 15(2), 109-120.

Marshall, W. L., Anderson, D., & Fernandez, Y. (1999). *Cognitive behavioural treatment of sexual offenders*. Chichester: John Wiley & Sons.

Marshall, W. L., & Barbaree, H. E. (1990). An integrated theory of the etiology of sexual offending. In W. L. Marshall & D. R. Laws & H. E. Barbaree (Eds.),

Handbook of sexual assault: Issues, theories, and treatment of the offender. New York: Plenum Press.

Marshall, W. L., Fernandez, Y. M., Serran, G. A., Mulloy, R., D., T., Mann, R. E., & Anderson, D. (2003). Process variables in the treatment of sexual offenders: A review of the relevant literature. *Aggression and Violent Behaviour, 8*, 205-234.

Marshall, W. L., Serran, G., Moulden, H., Fernandez, Y. M., Mann, R. & Thornton, D. (2002). Therapist features in sexual offender treatment: Their reliable identification and influence on behaviour change. *Clin. Psychol. Psychother*, 9, 395-405.

Marshall, W. L., Serran, G. A., Fernandez, Y. M., Mulloy, R., Mann, R. Thornton, D. (2003). Therapist characteristics in the treatment of sexual offenders: Tentative data on their relationship with indices of behaviour change. *Journal of Sexual Aggression*, 9(1), 25-30.

Marshall, W. L., & Marshall, L. E. (2000). The origins of sexual offending. *Trauma, Violence & Abuse, 1*(3), 250-263.

Marshall, W. L., & Serran, G. A. (2004). The role of the therapist in offender treatment. *Psychology, Crime & Law, 10*(3), 309-320.

Marshall, W. L., Ward, T., Mann, R. E., Moulden, H., Fernandez, Y., Serran, G., & Marshall, L. E. (2005). Working positively with sexual offenders. *Journal of interpersonal violence, 20*(9), 1096-1110.

Maruna, S. (2001). *Making good: How ex-convicts reform and rebuild their lives*. Washington, DC: American Psychological Association.

McCarthy, T. (1978). *The critical theory of Jurgen Habermas*. London: Hutchinsons of London.

McKenzie, W., & Monk, G. (1997). Learning and teaching narrative ideas. In G. Monk, J. Winslade, K. Crocket & D. Epston (Eds.), *Narrative therapy in practice: The archaelogy of hope* (pp. 82-117). San Francisco: Jossey Bass.

McLeod, J. (1990a). The client's experience of counselling and psychotherapy: A review of the literature. In D. Mearns & W. Dryden (Eds.), *Experiences of counselling in action*. London: Sage.

McLeod, J. (1990b). The practitioner's experience of counselling and psychotherapy: A review of the literature. In D. Mearns & W. Dryden (Eds.), *Experiences of counselling in action*. Oxford: Perrgamon.

McLeod, J. (1999). *Practitioner research in counselling*. London: Sage publications.

McLeod, J. (2003). *Doing counselling research (second edition)*. London: Sage.

McNamee, S., & Gergen, K. J. (Eds.). (1992). *Therapy as social construction*. London: Sage.

Meares, R. (2000). *Intimacy & alienation: Memory, trauma and personal being*. London: Routledge.

Meares, R. (2005). *The metaphor of play: Disruption and restoration in the borderline experience (Revised Edition)*. Northvale, NJ: Jason Aronson.

Mesner, M. A. (2001). Friendship, intimacy, and sexuality. In S. M. Whitehead & F. J. Barrett (Eds.), *The masculinity reader*. Cambridge: Polity.

Messerschmidt, J. W. (1999). Making bodies matter: Adolescent masculinities, the body, and varieties of violence. *Theoretical Criminology, 3*(2), 197-220.

Messerschmidt, J. W. (2000). Becoming "real men": Adolescent masculinity challenges and sexual violence. *Men and Masculinities, 2*(3), 286-307.

Monk, G., Winslade, J., Crocket, K., & Epston, D. (Eds.). (1997). *Narrative therapy in practice: The archaelogy of hope*. San Francisco: Jossey-Bass Publishers.

