A Portfolio of Academic, Therapeutic Practice and Research Work

Including an investigation titled: “Have You Ever Wondered What It Might Be Like To Try And Cuddle A Tiger? Towards a grounded theory of practitioners’ non-pathologising experience of aggression”

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List of published papers
Introduction to the Portfolio

This portfolio comprises the work I completed over a three year period as part of the requirements for the Practitioner Doctorate in Psychotherapeutic and Counselling Psychology. It is structured into three dossiers; Academic, Therapeutic Practice and Research; which are linked by my professional and personal experiences, and my own position in relation to counselling psychology.

There are two interrelated themes that run throughout the portfolio, explored from different perspectives that link the pieces contained within. The first is an exploration of the epistemological stances that can underpin the theories and knowledge that inform the practise of psychotherapy and counselling psychology. The second is an exploration of how the therapeutic relationship that is built between the practitioner and client is immensely important to the work that is to be undertaken.

These themes do not stand in isolation from my personal life but rather grew out of significant events during my history. As a boy my father became ‘disabled’ with a diagnosis of multiple sclerosis. As a child I could find no obvious differences in him which I could readily use to explain why he now had this diagnosis. This was very confusing, as in my eyes he was still the same man, yet it led to major changes in the structure of my family, and this permanently blurred the line for me between what was considered ‘normal’ and what was not. As Laing describes it, “Man as seen as an organism or man as seen as a person discloses different aspects of the human reality ...[and] one must be alert to the possible occasion for confusion” (1960; p22). Later in life I experienced a period of distressing physical symptoms myself which, having pursued the obvious medical route, led to my first experience of therapy. This therapy went far beyond a simple intervention for my symptoms; in fact seeming not to tackle them in any direct way, yet they did ease. Once again I came face to face with the ‘blurry’ and confusing overlap between the emotional and the physical, but this time I experienced the benefits that can be gained if one is able to negotiate this. These experiences ultimately attracted me to the idea of working within a profession that would allow me to try and walk the ‘tightrope’ between these two positions in the hope that it would benefit others in the same way I had benefited. I thus applied for the Practitioner Doctorate course and much of my work attended to exploring and negotiating how to ‘balance’ on the line between physical health and emotional health, organism and person in a way that would be beneficial.

Having worked within service development in the National Health Service (NHS) however, I was aware that within such contexts, the dominant discourse favoured those practitioners and theories that allied themselves to a physical/medical health perspective. The work contained within this portfolio pays attention to such contextual factors and how they may threaten to
'topple' the practitioner from the 'tightrope' where s/he might lose sight of the usefulness of an emotional perspective. Fortunately, having previously studied philosophy at undergraduate level, I incorporated this knowledge into my work to explore the epistemological assumptions that informed the discourses within such contexts. This allowed a consideration of alternative epistemological stances that might act as a counter-balance for the practitioner, turning a potential 'topple' into something more akin to a 'wobble' that allows for a continued consideration of both physical and emotional factors.

From my own experiences of therapy I had found that the therapeutic relationship is a relationship unlike any other I had experienced. The person of my therapist impacted upon me deeply leading me to the conclusion that it was not simply what we talked about that helped me, but who she was in herself. When I met her I had myself 'toppled' from the tightrope onto the physical [ill] health side of the floor. She supported me back onto the rope, accepting without complaint, that I would make it more 'wobbly' for both of us as we walked it together for that period of time. I am not sure I would have got off the floor had she not done this. Prior to entering training therefore, I entered therapy again, in an effort to be able to explore my capacity to fulfil this role for my own clients. The work contained throughout this portfolio acknowledges and explores the importance of the practitioner and client walking the line together, accepting that this might make it more 'wobbly' for both of them, but trusting, as I do, that this in itself is much more helpful than being stuck on the floor on one particular side.

Thus the themes of the therapeutic relationship and the epistemology of therapeutic practice are attended to in various different guises throughout this portfolio. The Academic Dossier contains three papers written during my training, all of which attend to the epistemology of the medical model of 'health and illness', considering the impact this has on therapeutic practice, particularly how it guides the relationship formed with the client, and considers alternative stances that might inform the work. The first paper specifically explores the diagnostic category of Attentional Deficit Hyperactivity Disorder, considering how the medical model helps or hinders the practitioner working with children who have received this label, and contrasts how this might be different for the practitioner who considers a more social constructionist stance to the work. The second paper moves on to explore the philosophical foundations of the psychoanalytic model, contrasting the positivistic stance with a more phenomenological one, and considers the impact this has on the client, practitioner and the work that is possible. The final paper then explores how the psychoanalytic practitioner might work with clients who have been referred through the medical model, having received a diagnostic label of borderline personality disorder, exploring the impact of such labels upon the therapeutic relationship.
The Therapeutic Practice Dossier is related to work carried out during the three years of clinical placements. It contains a brief description of each of my placements and the type of work undertaken within each of them, and also contains a Final Clinical Paper which discusses in more detail how these placements, plus my academic consideration of epistemology and the relationship have shaped my current stance towards being a psychotherapeutic counselling psychologist.

Finally, the Research Dossier contains three research pieces conducted over the three years of my training. The pieces are linked in that they all explore the theme of human aggression whilst considering how the epistemological stance one takes towards this can help or hinder the therapeutic process, particularly the impact this has upon the therapeutic relationship. In the first year a literature review revealed that the majority of psychological publications tended to view aggression from within a positivistic standpoint thereby considering it only from a negative point of view (pathology). This was contrasted with the existential phenomenological literature and considered how these two stances might compliment or contradict each other, particularly focusing on the implications for the therapeutic relationship. A research project carried out in the second year offered an alternative perspective to the majority of psychological publications by reporting on the experiences of a group of martial art practitioners who engaged with their aggression in a non-pathological manner, outlining the benefits of this for their self-development and thereby suggesting the need to go beyond the medical model when considering such issues in the therapeutic relationship. This theme was continued in a research paper carried out in the third year that offered a theory derived from interviews with therapeutic practitioners who engage with aggression in a non-pathologising manner.

References

Academic Dossier

Introduction to the Academic Dossier

The Academic Dossier is a collection of three papers written during the three years of my training.

The first paper explores the diagnostic category of Attentional Deficit Hyperactivity Disorder and how such a diagnosis helps or hinders the clinician working with children who may display this type of behaviour. This essay was written at an early stage of my training and drew upon my previous knowledge of the medical model and social constructionism, comparing and contrasting these two stances and considering the impact each might have on the therapeutic relationship.

The second paper, written in my second year, explores the possible epistemological underpinnings of the psychoanalytic model of therapy, comparing and contrasting the impact of a positivistic stance of a phenomenological one on the therapeutic relationship.

The third paper then considers how the psychoanalytic practitioner might engage and work with clients who have been referred through the medical model, having received a diagnostic label of borderline personality disorder, exploring the impact of such labels upon the therapeutic relationship.
Critically examine the diagnostic category of Attentional Deficit Hyperactivity Disorder and two models of its causation. To what extent are the category and models useful for the counselling psychologist in explaining and intervening in cases of children who display this type of behaviour?

Introduction

This paper critically discusses the cognitive and medical approaches to the concept and development of ADHD arguing that such approaches rest on particular philosophical foundations which guide the observations made, questions asked, and therefore conclusions reached (Babbage and Ronan, 2000). Having contrasted these two approaches in relation to their underlying philosophical backgrounds, it will be argued that these approaches are limited in the account they can offer and hence the interventions available.

What is ADHD?

It is unclear from the literature whether the condition of Attentional Deficit Hyperactivity Disorder (ADHD) can be precisely defined in psychological terms.

**DSM-IV (Diagnostic and statistical manual of mental disorders)**

The American Psychiatric Association's (1994) DSM-IV classifies ADHD in three ways: the 'inattentive type' where the child is considered to display six or more symptoms out of nine from their list of 'inattention' symptoms; the 'hyperactive-impulsive type' where the child displays six or more symptoms from the list of 'hyperactivity-impulsivity' symptoms (six 'hyperactive' and three 'impulsive' symptoms); and the 'combined type' where the child is considered to display six or more symptoms from either list.

**ICD-10 (International classification of mental and behavioural disorders)**

The ICD-10 (World Health Organisation, 1992) has a similar list of symptoms for 'hyperkinetic disorder' (their equivalent). Diagnosis under this criterion requires six out of nine symptoms of inattention, three out of five symptoms of hyperactivity and one out of four symptoms of impulsivity.

Diagnosis under ICD-10 or DSM-IV requires symptoms to have been present for at least six months before the age of seven (Hay, McStephen & Levy, 2001), "to a degree that is maladaptive and inconsistent with the developmental level of the child" (Munden & Arcelus,
2000 p.15) and not caused by any other disorder such as anxiety or personality (Munden & Arcelus, 2000).

**How does ADHD develop?**

Historically the predominant developmental models of disturbing behaviour in children attribute the causes of such behaviour to either cognitive or medical factors, and ADHD is no exception.

**Cognitive Model**

The cognitive model views psychological difficulties as caused by missing, delayed or differing cognitive processes (Barnes & Bancroft, 1995; Faulkner & Lewis, 1995). In the case of ADHD research has focused on the development of the cognitive structure known as 'executive function'. Executive functions are described as high level functions that allow flexibility, planning, and inhibitory control (Oates & Grayson, 2004), allowing children to override habitual responses to prepotent behaviour, stay on-task longer, become more flexible in thinking and behaviour, engage in more sophisticated planning and decision making, and hence learn new skills (Oates & Grayson, 2004). Abnormality in the development of executive functioning results in an inability to organise thinking and hence act in a planned, appropriate and effective manner. The child displays hyperactivity, impulsiveness and inattention, as it is drawn from one prepotent stimulus to the next, unable to stay on task, plan or prioritise their actions (Oates & Grayson, 2004).

**Medical Model**

The medical model views psychological difficulties within a 'disease' paradigm as used in traditional medicine (Barnes & Bancroft, 1995). The model has been successful where identifiable disorders, such as chromosomal differences, illness or trauma cause psychological changes which require intervention. In the case of ADHD, studies have suggested differing levels of neurotransmitters (dopamine and noradrenaline) (Munden & Arcelus, 1999), which can be controlled by the use of Ritalin (Green & Chee, 1997), displaying a response rate around 70% (Treacy, 1999). Further evidence shows that trauma to the pre-frontal cortex in the brain presents symptoms of abnormal executive functioning (Changeux, 1985; Goldstein, 1944), hence dopamine and noradrenaline are presumed to be involved in executive functioning and occurring in the pre-frontal area of the brain (Green & Chee, 1997). Hence this model assumes that children with ADHD have differences in the working of the pre-frontal cortex. In the absence of trauma or illness, the model suggests possible genetic

**Critical Analysis**

Both models offer useful frameworks for understanding the concept and development of ADHD but their underlying methodology relies upon standardised measures/interventions and ‘tools’, developed within positivistic science, leading mainly to pharmaceutical treatment (Woodhead, 2002). This methodology has been popular because if a condition and its effects on behaviour can be categorised, the outcomes of any interventions should be readily measurable, and predictable in valid and generalisable ways (Oates, 2004).

However, as Roth and Fonagy (1996) point out, “for many therapists, reduction of outcomes to a series of scores is unsatisfactory”, and Sameroff (1991) suggests that these models are over-simplistic and limited in the account they can provide. As, Woodhead (2002) points out;

“These children are both disturbing to, as well as disturbed by, family, school and society. They are troublesome as well as troubled, disorderly as well as disordered”

(p.46)

This has led to a growing concern about the validity of such models that presume particular directions of causality. The medical paradigm’s emphasis on internal causes removes attention from the role child and society might play in their development and, the cognitive model’s emphasis on cognitive processes removes attention from the social environment within which the child interacts (Barnes, 2002). Whilst psychological intervention should ideally focus on the ‘primary’ cause of difficulty (Faulkner & Lewis, 1995), in the case of ADHD, it is not clear what the ‘primary’ cause is. Hence psychologists have to target ‘secondary’ effects which are multiple, complex, subject to change over time, and related to interactions with social environment (Hay, McStephen & Levy, 2001), e.g. social background (Rutter, Tizard & Whitmore, 1970), gender (Davie et al, 1972), age (Tizard et al, 1988), parental marital relationships, maternal mental state and parental attitudes (Richman et al, 1982).

The lack of universal standards for appropriate behaviour (Woodhead, 2002) further complicates matters. The boundary between normal, boundary testing behaviour in childhood and more problematic behaviour is difficult to define. Problematic behaviour may take on different expressions over time (Jenkins et al., 1984), is always expressed within the context of social relationships (Woodhead, 2002), and cultural expectations (Downey, 2003), whether it is biologically based or not. Whilst developmental changes are usually associated with
particular phases in childhood, this is not always the case, e.g. under stress children tend to 
function "at social and cognitive levels lower than would otherwise be the case." (Downey, 
2003 p.334). Further, behavioural differences across relationships/contexts are only stable in 
that the relationships/contexts are also stable (Dunn & Kendrick, 1982). Barkley et al. (1985) 
demonstrated how mothers of children receiving Ritalin were more interested in their child's 
behaviour when the child moved off-task, rather than scolding them and attempting to modify 
their behaviour as was the case in the placebo group. More general studies have shown that 
mothers' attitudes, measured whilst their children were still in the womb, related to how they 
perceived their children's temperament once they were born (Vaughn et al, 1987), and 
research suggests that children's early behaviour has an enduring influence on their 
parents/caregivers perceptions long after the behaviour itself has changed (Brazelton and 
Cramer, 1991; Oates, 2004). Hence relationships with primary caregivers have already, to 
some extent, been shaped by early interactions, which, in turn, shape the child's 
development. In this way it is very difficult to disentangle the social/environmental effects on 
development from the genetic and biological (Oates, 2004).

Therefore labeling the child with ADHD without accounting for the severity of the child's 
difficulties in respect to the developmental expectations for their age group (Barnes, 2002), 
context within which the behaviour is recorded (Woodhead, 2002), and the contextual 
relationships that influence it (Downey, 2003) may limit the achievements and development 
that are possible. The child may be perceived as passive, without consideration of their 
particular needs and distanced from others considered 'normal'. This may reflect a growing 
social trend where "people are all too ready to accept a medical label for their difficulties" 
(Fitzpatrick, 2001 p.113).

However, to provide a more holistic perspective that places the child’s developing life in 
context, counselling psychologists must, to some extent admit that objective, perspective-less 
assumptions are limiting (Crossley, 2000; Henwood & Pidgeon, 1992; Riessman, 1993; 
Sullivan, 2003; Willig, 2001). Downey (2003) argues that "any adequate formulation of 
childhood difficulties must acknowledge and include the dynamic and reciprocal relationships 
between children and their environment" (p.328), where development is viewed as a complex 
process of continuous dynamic interaction between child and environments across time, 
involving relationships with others, all of which impact upon each other (Sameroff, 1991). It is 
not helpful therefore to objectify experiences of problem behaviour, removing them from the 
context and people who express them. Nor can it be easily demonstrated that one determines 
the other (Sameroff, 1991; Shottter, 1998). Hence, there may be many different 
conceptualizations of problematic behaviour, with many contributing factors, of which genetic 
or socio-cultural environment (Woodhead, 2002), family, gender, age, and the child itself are 
but a few (Lerner & Busch-Rossnagel, 1981). It follows that, if counselling psychologists can
understand problematic behaviour within the context of which it expresses itself and include a consideration of the dynamic relationships that may influence it, whilst resisting reducing it to a 'label', this may allow for a more useful consideration of the child's needs (Pilgrim, 2000; Shotter, 1998). So, "from this perspective, any attempt to categorise or label the client – for example, by using a psychiatric diagnosis [such as ADHD] – can be seen as inappropriate and unhelpful, a misunderstanding of the true nature of persons." (McLeod, 2003 p.142).

Practical Advantages

It is hoped that by a consideration of the multitude of different perspectives and factors that contribute to behaviour within a particular context, this may help to clarify the situation, and facilitate an exploration of alternative possibilities (Sameroff, 1991). This does not deny biological or genetic factors, accepting that for children development is more dependent on these processes than for adults (Baltes, 1987), but also enables practitioners to be involved in helping clients to become aware of age-graded expectations within their society, thus to create individual goals in relation to this normative timetable (Rodgers, 1984). However, this approach also accepts that biological and genetic factors are but two of many different intertwined pathways to psychological outcomes which require investigation in context (Lerner & Busch-Rossnagel, 1981).

This has advantages over the medical approach in that it allows the counselling psychologist, parent or teacher to respond realistically to the child and the context, whilst maintaining an open dialogue between them (Pilgrim, 2000; Sameroff, 1991; Shotter, 1998). This recognizes the child’s active role in the process rather than treating them as a passive 'victim' of external circumstances (Woodhead, 2002). This empowers and enables the child to begin to consider and take responsibility for how their choices influence other's responses to them (Bell, 1968; Sameroff and Chandler, 1975). Hence, problematic behaviour is not considered a biological or environmental deficit, but rather an inability to consider alternative possibilities (Bor, Legg & Scher, 1996). This also empowers counselling psychologists, parents, teachers by making them aware of their active role in the process of exploring such alternatives.

By recognising that "social understanding evolves through relations with others...[this approach also recognises that so does] social misunderstanding" (Monk, 2002; p9), leading to negative stigma surrounding diagnostic labels such as 'ADHD (Barnes & Bancroft, 1995). This enables the counselling psychologist to avoid becoming 'trapped' into a pattern of behaviour by the application of a particular label (Barnes & Bancroft, 1995; Bor, Legg & Scher, 1996), and focus instead upon the creation of a meaningful relationship with the child within which alternatives can be explored (Woolfe, 1996).
Disadvantages

Some caution must be stressed in the abandonment of searching for simple causal explanations and diagnostic classifications. If therapy is restrained by the child's developmental ability to participate (Downey, 2003), or if faced with a multitude of possible alternatives it may be unclear how to proceed or who has responsibility for decision making, thus disinclining traditional power holders (clinicians) to allow any distribution of power (Sullivan, 2003). Sullivan (2003) has pointed out that adopting a shift towards management of uncertainty would require a revolutionary transformation that most would be unwilling to approach, particularly perhaps due to the reinforcement of medical approaches within contexts such as education (Sugarman, 2003), the NHS (Chambers, 1998; Garelick, 2000), and the attitudes of the psychiatric profession (Miller, 1996). It has been argued that within such contexts, diagnostic classifications may be necessary in communicating with other health care professionals (Sadock & Sadock, 2001).

Conclusion

It can be seen then that the concept of ADHD is both difficult to define precisely and, perhaps partly due to this, difficult to assess. There is theoretical conflict over how much effect society has in shaping its development. Medical positivistic theorists who argue that ADHD is a biological essence, not affected by social/environmental factors, view the child as essentially passive in its development, and tend to measure it quantitatively leading to standardised interventions. However, there is evidence to suggest that ADHD is, at least in part, affected by social/environmental factors, and that children and society/environment are active in the developmental process, suggesting that these contextual factors must be considered if intervention is to be meaningful or useful at all.
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Critically examine the philosophical foundations of the Psychoanalytic Model. To what extent are these useful for the counselling psychologist working within this framework?

Introduction

This paper critically explores the positivistic, deterministic foundations upon which Freud aimed to ground the psychoanalytic model of therapy arguing that these particular philosophical foundations guide the observations made, questions asked, and therefore conclusions reached (Babbage and Ronan, 2000). Having outlined the underlying philosophical foundations of psychoanalysis, it will be argued that these foundations limit the account they can offer and hence the interpretations available, leading the practitioner to make assumptions that deny a full exploration of as wider context as possible. It will be argued that a less strict positivistic deterministic approach would do more justice to the model.

The philosophical foundations of psychoanalysis

Freud held a "scientifically inspired anti-philosophical stance" (Smith, 1999; p180) toward his theories, in line with current thinking of the time. The predominant philosophical underpinnings of psychoanalysis therefore adopted a positivistic, deterministic stance.

Determinism

Determinism holds that that "all events are determined by a sequence of causes... therefore nothing happens by accident ... [and] this means that we can trace causal links between our behaviour in the here and now and our past... [hence] what happened to us as children is seen to shape our personalities in a very profound way" (Lemma-Wright, 1997; p50). This suggests that habitual patterns of relating (often from early childhood) can become developed and repeated in current relationships. Often we 'transfer' feelings and attitudes from the past onto others in the present whether such reactions are appropriate or not (Lemma-Wright, 1997). Freud argued, "a thing which has not been understood inevitably reappears" (1909; p280). Hence for the practitioner working psychodynamically, the extent to which the past determines the client's present is related to the degree to which they remain unaware of its significance.
Positivism

Positivism holds that in order for statements to be meaningful, they must be verifiable, i.e. they must be grounded in empirical proof. However, as Popper later argued, no amount of observations can ultimately prove a statement true, but simply one confirmation can prove a statement wrong (Smith, 1999). Therefore, positivistic scientific theories must be, in principle, falsifiable to determine their truth or falsity.

The implications, therefore, for psychoanalysis, if it is to be grounded upon a positivistic deterministic foundation, is that our past must determine our present (until it is brought into our awareness) and that therapist interpretations' that seek to bring the past into the present, must be, in principle, able to be tested through empirical observation (Smith, 1999).

The National Health Service (NHS)

Whilst Freud outlined his ideas approximately a hundred years ago, such a stance might seem equally attractive for the psychoanalytic practitioner working in today's NHS where it is equally obvious that treatments grounded in a particular version of scientific proof are given preferential status. As Chambers (1998) points out, the NHS operates with a hierarchy of best evidence, which comprises of five levels, at the top of which are random controlled trials (RCTs), which, supposedly, represent the most robust evidence, moving down through controlled trials, less controlled trials, multiple non-experimental studies to descriptive studies at level five, which, supposedly, represent the least robust evidence. Within the NHS therefore, empirically supported therapies are given preferential status and “Thus, only the highly specified, structured therapies with demonstrable, measurable outcomes have the opportunity to try for funded research” (Monk, 2000; p.8)

Methodological incompatibility

However, there are some serious methodological difficulties for psychoanalysis to demonstrate its claim to be grounded in empirically observable truth. Although interpretations must be coherent; “after many attempts we become absolutely certain...which piece belongs in the empty gap” (Freud, 1896, p205); coherence, “...is a necessary but not a sufficient condition for regarding a hypothesis as true” (Smith, 1999; p184). As Popper argued, although psychoanalytic theory might appear coherent enough to explain a great deal, it is “compatible with everything that would happen” (1974, p985); it cannot be scientific because it is so broad that it is non-falsifiable (Smith, 1999). Freud therefore argued that the truth of interpretations rest on their curative ability, i.e. interpretations tally with real unconscious ideas from our past, and once this truth is made conscious we are no longer determined by it, becoming cured and
demonstrating it as truth (Smith, 1999). Nagel (1959), however, points out that “Freudian formulations... have so much 'open texture', to be so loose in statement, that... they are unquestionably suggestive” (p42). Hence, if the client accepts that they will be 'cured' and avows the practitioner's interpretations then “This implies that... there remains insidious pressure on the patient to fall in with the analyst’s way of thinking...[and hence] Data taken from the therapeutic situation are useless for objectively validating psychoanalytic theories because they are 'epistemically contaminated' by that very situation.” (Smith, 1999; p185/6). Hence it can be questioned whether “the curative effect of psychoanalytic interpretations flow from their suggestive power rather than from their truth.” (Smith, 1999; p185).

Therefore it is important for psychoanalysis to rule out the effect of suggestion in order to gain empirical support. Yet Freud himself openly acknowledged the element of suggestion in the positive transference, and the need to work with this during therapy (1916/17). In admitting the existence of positive transference, psychoanalytic theory therefore accepts the impossibility of testing the validity of practitioner interpretations and these methodological difficulties have not been satisfactorily solved by post-Freudian psychoanalysts (Grunbaum, 1984, 1993). At present therefore, psychoanalytic work cannot be empirically verified, nor hold status within the NHS’s hierarchy of evidence.

An alternative stance

However, one must question the appropriateness of Freud’s determination to take a "scientifically inspired anti-philosophical stance" (Smith, 1999; p180), and the pressure added by the “...supremacy of the RCT paradigm in the NHS” (Monk, 2000; p.7). As Arthur (2000) points out, psychotherapists rely “...predominantly on their intuition rather than the physical senses and process their knowledge through the use of feeling by introspective analysis, insight and empathy” (p.25). Such a use of the self does not lend itself to empirical observation which relies upon “physical senses for information gathering...thinking over feeling...and realistic...value observation and measurement” (p.25). Therefore Smith (1999) argues, “one response...is to argue that psychoanalysis is not a natural science...[but rather] an 'interpretative art'” (p186). Hence to base its underlying epistemology on empirically validated scientific claims maybe completely inappropriate. If so, Holmes (2000) rightly points out that psychotherapy would have to betray its core ideologies if it does not want to be discriminated against in the NHS. To force psychoanalysis to adopt a positivistic, deterministic foundation would introduce methodological and epistemological limitations that detract from the value it can provide its clients. Some of these are outlined below.
Comments on Causality

A strict deterministic stance assumes that if practitioners can uncover the client's significant past relational patterns, then interventions can be made, that allow for change in current relations in a predictable manner. Whilst research has demonstrated the importance of our early relationships to our social, emotional and cognitive functioning (Murray-Parkes et al., 1991), the results of such research have also demonstrated that "the way in which the past shapes the present is not consistently predictable" (Lemma-Wright, 1997; p57). Therefore one must question the deterministic assumption about the nature of time as unilinear and causal, moving from past to present into future. Although attractive in its simplicity, assumptions like these would not do justice to all the factors associated with the full range of human experience. As Cooper (2003) points out, any attempt to "reduce...being down to a set of essential [past] components would... diminish the fullness of...humanity" (p10) and ignores how human beings actually experience their world (Heidegger, 1926/1962). Past, present and future are not experienced in linear succession but are multidimensional. Our present experience is inevitably informed by anticipations based on the past, but we do not perceive our present as being caused by the past (Hicklin, 1998). Humans then, have a dynamic existence that is in constant flux (Merleau-Ponty, 1945/1962). It makes little sense therefore to suggest that things are static enough to find simple linear, causal relationships between the past and the present (Lemma-Wright, 1997). As Freud argued, "all of us are essentially divided beings, permanently out of touch with some of the most vital aspects of our being" (Smith, 1999; p74/5). To offer only strict deterministic interpretations exacerbates this and "denies the inherent complexity of the human condition and the many forces and influences which shape us" (Lemma-Wright, 1997). Hence, practitioners cannot claim to understand all that actually matters to the client (Sullivan, 2003).

Comments on Choice

If the past becomes seen as deterministic of the present, assuming unilinear causal connections, this also ignores the active role of the individual and society in constructing such connections (Winnicott, 1962). Whilst there may be some basic past 'givens' of our being which limit our choices (Heidegger, 1926/1962), and there is plenty of evidence to support this claim (Lemma-Wright, 1997), the client is still free to choose his responses to these (Sartre, 1943/1958). Strict causal models, however, assume that individuals are essentially separate, with a distinction between subject and object, therapist and client. It follows that the therapist can stand outside his/her personal bias and describe the client objectively in terms of their past. As Freud originally suggested, the therapist's subjective reactions to the client (counter-transference) were an obstacle to therapy (1910). It may therefore be tempting for the therapist to interpret his role as simply providing causal interpretations based upon the past,
and/or it may be the client’s wish to passively wait for the practitioner to give an answer (Lemma-Wright, 1997). This may reflect a growing social trend where “people are all too ready to accept a medical label for their difficulties” (Fitzpatrick, 2001 p.113), “denying the freedom and responsibility that I, as an individual, hold... [and] falling in with the crowd.” (Yalom, 1980, p.24) or the therapist’s interpretation which is taken as a ‘given’ rather than as plastic and contingent (Lemma-Wright, 1997). This allows the individual (therapist or client) to escape responsibility into illusions of outside structure. However, this objectifies the client, denying their unique, unclassifiable subjectivity and their full ability to become aware of their potential possibilities. Therapist and client are therefore unable to choose their responses in a manner that is meaningful and right for them, colluding with their capacity for self-deception (Cooper, 2003). This leads them to live an inauthentic life, a false self (Winnicott, 1960), the object of other peoples’ values, part rather than whole object (Klein, 1957) feeling powerless, hopeless, and guilty (Bugental, 1981). This therefore sets up the dynamic where each person in the relationship is trying to avoid being objectified by objectifying the other, the implications of which leaves each isolated and apart, with feelings of loneliness (Cohn, 1997), denying them their autonomy, responsibility, and ability to relate, possibly reinforcing the belief that their only option is pre-determined (Cooper, 2003) and ultimately making them less open to wider definitions of themselves and their freedom of choice (Boss, 1963).

Arguably then, it is more “valuable...for the client to confront those beliefs and values that he or she actually holds, as opposed to those s/he might claim to hold” (Spinelli, 2006) or those imposed upon them by the therapist. As Lemma-Wright (1997) points out “It is the patient ideally who arrives at his own interpretations through the process of exploring how he feels and making links between the past and the present” (p191). Hence the practitioner focuses on ‘the creation of a space where the client’s story can be heard’ (Cohn, 1997: p33). Rather than focusing purely on the past, the practitioner aims to gain as full a description of the client’s world as possible whilst clarifying assumptions that arise out of this process. The aim therefore, is a genuine dialogue that recognises the autonomy and uniqueness of the other, treating the patient as a whole object (Klein, 1957), where limitations and possibilities for wider choice and change are ‘unfolded’ and acknowledged (Spinelli, 1989).

**Comments on transference**

However, in practice the creation of such a space may not be an easy task. Past assumptions implicit in the client’s definition of themself may lead them to experience another as a person of a certain kind. Often transferring feelings and attitudes from the past into the present whether such reactions are appropriate or not (Lemma-Wright, 1997). In doing so, there is some denial of the uniqueness of the other (Klein, 1957), which may make the relationship less transparent and in need of clarification and elucidation (Cohn, 1997). The therapeutic
relationship therefore offers a space within which to explore and uncover early experiences which influence present relationships, both outside therapy and with the therapist. However, these can conflict with our beliefs about how we are with others, leading to feelings of anxiety, guilt and powerlessness (Boss, 1963; Cooper, 2003; Yalom, 1980). In such a situation, it may seem more tempting to deny any insight, hence subjecting relations to further rejection, distortion and destruction (Fromm, 1974).

If one accepts, however, that we have the capacity to withdraw or deny our relatedness to others (or be denied); this still constitutes a form of relatedness. It follows that humans, therapist and client, cannot be described in isolation from each other. By being aware of this, this enables the practitioner to avoid the stigma of causal approaches that label the individual as passive in favour of focusing on promoting a meaningful relationship characterised by acceptance and authenticity (Woolfe, 1996) where each may be transformed by the encounter (Buber, 1923/1958). Hence nothing is assumed about the client’s style of human relatedness. By recognising this, the therapist is able to use his counter-transference, abandoning the need to describe the client objectively (Winnicott, 1956) and can respond to the client’s tendency to deny or distort any new insight, aiding change in the individual and environment, whilst maintaining a negotiating/collaborating relationship with the client (Pilgrim, 2000; Sameroff, 1991; Klein, 1957). In doing so, this allows the client’s definition of self and others to be challenged by their experiences, becoming aware of the “limitations and constraints which may be placed on us as a result of early experiences” (Lemma-Wright, 1997; p58), and achieving a measure of self-realisation and control over current relationships and as a result.

A word of caution

Some caution must be stressed in the abandonment of the positivistic, deterministic foundations of psychotherapy. Sullivan, (2003) has pointed out that adopting a shift towards management of uncertainty, where there are no set techniques or agendas that can be easily explained would require a revolutionary transformation that most would be unwilling to approach, particularly within the NHS (Chambers, 1998; Garelick, 2000), and the psychiatric profession (Miller, 1996). It has been pointed out that within such a context, the practitioner is under increasing pressures (from hospitals, insurance companies, governmental agencies, and educational establishments) to provide assessments, histories, and diagnostic classifications within short periods of time that sum up their clients in order to communicate with other health care professionals (Barnes, 2002).
Conclusion & Implications for practitioners

Within the positivistic deterministic paradigm therefore, there are particular assumptions about the nature of time, causality, and human relatedness that limit the exploration possible within therapy.

In arguing against these assumptions, the objectivity of the practitioner is denied, acknowledging that all relations are intersubjective. Hence the practitioner aims to provide a space where an exploration of what matters to the client can occur. The practitioner acknowledges that this exploration is influenced by the past, but also by social cultural understandings including the relationship that the therapist forms with the client. This denies strict causality, acknowledging the client's autonomy. Hence the practitioner avoids bringing normative judgements, such as causal explanations, that risk further denying this freedom.

This does not deny past experiences, accepting that existence is bounded in very real ways, but enables practitioners to be involved in helping clients to become aware of how they relate to their past. This facilitates an investigation of how such a relational stance facilitates or hinders the client's ability to meet their possible potential in a manner which is right for them. This can empower practitioner and client by generating new understanding, making them aware of their active role in the process, and their ability to collaborate in new ways with others once they have become aware of their assumptions.

Despite these arguments, however, practitioners are left working within environments, such as the NHS, that demand one-sided causal explanations, based on positivistic, deterministic science, that limit the possibilities for exploration of a client's ability to meet their potential. This limits the understanding of the needs of the client, and the social environment in which they interact, perpetuating their difficulties.
References


Paper 3:

Refusing to Bow: A critique of the diagnostic category of Borderline Personality Disorder considered from an Object Relations viewpoint.

Introduction

This paper critically discusses the concept and development of Borderline Personality Disorder (BPD). As Cashden (1988) points out, “the particular stance taken towards psychopathology is a direct derivative of the theoretical perspective to which one subscribes” (p53). Therefore, having critically outlined BPD, and the medical model from which it emerged, this will be contrasted with the Object Relations perspective, exploring the interventions available, with the clinical examples where appropriate.

BPD

According to the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR), BPD is classed as an Axis II disorder, which requires any five out of the following nine criteria to be present for a significant period of time beginning before adulthood:

1. Frantic efforts to avoid real or imagined abandonment.
2. Unstable and intense interpersonal relationships characterised by alternating extremes of idealization and devaluation.
4. Impulsivity in at least two areas that is potentially self-damaging.
5. Recurrent suicidal ideation/attempts or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood.
7. Chronic feelings of emptiness/worthlessness.
8. Inappropriate anger.
9. Transient, stress-related paranoid ideation or severe dissociation.

Although not all those with a diagnosis of BPD display the ‘criteria’ in the same way, or share the same background history, I hope to illustrate the kind of difficulties that those with BPD, and those around them, might encounter by describing a ‘client’ I worked with.

1 In order to preserve confidentiality this ‘client’ is actually an amalgamation of several clients I have worked with, all of whom had been given the label of BPD, and contains no identifying data for any of them.
This female client had a long psychiatric history stretching back to her teenage years where she had begun self-harming. Her distress eventually led to a suicide attempt in her early twenties by overdose (criterion 5). Her family had all experienced her angry outbursts, tantrums, and sullen moods (criterion 8). She accused them of being unjust, patronising her, and treating her as stupid. She experienced them as a group within which she somehow didn’t fit or wasn’t wanted (criterion 1). She felt that the boundaries that her parents laid down were unreasonable, although many of them seemed reasonable to others when she recounted them. At times they made no sense to her, and left her feeling frustrated, angry, misunderstood, and patronised. She often experienced low, depressive moods, feelings of worthlessness (criterion 7) and self-doubt (criterion 3). These difficulties were not limited to her home life, but were experienced at school with teachers and peers, and later with colleagues and managers in the jobs she had. Her motivation and ability to keep up her schooling and relationships was limited and she struggled to complete her education and gained few qualifications. As an adult she also struggled to hold down jobs and spent a lot of time unemployed feeling unable to work. She experienced the world as a place within which no one wanted to help her to fit (criterion 2). She felt there was no one to turn to, and so dealt with her emotions by ‘lashing’ or ‘storming’ out, and/or turning them on herself.

I experienced her as clever and intelligent, but very concrete and factual. She complained therapy was ‘pointless’ and that she could not understand how it would help. When explanations, interpretations, or empathic links were attempted, she would change from being friendly to accusing me of being obtuse, not giving clear guidelines, having all the power, and not ‘caring’. She generally attributed changes in herself to her anti-depressants or mood stabilisers, and changes in therapy to coincidence or external circumstances. Attempts to engage her would make her frustrated, and in the early stages, she would often ‘storm’ out. This seemed to echo her family’s experience of her to some degree. They had attempted to ‘help’ her but had ultimately relied upon mental health services when their attempts were unsuccessful.

The Medical Model

Diagnostic categories such as BPD arise from psychiatry which is underlined by the ‘medical model’. This views psychological difficulties as ‘symptoms’ of an ‘illness’ located within the client (Woolfe, 1996). It assumes that if the ‘symptoms’ can be categorised, then treatment (usually pharmaceutical) can be standardised and should lead to predictable improvements in ‘symptoms’ (Sackett & Rosenberg, 1995).

This model is dominant within the NHS (Chambers, 1998; Garelick, 2000), perhaps due to reinforcement of the use of drug therapies (Albee, 2000). Within such a context, diagnostic
classifications may be necessary in communicating with other health care professionals (Sadock & Sadock, 2001). Certainly within the psychotherapy department where I worked with this client such communication was considered essential at two levels. Firstly, upon referral, such diagnostics gave some indication as to the severity of the difficulties, and some indication of what may become present within the therapy. Secondly as part of the NHS, the department was somehow required to empirically demonstrate successful outcomes for 'target' issues in order to prosper and/or survive (Monk, 2003; Roberts; 1997).

Critical Analysis

There is a risk that reducing clients to diagnostic categories may over-simplify and perpetuate their problems (Roth and Fonagy, 1996). If emphasis is placed upon diagnostics, without accounting for context and significant relationships, then the client’s particular needs may be ignored, and they may be considered ‘not normal’ and disempowered. As Brandchaft and Stolorow (1984) argue, the instabilities of BPD often occur in contexts where the problem is located ‘inside’ the individual by unempathic practitioners who do not acknowledge the impact of their way of being on the client.

Hence in these settings, practitioners may be perceived as powerful, judgemental, and active, but paradoxically constricted to considering BPD only as a (pathological) symptom in need of removal. Any attempt to step outside a discussion about ‘symptoms’ may be met with confusion and suspicion (Spurling, 2003), but only discussing ‘symptoms’ may perpetuate them.

It could be argued that the relationship with the client described earlier, was typical of this, and she experienced herself, and me, from this viewpoint. Whilst she could accept pharmaceutical treatment from her psychiatrist, she was initially unable to engage in any discussion with me about the relational aspects of her difficulties.

It is argued therefore that the medical model offers a limited understanding of BPD and hence may reduce interventions available to or used by practitioners.

Object Relations

In contrast to the ‘medical model’, the Object Relations model considers ‘symptoms’ as “disturbances in interpersonal relationships” (Cashden, 1988; p53). This does not deny ‘internal’ factors, but acknowledges that it is hard to disentangle these from significant relationships.
This perspective suggests that pathology develops if children are only valued by primary caregivers for limited forms of behaviour, rather than loved for being wholly themselves. The child is brought into conflict with caregivers when they inevitably display those aspects that are 'disapproved' of. This leads the child to encounter the threat or actuality of withheld love and/or abandonment, and can prompt them to doubt their self-worth, their ability to form and sustain subsequent meaningful relationships, and their ability to 'exist' without them. Consequently, the child searches for means by which to ensure that significant others, always remain in their lives, bound to them, in order to maintain their sense of self-worth (Cashden, 1988).

The child may therefore attempt to deny those aspects of themselves that are not in accordance with those valued by the caregivers, to develop what Winnicott (1956, 1960) termed a 'false self'. This is not entirely possible, hence the child must attribute the denied aspects to someone else when they emerge (Lemma-Wright, 1995). Simultaneously, the child pressures the other, emotionally and behaviourally, into 'accepting' those 'split' off parts as their own (Klein, 1957), by using an implicit promise or threat. Unfortunately, this usually leads to conflict within the relationship, as the other struggles to avoid being 'used', and often leads, ironically, to abandonment. This simply confirms the belief that part of them is undesirable. Hence, these relational patterns become habitual and generalised to all significant relationships.

Anxieties about separation, abandonment, and conflict about the expression of emotional need have been shown to be common in those labelled with BPD (Bateman & Fonagy, 2005) and I noticed that any suggestion to my client that she might feel angry was normally deflected by denial and accusations that I was being unhelpful and persecutory - that it was actually me who was angry with her. Cashden (1988) notes that clients can use criticism and the challenging of competencies to attempt to keep the other bound to them, as the criticism contains the implicit threat of "You can't survive without me" (p66).

However, to locate these problems, and need for change within the client; categorising it (in this case as BPD) as the medical model suggests, may collude with the client's attempts to keep others bound to them by manipulating their sense of responsibility, i.e. because they are 'ill' they 'cannot cope alone'. Rather, Object Relations views the relationship itself, rather than the client, as the focus for change. This has advantages over the medical approach in that rather than the client being considered a passive 'victim', they are considered active in perpetuating or resolving their issues once they are able to see the assumptions that underpin their decisions. This empowers practitioners and clients, making them aware of their role in the process and their ability to consider alternatives once they have become aware of them,
rather than being 'stuck' in a particular pattern of behaviour by the application of a diagnostic label.

Therapy

Practitioners informed by the Object Relations perspective therefore aim to construct a relationship which facilitates relational patterns to emerge. This is characterised by commitment, communication of empathic understanding, and perhaps even cautious and likely-to-succeed suggestions (Cashden, 1988). The practitioner resists doing too much too soon; before the client is prepared. This allows the client to begin to see therapy as less characterised by the stereotypes of the medical model. Therapeutic bonding occurs and the client's inner 'object' world begins to be reflected in the relationship (Bateman & Fonagy, 2006).