Muran, J. C. (2002). A relational approach to understanding change: plurality and contextualism in a psychotherapy research program. *Psychotherapy Research, 12*(2), 113-138.

Nisbet, I. (2005). *What is it that we do, and why: Criticisms of treatment programs for adolescents who have sexually offended*. Brisbane.

Nisbet, I., Rombouts, S., & Smallbone, S. (2005). *Impacts of programs for adolescents who sexually offend*. Ashfield: NSW Department of Community Services.

Norcross, J. C. (Ed.) (2002). *Psychotherapy relationships that work.* Oxford, Oxford University Press.

Nussbaum, M. C. (1994). *The therapy of desire: Theory and practice in Hellenistic ethics*. Princeton, New Jersey: Princeton University Press.

Orange, D., M. (1994). Countertransference, empathy, and the hermeneutic circle. In R. D. Stolorow & G. E. Atwood & B. Brandchaft (Eds.), *The intersubjective perspective*. Northvale, NJ: Jason Aronson.

Orange, D. M. (1995). *Emotional understanding: Studies in psychoanalytic epistemology*. New York: The Guildford Press.

Orange, D. M., Atwood, G. E., & Stolorow, R. D. (1997). *Working intersubjectively: Contextualism in psychoanalytic practice*. Hillsdale, NJ: The Analytic Press.

Orbach, S. (2002). *The Impossibility of Sex*. New York: Simon & Schuster.

Ornstein, P. H. (1999). Conceptualization and treatment of rage in self psychology. *Journal of clinical psychology, 55*(3), 283-293.

Palazzoli, S., Boscolo, L., Cecchin, G., & Prata, G. (1980). Hypothesizing-circularity-neutrality. *Family Process, 19:* 73-85.

Pare, D. A., & Larner, G. (Eds.). (2004). *Collaborative practice in psychology and therapy*. New York: The Haworth Clinical Practice Press.

Parton, N., & O'Byrne, P. (2000). *Constructive social work: Towards a new practice*. Houndmills, Basingstoke: Palgrave.

Pelias, R. (2004). *A methodology of the heart: Evoking academic and daily life*. Walnut Creek: Altamira Press.

Perry, B. D., & Szalavitz, M. (2006). *The boy who was raised as a dog: And other stories from a child psychiatrist's notebook*. New York: Basic Books.

Phillips, A. (1988). *Winnicott*. London: Fontana Press.

Polkinghorne, D. E. (1988). *Narrative knowing and the human sciences*. New York: State University of New York Press.

Polkinghorne, D. E. (1995). Narrative configuration in qualitative analysis. In J. A. Hatch & R. Wisniewski (eds) *Life History and Narrative.* London: Falmer Press.

Polkinghorne, D. E. (2004). *Practice and the human sciences: The case for a judgment-based practice of care.* Albany,NY: State University of New York Press.

Pollack, W. (1999). *Real boys: Rescuing our sons from the myths of boyhood*. New York: An Owl Book Henry Holt and Company.

Polster, E., & Polster, M. (1973). *Gestalt therapy integrated*. New York: Brunner/Mazel.

Pope, M., & Englar-Carlson, M. (2001). Fathers and sons: The relationship between violence and masculinity. *The Family Journal: Counselling and Therapy for Couples and Families, 9*(4), 367-374.

Popper, K. R. (1959). *The logic of scientific discovery*. New York: Basic Books.

Pringle, R. (2001). Competing discourses: Narratives of a fragmented self, manliness and rugby union. *International Review for the Sociology of Sport, 36*(4), 425-439.

Rabinow, P. (Ed.). (1997). *Michel Foucault Ethics Vol 1: Subjectivity and truth*. London: Penguin Books.

Real, T. (1990). The therapeutic use of self in constructionist/systemic therapy. *Family Process, 29*(3), 255-272.

Reed-Danahay, D. E. (1997a). Introduction. In D. E. Reed-Danahay (Ed.), *Auto/Ethnography: Rewriting the self and the social* (pp. 1-17). Oxford: Berg.

Reed-Danahay, D. E. (Ed.). (1997b). *Auto/Ethnography: Rewriting the self and the social*. Oxford: Berg.