At this stage the practitioner uses their counter-transference, in league with the client's history, to identify any attempts to manipulate him and the relationship, and directly communicates his refusal to "bow to the patient's demand" (Cashden, 1988; p121).

This challenges clients' means of avoiding abandonment, demonstrating that the practitioner refuses to capitulate and be 'bound' in the relationship. Simultaneously it may be experienced as a rejection of the parts that clients feel others should always accept. Clients may experience vulnerability, anxiety, depression, and/or rage and intensify their attempts to 'bind' the practitioner. The client described earlier, would demand explanations, withdraw, retreat into silence, fly into rages, sulk, threaten to leave, accuse me of being hateful/destructive, and/or threaten to self-harm, especially if a break (holiday) was approaching. Writers suggest that phenomena such as this are often attempts to prevent the practitioner from 'abandoning' the client by using the implicit message "I can't cope without you" (Cashden, 1988; Valenti, 2002).

Generally, such responses aim to provoke practitioner's anxiety, causing them to question whether they have 'sabotaged' the therapy by making the client 'worse' and therefore reverse their decision to resist the clients' demands. Thus this ultimately is designed to reduce the clients' anxiety. However, to capitulate, no matter how difficult it is to continue, would simply ally the practitioner with the client's demands, perpetuating the client's habitual patterns of relating. Rather, the practitioner must continue to counter the client's demands so they both experience and confront the powerful feelings present in the relationship. The practitioner must demonstrate that these seemingly overwhelming emotions are 'survivable' (Spurling, 2003). Any attempt at this stage to question, analyse, interpret, and/or explain what is taking place, shifts the therapy into the realm of the cognitive/intellect, defuses the direct emotional
impact and learning that is possible, and may lead to further dysregulation in the client’s affect (Bateman & Fonagy, 2006). Simultaneously, the practitioner restates his/her commitment directly and concretely in order to demonstrate that he/she still cares, is rejecting the projective identification rather than the client, and that the therapy is not over (Cashden, 1988).

By the continued reassurance and presence of the practitioner, the client slowly and experientially learns that “the split-off ‘bad’ parts of the self are not grounds for abandonment” (Cashden, 1988; p121). The client begins to see that they are desirable in their own right and begins to let go of their dependency and the need to control others.

This is a turning point in therapy, bringing a sense of relief for both client and practitioner, where the relationship takes on a different quality even though most clients are unaware of this change (Cashden, 1988). It is at this point that the therapist, drawing on his experiences with the client, can help them to gain an intellectual appreciation of what has happened (Fonagy & Bateman, 2007). Ideally then, self-exposure is no longer automatically associated with danger, the client becomes less dependent on the therapist to feel secure and valued, and the end of treatment, the emotions that this evokes, can be discussed. The ending offers the opportunity for the practitioner to share his feelings of loss with the client and, for the client, perhaps for the first time, to leave another feeling valued, without experiencing rejection and a catastrophic loss.

I began to experience some of these changes in the client’s relational style during my time at placement, as I began to feel less ‘used’ but the ending of my given time prevented me from following this client any further in her therapy.

Caution

Some caution must be stressed in the use of Object Relations therapy for BPD clients. Such work generates high levels of affect making continuous containment difficult (Valenti, 2002). It has been noted that this is not always manageable and, coupled with patterns of conflictual endings, may lead to premature termination by the client. Whilst this does not always imply a lack of improvement, evidence suggests that the longer clients stay in treatment, the more they improve (Waldinger & Gunderson, 1984).

Further, the current emphasis within health care upon empirical demonstration of specific techniques for ‘target’ issues within cost-effective, time-frames (Monk, 2002; Roberts, 1997) disadvantages therapies, such as Object Relations, which focus on the human condition as a whole and argue that reducing therapy to focus on particular subsection of human experience
(diagnostic categories) is contra-indicated. The problem is compounded by the difficulties of measuring such typically long-term, open-ended therapies empirically (Fletcher, 2007).

This has given rise to a multiplicity of alternative treatments that lend themselves better to the criteria of the health care system (Waldinger & Gunderson, 1984). More recently, two particular treatments have come to dominate in the treatment of BPD; mentalization-based treatment (MBT) and dialectical-behaviour therapy (DBT). To some extent these are to be welcomed as they remind practitioners that there are some clearly identifiable and unhelpful patterns of object relations for those with BPD (Bell, Billington, & Cicchetti, 1988). Further, the success of the DBT model raises questions for Object Relations surrounding when and how cognitive/behavioural interventions may be useful. Similarly, both MBT and DBT highlight the necessity of preparatory work, especially for BPD clients, to enable them to 'use', rather than be overwhelmed by, intensive therapy (Waldinger & Gunderson, 1984). These models both stress the importance of modeling a 'not knowing' stance towards clients, the need to model continual reflection of thoughts, and to stress that practitioners do not have privileged knowledge of the client's process. This reinforces the perception of a non-judgemental relationship, and encourages the client to be able question their own assumptions and means of relating towards others (Fonagy & Bateman, 2007).

**Conclusion**

The medical model, out of which diagnostic categories such as BPD were formed, views the diagnostic criteria of such categories as 'symptoms' of pathology located within a passive individual.

The object relations perspective however, views such 'symptoms' as the results of attempts to manipulate others into remaining in relationships with oneself, whilst simultaneously trying to 'split' off parts of the self that are perceived as 'bad', and expected to result in abandonment. Unfortunately, such attempts to control the self and others, generally undermines relationships, leading to conflict, more 'symptoms', and ultimately abandonment. This reinforces and perpetuates these patterns.

Recognising this enables the object relations practitioner to focus on promoting a meaningful, committed, relationship in which the relational phenomena that characterise BPD can be expressed and challenged, and hence a new kind of relationship can be experienced. Over time this encourages the client to feel valued for who they are rather than what they do, leading to less 'distorted' perceptions of oneself and others, and therefore the ability to form more appropriate relationships. This has advantages over the medical approach in that the client is empowered, rather than being considered a passive 'victim'. Hence, problems are
considered the inability to perceive alternative possibilities rather than personal deficits. This empowers practitioners and clients, allowing for the exploration of assumptions that leads to the ability to consider wider possibilities, rather than being 'stuck' in a particular pattern of behaviour through the application of a diagnostic label.

However, the practitioner must also acknowledge the contextual constraints that impinge upon this type of work in the current health care system. Further, new models, such as DBT and MBT, can inform the practitioner of new theories in how to work more effectively with this client group, aiding their ability to use therapy, avoiding early termination, and balancing the timing and effectiveness of cognitive/behavioural interventions.
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Therapeutic Practice Dossier

Introduction to the Practice Section

The Therapeutic Practice Dossier described the three clinical placements I undertook during the three years of training; short-term (average six sessions) therapy within a primary care GP surgery, long-term (one year) therapy within a secondary care psychotherapy department and shorter-term (average twelve to twenty-four sessions) therapy across three CMHTs.

These placements allowed me to gain experience of the patient pathway through the National Health Service (NHS) and an understanding of how such services refer and relate to each other. This is particularly helpful considering the current agenda for future mental health services which focuses on a ‘stepped care’ approach.

These placements also allowed me to work with different therapeutic models including humanistic models in the first year, psychodynamic perspectives in the second year and cognitive-behavioural/integrative approaches in my third year. I worked with a range of clients and presenting issues, and was given the space to consider my work from a multitude of perspectives allowing me to understand how context and interpersonal factors can influence treatment decisions.

The Therapeutic Practice Dossier also includes my Final Clinical Paper which discusses my perceptions of my training and how these have contributed to my current stance as a psychological practitioner.
Description of Clinical Placements

Year 1

In my first year my placement was in a Primary Care GP Surgery that offered six to twelve sessions. The clients were referred by the GP, practice nurse, in-house health visitor, or self-referred and this was normally their first experience of therapy. I was able to work with a range of clients in terms of age, gender, cultural background, social class, educational level and presenting issues.

I was part of a team, working humanistically, supervised by the in-house counsellor (Dip.Couns. BACP Accredited UKRC registered), alongside one other counselling psychology trainee. We worked as part of the surgery's multidisciplinary team which included three GPs, the practice manager, physiotherapist, and health visitor. As part of this team I was able to develop both my written and verbal communication skills regarding my clinical work.

During this year I was also able to attend induction training held by the Primary Care Trust that consisted of a Child Protection workshop and a lecture on the principles of Clinical Governance. The training was also attended by nurses and occupational therapists and I was therefore exposed to a wider perspective of some aspects of the Trust.

Year 2

In my second year I moved into a placement within a secondary care psychodynamic therapy department that offered long-term therapy of normally two or three years but this was adapted for my clients who were reassessed at the end of my year with them. The clients were referred from a number of sources including GP, Counsellors, Psychologists, Social Workers, and Community Psychiatric Nurses and had normally had at least one experience of therapy before. Many of them had long standing histories of emotional difficulties with numerous mental health input such as psychiatry inpatient and outpatient treatment.

During the year I worked with two clients individually and co-facilitated a closed unstructured group for young people aged between twenty and thirty. I was thus involved with a number of clients ranging in terms of age, gender, social class, educational level, occupational status, previous diagnostic categories, and I was therefore exposed to a range of presenting issues.

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1 Client studies, process reports and log books were produced for all these placements. Due to the need to maintain client confidentiality these are not included in the portfolio but form part of the appendices available to the exam board.
I worked psychodynamically, supervised by a consultant psychotherapist (BAP, IAAP, BPC, UKCP), alongside one other counselling psychology trainee. We were included in the weekly team meeting with the department’s 5 psychotherapists and during the year we were asked to conduct and present the results of an audit collating the diagnostic information included in referral information for all the clients currently undergoing treatment in the department. The results of this audit demonstrated that little diagnostic information was included and consequently I learnt that this made it hard for the department to demonstrate the degree of difficulty involved in the work they undertake. In discussion at the team meeting, it was decided to action this by creating a future plan to educate referrers of the need to include such information.

The department worked closely with Psychiatry, Specialist Psychological Therapies, Family Therapy, and the Neuropsychology departments within the Trust. The service as a whole was therefore able to provide a range of psychological services and I was able to gain exposure to ‘in-house’ referrals, multi-disciplinary formulation, lunchtime seminars, a one day workshop outlining the latest cognitive behavioural protocols for clients who ‘hoard’, and weekly psychiatric/GP educational case presentations.

**Year 3**

In my third year I began work across three Secondary Care Community Mental Health Teams offering psychological interventions of an average twelve to twenty four sessions for adults with severe and enduring mental health difficulties. Clients were referred from a number of sources including GP, Psychiatrists, Social Workers, and Community Psychiatric Nurses but due to the complexity and longevity of their difficulties, most had been involved with psychiatric services at some point in their history. I worked individually with a number of clients ranging in terms of age, gender, social class, educational level, occupational status, previous diagnostic categories and presenting issues during the year. Alongside two occupational therapists I also co-facilitated a closed structured group for eight individuals focusing on anxiety management. I was supervised by a counselling psychologist who supported my learning of the Cognitive Behavioural model but also encouraged me to integrate my previous knowledge of other models in order to meet the complex needs of the clients who presented.

I was invited to the allocation meetings within each CMHT, team psychology meetings and monthly psychology locality meetings. This allowed me to gain a wider perspective of the work that was being carried out across the Trust including the development of Mentalisation Based Therapy (MBT) and Dialectical Behavioural Therapy (DBT) groups for clients with issues relating to a diagnosis of borderline personality disorder.
Due to the multidisciplinary nature of the CMHTs I was able to partake in a number of duty assessments carried out by the team in addition to my psychology commitments. Further, I was also able to liaise with the psychiatric services within the Trust and spent two shifts on the inpatient ward and observed a session of electroconvulsive therapy (ECT). This allowed me to gain a wider perspective of the services available within the local area and therefore made me somewhat more informed about some of the experiences of my clients.
Final Clinical Paper

As I began to think about this paper, it seemed impossible to capture how I engage with theory, research and practice in only five thousand words. I had to make some difficult choices about what to include or exclude, and decided that as each research project I undertook during my training includes a section within which considerable personal reflection was undertaken (see the Research Dossier of this portfolio) I would not focus on this aspect here. Instead I have tried to present specific themes that drove my continuing development as a therapeutic practitioner and I have exemplified these with significant moments that shaped the direction of my journey. All references to clients have been disguised to protect their anonymity.

Use of the Self & the Relationship

Several years before I even began thinking about training as a psychologist, in fact standing in the way of me feeling able to begin my undergraduate degree, I had several distressing and ongoing personal experiences which led to my first experience of therapy as a client. What I am prepared to share about that therapy is what I felt to ultimately be the most helpful factor in that change process that impacted me in a way that I had never before experienced. That factor was not some theory or technique, but actually the effect of the person of my therapist on me; a feeling when I was around her that influenced me very much but that I find impossible to describe in words.

I now realise that it was this, not the multitude of research that echoes it, that has perhaps influenced my opinion that it is the therapist themselves that is extremely important therapeutically. My curiosity about what it meant to be a therapist was raised and I was fascinated about how being a therapist seemed not just a role but something that was embodied and lived.

Based upon this conviction that who you were and what you embodied yourself was somehow very important in the therapeutic process, it made perfect sense to me that counselling psychologists should have to undergo their own therapy during training. In fact, part of what attracted me to this course was to enter a profession that supported and valued personal, as well as professional, growth as not only possible but essentially necessary to the work that must be undertaken. So before I even applied for the course I re-entered into therapy again as part of this process and again experienced the rewards that come through being with a therapist.
As I began my first placement in a General Practitioner (GP) surgery providing brief therapy (on average six sessions) to adults referred by their GP, I was very anxious whether I would be able to live up to my perceived standard of my therapists. My early client work therefore was characterised by my attempts to contain my anxiety through an almost obsessive maintenance of the core conditions of genuineness, empathy, and unconditional positive regard (Rogers, 1957). This model fitted perfectly with my first supervisor who seemed to embody it in how she related to me in supervision. She set up the boundaries of time and what was, and was not, appropriate material for supervision in our first session, but then encouraged me to bring what I felt I needed to rather than imposing any agenda, recognising my own anxieties and feelings of inadequacy whilst pointing out strengths in my work where appropriate. This allowed me to feel valued and worthwhile, and I very slowly began to feel a bit more confident and capable. I reasoned that if it worked for me, it might work for my clients.

Unfortunately however, I noticed that the ‘did not attend’ (DNA) rate of my clients was high and several were discharged on the basis of repetitive non-attendance. Although my supervisor reassured me that this was normal in primary care work this seemed most unsatisfactory to me; not a good outcome for those clients. As Rogers (1957) points out, therapeutic change can only occur if therapist and client are in psychological contact. Neither did it seem good for my confidence in my therapeutic ability, bringing up pressures and anxieties about whether I would have enough client hours to sit the end of first year viva. I did not know what was going ‘wrong’, whatever that meant, and resorted to trying to think and intellectualise my way out of ‘trouble’. I began to explore other research and models of therapy in the hope that answers would be forthcoming and I discovered the existential-phenomenological approach. Unlike the overtly optimistic stance of the person-centred approach, this model linked psychological difficulties with the attempt to deal with the ‘givens’ of human existence such as death, isolation, uncertainty, and ‘being’ in relation to others (Cooper, 2003).

Reflecting on my own therapy as a place where I was ‘being’ in relation to another, I could indeed empathise with how uncomfortable and distressing the therapeutic relationship could be at times when one comes into contact with feelings associated with acknowledging, talking about, and confronting “those beliefs and values that [one] actually holds, as opposed to those s/he might claim to hold” (Spinelli, 2006). I began to wonder whether I had not been giving adequate space to working with such discomfort in the room.
I used supervision to work on how and when to use this realisation in my interventions with my clients and, as I worked on these aspects of myself and my practice, I found that less of my clients were missing sessions. In fact some of them wanted to extend beyond six sessions into the maximum of twelve that I was able to offer e.g. Mrs D (portfolio appendix 6). This, amongst other realisations during the year, reinforced the importance of my own therapy and supervision in my mind and so I began to go to therapy twice weekly.

However, whilst the changes in my ability to maintain my relationships with my clients was reflected in the feedback from my first year viva, i.e. “Your working alliance is good” (Feedback to client study in the portfolio appendices 6), it was clear that there was still much room for improvement, i.e. “however, most of your responses are thinking orientated and you stay away from experiencing feelings. In many places it seems that you keep your client safe from feelings” (Feedback to client study in the portfolio appendices 6).

As I entered my second year, therefore, it seemed to me that the pressure was on to address this, particularly given the psychodynamic emphasis on the use of feelings (transference and counter-transference) and I worked hard in therapy with these issues.

This then began a difficult ongoing process in which I learnt about my reliance on intellectual and theory driven thinking, which tends to be at the expense of my own feelings. Unsurprisingly, my therapist noted this tendency meant that I related to her in a particular way leaving little space for my feelings, particularly about her to come into awareness. Thus, inadvertently, I realised this had implications for my practice as it kept me distanced from clients, creating a divide between us, making it difficult to empathise with them at anything other than a cognitive level, and thus ignoring a whole aspect of their phenomenology.

As I worked my way through this issue, I felt myself beginning to recognise more of myself, my feelings, and others. These changes ‘spilled’ over into my placement in a secondary care National Health Service (NHS) psychotherapy department. For example, I became increasingly conscious of my ability to use supervision to support me and my work. My supervisor, a Jungian trained analyst, was validating, encouraging and understanding, framing my lack of experience working in the psychodynamic model as something that could be added to in addition to the skills I had already developed, rather than some kind of deficit. She was able to make suggestions about what might be occurring emotionally in my relationships with my clients but also demonstrated this experientially in the supervisory relationship, which I shared with another trainee, suggesting underlying emotive reasons for the dynamics between us as and when it became appropriate. I felt safe to turn to her and the team to help me contain, and understand how to work with emotions in practice.
I still valued my skills from my first year to form a boundaried therapeutic relationship, but my new found appreciation for allowing feeling into the room, caused me to develop upon my theoretical understanding.

I turned to the British object relations school of psychotherapy (Klein 1957, Winnicott, 1956; 1962) which holds that, based upon a relational pattern that one may not be fully aware of, one will attempt to deny those aspects of themself that are not in accordance with those valued by early caregivers, in an attempt to maintain relationships.

This made a great deal of sense when I considered my own difficulty bringing my emotions into my relationships. It also made sense in considering my client Ms J (portfolio appendix 7) who presented with, amongst other things, a desire to self-harm and flashbacks of sexual abuse she suffered in her past. In our relationship she told me she perceived herself as ugly, bad, and unlovable. She was able to talk about how much she liked therapy, but found it difficult to talk about the difficulties she had experienced in life feeling guilty that this would upset me. Further she found it difficult to express any feelings of dislike for me, e.g. when I introduced the need to work towards our ending, she expressed anger towards the assessing psychoanalytic therapist in the team for 'misinforming' her about the length of time she would have with me, rather than any anger towards me myself. Informed by the object relations model, I understood this as Ms J keeping those parts of herself that she considered negative, such as her anger and shame, out of our relationship, perhaps for fear that, should she reveal them, I would abandon or abuse her, as she had experienced in her past relationships with men.

Thus the object relations approach gave me a framework to integrate my intellectual, theoretical understanding of the clients' difficulties, with the new found attention I was trying to pay to the emotions that developed in the relationship. In doing so, I realised that it was not always helpful to try and 'protect' my clients or myself from feelings but actually to leave 'space', such as silence, resisting doing 'too much too soon', in order for these emotional relational dynamics to begin to emerge as the focus of the work.

The focus of my practice

In order to explain how I began to develop my practice based upon my understanding of these dynamic relational patterns, I must detour to talk about my own therapy, again.

My therapies have not been goal or symptom-orientated, although they have often helped me to deal with distressing 'symptoms'. Whilst my therapists have offered me advice, opinion and suggestion at times, therapy has more been a safe space to explore. One might therefore
argue that it was the supportive nature of the therapies, or the insight I gained, or the modelling of my therapists, or all of these that aided me in my distress. However, somehow none of these seem entirely adequate to describe how being with my therapists as people impacted upon me in a deeply positive way. I realise that these experiences, in addition to my beliefs about the importance of the therapist themself, left me strongly believing that dealing with 'symptoms' alone, whilst perhaps helpful, was not always adequate.

In addition, I have enjoyed volunteering with special needs children and their families in my spare time for many years prior to the course, within an organisation working from an underlying social, as opposed to medical, approach. This made it possible for volunteers, without specialist medical knowledge, to be able to interact with the children as they would any other individual, by getting to know them and their individual abilities, preferences, likes and dislikes. It was clear that the children, for the most part enjoyed themselves, as did the volunteers, and many of the parents commented upon how this environment allowed their children to participate in activities that they were excluded from, or found it too difficult to participate in within other contexts. As my own father became 'disabled' when I was young (multiple sclerosis), the combination of these experiences led me to a strong conviction that the line between special needs and non-special needs, 'health' and pathology, was extremely blurred.