Reupert, A. (2007). Social worker's use of self. *Clinical Social Work Journal, 35*, 107-116.

Rich, P. (2003). *Understanding, assessing and rehabilitating juvenile sexual offenders*. Hoboken, New Jersey: John Wiley & Sons.

Rich, P. (2006a). *Attachment and sexual offending: Understanding and applying attachment theory to the treatment of juvenile sexual offenders*. Chichester: John Wiley & Sons.

Rich, P. (2006b). From theory to practice: the application of attachment theory to assessment and treatment in forensic mental health services. *Criminal Behaviour and Mental Health, 16,* 211-216.

Richardson, L. (1994). Writing: A method of inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Hanbook of qualitative research* (pp. 516-529). Thousand Oaks, CA: Sage.

Richardson, L. (2000). Evaluating ethnography. *Qualitative Inquiry, 6*(2), 253-255.

Richardson, L., & St. Pierre, E. A. (2005). Writing: A method of inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *The sage handbook of qualitative research (third edition)* (pp. 959-978). Thousand Oaks: Sage Publications.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of consulting psychology, 21*(2), 95-103.

Rogers, C. R. (1967/1976). The interpersonal relationship: The core of guidance. In C. R. Rogers & B. Stevens (Eds.), *Person to person: The problem of being human* (pp. 89-103). London: Souvenir.

Ross, E. C., Polaschek, D. L. L., & Ward, T. (2008). The therapeutic alliance: A theoretical revision for offender rehabilitation. *Aggression and Violent Behaviour, 13,* 462-480.

Rothberg, D. (1993). The crisis of modernity and the emergence of a socially engaged spirituality. *ReVision, 15*(3), 105-114.

Ryan, G. (1997). Sexually abusive youth. In G. Ryan & S. Lane (Eds.), *Juvenile sexual offenders: Causes, consequences, and correction* (New and revised edition ed.). San Francisco: Jossey-Bass.

Ryan, G. (1999). Treatment of sexually abusive youth. *Journal of interpersonal violence, 14*(4), 422-436.

Ryan, G., & Lane, S. (1997a). Integrating theory and method. In G. Ryan & S. Lane (Eds.), *Juvenile sexual offending: Causes, consequences, and correction (New and revised edition)*. San Francisco: Jossey-Bass.

Ryan, G., & Lane, S. (Eds.). (1997b). *Juvenile sexual offending: Causes, consequences, and correction (new and revised edition)*. San Francisco: Jossey-Bass.

Sable, P. (2008). What is adult attachment? *Clinical Social Work Journal, 36*:21–30

Safran, J. D. (Ed.). (2003). *Psychoanalysis and Buddhism: An unfolding dialogue*. Somerville, MA: Wisdom.

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York: Guildford.

Saleebey, D. (Ed.). (1992). *The strengths perspective in social work practice*. New York: Longman.

Sampson, E. E. (2003). Unconditional kindness to strangers: Human sociality and the foundation for an ethical psychology. *Theory & Psychology, 13*(2), 147-175.

Sanderson, C. (2006). *Counselling adult survivors of child sexual abuse*. London: Jessica Kingsley.

Satir, V. (2000). The therapist's story. In M. Baldwin (Ed.), *The use of self in therapy (Second edition)* (Second ed., pp. 17-27). New York: The Haworth Press, Inc.

Saxe, G. N., Ellis, H. B., & Kaplow, J. B. (2007). *Collaborative treatment of traumatized children and teens: The trauma systems approach*. New York: Guilford.

Schore, A. N. (2003a). *Affect regulation and the repair of the self*. New York: W.W. Norton.

Schore, A. N. (2003b). Early relational trauma, disorganized attachment, and the development of a predisposition to violence. In M. F. Solomon & D. J. Siegel (Eds.), *Healing trauma: Attachment, mind, body, and brain* (pp. 107-167). New York: W. W. Norton.

Schore, A. N. (2005). A neuropsychoanalytic viewpoint: Commentary on paper by Steven H. Knoblauch. *Psychoanalytic Dialogues,* 15: 6, 829-854.