Upon joining the course, therefore, I was unclear about the value of focusing on symptoms and pathology. However, in my first year placement, many of my clients had not engaged in therapy previously and were engaging exactly because their GP had suggested it in response to their concerns about particular 'symptoms'. They often therefore arrived with their own assumptions and expectations. This was the case with both Mrs B (portfolio appendix 4), who had gone to her GP primarily regarding her chest pains, and Mrs C (portfolio appendix 5) who experienced panic attacks but feared that they were signs of something physically wrong with her. In their own way both seemed to arrive hoping that that therapy would somehow take away their distress and/or the physical sensations that accompanied it. In turn I felt anxious, confused, and under pressure when confronted with expectations such as these. I explored this in supervision and was assured that it was not my job, nor was it possible, to 'cure' them or 'remove' their problems in the way they hoped. I therefore would often simply try and be straightforward and congruent in my responses, saying something like, "I understand that these feelings are distressing and you would like to get rid of them but I'm not sure whether or not we can get rid of our emotions like that. Maybe you could tell me a bit more about them?" I think I hoped that if I could get them to tell me more about their difficulties, then a way forward would present itself (whatever that would be).
Outcome-wise, whilst Mrs B prematurely terminated therapy, Mrs C continued and ultimately reported that she became somewhat more confident, that her anxiety attacks were less frequent and more manageable. Whilst a seemingly improved outcome for the client, I still felt troubled. I felt limited if I only considered symptoms, yet could empathise with my clients’ desire to ‘tackle’ them directly.

However, through my growing knowledge of object relations I came to understand my anxiety in response to the client’s distress about their ‘symptoms’ as natural, and useful information about the client’s attempts to deal with their issues. One way of conceptualising such dynamics is as a communication from the client about their feelings of powerlessness and their expectations of the therapist as powerful and expert; something I did not feel at all. Of course the practitioner may be able to offer useful suggestions, but I also became aware through discussions in supervision that one has to be careful that one does not become part of a relational pattern where focus is directed towards the client as a passive victim, assumed to be ‘ill’, with symptoms located within them. The practitioner may then become limited to considering only the removal of symptoms (Woolfe, 1996) and any attempt to step outside a discussion about ‘symptoms’ may be met with confusion and suspicion (Spurling, 2003), making it impossible to explore anything else. This may perpetuate the client’s habitual patterns of relating, which, more than likely, leads to conflict and perhaps perceived confirmation that part of them is undesirable, thus perpetuating their negative feelings about themselves.

Thus focusing solely on symptoms can shift therapy away from a consideration of the powerful feelings that might be present in the relationship, thus defusing the direct emotional impact and learning that is possible, leading to further dysregulation in the client’s affect (Bateman & Fonagy, 2006).

So, in my second year, even though I was involved with a number of clients who had been given various ‘diagnoses’, such as Munchausen’s, borderline personality disorder, post traumatic stress disorder, and schizophrenia, based upon a range of ‘symptoms’ such as self-harm, suicidal ideation, sexuality issues, depression, anxiety, I felt it was important to use my counter-transferential feelings and sometimes resist my urges to act upon symptoms, trusting that this would allow powerful emotions to come into the relationship and implicitly demonstrate that these seemingly overwhelming emotions were ‘survivable’, hopefully thus empowering clients and allowing them to gain greater intimacy and trust in relationships.

In practice, this can be seen in my work with Ms J, who, when she became distressed, would tell me how strong her desire to self-harm became. This aroused my anxiety, making me feel like I was not doing enough. As this necessarily raised my own emotional discomfort, I turned
to supervision, the team, and to therapy (which I began attending three times weekly) to contain my feelings, resisting the temptation to try and do something other than acknowledging her distress and reassuring her that I would be there the following week.

Ultimately, this seemed to be helpful for Ms J who engaged well with therapy, never missing a session. Further, towards the end of our work she told me that her urge to harm herself had diminished and she was less troubled by her flashbacks of the past. In addition, she was less isolated, getting a new job and joining a computer course. She was considering how she would like her therapy to continue, even being able to think about taking what felt for her like a big risk in joining one of the groups the department ran.

Considering the relatively short amount of time I had worked with Ms J (less than a year), I felt our relationship had begun to offer us alternative possibilities for relating, was thus a good outcome for our work, and a good enough platform for Ms J to develop this aspect of herself further should she choose to.

I believe this approach is therefore extremely helpful to those clients who have the time, patience, perseverance and commitment to engage with it. However, I am aware that such work does not suit every client all of the time and thus it is not always clear what approach to take. From my own experience of therapy I have experienced the extremely distressing feelings that this approach can bring up and know this may feel too uncontainable for some. As I moved into my third year, where I was encouraged to consider a range of models to try and meet the complex needs of the clients, I often found it extremely difficult to decide upon the most useful way to proceed; when to directly address symptoms and when not to (the pros and cons of the object relations approach are discussed in more detail in a paper included within the Academic Dossier of this portfolio).

**The influence of Context**

Within the NHS, mental health services are under increasing pressures to demonstrate the efficacy of their treatments in reducing 'symptoms'. In team meetings within the psychodynamic department I became aware of the pressure, anxiety and conflicts faced by the therapists to justify their roles (Agenda for Change) and their position within the Trust as it aimed for Foundation Status through the need to meet government targets placed upon it, e.g. empirically measured improvements in 'symptoms' and keeping waiting lists short. However, I was protected from these in many ways, e.g. I was able to work with my clients for the duration of my year long placement and, despite pressures for the department to justify its use of facilities, such as room availability, they still provided me with the same room every week within which to see my clients.
Such environmental/contextual factors aided me in providing the high levels of continuous containment and stability (Winnicott, 1956; 1962) needed for a continued engagement with the subtle emotional, relational patterns that emerge using the object relations approach. Whilst I am grateful to the psychodynamic team for protecting me against these, this was not the case in my third year.

As I began my final placement within the CMHT, however, I was no longer protected. There was a level of pressure on the team, including me, to keep therapies more time limited, i.e. average twelve sessions, in order to keep waiting lists low, and to demonstrate improvements in 'symptoms'. It was impossible to secure the same room at the same time every week, much as I tried, within an even more overcrowded working environment.

Whereas, within the psychodynamic therapy department, the use of reasonably 'pure' object relations therapy had therefore been made possible, such work seemed completely contraindicated within such a 'chaotic' context as the CMHT, where continuous containment could not be provided environmentally, nor was there the luxury of time to leave space for the relational patterns to emerge and be experienced. To attempt such work within such a context risked clients feeling 'unsafe', thus becoming further dysregulated.

Although I tried not to lose touch with my psychodynamic knowledge and use of the transference, in these, less than ideal circumstances, it was hard not to agree that a more structured, focused way of working, based on clearly identifiable, measurable and unhelpful patterns, would certainly make life easier, even if it did leave me sometimes feeling that it was not entirely adequate to meet the clients needs.

However, I found it really anxiety provoking to consider the therapeutic implications of switching to a style that required me to impose structure, and direction, placing emphasis upon cognitions and symptoms, apparently in contradiction to some of what I had come to believe about the role of the therapist and the therapeutic relationship.

Whilst, I had my doubts about the effectiveness of this way of working, wondering whether this would once again leave me 'protecting' my clients from the emotions in the room, I was to be shown that compromise was possible. For example Miss K presented with a diagnosis of depression, reporting that she had found herself demotivated, more and more unable to work on her academic studies, and therefore more despondent. However, within the first session she also told me that she struggled to accept help, always wanting to be the one helping, and found herself challenging authority whenever she encountered it.
My supervisor stressed the need to use the relationship as, “an arena in which people behave according to their beliefs about relationships...Therefore, what goes on in the relationship can be used as valuable information to help understand and conceptualise the client’s difficulties...and can be seen, not as obstacles in therapy, but as a rich source of information” (Sanders and Wills, 2006; p61). Using traditional ‘change’ strategies with Miss K was contra-indicated because it would place me as a figure of authority and thereby create resistance and conflict, reinforcing her perceptions and make the therapeutic relationship feel further invalidating and conflictual (Lau & McMain, 2005).

What seemed to be required was to place greater emphasis on validation and acceptance in the relationship. Using the new literature on mindfulness (Kabat-Zinn, 1982), we observed, acknowledged, accepted and trusted in any thoughts and feelings that came up in sessions without any attempt to change them on the assumption that they were all accurate and valid responses with therapeutic benefit (Lau & McMain, 2005). This helped to foster an environment where the client felt accepted and validated, and Miss K engaged with this process and this eventually led to a change in the way she talked about our relationship, allowing her to say she found it supportive, unlike some of her earlier relationships. At around the same time, she began to work on her studies again, saying she was enjoying it. This led us to discuss the possible link between her emotions, even the more difficult ones, and her passion for writing, and how this may have become 'blocked'. We were then able to discuss the process of ending therapy, the difficult emotions it brought up for her, as she admitted she would miss it and me, but also her ability to contain her emotions and generalise from our work to be able to turn to others for greater support in the future.

**Conclusion**

Whilst I am aware that within the NHS, therapies such as CBT, focusing on specific ‘symptoms’ and diagnostic categories, are in favour, this does not necessarily mean that such therapies are more helpful to clients. It simply means that other therapies, such as psychodynamic therapy, are harder to measure by the criteria the NHS prefers. For example, as Arthur (2000) points out, psychotherapists rely “predominantly on their intuition rather than the physical senses and process their knowledge through the use of feeling by introspective analysis, insight and empathy” (p.25). Such a use of the self does not lend itself to empirical observation which relies upon “physical senses for information gathering...thinking over feeling...and realistic...value observation and measurement” (p.25).

Some psychodynamic therapists have responded to these pressures by compromising and developing alternative psychodynamically informed treatments that lend themselves better to the criteria of the health care system, e.g. mentalisation based therapy (Fonagy & Bateman,
2007). There also seems to be similar movement from some counselling psychologists, for example, I have heard the suggestion that psychometric assessment be included in our training in order to "improve our employability in organisations such as the NHS" (Rowe, 2008: p70).

I do believe that shorter therapies, structure, questions, cognitive interpretations, or focus on particular areas of concern, such as 'symptoms', can be helpful and they do have a place in therapy. It is clear from my own experiences as a client and with my clients that they have been, to some degree, helpful in their struggles with their difficulties.

However, whilst this paper shows I was able to work this way during my training to meet the demands placed upon me by the context of the CMHT, having been given the opportunity to work psychodynamically I am aware that such interventions can also limit the possibility of an exploration of the difficult emotions that come up when two human beings attempt to form a unique relationship.

As I come to the end of the course, therefore, facing the loss of the further protection of my 'in training' status, I do, however, feel that the decision about how to practise is not always clear and this will form an ongoing area of my development. However I feel that I have been well prepared to be able to consider options that do not necessarily meet my particular worldview and as such am hopeful that I will not be overwhelmed by this anticipated ongoing challenge
References


Research Dossier

Introduction to the Research Dossier

The Research Dossier contains three research pieces conducted over the three years of my training. A literature review conducted in the first year and two empirical studies conducted one in the second year and one in the third. The year one literature review and year two empirical piece were both submitted in shortened form for publication and a list of references for this is included at the end.

The pieces are linked in that they all explore the theme of human aggression, a topic that has interested me from long before I joined the course (this is discussed in more depth in the personal reflection sections contained as an appendix to each research piece).

The literature review undertaken within my first year revealed that the majority of psychological publications tended to view only the problematic aspects of aggression which limited the interventions available to practitioners working with such issues and therefore the possibilities open to their clients. This was contrasted with the existential phenomenological approach to practice which holds an anti-pathologising stance towards such phenomena. The review considered how such a stance would differ from the traditional one, and therefore what gains it would offer the practitioner and client who engaged with their aggression using it.

Following on from this, the second year empirical Interpretative Phenomenological Analysis explored what such an engagement with aggression might be like from the perspective of a group of martial art practitioners who identified as engaging with their aggression in a non-pathologising manner. The findings offered an alternative to the current psychological literature, showing the value that participants placed upon the process of engaging with, rather than 'removing', their aggression. This therefore led to a discussion that considered what implications these findings have for practitioners, particularly the benefits that might be gained from an engagement with it in practice.

A third year Grounded Theory Study was then carried out with therapeutic practitioners who identified as engaging with aggression in a non-pathological manner in order to offer a model that could then be adopted by practitioners who wished to engage with aggression in this manner.
Year 1: *Being Aggressive: An existential-phenomenological critique of the psychological literature on Human Aggression*

Roly Fletcher

Supervised by Martin Milton
Abstract

There is a large body of psychological literature on the subject of human aggression. The literature suggests that human aggression is commonplace in everyday life, particularly in the work of health care professionals. Practitioners therefore need to understand more about it to inform their work. It seems significant then that the current literature has only engaged with human aggression from the standpoint of positivistic science. This perspective aims to define human aggression in simple terms, discover its causes, and hence suggest interventions that seek to prevent it. This provides only a limited one-sided view of the broad phenomenon of human aggression. It assumes that aggression is the result of 'causes' which cannot be controlled by individual, and implies that all aggression is pathological. It is argued, however, that models based upon such assumptions cannot and do not account for the full range of experiences of aggression in the client's world. This omission seems important to address, and therefore, having critically outlined current models of human aggression, this paper turns towards considering human aggression from within an existential-phenomenological paradigm. This paradigm, in contrast to positivistic science, emphasises the client's experiences and their active freedom to choose. Aggression is therefore considered in terms of the client's freedom to actively realise their potential possibilities or deny them. This paper outlines the implications this has for practitioners working with aggression from within such a paradigm. Each client is considered unique and autonomous, hence normative judgments are avoided. Instead the practitioner recognises their part in a unique collaborative relationship that strives to understand the meaning of aggression from within the client's perspective. It is suggested that such an exploration will unfold possibilities for greater awareness and choice, for both practitioner and client.
Introduction

Aggression can be found in many forms in everyday life, through personal experiences and through the media (Breakwell, 1997; Renfrew, 1997). It manifests itself physically; emotionally; as stalking, sex attacks, road rage, shootings, fighting, family assault, child abuse, and domestic violence to name but a few (Breakwell, 1997; Geen & Donnerstein, 1983; Renfrew, 1997). Unsurprisingly violence is present in virtually all workplaces (Flannery, 1995). In particular, 'Violence is a growing psychosocial problem in the health care working environment' (Carlsson et al., 2000; p.533), even in departments not normally considered at risk (Whittington et al., 1996). One in every two hundred health care professionals suffer major injuries following violent attacks, one in ten requiring first aid. One in twenty are threatened with some form of weapon, and one in six threatened verbally (Breakwell, 1997). In psychiatric settings, seventy-three per cent report having been assaulted at least once and twenty-eight per cent report being assaulted at least four times (Poster & Ryan, 1989). This represents a rate twenty six times higher than reported assaults on the general public (Breakwell, 1997). Further, these figures represent only reported assaults, hence they probably underestimate the true situation (Renfrew, 1997). This results in financial costs to organisations and significant emotional, social, biophysical and cognitive difficulties to the victims (Lanza, 1992; Poster & Ryan, 1989). It has been argued that for caring professionals, aggression issues are pertinent, and need to be better understood to inform our work (Breakwell, 1997).

However, the current literature has mainly focused on defining and explaining aggression through generalised models (e.g. biological/biomedical or environmental) in an attempt to find standardised ways to prevent and 'treat' those who would perpetrate it (Carlsson et al., 2000). This paper argues that standardised causal models have particular philosophical foundations which guide the observations made and conclusions reached (Babbage & Ronan, 2000). This paper critically outlines current generalised approaches to aggression in relation to their underlying philosophical backgrounds, arguing that they limit the practitioner's understanding of the meaning of aggression in their client's life, leading the practitioner to make pathological assumptions that ignore the possibility that healthy and appropriate expression of aggression may be a natural way to move towards greater realisation of the self. The paper will turn toward considering what an existential phenomenological approach might offer to those researching and working with aggression, arguing that a more phenomenological descriptive exploration of as wide a context as possible is needed.
What is aggression?

It is not clear from the literature whether aggression can be precisely defined in psychological terms. Whilst there is a large body of literature on the subject (a recent Psychinfo search produced more than 10,000 results), aggression seems to be an extremely general term that has many nuances (Reber & Reber, 2001). The Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) classification of psychiatric disorders provides little help to the practising clinician trying to define aggression. It is often difficult to differentiate between terms in the literature such as assertiveness, aggression and violent behaviour (Breakwell, 1997). Whilst all these terms all imply confrontation, it is the motivation for each that differs (Breakwell, 1997). Some authors suggest that assertiveness reflects an attempt to maintain one's individuality, whereas aggression reflects an attempt to cause undesired harm from the perspective of the victim (Anderson & Bushman, 2002; Bushman & Anderson, 2001; Baron & Richardson, 1994; Berkowitz, 1993; Geen, 1990). However, in practice, assertiveness can often 'slip' into an attempt to inflict harm (physical or psychological) if one does not know how to be assertive without causing harm, or when assertiveness fails (Breakwell, 1997). Further, whether a harmful act is considered intentional is heavily influenced by the perception of the victim (Breakwell, 1997). This has made it difficult for researchers to demonstrate any common set of characteristics for perpetrators or victims, or any common identifying factors such as anti-social traits, pathology or a lack of training. Further such definitions of aggression tend to imply that all aggression can be categorised as harmful, anti-social, illegal and/or pathological (Fromm, 1974), even though there is evidence that aggression can be found in socially acceptable activities such as sport, economic competition, national defence and politics (Breakwell, 1997). As Milton (2005) argues 'much psychological and psychotherapeutic literature simply fails to attend to the experience of fighting...[which] is not necessarily useful as it invites psychologists to think only of the problematic aspects of fighting and limits our understanding of its value and meaning' (p.6-7). From an existential-phenomenological perspective such one-sided views are unacceptable (Cohn, 1997), limiting the possibilities for alternative options (see 'comments on choice' below).

Because of these difficulties, definitions in the literature tend to be broad. However, in order to avoid being so broad that the term becomes meaningless, the literature distinguishes between 'emotional' and 'instrumental' aggression. Instrumental aggression is described as used to meet a specific goal, e.g. trying to win in a competitive sport, or fighting off an attacker (Caprara, Barbaranelli & Zimbardo, 1996; Berkowitz, 1989; 1993; Geen, 1990). The literature assumes that instrumental aggression is therefore rational, and self-evident, requiring no further psychological study to explain it other than to identify the goal the aggressor is trying to reach (Breakwell, 1997). Emotional aggression, however, is not considered rational, or self-evident. The motivation for emotional aggression is assumed to be a desire to be aggressive
or experience aggressive emotions; it is therefore considered an end in itself. This makes things uncomfortable for those seeking to predict and intervene because it is unclear what causes this emotional desire. Psychological investigation has therefore tended to focus on emotional forms of aggression (Breakwell, 1997). However, in practice, acts of aggression will often be both emotional and instrumental (e.g. racial/sexual harassment is overtly emotional but also motivated by power struggles between individuals and groups). The link between the goal and the aggression may only be evident to the attacker, hence it may not be obvious, rational and/or realistic to anyone else (Breakwell, 1997). The distinction between the two is heavily influenced by the way the context is perceived.

These difficulties are reflected in the multitude of definitions of aggression used in the literature, which differ across studies making it extremely difficult to compare them directly (Breakwell, 1997; Johnson & Hauser, 2001). Hence aggression is extremely difficult to define, with some writers claiming that it is impossible to do so (e.g. Johnson, 1972). From an existential-phenomenological perspective, even the attempt to create a generic definition runs the risk of ignoring the uniqueness of the individual client, and the active role that they play (see 'comments on causality' below).

Models trying to Explain Aggression

In focusing on individual acts of aggression, any definition is further confused by the multitude of theoretical underpinnings that are reflected in much of the literature (Reber & Reber, 2001). Historically the predominant models that attempt to explain aggression at a general level attribute the causes to either biological and/or environmental factors. These models are outlined briefly below.

Biological Models

Biological models assume that the causes of aggression are placed within the biological make-up of the individual, such as instincts (e.g. Lorenz, 1966), 'drives' (e.g. Freud, 1923), genes (Wilson & Herrnstein, 1985), gender (Geen & Donnerstein, 1983), hormones, cognition, and/or neural psychological factors (Renfrew, 1997). For example, Lorenz (1966) argues that the energy for specific aggressive acts (along with other instinctive acts) is continually building up in the neural centres related to that behaviour, and once enough energy has accumulated, that act will take place regardless of the presence of any external stimulus. This model assumes that the aggression instinct developed due to its survival and evolutionary value, e.g. the 'balanced distribution of animals of the same species over the available environment' (Lorenz, 1966; p.40). Aggression then, allows humans to compete for limited resources and defend their territory against 'trespassers' (Gross, 1993; p.444). Within such territories, ritualised behaviour allows a way for individuals to discharge their aggressive energy, with
relatively little harm to others who share the territory. Rituals also allow a clear victor to emerge and hence maintain social order within the group. However, the model suggests that the aggressive instinct is no longer controllable because developments in modern technology/weaponry has removed combat from the face-to-face situation at which the rituals operate (Gross, 1993). Hence man is left with the search for (production of) stimuli for the release of aggression in ways which are socially acceptable, e.g. sport, economic competition, physical occupations, national defence, and mastery of nature and the world in general. It is assumed that if man does not succeed in this, his aggression will inevitably 'explode' (Gross, 1993). Some authors have found this theory useful in explaining sexually aggressive behaviour such as rape. The suggests that sexual aggression may have originated as a means for men to ensure reproductive success by mating with as many females as possible, including those who are unwilling. Hence, it is assumed that, rape may have evolved as a method of overcoming the female ability to choose, but is now innate and must be controlled (Thornhill & Thornhill, 1992).

Freud's (1923) psychoanalytic 'drive' model is similar to the ethological model of Lorenz (Moore, 1995). Freud (1923) suggests that 'the tendency to aggression is an innate, independent, instinctual disposition in man...it constitutes the powerful obstacle to culture' (Freud, 1946; p.102). This tendency (like Lorenz.'s model) builds up until it must be discharged. Freud considered that aggression must be 'dealt with in various ways; in part they are rendered harmless by being fused with erotic components, in part they are diverted towards the external world in the form of aggression, while for the most part they undoubtedly continue their inner work unhindered' (Freud, 1923; p.79). Some support for this approach is provided by studies of people who commit brutal crimes. Megargee (1966), for example, reported that brutally aggressive crimes are often committed by over controlled individuals that repress their anger until it builds up and an objectively trivial incident provokes an outburst, after which the aggressor seems once again passive and incapable of aggression.

Evidence for both models is provided by studies which correlate aggression in family, twins and adoption. Wilson & Herrnstein (1985) indicated that studies done up to 1984 support the idea of genetic contributions, e.g. Brunner et al. (1993) studied the inheritance of aggression over several generations and claimed to identify the gene that would normally play a role in the breakdown of brain chemicals involved in producing aggression. Studies on criminal aggression have claimed to identify gene or chromosomal abnormalities which may result in changes in the levels of chemicals that produce aggression or those need to suppress it. At a neurochemical level, researchers have identified lower levels of neurotransmitters such as acetylcholine, norepinephrine, and serotonin which lower inhibitory control over aggression (Renfrew, 1997). Neurochemical differences can also be found between genders, i.e. serotonin levels (Renfrew, 1997), as well as differences in hormonal levels, body type
intelligence and personality, all of which may be related to aggressive behaviour (Wilson & Herrnstein, 1985; Geen, 1983). Studies of brain function (or malfunction) suggest that the destruction of certain brain structures (e.g. limbic system) may produce some loss of the inhibitory mechanism for aggression (e.g. Silver & Yudofsky, 1987). Research into the controls governing consensually based sexual behaviour have supported brain structure and sexual hormone dysfunction research, suggesting the result could be sexually aggressive behaviour such as rape and child abuse (Renfrew, 1997).

Biological models then assume that aggression is a need, like sleeping or eating, that is not learned, but placed within the biological make-up of the individual. Hence the individual and the environment are not considered active; rather aggression is considered biologically determined and inevitable. Further they assume that aggression is universal within all humans (who have the same biological make-up or meet the same biological criteria), and that we differ only in the ways in which we demonstrate it. As such, it follows that aggression is unpredictable and could occur at any time, in any form, making things 'uncomfortable' for those seeking to predict and intervene (Breakwell, 1997). Hence interventions centre around treatment, i.e. pharmaceutical (Lewis, 1981), brain stimulation (Renfrew, 1997), and neurosurgical techniques (Dieckman et al. 1979).

However, this view of aggression has come under fire from many contemporary biologists and ethologists, who believe that aggression is reactive and modifiable by a variety of internal and external conditions (Hinde, 1974). The evidence for Lorenz and Freud's energy type models is very sparse indeed (Gross, 1993) and no research has demonstrated any specific changes in physiological measures before and after aggression (Siann, 1985). The evidence for the role of the brain in aggression is based mainly on animal experiments and has tended to demonstrate statistically weak correlations and inconsistencies, without being able to account for other physical, psychological, social and environmental factors which may be involved (Gross, 1993; Siann, 1985) and so any generalisation to humans must be cautiously made (Gross, 1993). Similarly, it has been argued that the model contradicts studies which demonstrate cultural differences in the degree and kind of aggression considered permissible (Gross, 1993). Whilst studies which correlate aggression in families, twins and adoption, imply genetic transference, they do not demonstrate genetic causality, and hence uncontrolled environmental variables cannot be ruled out (Renfrew, 1997). It is a further leap to suggest that, based upon this little evidence, there are specific personality features including aggression that then 'cause' behaviour such as rape, and there is no direct genetic evidence to support specific claims of such rape-specific adaption. Hence authors cannot rule out the presence of environmental variables during development, or environmental differences in sexually aggressive behaviour (Thornhill & Thornhill, 1992). Similarly gender differences in aggression may not be totally attributed to biological differences, for this excludes the role of
sex role socialisation and cultural norms (Campbell & Muncer, 1987; Driscoll et al., 2006). There is empirical evidence that demonstrates that in every group observed there are female participants who are fully as aggressive as men (Maccoby & Jacklin, 1974). These arguments are in line with the existential-phenomenological perspective that argues that any individual cannot be described in isolation from their environment (see 'comments on choice' below), all being is 'Being-in-the-world' (Cohn, 1997, p.13).

*Environmental Models*

The literature has attempted to acknowledge the role of the environment in human aggression. Environmental models argue that environmental influences are more important determinants of human aggression than biological factors (Bandura, 1973). For example, social-learning theory considers aggression as 'behaviour...learned observationally through modelling' (Bandura, 1977; p22). This model suggests that the causes of aggressive behaviour lie within early childhood, i.e. parenting style, and/or society, i.e. social norms (Kessen, 1979; Murray & Stein, 1991). The child learns aggression by imitation of its caregivers, who reward this behaviour in the child (e.g. Bandura, Ross & Ross, 1963; Bandura, 1973; Bandura, 1986). The child's aggression is also reinforced if it successfully removes something regarded as unpleasant (Anderson & Bushman, 2002). If consistent over time, that behaviour tends to generalise to become regarded as a child's 'guide for action' (Bandura, 1977; p22) that is perceived as socially acceptable.

This theory is consistent with anthropological and sociological evidence that has shown differences in societal values for aggression, and in the way subcultures allow aggression to be expressed (Breakwell, 1997). Studies have identified the roles of group norms in making aggressive behaviour more socially acceptable (Staub, 1991). Group norms subdue individual responsibility, diffusing it across group members, hence lessening individual inhibitions toward aggression (e.g. Zimbardo, 1970; Prentice-Dunn, 1990). At the same time, research has suggested that there is an individual tendency to remain allied with these group norms no matter how irrational or abnormal they may seem (Janis, 1976). Further, several studies have identified the early influences of parental practices (Geen & Donnerstein, 1983) and televised violence that are correlated with later aggressiveness, both in controlled settings (e.g. Anderson, 1977; Comstock, 1980; Geen, 1976; Goranson, 1977; Murray & Kippax, 1979) and natural settings (e.g. McCarthy et al., 1975). This theory therefore accounts for gender differences, or lack thereof as the result of the reinforcement of gender appropriate behaviours (Bandura, 1973; Maccoby & Jacklin, 1974). The model also provides a theoretical framework to account for interracial aggression (Geen, 1990), child abuse (Renfrew, 1997), and domestic abuse (Renfrew, 1997).
Environmental models then assume that aggression is learnt and the social environment is considered active in determining it. The individual, and their biology, is seen as a passive victim of a lack of 'goodness of fit' between their behaviour and social environment (Chess & Thomas, 1984; Richardson, K., 1994). Studies have focused on the principles of conditioning and learning which are likely to produce aggressive behaviour (e.g. Baron, 1983), and hence interventions centre on the use of these to reduce aggression or produce alternative behaviour (Renfrew, 1997). For example, teaching alternative, non-violent techniques (Walker, 1981), such as empathy. Alternatively, the use of distracting techniques may produce alternative behaviour, e.g. petting a puppy (Baron, 1983).

Whilst this theory has some value for practitioners who are able to consider their client's background, this is not always possible in practice and assumes that this information is available prior to intervention (Breakwell, 1997). The evidence suggests that this kind of social learning takes place over a significant period of time (years) and hence it is counter intuitive, to suggest that short-term interventions would result in obvious/interpretable and long lasting changes. From an existential-phenomenological perspective, the environmental model also makes particular assumptions about how 'past' environments 'cause' present behaviour, that risk ignoring how human beings actually experience their world (Cooper, 2003). Hence there is also a risk that 'the disappearance of this symptom would leave many questions unconsidered' (Cohn, 1997; p.120) – see 'comments on causality' below.

**Aversive Situation Theory**

The aversive situation theory argues that biological and environmental factors cannot be considered independently and that any theory of aggression must account for their interaction (Renfrew, 1997). This model assumes that aggression is one possible response to any unpleasant, abnormal, and/or unacceptable physiological stimulation/arousal, such as frustration (Dollard et al., 1939), pain (Renfrew, 1997), noise (Kryter, 1970), crowding (McBride et al., 1965), heat (Baron & Bell, 1976), erotic stimuli (Donnerstein & Barrett, 1978), and/or isolation (Renfrew, 1997). This theory is supported by cognitive theory which suggests that external stimuli trigger cognitive patterns which result in behaviour. Which cognitive patterns are activated by the stimuli, and hence which behaviour results, is in part determined by patterns of past actions and their success (Berkowitz, 1989). Hence the cognitive pattern with the strongest link to that particular stimulus will be activated. However, the strength of the link between a cognitive pattern and stimuli can be increased if cognitive 'cues' for that particular pattern are present in the environment (Anderson, Benjamin & Bartholow, 1998). In the case of aggression, it has been suggested that the presence of certain cultural norms, clothes, music, weapons (Anderson, Benjamin & Bartholow, 1998), alcohol (Gustafson, 1994) or drugs (Bushman, 1993) may increase the likelihood of this pattern of cognition being
activated. Similarly aggression, as a response, is more likely in situations where other possible responses (such as avoidance or flight) are not possible, where the situation was not anticipated, and where the situation is perceived as being caused deliberately and/or without good reason (Kulick & Brown, 1979; Berkowitz, 1969; 1993).

This model therefore assumes that both biology and environment are considered active in producing aggression. The individual is still, to some extent considered, passive, and subject to these influences. Research and interventions have therefore focused on predicting the types of circumstances in which aggression might manifest, and changing these in an attempt to avoid aggression as a response. The literature has produced some generalised cognitive 'cues' likely to increase aggression (see above) and it has also produced some which are likely to decrease it, e.g. threat of retaliation (Miller, 1941). Other interventions focus on changing the 'strength' between cognitive cues, e.g. cognitive therapy.

However, the interaction between biology, cognition and environment tends to be complex. For example, the presence of a cue such as alcohol may affect brain functions that inhibit behaviours such as aggression (Gustafson, 1994), or alter perceptions of social cues that are associated with aggression, or alter accurate assessment of risky behaviour (Bushman, 1993). However, 'there appears to be little support for the hypothesis that alcohol directly affects aggression' (Bushman & Cooper, 1990 p.9). In fact some authors have suggested that the presence of alcohol increases aggression simply because individuals expect it to (Gustafson, 1994, Bushman, 1993). Further, the literature demonstrates the complexity of the relationship between alcohol, aggression and social factors, e.g. when a non-aggressive option is available individuals under the influence of alcohol are less likely to be aggressive (Gustafson, 1994), and women are less likely to be the target of aggressors of either gender who are intoxicated (Bushman & Cooper, 1990). Similarly, the relationship between drug use and aggression is complex. Whilst research conducted under laboratory conditions has suggested a tendency towards increased aggression by those under the influence of drugs (specifically depressants, codeine, marijuana) compared to placebo groups (Bushman, 1993), it is unclear whether the drugs are the direct cause of aggression or create internal changes that make aggression more likely. However, the literature reflects that in practice, it is difficult to attribute direct causality, partly because the pharmacological state of the aggressor is often unrecorded (Goldstein, 1985). Further, it is difficult to assess the direct contribution of the drugs in comparison to social factors, e.g. some authors have argued that drug related aggression can be motivated more by the need to rob in order to buy more drugs. (Goldstein, 1985). Hence, 'early reports which sought to employ a psychopharmacological model to attribute violent behavior to the use of opiates and marijuana have now been largely discredited' (Goldstein, 1985 p3). These complexities make it difficult to demonstrate reliable and predictable causal relationships, and make it unclear whether to target intervention at a
biological, cognitive and/or environmental level (Gross, 1993). Existential-phenomenologists acknowledge such difficulties, and in fact argue that 'to isolate any particular aspect from the total situation of which it is a part' is to 'distort' and falsify that which the individual actually experiences (Cohn, 1997, p34) – see 'comments on causality' below.

**Existential-phenomenological critiques**

**Comments on Complexity**

Even taken together, however, these models contain conflicting assumptions that confuse matters further. In the case of biological theory, aggressiveness is assumed to be innate and must be acknowledged and controlled, or it will take control. Aversive situation theory views aggressiveness as innate but argues that it will only take control when triggered by some external stimuli. The social learning approach however, denies aggressiveness is innate, considering it learned through interaction with the environment over time. It is therefore very difficult to disentangle the social/environmental effects from the biological (Oates, 2004). Although attractive in their simplicity, standardised explanations like these cannot take into account the complexity associated with the full range of aggression. The existential-phenomenological paradigm argues that 'a human being is inseparable from their social context' (Cooper, 2003. p.ix). Any attempt to 'reduce...being down to a set of essential components would be to diminish the fullness of...[their] humanity' (Cooper, 2003. p10). Hence any theory which focuses on such components, i.e. biology or environment, cannot account for the full meaning of aggression in the context of the situation (Johnson & Hauser, 2001). Such models offer only a limited interpretation of a complex phenomenon (Breakwell, 1997) and hence, cannot claim to fully understand the experience of their clients (Sullivan, 2003).

**Comments on Causality**

Common to all such models is their underlying methodology which relies upon standardised measures and interventions, underpinned by positivistic science (Woodhead, 2002). This methodology has been popular because it assumes that if one can provide simple, causal explanations, then one can ultimately intervene at a causal level to change or prevent aggression in predictable ways. However, it has already been shown that it is not clear what the 'primary' cause of aggression is. Hence psychologists using such models end up targeting 'secondary' effects which are numerous, complex, unlikely to be static, particularly in response to interactions with the social environment (Geen, 1990). For the existential-phenomenological practitioner, a focus on context means one cannot 'isolate any particular
aspect from the total situation of which it is a part’ without distorting and falsify that which the individual actually experiences (Cohn, 1997. p34).

Further, inherent to models that assume that our biology/environment cause mental phenomena, is an assumption about the nature of time. Time is assumed to be unilinear and causal, moving from past to present into future. However, this ignores how human beings actually experience their world (Heidegger, 1926/1962). Past, present and future are not experienced in linear succession but are multidimensional. Our present experience is inevitably informed by expectations based on the past, but we do not perceive our present as being caused by the past (Hicklin, 1998). Further, we are always anticipating and consciously moving towards the future within the present. Hence, the present can be perceived as preceding the past and containing the future (Heidegger, 1926/1962). Humans then, have a dynamic existence that is in constant flux (Merleau-Ponty, 1945/1962). It makes little sense therefore to suggest that things are static enough for aggression to be caused by past biological/environmental events. Therefore ‘there cannot be an ‘assessment’ as this would imply an objective situation independent of time, place and the contribution of the assessing therapist’ (Cohn, 1997. p34). Hence, standardised interventions based on such assessments simply perpetuate a myth of fixed ‘truths’ and ‘realities’ (Yalom, 1989) which further isolates the client from the world of which he is a part (Cohn, 1997). From this perspective aggression ‘is only one aspect of the total situation, and the disappearance of this symptom would leave many questions unconsidered’ (Cohn, 1997. p120). Hence, these assumptions about time and causality restrict practitioners to a limited view of aggression that does not fully account for what actually happens in the relationships between an aggressive person and others (Johnson & Hauser, 2001).

Comments on Choice

The practitioner is therefore limited to a one-sided view of aggression which only includes those aspects that one individual has in common with another (Spiegelberg, 1972). They do not give an account of those aspects of the client’s aggression that are unique to them. This leads to an understanding of human aggression at a generic level which has been criticised as inadequate because it does not distinguish between different types of aggression (Bandura, 1986; Fromm, 1973). Focus is directed towards the individual as passive victim of their aggression, without consideration of their particular needs. The individual is collected under a generalised heading, which limits the practitioner in understanding the meaning of aggression in their client’s life (Carlson, 2003). In accepting such a generalised label, the practitioner cannot fully account for the wide range of aggression met in the consulting room (Johnson & Hauser, 2001). Further, the client is distanced from others who do not share this label. This leads the practitioner to make pathological assumptions that deny the possibility
that healthy and appropriate expression of aggression may be a natural way to move towards greater self development (Diamond, 1996; May, R. 1953). Hence such approaches ignore that a healthy engagement with aggression may ultimately reduce inappropriate violence (DeBaryshe & Fryxell, 1998). For example, Frantzis (1998) points out, ‘consistent martial arts training of any kind can...help human beings...to move beyond the instinctual flaring of violence-causing emotions’ (p.5). Similarly Allen (2002) states, ‘An Army trained solely for aggression and war can make the transition to policing as a Peace-Keeping Force relatively easily. But ask an Army who’s only role has been shepherding civilians and kissing babies to suddenly go to war and it will fail miserably’ (p1).

The existential paradigm argues that whilst anatomically and physiologically human beings are limited, such limits/givens’ give rise to sociocultural assumptions which may present themselves as ‘givens’ when in fact they are not. To provide a biological or environmental deterministic explanation ignores the role the individual or social environment might play in the development of their aggression. There is a danger then, that our biology or environments become seen as deterministic of our aggression, assuming unilinear causal connections between our anatomy, physiology, and our way of being, which entirely ignores the active role of the individual and society in constructing such connections (Cohn, 1997).

The existential phenomenological perspective argues that ‘man first of all exists...and defines himself afterwards’ (Sartre, 1943/1958: p28). Rather than considering man from the causal deterministic standpoint of the natural sciences, the existential-phenomenological paradigm views man from the standpoint of being free to self-realise/become himself, or being free not to. Hence the freedom to make choices is one of the ‘givens’ of human existence, and those choices form our identity and characteristics. That which we consider ourselves is therefore in constant flux depending on our choices (Cooper, 2003). Therefore our patterns of behaviour are not static or unchanging but fluid with respect to the choices we make. Whilst there may be some basic biological/environmental ‘givens’ of our being which limit our choices (Heidegger, 1926/1962), man is still free to choose his response to these givens (Sartre, 1943/1958; Serban, 1970). Therefore to limit/force the understanding of the client’s aggression into preconceived biological/environmental theories, which consider the individual as a passive ‘victim’, denies them their autonomy and responsibility. Hence, the individual may become less open to wider definitions of themselves and their freedom of choice (Boss, 1963).

The existential-phenomenological approach, also acknowledges that our freedom of choice comes at a price. Our chosen definitions of ourselves may conflict with how we actually experience ourselves (Spinelli, 1994). Rather than adapt our definition of ourselves, it may be more tempting in some situations, to disown these experiences. For example, an individual
who chooses to be aggressive, in a world which pathologises aggression (see above), may deny his ability to choose, blaming biological/environmental causes, in order to maintain his experience of himself as socially acceptable. This may reflect a growing social trend where 'people are all too ready to accept a medical label for their difficulties' (Fitzpatrick, 2001 p.113). It is counter intuitive to suggest then, that these denied aspects of the self can be accessed by biological/environmental causal investigation. An examination of these 'givens' alone would lose the emphasis on the freedom of choice and uniqueness that characterises man's existence (Macquarrie, 1972). To do so would collude with the individual's capacity for self-deception and ironically this may reinforce the client's belief that their only option is, for example, aggression (Cooper, 2003).

Existential-phenomenological practitioners therefore consider it more 'valuable...for the client to confront those beliefs and values that he or she actually holds, as opposed to those s/he might claim to hold' (Spinelli, 2006) or those imposed upon them by psychological models. Hence the practitioner focuses on 'the creation of a space where the client's story can be heard' (Cohn, 1997: p33). The practitioner aims to gain as full a description of the client's world as possible whilst clarifying assumptions that arise out of this process. The aim is a genuine dialogue that recognises the autonomy and uniqueness of the other, where limitations and possibilities for wider choice and change are 'unfolded' and acknowledged (Spinelli, 1989).