Schore, A. N., & Schore, J. R. (2008). Modern attachment theory: The central role of affect regulation in development and treatment. *Clinical Social Work Journal, 36*, 9-20.

Sedgwick, D. (1994). *The wounded healer: Countertransference from a Jungian perspective*. London: Routledge.

Serran, G., Fernandez, Y., & Marshall, W. L. (2003). Process issues in treatment: Application to sexual offender programs. *Professional Psychology: Research and Practice, 34*(4), 368-374.

Seuss, D., & Seuss Geisel, T. (1971). *The Lorax*. New York: Random House.

Shotter, J. (1994). *Conversational realities*. London: Sage Publications.

Siegel, D. J. (1999). *The developing mind: How relationships and the brain interact to shape who we are*. New York: The Guilford Press.

Siegel, D. J. (2003). An interpersonal neurobiology of psychotherapy: The developing mind and the resolution of trauma. In M. F. Solomon & D. J. Siegel (Eds.) *Healing trauma: attachment, mind, body, and brain* (pp. 1 -56). New York: W.W. Norton & Company.

Siegel, D. J. (2007). *The mindful brain: Reflection and attunement in the cultivation of well-being*. New York: W.W. Norton & Company.

Sinclair, S. L., & Monk, G. (2005). Discursive empathy: A new foundation for therapeutic practice. *British Journal of Guidance & Counselling, 33*(3), 333-349.

Slattery, G. (2003). Working with young men: Taking a stand against sexual abuse and harassment. In C. White (Ed.), *Responding to violence: A collection of papers relating to child sexual abuse and violence in intimate relationships* (pp. 169-186). Adelaide: Dulwich Centre.

Smallbone, S. (2006). Social and psychological factors in the development of delinquency and sexual deviance. In H. E. Barbaree & W. L. Marshall (Eds.), *The juvenile sex offender* (pp. 105-127). New York: Guilford Press.

Smallbone, S. W. (2005). Attachment insecurity as a predisposing factor for sexually abusive behaviour by young people. In M. C. Calder (Ed.), *Children and young people who sexually abuse: New theory, research and practice developments*. Dorset: Russell House Publishing.

Smith, C. (2004). Relational attunement: Internal and external reflections on harmonizing with clients. In D. A. Parre & G. Larner (Eds.), *Collaborative practice in psychology and therapy* (pp. 85-96). New York: The Haworth Clinical Practice Press.

Smith, L. T. (2005). On tricky-ground: Researching the native in the age of uncertainty. In N. K. Denzin & Y. S. Lincoln (Eds.), *The sage handbook of qualitative research (third edition)* (pp. 85-108). Thousand Oaks: Sage.

Solomon, J., & George, C. (1999). The measurement of attachment security in infancy and childhood. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications*. New York: Guildford Press.

Solomon, M. F., & Siegel, D. J. (Eds.). (2003). *Healing trauma: Attachment, mind, body, and brain*. New York: W. W. Norton.

Sonkin, D., & Dutton, D. (2002). Treating assaultive men from an attachment perspective. In D. Sonkin (Ed.), *Intimate violence: Contemporary treatment innovations*. New York: Haworth.

Speedy, J. (2008). *Narrative inquiry & psychotherapy*. London: Palgrave Macmillan.

Spence, D. (1982). *Narrative truth, historical truth*. New York: Norton.

Sroufe, L. A. (1995). *Emotional development: The organization of emotional life in the early years*. Cambridge: Cambridge University Press.

Stern, D. B. (2003). *Unformulated experience: From dissociation to imagination in psychoanalysis.* New York: Psychology Press

Stern, D. N. (1985/2000). *The interpersonal world of the infant: A view from psychoanalysis & developmental psychology*. New York: Basic Books.

Stern, D. N. (2004a). *The present moment in psychotherapy an everyday life*. New York: W. W. Noron.

Stern, D. N. (2004b). *The present moment in psychotherapy and everyday life*. New York: W.W. Norton & Company.

Stolorow, R., Atwood, G., & Brandchaft, B. (Eds.). (1994). *The intersubjective perspective*. Northvale: Jason Aronson Inc.