Comments on relatedness

In practice the creation of such a space may not be an easy task. In acknowledging that humans have the capacity to choose how to respond to the 'givens' of their being, it follows that client's have the capacity to choose how to relate to their therapists' and to others (Cooper, 2003). Assumptions implicit in the client's definition of themself may lead them to experience another as a person of a certain kind. In doing so, there is some denial of the uniqueness of the other, which may make the relationship less transparent and in need of clarification and elucidation (Cohn, 1997). Relationships therefore, can become a place where the individual's definition of self and others can be challenged by their experiences, and hence relationships become a place for self-realisation. From this perspective, aggression can be viewed as a relational choice that can lead to the 'realising [of] one's own spirit' (Allen, 2004). As Frantzis (1998) argues,

'As humans, we may have inherited from our remote primate ancestors a deeply ingrained need to engage in behaviours of domination and submission. Such displays occur often in society, individually on both physical and psychological levels – as within competitive groups from sports to
business – and in the political arena, where disputes and wars have been a constant in human history. By its very nature, the field of martial arts deals directly with this area of human existence, not by sublimating our natural violent tendencies, but by delving into them. Ideally, the practice of martial arts initially gives individuals a visceral understanding of the core causes of our inclination toward violence’

(p.5)

In such an instance, the existential-phenomenological practitioner would not wish to make pathological assumptions about the client’s aggression that denies them their autonomy and ignores the possibility that healthy and appropriate expression of aggression may be a natural way to move towards greater realisation of the self. Rather, the practitioner aims at a genuine dialogue where the implications of such a stance are explored, along with the possibility for greater realisation (Spinelli, 1989).

However, it may not always be easy to explore the assumptions which guide our relational choices. Our experiences of being with others can conflict with our beliefs about how we are with others. The resulting awareness of our freedom to choose who we are and how we relate can lead to feelings of anxiety, guilt and powerlessness (Boss, 1963; Cooper, 2003; Yalom, 1980). This is described as ‘the giddiness of freedom’ (Kierkegaard, 1844/1980: p61). In such a situation, it may seem more tempting to deny the new experience, hence subjecting relations to further rejection, distortion and destruction (Fromm, 1974). One means of ‘denying the freedom and responsibility that I, as an individual, hold, is by falling in with the crowd.’ (Yalom, 1980, p.24). In this case, aggression would be seen as a social value of others that the individual takes as a ‘given’ rather than realising its plasticity and contingency. This allows the individual to escape responsibility into illusions of outside structure, but denies them their full ability to become aware of their potential possibilities. The individual is therefore unable to choose their responses in a manner that is meaningful and right for them. This leads them to live an inauthentic life, the object of other peoples’ values, feeling powerless, hopeless, and guilty (Bugental, 1981). Ironically, in the attempt to avoid being objectified and powerless, Fromm (1974) suggests that the individual may embark on a compulsive search for absolute power. This may manifest itself as the desire of control over other living beings, and one possible way to achieve this is through an aggressive relational stance. This then denies others their unique existential subjectivity, and objectifies them (Potter-Efron, 2005) and therefore sets up the dynamic where each person in the relationship is trying to avoid being objectified by objectifying the other. Such a relationship is inevitably frustrating, conflict ridden and prone to anxiety and further aggression (Sartre, 1943/1958). Whilst this allows the individual to escape into an illusion of power and certainty, the implications of this style of relatedness are that one is isolated and apart, leaving them with feelings of loneliness (Cohn,
Many studies have connected loneliness with subsequently heightened aggression (Baker, 1998; Diamond, 1996; Hyman & Perone, 1998; Raywid & Oshiyama, 2000; Sandhu, 2000; Sapphire, 1999).

Causal models tend to assume that individuals are essentially separate. Hence relations between them may (or may not) be established (Cohn, 1997). There is therefore a distinction between subject and object, therapist and client. It follows that the therapist can stand outside his/her own personal bias and describe the client's aggression objectively in terms of their biology or environment. However, such interventions objectify the client, denying them their unique, unclassifiable subjectivity (Buber, 1923/1958). However, this risks entering such a relationship where each person in the relationship is trying to avoid being objectified by objectifying the other. This may then reinforce the client's belief that their only option is, for example, aggression (Cooper, 2003).

The existential-phenomenological approach, however, argues that client cannot be described objectively. All human experience takes place within a context, and this inevitably is a context that contains others. Aggression then must be seen as embedded in the interactions of people, the particular circumstances they find themselves in and the wider relations/cultural norms which are also present (Cohn, 1997; Fromm, 1974). Whilst we have the capacity to withdraw or deny our relatedness to others (or be denied); this still constitutes a form of relatedness. Hence all being is 'being-with-others' (Heidegger, 1926/1962; 155). It follows that humans, therapist and client, cannot be described in isolation from each other. All practitioner interpretations are situated in socially-constructed meanings that are not separable from the observer or the observed (Heidegger, 1926/1962). Therefore the existential-phenomenological paradigm asserts that the therapist cannot claim to describe or intervene in the client's aggression objectively, standing outside his/her own personal bias (Cooper, 2003). By being aware of this, this enables the existential-phenomenological practitioner to avoid labelling the individual, as in causal approaches, and thus perpetuating assumptions that they are powerless and passive, but rather focusing on a meaningful, authentic relationship within which opportunities for transformation can exist (Buber, 1923/1958). Hence nothing is assumed about the client's aggressive style of human relatedness. As Serban (1970) points out, 'If man is seen existentially as his freedom to self-realise or not, himself, then the aggressiveness can be interpreted as a modality of experiencing his freedom [or denying it] in a situation' (p16). By recognising this, the therapist can respond to the dynamics of the situations, assuming the client and themselves are working together within this flux (Pilgrim, 2000; Sameroff, 1991; Shotter, 1998). This state of intersubjectivity is perceived as always flexible (Cooper, 2003). Hence behavioural differences across relationships/contexts are only considered stable in that the relationships/contexts are also stable (Dunn & Kendrick, 1982).
A word of caution

Some caution must be stressed in being critical of simple causal explanations and diagnostic classifications however. Sullivan (2003) has pointed out that adopting a shift towards management of uncertainty, where there are no set techniques or agendas that can be easily explained (Carlsson et al., 2000) would require a revolutionary transformation that most would be unwilling to approach, hence disinclining traditional power holders (clinicians) to allow any distribution of power (Sullivan, 2003). Causal explanations dominate within the psychiatric profession (Miller, 1996) and the NHS (Chamber, 1998). It has been pointed out that within such a context, the practitioner is under increasing pressures (from hospitals, insurance companies, governmental agencies, and educational establishments) to provide assessments, histories, and diagnostic classifications within short periods of time that sum up their clients (Cohn, 1997; Yalom, 1989) in order to communicate with other health care professionals (Barnes, 2002).

Conclusion & Implications for practitioners

It can be seen then that the concept of aggression is both difficult to define precisely and, perhaps partly due to this, difficult to assess. There is theoretical conflict within positivistic science over how much effect biological or environmental factors have in causing it. Such theories view the individual as essentially passive in its development, and tend to measure it quantitatively leading to standardised interventions. This perspective makes particular assumptions about the nature of time, causality, and human relatedness. These assumptions have led to a limited biological/environmental exploration of human aggression, with interventions that imply it is determined or even pathological.

However, the existential-phenomenological paradigm argues against these assumptions. The approach denies the objectivity of the practitioner, acknowledging that all Being is intersubjective. Hence the existential-phenomenological practitioner aims to provide a space where an exploration of the client's actual concerns can occur. The practitioner acknowledges that this exploration is influenced by social narratives (Dreyfus, 1997) including the relationship that the therapist forms with the client (Deurzen-Smith, 1988). This approach denies biological/environmental causality, acknowledging the client's autonomy and freedom to realise themselves (or deny that freedom) in any given situation (Sullivan, 2003). Hence the practitioner avoids bringing normative judgements, such as biological/environmental causal explanations, that risk further denying this freedom (Condrau, 1998). Hence, this approach does not assume it has to 'rid' the client of their aggression, but strives to explore the full complexities of it in the client's life and not reduce it to fixed retrospective labels (Pilgrim, 2000).
In undertaking such an exploration, it is hoped that a clearer understanding of the client and their aggression, can be provided, without denying biological or genetic factors, accepting that existence is bounded in very real ways, but enabling practitioners to be involved in helping clients to become aware of how they relate to these. This facilitates an investigation of how such a relational stance facilitates or hinders the client in meeting their possible potential in a manner which is right for them (Sameroff, 1991). This can empower and reduce unnecessary fear by generating new understanding of practitioner and client's active stance in this process and hence lead to the ability to manoeuvre and negotiate their position as their assumptions become clearer (Cooper, 2003; Serban, 1970).

Despite these arguments, however, the existential paradigm has been relatively neglected in the literature on human aggression, and hence there has been little investigation into the experience of aggression itself (Carlsson et al., 2000) or the greater meaning of aggression in people's lives (Potter-Efron, 2005). Practitioners are left with limited causal explanations that hinder a full exploration of a client's ability to meet their potential in a manner which is right for them. Instead aggressive clients are considered passive, and grouped together with others under a label which may be entirely inappropriate. Practitioners are therefore not informed of the potential value of aggression for any client, and are left considering it pathological, in need of control or removal. As Allen (2004) points out, 'This philosophy is nice, politically/socially correct... pleasing for those who know in themselves they have no stomach for the real thing.'
References


kungfu.co.uk/article1.html


Appendix 1 – Literature Searches

The three most fruitful searches

Having started my search for literature on aggression with Psychinfo, I soon found myself engulfed in thousands of results, much of which was too specific for my initial needs, e.g. ‘Acute effects of gabapentin on laboratory measures of aggressive and escape responses of adult parolees with and without a history of conduct disorder’. At this early stage in the searching process, my knowledge was too limited to limit these searches. I therefore decided it would be more fruitful to get some general literature from what was already available in the University library. This strategy paid off, and hence my first most fruitful search was one for ‘human aggression’ at the university library (see ‘search 1’ below). This gave me an overview on current theories of aggression and allowed me to focus my further reading. Whilst Psychinfo provided me with fewer results (45) when I searched for ‘existential’ and ‘aggression’, without a grounding in existential-phenomenological theory, I was unable to engage with this literature. Once again, it was more fruitful to do a general search for existential literature that was already available at the university library (see ‘search 2’ below). From this I was able to gain a more general understanding and move into specific literature searches. In order to search for any specific literature that had examined aggression from within an existential-phenomenological perspective I found Google to be the most fruitful (see ‘search 3’ below). This provided a good overview that included results from pubmed and other databases that were not included on psychinfo necessarily.

I have listed the other online searches that I used during my literature review below. However, these searches do not represent the full range of sources that I used. A number of articles were referenced from within the general texts that I read and hence did not come from online database searching directly. I also had conversations with other students who were researching aspects of aggression (e.g. domestic violence) to gain a greater sense of confidence in my coverage of the literature. However, in a field this saturated with literature, and with tight deadlines to meet, there was a balance to be found between the depth of my searches and producing a convincing argument in writing.

All searches

Psychinfo

Aggression
“human aggression”
human and aggression
aggression and existential
aggression and phenomenology
Anderson and priming
Bandura and "social learning"
Aggression and "social learning"
Baron and aggression
Berkowitz and aggression
Aggression and frustration
Aggression and "aversive stimuli"
Dollard
Dollard and aggression
Aggression and cognitive
Aggression and "cognitive behavio*"
Aggression and therapy
Aggression and counsel
"Human aggression" and therapy
"Human aggression" and counsel*

University Library

Aggression
Human Aggression
Existential
Existential-phenomenology
Existential practice
Existential therapy
Existential psychotherapy
Phenomenology
Freud
Fromm
Fromm and human destructiveness
Lorenz

PubMed

Aggression
Aggression and Existential
Aggression and phenomenology
Aggression (Review)

(a) MeSH (Medical SubHeading) search for "Aggression"

(b) Used this but limited the search to "Major topic", "psychology" & "therapy"

(c) In PubMed further limited it to "Human" & "Review Articles Only"

Google

Aggression
"Human aggression"
Existential aggression
Aggression phenomenology
Aggression existential-phenomenology
Aggression frustration
Aggression "aversive stimuli"
Aggression alcohol
Aggression drugs
Aggression biology
Aggression environment

Google Books

Existential and aggression
Phenomenology and aggression

Search 1

University of Surrey Library

Searched for: Human Aggression

There are 6 titles matching your search.

1 Human aggression
Storr, Anthony, 1920-
Publication Date: 1970
Control Number: 0140212345
Copies: Shelved at 152.438 1 copy - Show Copy
2 Human aggression / Russell G. Geen. - 2nd ed
Geen, Russell G., Russell Glenn Other titles by Author(s)
Publication Date: 2001
Control Number: 0335204724
Copies: Shelved at 302.54 2 copies - Show Copies

3 Human aggression : naturalistic approaches / edited by John Archer and Kevin
Publication Date: 1989
Control Number: 0415030366
Copies: Shelved at 152.438 2 copies - Show Copies

4 Human aggression and conflict : interdisciplinary perspectives / (by) Klaus
Scherer, Klaus R. (Klaus Rainer) Other titles by Author(s)
Publication Date: 1975
Control Number: 0134446208
Copies: Shelved at 152.438 1 copy - Show Copy

5 Human sexual aggression : current perspectives / edited by Robert A. Prentky
Publication Date: 1988
Control Number: 0897664515
Copies: Shelved at 157.737 1 copy - Show Copy

6 The nature of human aggression / Ashley Montagu
Montagu, Ashley, 1905- Other titles by Author(s)
Publication Date: 1976
Control Number: 0195018222
Copies: Shelved at 152.438 2 copies - Show Copies

Search 2

University of Surrey Library

Searched for: Existential

There were 65 titles matching this search (first 3 pages of 7 shown here)

1 An exploration of counselling/psychotherapy in an oncology setting OR : What
Heywood, Elaine Other titles by Author(s)
Publication Date: 2000
2 Berdyaev's philosophy: the existential paradox of freedom and necessity, a
Nucho, Fuad Other titles by Author(s)
Publication Date: 1967
Control Number: b6711339
Copies: Shelved at 19 2 copies - Show Copies

3 Case studies in existential psychotherapy and counselling / edited by Simon
Publication Date: 1997
Control Number: 0471961922
Copies: Shelved at 616.8914 2 copies - Show Copies

4 Child abuse: the existential dimension / Neil Thompson
Thompson, Neil Other titles by Author(s)
Publication Date: 1992
Control Number: 1857840038
Copies: Shelved at 157.736 1 copy - Show Copy

5 The concepts of psychiatry [electronic resource]: a pluralistic approach to
Ghaemi, S. Nassir Other titles by Author(s)
electronic resource
Publication Date: 2003
Control Number: M0038319SR
Link: e-link
Copies: Shelved at 1 copy - Show Copy

6 The discovery of being: writings in existential psychology
May, Rollo Other titles by Author(s)
Publication Date: 1994
Control Number: 0393312402
Copies: Shelved at 150.192 1 copy - Show Copy

7 The divided self: an existential study in sanity and madness / R.D. Laing
Laing, R. D. (Ronald David), 1927- Other titles by Author(s)
Publication Date: 1965
Control Number: 0140207341
8 The divided self [electronic resource] : an existential study in sanity and
Laing, R. D (Ronald David), 1927- Other titles by Author(s)
electronic resource
Publication Date: 1999
Control Number: M0031562SR
Link: e-link
Copies: Shelved at 616.89 1 copy - Show Copy

9 The educated man : studies in the history of educational thought
Nash, Paul, 1924- Other titles by Author(s)
Publication Date: 1980
Control Number: 0898740592
Copies: Shelved at 37.01 8 copies - Show Copies

10 Embodiment and experience : the existential ground of culture and self / edi
Publication Date: 1994
Control Number: 0521452562
Copies: Shelved at 306.461 1 copy - Show Copy

11 Emotions : experiences in existential psychotherapy and life / Freddie Stras
Strasser, Freddie Other titles by Author(s)
Publication Date: 2005
Control Number: 0715628372
Copies: Shelved at 150.192 2 copies - Show Copies

12 The English existential
Jenkins, Lyle Other titles by Author(s)
Publication Date: 1975
Control Number: 348410192x
Copies: Shelved at 420:415 1 copy - Show Copy

Referenced on 1 reading list. Search Reading Lists
Publication Date: 2003
Control Number: 1572307668
Copies: Shelved at 157.94 3 copies - Show Copies
14 Everyday mysteries: existential dimensions of psychotherapy / Emmy van Deurzen. Publication Date: 1997

15 Existence and therapy [electronic resource]: an introduction to phenomenology / Ulrich Sonnemann. Publication Date: 1954

16 The existential background of human dignity / Gabriel Marcel. Publication Date: 1963

17 Existential child therapy: the child's discovery of himself / edited by Cla. Publication Date: 1966


19 Existential counselling and psychotherapy in practice / Emmy van Deurzen. Publication Date: 2002
20 Existential counselling in practice; Emmy van Deurzen-Smith
Van Deurzen, Emmy Other titles by Author(s)
Publication Date: 1988
Control Number: 0803981260
Copies: Shelved at 616.891 3 copies - Show Copies

21 The existential experience
Harper, Ralph Other titles by Author(s)
Publication Date: 1972
Control Number: 080181409x
Copies: Shelved at 1(091) 1 copy - Show Copy

22 Existential foundations of medicine and psychology / by Medard Boss / transl
Boss, Medard, 1903- Other titles by Author(s)
Publication Date: 1994
Control Number: 1568214200
Copies: Shelved at 61.01 2 copies - Show Copies

23 Existential humanistic psychology / edited by Thomas C. Greening
Publication Date: 1971
Control Number: 0818500166
Copies: Shelved at 150 1 copy - Show Copy

24 The existential imagination / edited by Frederick R. Karl and Leo Hamalian
Karl, Frederick R. (Frederick Robert), 1927- Other titles by Author(s)
Publication Date: 1973
Control Number: 0330238086
Copies: Shelved at 8.3 1 copy - Show Copy

25 Existential journalism
Merrill, John Calhoun Other titles by Author(s)
Publication Date: 1977
Control Number: 0803819285
Copies: Shelved at 07 1 copy - Show Copy

26 Existential Marxism in postwar France : from Sartre to Althusser
Poster, Mark Other titles by Author(s)
Publication Date: 1975
Control Number: 0691072124
Aggression and mass aggression--the existential point of view.
Adaptation, Psychological* Adult Aggression* Anxiety Existentialism* Female Humans Male Social Behavior PMID: 5506989 [PubMed - indexed for MEDLINE]
Individual and mass aggression: an existential view.

The effects of existential-phenomenological group counseling on ... This study compared effects of existential group therapy on internal-external locus of control orientation, self-efficacy, and aggression in police officers ...
digitalcommons.wayne.edu/dissertations/AAI9932958/ - 8k - Cached - Similar pages

Rev. chil. neuro-psiqiatr. vol.42 no.3; Resumo: S0717 ...
The suffering involved provokes typical coping reactions and patterns of aggression. Existential analytical psychotherapy of depression therefore takes a ...
www.scielo.cl/scielo.php?script=sci_abstract&pid=S0717-92272004000300005&lng=pt&nrm=iso&t... - 7k - Cached - Similar pages

AGGRESSION AND THE CONFLICT HELIX
One such transformation is manifested through existential psychotherapy, as in the work of Rollo May. May's major analysis dealing with aggression is Power ...
www.hawaii.edu/powerkills/CIP.CHAP2.HTM - 88k - Cached - Similar pages

[DOC] Existential-Analytical Understanding and Psychotherapy in ...
File Format: Microsoft Word - View as HTML
The suffering involved provokes the typical coping reactions and patterns of aggression. The Existential Analytical psychotherapy of depression therefore ...
www.twu.ca/.../Colloquia%20&%20Open%20House/2004-2005/Laengle/Laengle%20November%20workshop.doc - Similar pages

philosophy questions 14
While the Freudian analysis focuses on the notions of aggression and catharsis, the existential account of our enjoyment of frightening scenes is that they ...
www.philosophos.com/knowledge_base/archives_14/philosophy_questions_1467.html - 21k - Cached - Similar pages

VIKTOR FRANKL INSTITUT . Logotherapy and Existential Analysis
The frustration of the existential need for meaningful goals will give rise to aggression, addiction, depression and suicidality, and it may engender or ...

ESSSST Student Prize - 2004
Tillich combines this with his existential theological and connects aggression to the frustration and "angest" that is the reaction to an alienated life. ...

[PDF] The ESSSAT Student Prize 2004 has been awarded to Marie Verjrup ...

Amazon.co.uk: The Anatomy of Human Destructiveness: Books
The general view presented by Fromm is that malignant aggression is the consequence of existential needs interacting with the modern, industrial age. ...

[PDF] Existential-Analytical Understanding and Psychotherapy in ...

Vegetarian News - Food, Aggression, and Reverence for Life
It's merely an act of self-asserting aggression, a necessity for survival, ... try and come to understand how exactly food affects our existential totality. ...
shortessays

Psychoanalysis needs existential philosophy to properly comprehend itself as ... The human passions, broadly categorized as sexuality and aggression, ...

www.yorku.ca/dcarveth/existentialism - 32k - Cached - Similar pages

Education Update - Books

Man is an existential animal, gifted with reason and imagination that make him aware of his environment and self-aware of ... Nobelist on Aggression in Man ...

www.educationupdate.com/archives/2001/oct01/oct01_articles/book_baum.html - 60k - Cached - Similar pages

REPORTS

Aggression is a permanent energy and existential characteristic of organic matter. Its energy serves to preserve organic processes. Aggression, therefore ...

www.ess.uwe.ac.uk/documents/repyug2.htm - 33k - Cached - Similar pages

Mental Help Net - Workplace Issues - Perspectives - Vol. 4, No. 2 ...

4, No. 2 - Disarming Aggression and Organizational Power Struggles ... Verbal Martial Arts. I also shared an existential encounter at a previous conflict ...

mentalhelp.net/poc/view_doc.php?type=doc&id=385&cn=207 - 76k - Cached - Similar pages

The Lincoln Plawg - the blog with footnotes

An existential threat is the thermonuclear weapon of justifications for war. ... to that aggression - an existential threat means that the gloves are off. ...

lincolnplawg.blogspot.com/2003/03/war-dont-say-we-werent-warned-part-1.html - 24k - Cached - Similar pages

(the cry) existentialism sartre nietzsche kafka kierkegaard de ...

on line philosophy magazine, existentialism, internet design, thecry.com, ... Have we never had further resort to violence or to aggression? ...

www.thecry.com/existentialism/sartre/crimes.html - 39k - Cached - Similar pages

Carrie Winterowd, Steve Harrist, Nancy Thomason, Sheri Worth, and ...

Existential/Meditative spirituality was the most significant predictor of anger aggression (Anger Expression-Out), but Existential/Meditative Spirituality ...

muse.jhu.edu/journals/journal_of_college_student_development/v046/46.5winterowd.html - Similar pages
Kunstmuseum, Bundesstadt Bonn
... to the adjacent Knoebel room or from the wild aggression and existential menace that is communicated by Baselitz's "Straßenbild" (Street Picture). ...

That is, an existential–phenomenological approach, is used to examine impulsivity as ... boys with ADD/ADHD tend to act out, show aggression, and engage in ...

"The Orwell Temptation" by Joshua Micah Marshall
Yet there is a temptation for liberals, who watch the Bush administration launch out onto repeated military forays that mix military aggression with ...

"Existential psychotherapy" initially referred to the work of a group of therapists ... or impulses, for example, those relating to sexuality or aggression. ...

Ozark Guidance - Workplace Issues - Perspectives - Vol. 4, No. 2 ...
2 - Disarming Aggression and Organizational Power Struggles ... Verbal Martial Arts. I also shared an existential encounter at a previous conflict ...
Caversham Booksellers
Existential/Spiritual Anger Management Approaches ... Group and Individual Approaches to Anger and Aggression Management Introduction ...

Anger Management | Controlling Aggression | Questia.com Online Library
It is idealistic to believe...and existential tasks of life. However, employing.... ... Using Effectively 31 Anger Management and Aggression Control 33. ...

https://www.questia.com/library/psychology/ counseling-and-therapy/anger-management.jsp -
Appendix 2 – Self Reflection

I have been training in kung fu for 10 years and during this time I have immersed myself in much of the literature and philosophy behind eastern martial systems. I have directly benefited in my health and fitness. However, as well as an emphasis on health, the style I practise emphasises training for reality as far as is possible. There is an emphasis, both in the training and the literature, on training the ‘mind-set’ that is required for effective fighting. Developing this ‘mind-set’ has meant that I have had to engage directly with my own capacity for aggression, and this capacity in the others. This engagement brought about many internal conflicts for me, but each of which allowed me to grow personally when I resolved them. As time went by, this direct engagement with aggression helped me to grow in confidence, allowing me to deal with physical conflict as and when it arose. I no longer flinched and hesitated when under pressure – not just in the training hall. Ironically, I felt less need to prove anything by being aggressive.

Upon starting my practitioner doctorate training, I happened into a conversation with Martin Milton where he told me about the research he had recently undertaken on the meaning of fighting for those who fight. I immediately thought of my own interest in this area and this conversation opened up the idea for me to look at aggression from a psychological perspective. This would add to my personal experiences and hopefully allow me to integrate my positive experiences into my therapeutic work.

However, the research enterprise was full of surprises for me. My initial searching soon made me realise that there were thousands of articles on aggression and I felt out of my depth. I had to change tack. I narrowed my searching to literature that reviewed the general psychology of aggression. This led to my second surprise. The literature seemed to define aggression as an attempt to inflict unwanted harm on others, and therefore research had focused on trying to find what caused it, in an effort to prevent or control it. This one-sided pathological view did not represent my experiences at all. I felt angry that the literature ignored any reference to healthy expressions of aggression, personal growth and self realisation. If I were a client, I would find it difficult to engage with a therapist who believed that all aggression was pathological. How could such a therapist understand the meaning of kung fu in the context of my life? I widened my reading in order to try and find any literature that explored the fuller meaning of aggression. After all there was so much literature; it would have been easy to miss something. However, try as I might, I could find none.

I had become interested in existential-phenomenological models of therapy early in my practitioner training. I had studied philosophy at undergraduate level, and found it easy to engage with the underpinnings of existentialism. I was particularly impressed with their
abandonment of notions of 'objectivity', 'truth', and 'causality' in favour of a focus on context, meaning and relatedness. It seemed that the existential literature would give me a suitable framework from which to begin to deconstruct the foundations of the positivistic causal literature on aggression, and to suggest an alternative way of viewing aggression – a way that values the unique perspective of the client, without bringing normative or pathological judgements, remaining open to the idea that aggression can be a healthy means of self-realisation.

However, this was not an easy task. The existential-phenomenological literature had not turned its attention towards aggression per se, and so it required an imaginative leap to turn what had been more general reactions against positivistic science or psychoanalytic arguments, towards a specific focus on aggression. Further, the literature on human aggression was vast. There was no way I could ensure totally that I had done justice to the whole field. I had more than one meeting with Martin to discuss my anxious feelings. I could particularly relate to existential angst being rooted in the lack of firm, fixed, solid, objective 'truths' upon which to base our choices. I too could not be sure that my arguments were grounded in a total search of all the literature. However, to some extent, this angst motivated me to immerse myself further and brought about a greater understanding of both current theories of aggression and existential-phenomenology and the implications of both for my practice. This review outlines that understanding as it presently stands.
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Year 2: *Being Aggressive: An interpretative phenomenological analysis of kung fu practitioners experience of aggression*

Roly Fletcher

Supervised by Martin Milton
Abstract

Whilst human aggression is discussed widely in psychological literature, it is often addressed from the standpoint of positivistic science which suggests it is outside the control of the somewhat passive individual, who requires interventions to prevent or control it, implying that all aggression is pathological. Whilst this has its uses, it provides only a one-sided view, and contributes little to a fuller understanding of the experience of aggression. This paper begins to address this 'gap' in the literature by presenting findings from an Interpretative Phenomenological Analysis into the experience of being aggressive. The study reports data from semi-structured interviews with six martial arts practitioners and shows how participants described the process of learning to deal with a physical aggressor in training, the difficult feelings they had to confront (including their own fear and aggression), and the inner resources they drew upon during this process. In doing so, participants described achieving a state they called 'intent' which allowed them to deal with an aggressor with relative ease. In contrast to the current psychological literature, participants described themselves as active in engendering their own aggression, and outlined some of the more positive aspects that it played in their lives. Some of the questions this raises for practitioners, and areas for further research, are then discussed.
Introduction

Human aggression is found in many forms in everyday life and this is reflected in the wealth of psychological literature on the subject. However, a review of this literature (Fletcher and Milton, 2007) showed it focused mainly on defining and explaining aggression through generalised models, independent of context and subject, in an attempt to find standardised ways to prevent and 'treat' those who would perpetrate it. Such standard causal models rest upon particular philosophical foundations that result in the assumption that aggression is the result of 'causes' outside the control and awareness of the somewhat passive individual, and ultimately imply that all aggression is pathological, in need of 'removal' (Fletcher & Milton, 2007).

There is little literature which contributes to a phenomenological understanding of aggression or the meaning of aggression in people's lives. Therapeutic practitioners are therefore left with one-sided causal explanations that ignore the possibility that healthy expression of aggression may be a pathway towards greater realisation of the self. Without being able to engage with the more positive aspects of aggression, practitioners risk 'disowning' their own aggression and attempting to 'suppress' that of their clients. Aggressive clients are considered passive (and pathological), denied their autonomy, unable to explore their needs and the needs of the environment in which they interact, denied the possibility to meet their potential in a manner which is right for them, and grouped with others under a label which may be entirely inappropriate (Fletcher & Milton, 2007). Ironically, in the attempt to avoid being objectified in this manner, a power struggle may ensue within the relationship, which is inevitably frustrating, conflict ridden, prone to anxiety and further aggression (Sartre, 1943/1958).

It would be helpful, therefore, to acknowledge the intersubjectivity of any relationship in which aggression is present and avoid, as far as possible, assumptions of objectivity which lead to normative judgements that stigmatise all aggression as 'unhealthy' or pathological. What is needed are studies which strive to discover the fuller meaning (including the value) of aggression. There are very few studies which have begun to explore aggression in this light (e.g. Milton, 2005); and so practitioners have to turn to other sources, such as those found within the field of martial arts, to find non-pathological encounters with human aggression. As Frantzis (1998) points out, "By its very nature, the field of martial arts deals directly with this area of human existence, not by sublimating our natural violent tendencies, but by delving into them." (p18). Martial artists, unlike the psychological literature, explicitly acknowledge the possibility that healthy and appropriate expression of aggression may be a natural way to move towards greater realisation of the self.
This study attempts to begin to bridge the 'gap' between the psychological literature and martial arts by exploring the experience and meaning of aggression for martial art participants who are considered 'non-pathologisers' of aggression; who engage with it in an effort to gain greater realisation of their self. It is hoped that this will provide alternative suggestions for how to engage with aggressive clients.

**Method**

**Sample**

In an effort to offer an analysis that does not lose the "subtle inflections of meaning" (Brocki & Wearden, 2006; p94), whilst still allowing a large enough range of individuals to talk about their experiences in depth, this study interviewed 6 martial arts practitioners face-to-face. As the 'typicality' of the perceptions and interpretations of these martial art practitioners cannot be ascertained, it is subjective and specific to them. Participants were recruited from one particular school of martial arts, that is explicit about their use of aggression. Recruiting solely through this Institute clearly limits the transferability of the findings, but these participants were attractive as co-researchers because they are in line with Brocki and Wearden's (2006) suggestion that participants be recruited on their ability to provide "interesting insights into the subjective...processes involved [in their] experiences [and] contribute to understanding [this] area of interest through a deeper, more personal individualised analysis" (p.99). As with any qualitative study, this study makes no claim to be exhaustive, or to form a more general picture, themes or processes in the engagement of aggression. Instead the study provides "adequate contextualisation", as suggested by Brocki and Wearden (2006; p.95), in order to provide some insights into the experiences that are currently absent in the psychological literature.

Recruitment, used advertisements (containing brief information and contact details) placed within the training room following prior formal agreement with the director and was limited to students aged 18 or over, currently in training, who have achieved grade 4 in the system or higher as;

"Someone who is working on grade 5 is probably the lowest grade to go for, as up to there it's still techniquey...5 is the first entry grade, so things are a bit more mental...[Below this students] have only just encountered aggression aimed at them, and so are having to get to grips with bringing some sort of aggression out of themselves, even though they may not have control of it." (Fenegan, 2006)
These criteria were a way of attending to participants' well-being and were considered likely to recruit participants who have a deeper level of engagement with their aggression. Such participants can be thought of as possessing experience that was currently absent in the psychological literature and hence are considered the primary experts (Brocki and Wearden, 2006; p90)

No exclusion criteria were set in terms of gender, age, race, sexual identity or other demographic characteristics.

After potential participants expressed interest, they were approached by telephone, which allowed confirmation of their membership of the Institute, their level of training, and their ability to give informed consent. This initial assessing allowed for some screening of suitability before meeting face-to-face, thereby giving greater protection of well-being for both participant and researcher. Participants were then sent an 'Information for Volunteers' pack which included a Consent form and background information questionnaire. Upon return of the signed consent form, they were considered eligible to take part. A suitable time for interview was then arranged. All of the interviews took place within a private distraction-free room; 4 at the training Institute, 1 at the University of Surrey, and one at a student's home.

**Interview Schedule**

The interview aimed to elicit an account of the participants' experience of aggression and hence a semi-structured interview schedule was used to allow the participants the freedom to speak freely and openly. Willig, (2001; p22) suggests this will "generate novel insights for the researcher", whilst enabling the researcher to "maintain control of the interview" and the original research question.

The interview schedule was developed in collaboration with Martin Milton (supervisor). The interview schedule aimed to explore participants' experiences of aggression (own and others), both within their training and outside of the training.

A pilot interview was carried out prior to the main interviews, at the end of which the participant was given the opportunity to give feedback about the procedure. This informed the interview schedule and the way the main interviews are conducted, by the suggestion of adding some 'warm up' superficial questions at the beginning, e.g. "how long have you been training in this approach?". All interviews were digitally recorded, and then transcribed verbatim. They were stored securely, and names and demographic data were changed in the analysis to ensure confidentiality. At the end of the project the recordings were destroyed.
Ethical Considerations

Ethical approval was granted by the School of Human Sciences Ethics Committee at the University of Surrey.

It was considered unlikely that the interview would elicit highly painful or upsetting material for the participants but they were informed of their right to stop the process at any point (both in their information pack and before interview). I provided participants with my contact details so they could ask any questions they had about the study at any time. The interview style was based around the principles of the counselling interview (Coyle, 1998), so that, should the experience have elicited sensitive topics, the interviewer was able to respond to the interviewees distress whilst not losing sight of the research topic. This allowed the researcher to include all reactions to the topic, considering them relevant and hence not 'side-stepping' or avoiding them but considering them part of the participants contextual information surrounding their experience.

Participants were offered the chance to read the finished report following the summer exam board and provide any feedback they may wish to give. One participant responded with comments linked to the first half of the analysis and these are therefore included in the summary section.

Situating myself in the research process

As researchers are active in interpreting the participants' material, it is 'best practice' to reflect on their role in the process, and how this impacts the study, e.g. the research question, the selection of participants, the analysis, and so on (Brocki and Wearden, 2006; p.97).

As a practising martial artist of 10 years, my own engagement in this process gave me some insider experience into engaging with aggression. In particular, it placed me in a position that held no negative view of aggression, giving me an alternative view to the wealth of pathologising material in the current literature.

This made me ideally placed to gain access to participants, while raising the risk that participants assumed that I had a level of knowledge that readers of my analysis would not. In order to manage this, I attempted to bracket my knowledge as far as possible, asking participants to clarify any jargon specific to the system. In terms of analysis, my insider experience was useful as it helped me draw out themes that were perhaps not obvious to an outsider. Of course it created a risk of the introduction of bias in theme selection or missed details. This is inevitable in IPA research (Brocki and Wearden, 2006; p.99) and introduced...
the need to ensure credibility as far as is possible. In order to achieve this I kept self-reflective notes throughout the project, and my analysis was examined by my supervisor. In addition, interpretations were grounded by examples from the interviews. My findings were discussed with practitioners of this system who did not meet the eligibility criteria for interview. The different interpretative positions that my supervisor and the practitioners held meant that they were sensitive to the data in ways that differ from my own.

These steps are in line with Elliott et al.'s (1999) criteria for assessing qualitative research.

**Analytic Strategy and Procedure**

In moving away from the simple biological/environmental models of aggression in the current literature, there is an acknowledgment of the constructed nature of aggression and the importance of understanding participants' perceptions and interpretations (Fletcher and Milton, 2007). An Interpretative Phenomenological Analysis (IPA) (Smith, Jarman and Osborn, 1999) approach allows an exploration of these experiences and how participants make sense of them in order to gain a greater understanding of how these feature in participants' lives. Whilst approaches such as grounded theory (which might also be used to explore the experience of aggression) were considered, IPA seemed ideally suited to an exploration of participants' experiences of aggression.

The approach used within this study analysed the content of the transcripts using the IPA method described by Smith, et al., (1999). This aims to identify different themes from within the data, selected by prevalence, the immediacy with which passages exemplifies/summarises a point, and/or how the theme assists in the explanation of other aspects of the account. Each transcript was analysed individually. Initially the first transcript was read, and notes made of key phrases, summaries of content, connections between different aspects of the transcript and initial interpretations. From these notes, themes were identified that captured something essential about the quality of what was being said. Checks were continually made to ensure that emergent themes were consistent with the data and not simply a product of expectations that had been shaped by the researcher's awareness of relevant literature (or the analysis of other transcripts).

This allowed themes that captured something about the participants' account of aggression (and the loss of those themes that were not well represented in the text or marginal to the research topic), whilst remaining true to the real world perceptions of the participants and providing as full an account as possible.

This process was repeated in turn for each transcript following which a 'master list' of all
themes across transcripts was produced. The interpretative task of choosing which themes to include or exclude was then repeated.

In this analysis participants' real names were replaced with pseudonyms and the material is presented in a way that aims to protect participants' confidentiality appropriately. Data extracts are used to illustrate interpretations allowing the reader to assess persuasiveness for themselves. Care was taken to distinguish between the researcher's interpretations and the participants' original accounts. In the quotations, empty square brackets indicate where material has been omitted, material within square brackets is provided for clarification and ellipsis points (...) indicate a pause in the flow of participants' speech.
Analysis

Demographic Information

Due to the small and close-knit nature of the community from which participants were recruited the demographic information presented here is limited. This step is necessary to maintain confidentiality.

All the participants were white, heterosexual males and between the ages of 20 and 49. The occupations given were all distinct from each other and provided the participants with incomes that varied from between £15K and £20K, to between £30K and £40K.

Participants' length of time training in the system varied from 2.5 years to 14 years. Training with a teacher varied from weekly to twice a year, training with a partner varied from weekly to monthly and training alone varied from daily to monthly. Half the participants identified this training as their first experience of aggressive training. Previous aggressive experiences included other martial art styles (competitive and non-competitive), army and gangs.

The following section presents a description of participants' accounts of their engagement with aggression.

Data Analysis

Overall, participants suggested a dynamic process of aggression characterised by different but inter-related mental and physical experiences that lead to a sense of significant personal change. This can be represented diagrammatically (Figure 1). The process began with engagement with aggression aimed at participants (represented in the smallest circle), and led to engagement with different aspects of themselves (represented in the larger circles). This process was ongoing over time (represented by the arrow) and participants outlined the difficulties they faced in engaging with each of these aspects of themselves (represented in the rectangle). This process is described in full following the diagram.
Participants' Personal Experiences of the Process of Engaging with Physical Aggression in Training (Figure 1)

Barriers to Engaging in the Process
* No overt aggression in training
* Not enough patience
* Not able to control emotions
* Self-doubt
* Enthusiasm wanting it to improve self-image
* Not being "stubborn" enough
* Not wanting to overcome the fear

Aggression as Response to Aggression
* Difficult to define
* Multitude of possible expressions
* Expressed physically in training
* Consistent impression over time

Fear as Initial Response to Aggression
* Natural instinct of danger
* Makes you ready to act
* Distorts mental/emotional perception
* Increases physical/postural effectiveness
* Makes you want to run away so you can't get in and finish the fight

Time and Training
* Not necessarily linear
* Not guaranteed to work

'Intent' as Response to Aggression
* Total focus on finishing fight
* Not distracted by anything that would pull you away from task
* Balances out fear & aggression
* Not subject to distortions of mental/emotional perceptions
* Walk straight in without trying to get out the way
* Not wanting to do someone damage
* Like walking through a field of corn & brushes it aside
* Doing as much as necessary; not overly aggressive
* Control over physical posture/movement
Evolving and consistent engagement with aggression

Aggression was said to be difficult to define, suggesting that this was due to its emotional and subjective nature, "it’s quite a personal thing" (Gary). Despite this difficulty it is clear that participants were all deeply engaged with their aggression. This is demonstrated by their awareness of a multitude of possible ways in which they might express their experience. They described:

- "verbal and physical aggression" (John)
- "a purely physical side [and a] mental side" (Rob)
- "an emotional response to something" (Rob)
- "predatory aggression where it’s not personal [] and affective aggression where [] you’re doing it to intimidate [] like a status thing" (John)
- "a pride thing" (Peter)
- "anything that puts you ill at ease" (Peter)
- "to take the offensive" (Edd)
- a “conflict [] between people [that] taking it to its nth degree it ends in physical violence" (John)

The awareness of this complexity can be seen throughout the analysis. Despite this, participants were consistent in saying that aggression has a physical dimension. This is expressed as physical violence within their training. John said “aggression is part of the training we do, and you will experience it, you can go to a lesson and expect to be hit”. Despite the complexity, participants stated that their impression of aggression had remained consistent. Rob described this succinctly when he said: “I think I’ve changed a lot through doing martial arts but I don’t think my impression of an aggressor has changed”.

As can be seen in Figure 1, participants described an ongoing process of engaging with this aggression at both a physical level – e.g. John said “[we try to] apply techniques...under realistic circumstances” – and at an emotional level: “there’s always something new to learn, or a higher level of being able to control yourself and your emotions” (Rob)

While aggression may be experienced as constant, the engagement with it was said to lead to significant change. Edd said “it will change you for life [] and it will be forever changing”. This leads us to one specific experience that is thought to lead to change ... that of fear.