Strean, H. S. (1999). Resolving some therapeutic impasses by disclosing countertransference. *Clinical Social Work Journal, 27*(2), 123-140.

Strupp, H. H. (2001). Implications of the empirically supported treatment movement for psychoanalysis. *Psychoanalytic Dialogues,* 11:4, 605-619.

Sullivan, H. (1953). *Interpersonal theory of psychiatry*. New York: Norton.

Sussman, M. B. (2007). *A curious calling (second edition)*. Lanham: Jason Aronson.

Sussman, M. B. (Ed.). (1995). *A perilous calling: The hazards of psychotherapy practice*. New York: John Wiley & Sons.

Swenson, C. C., Henggeler, S. W., Schoenwald, S. K., Kaufman, K. L., & Randall, J. (1998). Changing the social ecologies of adolescent sexual offenders: Implications of the success of multisystemic therapy in treating serious antisocial behaviour in adolescents. *Child Maltreatment, 3*(4), 330-338.

Tangney, J. P., & Dearing, R. L. (2002). *Shame and guilt*. New York: Guilford.

Tedlock, B. (2005). The observation of participation and the emergence of public ethnography. In N. K. Denzin & Y. S. Lincoln (Eds.), *The sage handbook of qualitative research (thrid edition)* (pp. 467-482). Thousand Oaks: Sage.

Thakker, J., Ward, T., & Tidmarsh, P. (2006). A reevaluation of relapse prevention with adolescents who sexually offend: A good-lives model. In H. E. Barbaree & W. L. Marshall (Eds.), *The Juvenile sex offender* (pp. 313-335). New York: Guilford Press.

Tomm, K. (1987a). Interventive interviewing: I. Strategizing as a fourth guideline for the therapist. *Family Process, 26:* 3-13.

Tomm, K. (1987b). Interventive interviewing: II. Reflexive questioning as a means to enable self-healing. *Family Process, 26:* 167-183.

Tomm, K. (1988). Interventive interviewing: III. Intending to ask circular, strategic or reflexive questions? *Family Process, 27:* 1-15.

Tootell, A. (1999). "I give things a go": The story of how Dylan Wise rediscovered his confidence. *Gecko: a journal of deconstruction and narrative ideas in therapeutic practice, 1*, 11-30.

Tootell, A. (2003). *Decentring research: Reflecting on reflecting teams*. Adelaide: Unpublished Masters Thesis.

Tootell, A. (2004). Decentring research practice. *The International Journal of Narrative Therapy and Community Work*(3), 54-60.

Tootell, A., Wright, G., Hall, R., & Jenkins, A. (1997). *Stopping violence groups: A model of best practice for group work with men who wish to stop violent and abusive behaviour towards their women partners and family*. South Australia: Northern Metropolitan Community Health Service.

Tucci, J., Mitchell, J., & Goddard, C. (2010). *Response to national standards for out of home care consultation paper: Submission to the Department of Families, Housing, Community Services and Indigenous Affairs.*. Ringwood, Victoria: Australian Childhood Foundation and Child Abuse Prevention Research Australia, Monash University

Vivian-Byrne, S. (2004). Changing people's minds. *Journal of Sexual Aggression, 10*(2), 181-192.

Vygotsky, L. S. (1962). *Thought and language (Second Edition)*. Cambridge, MA: MIT Press.

Wachtel, P. L. (2008). *Relational theory and the practice of psychotherapy*. New York: The Guilford Press.

Waikato University (2007). *Human Research Ethics Regulations*. Waikato: University of Waikato.

Ward, T., & Brown, M. (2004). The good lives model and conceptual issues in offender rehabilitation. *Psychology, Crime & Law, 10*(3), 243-257.

Ward, T., Day, A., Howells, K & Birgden, A. (2004). The multifactor offender readiness model. *Aggression and violent behavior,* 9, 645-673.

Ward, T., & Eccleston, L. (2004). Risk, responsivity, and the treatment of offenders: Introduction to the special issues. *Psychology, Crime & Law, 10*(3), 223-227.

Ward, T., Hudson, S. M., & Keenan, T. (1998). A self-regulation model of the sexual offense process. *Sexual Abuse: A Journal of Research and Treatment, 10*(2), 141-157.

Ward, T., & Marshall, L. E. (2004). Good lives, aetiology & the rehabilitation of sex offenders. *Journal of Sexual Aggression, 10*(2), 153-169.

Ward, T., Melser, J., & Yates, P. M. (2007). Reconstructing the risk-need-responsivity model: A theoretical elaboration and evaluation. *Aggression and Violent Behaviour, 12,* 208-228.

Ward, T., Polaschek, D. L. L., & Beech, A. R. (2006). *Theories of sexual offending*. Chichester: John Wiley & Sons.

Ward, T., & Stewart, C. (2003). Criminogenic needs and human needs: A theoretical model. *Psychology, Crime & Law, 9*(2), 125-143.

Warner, M. S. (1997). Does empathy cure? A theoretical consideration of empathy, processing, and personal narrative. In A. C. Bohart & L. S. Greenberg (Eds.), *Empathy reconsidered: New directions in psychotherapy* (pp. 125-140). Washington, DC: American Psychological Association.

Weedon, C. (1997). *Feminist practice & poststructuralist theory (second edition)*. Malden, MA: Blackwell.

Weingarten, K. (2003). *Common shock: Witnessing violence every day, how are we harmed, how can we heal*. New York: Dutton.

Wexler, D. B. (1999). The broken mirror: A self-psychological treatment perspective for relationship violence. *J Psychotherapy Pract Res, 8*(2), 129-141.

White, M. (1993). Deconstruction and therapy. In S. Gilligan & R. Price (Eds.), *Therapeutic conversations* (pp. 22-61). New York: W. W. Norton.

White, M. (1995). *Re-authoring lives: Interviews and essays*. Adelaide: Dulwich Centre.

White, M. (1997). *Narratives of therapists' lives*. Adelaide: Dulwich Centre Publications.

White, M. (2007). *Maps of narrative practice*. New York: W. W. Norton.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: W. W. Norton.

Wilber, K. (1997). *The eye of the spirit: An integral vision for a world gone slightly mad*. Boston: Shambhala.

Williams, D. J. (2004). Sexual offenders' perceptions of correctional therapy: What can we learn? *Sexual Addiction & Compulsivity, 11*, 145-162.

Williams, D. J. (2006). Autoethnography in offender rehabilitation research and practice: Addressing the "us vs them" problem. *Contemporary Justice Review, 9*(1), 23-38.

Winslade, J. (2002). Storying professional identity. *The International Journal of Narrative Therapy and Community Work* (4), 33-38.

Winslade, J., Crocket, K., & Monk, G. (1997). The therapeutic relationship. In G. Monk, J. Winslade, K. Crocket & D. Epston (Eds.), *Narrative therapy in practice: The archaelogy of hope* (pp 53 - 81). San Francisco: Jossey-Bass Publishers.

Winter, G. (2000). A comparative discussion of the notion of 'validity' in qualitative and quantitative research. *The Qualitative Report,* 4 (3&4), March.

Wolf, E. S. (1988). *Treating the self: Elements of clinical self-psychology*. New York: Guilford.

Wolf, E. S. (1998). Optimal responsiveness and disruption-restorations. In H. A. Bacal (Ed.), *Optimal responsiveness: How therapists heal their patients*. Northvale, New Jersey: Jason Aronson Inc.

Wolsket, V. (1999). *The therapeutic use of self: counselling practice, research and supervision*. London: Routledge.

Worling, J. R., & Langstrom, N. (2003). Assessment of criminal recidivism risk with adolescents who have offended sexually. *Trauma, Violence & Abuse, 4*(4), 341-362.

Yalom, I. D. (1991). *Love's Executioner and Other Tales of Psychotherapy*. London: Penguin Books.

Yalom, I. D. (2001). *The gift of therapy: Reflections on being a therapist*. London: Piatkus.

Young-Eisendrath, P. (2004). *Subject to change: Jung, gender and subjectivity in psychoanalysis*. Hove: Brunner-Routledge.

Zimring, F. E. (2004). *An American travesty: Legal responses to adolescent sexual offending*. Chicago: University of Chicago.