Fear as a response to aggression

Participants described fear as being a common initial response to aggression in their early stages of training and was thought to be a “natural instinct of danger [making you] alert [and]
ready to act” (John). However, participants also described the emotional and embodied aspects of fear as interfering with their ability to act. This included distorted mental and emotional perceptions, e.g. “you get a heightened sense of what isn’t there” (John) and it also resulted in decreased physical effectiveness, e.g. “I wouldn’t be able to effectively do what I needed to do” (Rob). Lastly, it resulted in a “run for your life response” (Rob). Hence participants described their desire to engage in a process that would allow them to overcome the fear and confront aggression when it was aimed at them.

**Aggression as a response to aggression**

Participants suggested that “aggression will overcome the fear [] so aggression needs to be trained in” (Edd). But this was not seen as an easy process and participants initially found their aggression difficult to control. Gary said he felt like a “time bomb”, unable to “consider anything”. Bill described it as “blind rage” that would “spill over into daily life” at “inappropriate times”.

Within training, Bill felt that, like fear, his own aggression “destroys your physical posture” and hence you are “less efficient in your movement and power”. Bill noted that this made it hard to “obey the rules of kung fu [and hence he would] get hit”.

In order to use their aggression, participants engaged in a delicate and complex process. John said “I’ve got to be more aggressive than the person coming towards me but I’ve also got to be in control” and Edd added “you must have a clear mind [] if you train aggression into your thinking faculty then you could argue that you don’t have a clear mind”. So clearly, this complexity is difficult at times. However, with perseverance it is possible to find a way through these tensions. And participants termed this ‘intent’.

**‘Intent’**

At later stages of training, participants described being able to have an alternative response to aggression; a state which they termed ‘intent’. John described how ‘intent’, balances out both fear and aggressive responses; “the normal response is that it brings the passive people up, makes them a little bit more aggressive. It brings the aggressive people down”.

Peter described ‘intent’ as the “total commitment to doing something”. So when faced with an aggressor, and in contrast to the debilitating effects of fear, Rob said:

“you’re still completely aware of the fact that you’ve been hit but it doesn’t mean anything to you…you just let it go without even thinking about it, it’s not that you don’t notice it, you’re just not affected by it in any way”.
While in this state of intent participants were keenly aware of what was going on, rather than being subject to the mental/emotional distortions experienced when afraid. Rob expanded saying:

"it's more than just seeing what your opponents doing. It's being able to feel what they're doing and the changes in direction, forces they're making with their body [] you feel it on a different level because your emotional mind is not there at all".

Similarly, the state of 'intent' was embodied, and participants were not subject to the loss of postural/physical effectiveness experienced during fear. This was exemplified by John who said, "There's no sort of deviance, you're not physically trying to get out the way, and also you're able to attack at the same time".

The state of 'intent' is still an aggressive state; Rob described it as the will "to knock this person down and finish the fight as quickly as possible". However, in contrast to the purely aggressive response described earlier, 'intent' was described as being characterised by "not losing control [and] maintaining a state of equilibrium" (Bill).

Once experienced, intent reassured participants that they were not out of control, that their 'intent' would not 'spill' into their daily life. Peter said "intent for me doesn't have to be overly aggressive, it's doing as much as is necessary".

This experience of control includes an embodied dimension linking the physical and mental. Edd described it as "controlling your aggression means controlling your physical posture [] centering, mentally and physically".

As the participants talked, it was apparent that they were experiencing a struggle to articulate an experience that is both conceptual and embodied. However, there was an implication that the state of 'intent' was somehow peaceful, with a natural sense of pleasure and ease. Rob summed all this up by saying:

"[Intent is] almost impossible to describe it, you know it's taken me nine years to understand it. It's not even, it's not an emotion, it's not even, it's not a wanting to do someone damage, it's...when you're purely 'intentful' and you're in a fight, it's almost like walking through a field of corn as some old Chinese masters say, you just kind of brush the corn aside, right that's it and it's gone, and, there's no real feeling of aggression, but the physical act of being in the fight is being aggressive... it is as if you are fighting nothing. It's as if there's nothing there at all."
Barriers to engaging in the process

In contrast to the sense of ease implied by the state of ‘intent’, participants were clear about the struggles they had encountered to get to this point.

Five of the participants had trained in other martial arts but felt that none of these arts had allowed them to engage with ‘overt aggression’ (Bill). Gary summarised this saying:

“I’ve been training since I was about nine years old, I’ve done taekwondo, jujitsu, erm ninjitsu, erm, kickboxing, vambudo which is a mixture of tae kwondo and judo, jujitsu... it was like it was a sport really, there was never any aggression in it really”.

Each participant described a different struggle that they had to overcome in response to being exposed to such ‘overt aggression’. Rob noted; “an awful lot of people drop out at grade five because they can’t handle it”. For Peter it was self-doubt; “I can’t do this, it’s too hard”. For Gary it was confidence “my confidence in myself at that point was really destroyed [and] I fell to pieces”. And for Peter it was disillusionment, “you learn that fighting isn’t going to improve your self-image”.

Participants understood their emotions had to be controlled or they would not progress. Rob implied this, saying, “If someone has that much of a problem controlling their emotions then to actually take the first few steps in martial arts is going to be virtually impossible”. Peter agreed, saying, “[for someone with anger issues] I would recommend they go and talk to somebody before training”. Edd pointed out that gaining control of these emotions, “it’s a slow process, some take longer than others”.

Others agreed, saying this is “a very sensitive and gradual process [] that won’t “work no matter what” (John). Bill expanded on this, suggesting that the process isn’t necessarily linear, “the mind wants to pull you back [] it’s the nature of the mind”. Engagement with aggression seems to be like any other emotion in that there is thought to be no start or end point. Emotion implies a process of ongoing engagement and hence, Bill said, even “high level martial artists [] can be aggressive in inappropriate times [] some martial artists get to a very high level but never get away from that”.

Rob joked that he was able to keep going, despite the slow process and the feeling he might not be able to cope because, “I’m a stubborn bastard [laughs] I had the goal in mind all the time [and] I was going to finish the system, no matter how long it took me, no matter how hard I had to work at it”. Stubbornness (or at least hardiness) seemed to help Gary too, who said, “I
carried on and on and on, keep taking all these knocks and just picked myself up and kept going”.

For Peter however, it was the desire to try, and overcome his fear that kept him persevering. He said “well even if I can't do it, at least I've tried [] I came back because I wanted to overcome the fear”.

**Summary**

Participants' found that the process of engaging with a physical aggressor led them to confront their own fear, aggression, ability to cope, confidence, and sense of disillusionment. This was experienced as a slow (non-linear) process, which requires inner resources such as stubbornness, hardiness, perseverance, and an ability to gain control of their emotions. However, in doing so, participants experienced a state they called 'intent' which allowed them to deal with the aggressor with relative ease, without the disabling physical/mental effects of fear or aggression.

One participant, having reviewed this analysis, felt it important to emphasise that 'intent', “does not neutralise the presence of both fear and/or aggression. Even with a developed 'intent' they remain - but as you have put so well in the analysis - to a lesser or greater degree” (John). Further, the participant went on to reinforce the suggestion that achieving the state of 'intent' was an on-going, non-linear process saying, “it is important to state that perfect 'intent' is an impossible goal to strive for (which brings in the skill element)”.

The second half of this analysis describes how engaging in the process described above had impacted on their life outside training. They talked about the personal changes they had experienced, the reactions of friends and family to their training, and finally their perception of society's response to aggression more generally. These are represented diagrammatically (diagram 2) and described below.
Participants' perceptions of responses to aggression (theirs and others) outside training

CHANGING EFFECTS ON LIFE OUTSIDE TRAINING
* Increased confidence
* Less need to prove oneself
* Increased awareness of the damaging effects of fighting
* Reluctance to fight if it can be avoided, but not afraid of fighting if need be
* Greater awareness of situations that might lead to conflict
* Greater acceptance of aggression (own and others)
* Increased control over own aggression

PERCEIVED RESPONSES OF FRIENDS AND FAMILY
* Worry about being seen as a 'git'
* Worry that friends will become afraid
* Assume you will become more aggressive
* Competing with you
* Taking the mickey
* Assume you have super-human abilities

PERCEIVED SOCIAL RESPONSES TO AGGRESSION
* Backing off
* Disapproval
* Fear
* Judged as negative/wrong
* Disowning own aggression
* Own aggression coming out somewhere else
* Self-doubt when experiencing own aggression
* Greater aggression in long-run
Changing effects on Life outside training

Participants described their reluctance to engage in violence now because of their awareness of the potential damage they could do. Peter summarised this, "I don't really want to get into a fight because I'm actually going to have to hurt the other person". Similarly, Rob said "I know how much damage I could do".

On a personal level, John felt his training had allowed him to “become a bit more confident”. Gary felt he had less of a need to “prove” himself, and Bill said, "I don't feel aggressive that often any more [] I can't remember the last time I got to a full on state of white-knuckle rage. That hasn't happened for a long, long time".

Rob explained that, “Since I've been doing martial arts I've not been in a single fight, because [I can now] deal with aggression in a calm, controlled way”.

Peter, related this to the increased control he now had of his fear, saying, "you avoid it because you realise there is a very negative outcome rather than fear, you're not afraid of the fight or the outcome itself". Similarly, Rob said, “It still might be a perfectly valid thing to run away from someone, but I would be much more in control of what I was doing in response to this aggression. I'd consciously make the choice to fight or run away”.

Further, Gary said his training had helped him to “learn how to avoid getting yourself into the situation where you would become aggressive”. As an example he said “if I walk into a pub, the first thing I'll do is look around the room for the blokes that are most likely to start a fight and then I'll go to the other side of the pub, right away from them”.

However, participants also described an acknowledgment and acceptance that there are times when they need to be physically aggressive.

Edd said, “this is a last resort for you, there's no way out, then do it”.

John said, "[the aggressor] thinks he's better than you, he wouldn't start a fight if he didn't [] and you've got to change his mind as quickly as possible".

Similarly, Peter said “you get to the point where you either walk away there and then or you finish it [] but if this guy's not going to let you walk past him, then in some respects you just have to finish it".
This was somewhat of a paradox that emerged out of participants narratives. Whilst on the one hand, participants were describing a need to be physically aggressive at times; it also became clear that they did not consider themselves to be aggressive people.

Bill emphasised this when he said, “This might sound odd, if I have to protect myself from somebody and I hit them [but] there is no violence or aggression in my mind then that’s just me doing what I have to do”.

Rob also reflected this saying, “Most martial artists who are, who are trained up to that level are the nicest people, they will go out of their way to help absolutely anybody in any situation, erm, so it’s a bit of paradox really”. He expanded on this saying, “it’s something that has to be done in order to protect me, in order to protect the people I’m with, maybe even the person who’s attacking me. You know, I have no desire for anyone to get hurt [] you can stop at any time, you can switch it off at any time. And that’s the point where you turn round, call an ambulance, make sure he’s ok, you know, and walk away”.

Responses of friends and family

In contrast to participants’ acceptance of their aggression, and continued experience of themselves as ‘nice people’, Rob expressed his concern that his friends would become afraid of him. He said, “My friends have never seen me in a fight, I wouldn’t want them to see me in a fight [because] the last thing I want is for any of my mates to be afraid of me”. He expanded, saying, “my family generally, I think they’d probably have a similar reaction to my friends”.

Peter too worried that if his friends saw him fight, they would think he was “a bit of a git”, and would “start to think less of you”.

Similarly, John stated that in the past his girlfriends had “difficulty understanding why you’d want to put yourself in a situation where you’re fighting someone”, and that this led to the assumption that “it would lead to you becoming an aggressive person”.

Bill echoed this when he said they assume that “you want to learn to fight, you must be aggressive”. Bill also suggested that martial artists have an unrealistic stereotype as “some kind of super human being”.

Perhaps unsurprisingly then, Bill said that his friends made “silly jokes”, such as “I’d better not upset him in case he beats me up”, and John echoed this saying that his friends “take the mickey”; for example asking, “can you break a brick with your hands” or “if you’re in a situation can you deal with it”. 

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Less obviously, however, Peter suggested that his friends would always be wondering “if I could have him?”. This, more sinister, element of competition was present for John also, who suggested that his friends would always be trying to work out if, “I could have you easy or I have to treat you with a bit more respect”.

**Social responses to aggression**

Rob's suggestion, that his friends would be afraid of his aggression, was expanded into a more social response by John, who said that generally “a very fearful response [to aggression is] going to be publicised negatively” and that this means that “people would sort of back off [saying] I don’t approve”.

Edd agreed with John, saying, “many people would see aggression as a negative because it involves physical violence”. He expanded saying, “you’re going to have a hard time convincing anyone who isn’t of the ilk, that aggression is a good thing [and] I’ve got the feeling that the people you’re writing this for [will] think aggression is a totally wrong thing”.

It is perhaps unsurprising then, that John suggests that people try to disown their aggression. He said, “people would think that they’re not aggressive and other people are”. He suggested that although “everybody has aggression” those who disown it are “not able to accept it as part of, you know, that’s just what happens”.

It is interesting to note that, somewhat in contrast to these views, Edd suggested that there was a difference between some people. He said that “[most] people don’t really want to hurt anyone else [but] there are individuals who don’t think like that [and] they’re mentally ill, there is something wrong with them [they have] some kind of an illness which they are out of control of”.

Several of the participants, however, agreed with John, and went on to suggest that it was impossible to disown your aggression.

Bill suggested that “If you suppress something it will come out in another way’. He expanded saying “It is like if you have a half inflated a balloon; if you push on one side of it, it will come out somewhere else”.

Gary agreed saying, “I can put on a happy face, pretend I’m happy, but at the end of the day I always have these dark niggling thoughts inside [and] I get very negative and lose interest and you can see that straight away”.

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John suggested that this might lead to self-doubt, "I suppose self doubt will creep in their mind and they will think 'my god what's wrong with me'".

In contrast to his earlier comments, Edd too suggested that attempting to suppress/disown aggression was ultimately pointless, "it's there whether they like it or not, let's try and see what it can do rather than pretend it doesn't exist [there is] no point following any philosophy that is at one extreme or the other". He went on to argue that this would ultimately result in more aggression. He said, "[kids] are going to think aggression's ok all the time, 'we can be abusive and aggressive to everybody, no one is going to say anything, what can they do?'".

**Summary**

It can be seen that participants valued the effects that engaging with their aggression had in their lives outside training. Participants described increased confidence, lowered feelings of aggression, greater ability to avoid conflict, but an acceptance that they could both deal with it when necessary, and that it did not change their perception of themselves as a nice person.

However, participants were concerned that friends and family might be afraid of them or think of them as a 'git' if they ever witnessed their ability to fight. Participants suggested that, in opposition to their own experiences, close relations might consider training in the martial arts to make you more aggressive, or have 'super-human' abilities. Participants therefore found their friends trying to compete with them, or taking the 'mickey'.

At a wider social level, participants felt that aggression was feared, disapproved of, and judged as negative. Participants suggested that people would 'back off' from aggression, which included trying to disown their own. However, participants felt that this would simply result in self-doubt, and greater aggression in the long-run.
Discussion

Whilst the current psychological literature invites practitioners to consider only the problematic aspects of aggression, suggesting that their role is to 'banish' it forever, this seems counter-intuitive if one considers the experiences of the participants in this study. Hypothetically, had one attempted to 'rid' these participants of their aggression when they felt it was out of control, this would have 'halted' their process and their progress, leaving them subject to their initial fear, and unable to go through their uncontrolled aggressive response to reach what they called the state of 'intent' characterised by a sense of calmness and greater control. Participants would have been 'labelled' as essentially passive (and pathological), risking them feeling helpless, hopeless, and afraid, rather than active and autonomous. Practitioners in turn would be left attempting to work with the client's anxieties, unable to 'tap' into the valuable resource of aggression (theirs or the clients). If practitioners do this, they risk being unable to recognise the individual's autonomy and hence the individual's freedom to realise themselves (or deny that freedom) in any given situation. Instead, they risk bringing normative judgements into the relationship, which ultimately might lead to greater frustration and aggression, distancing the client from themselves and others considered normal, and not considering context and the social environment within which the client interacts.

Maybe what is needed in the therapeutic domain is an understanding of aggression as normal, healthy and appropriate. This might allow a therapist and client to 'align' themselves as 'same' (or at least grappling with similar aspects of Being), leading to a more collaborative relationship in which the fuller meaning of the aggression in the client's life can be explored. This potentially opens up greater opportunity to explore how the client uses their aggression to relate and act in the world, and how such a relational stance helps or hinders their ability to meet their possible potential in a manner which is right for them. Clients, like the participants within this study, are therefore given the opportunity to engage with their aggression, and reach their own valued state, the equivalent of 'intent'.

This suggests a number of areas for further research. Concepts, such as 'intent' have no equivalent with the psychological literature and so it is unclear what the therapeutic equivalent of this state of ease would be, and how one could achieve it (for practitioner or client). It also raises questions as to whether it can only be achieved through the use of aggression. If this were the case it would challenge current therapeutic notions of therapeutic practice being characterised by warm, calm intimacy. It might mean that we would have to consider the appropriateness, ethically or otherwise, of voicing our aggressiveness towards our clients, or to engage in aggressive relationships with our clients. The dilemma is that if we do not facilitate some equivalent in therapy, we risk becoming directive and limiting in what clients can explore and achieve. Clients may value engaging with aspects of themselves that are less
comfortable or less socially acceptable, as did the participants in this study. Having said this, it may be difficult to 'attune' ourselves to this aspect of our clients and engage openly and honestly with their aggression. And maybe this is the core of the challenge we face where human aggression is concerned, and others such as martial artists, may have much to teach us.
References


MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Appendix A

Advert for Institute to Recruit Participants

Grade 4 or above?

I am conducting research to find out more about people’s experience of aggression, what it is like to be aggressive and what it is like to have other people’s aggression aimed at you.

I would like to interview practitioners who have achieved Grade 4 (or above). The interview will be an opportunity for you to talk freely about your experiences of aggression, and whilst I might ask you some questions, I will also be aiming to arrive at an accurate understanding of your own account, so we will talk about aggression as broadly as you may want to consider it.

If you think you might be interested in being interviewed please contact me for more information.

Roly Fletcher
Tel: 01483 689176
Email: r.fletcher@surrey.ac.uk
Appendix B

CONSENT FORM

I the undersigned, being head of the Institute, voluntarily agree to allow the study **Being Aggressive: Kung fu practitioners experience of aggression** to be conducted through the Institute.

I have read and understood the Information Sheet which will be provided to practitioners who agree to take part in the study. I am aware of the nature and purpose of the study. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given if I did ask questions.

I understand that any data derived from any individual interviewee will be treated in accordance with the Data Protection Act (1998).

I therefore consent to allow recruitment and interviewing of practitioners to take place through the Institute.

Name (BLOCK CAPITALS) ........................................... Witness: ...........................................
Signed ................................................................
Date ................................................................

On behalf of all those involved with this research project, I undertake that professional confidentiality will be ensured with regard to any written material or audio recordings made. The use of any written material, audio recordings or transcribed material from the audio recordings will be for the purposes of research only. The anonymity of interviewees will be protected.

Name of researcher ...ROLY FLETCHER ...............
(BLOCK CAPITALS)
Signed ................................................................
Date ................................................................
Appendix C

Information Sheet for Volunteers

Title of project: Being Aggressive: Kung fu practitioners experience of aggression

Dear volunteer,

You have been given this information sheet because you have trained in this system to Grade 4 level or above and you also expressed an interest in taking part in this project. In my research I am interested in finding out about people's own accounts of their experiences of aggression and how this affects them and their life. I am writing to ask if you would help by allowing me to interview you and by sharing your particular account of engaging with aggression with me. The project has received ethical approval from the University of Surrey.

I am in my second year of training in Counselling Psychology and I have a particular interest in people's experience of aggression, what it is like to be aggressive and what it is like to have other people's aggression aimed at you. It is hoped that the research will ultimately improve psychological understanding of the role that aggression plays in people's lives. My supervisor for this project is Dr. Martin Milton. Martin is a senior lecturer at the University of Surrey.

The interview will take place at the Institute. The purpose of the interview is to allow you to talk freely about your experiences of aggression. Whilst I will ask you some questions, I will also be aiming to arrive at an accurate understanding of your account so there will be plenty of opportunity for us to talk about aggression as broadly as you may want to consider it. Whilst this may make the interview feel informal there are some important formalities that you should be aware of and these are listed below:

- You may decline to answer particular questions
- The interview will be tape recorded
- I will use some of what you say in the recorded interview in my research report
- The research report will be read by my supervisor and examiners
- The research report may be put forward for publishing, meaning that it could be read by anyone
Your confidentiality will be protected by removing the names of people and places that may connect what is written in the report with you. The tape recorded interview will be kept in a secure place at all times and it will be put into written form as soon as possible after the interview. At the end of the project the actual recording will be destroyed.

You do have the right to stop the interview and/or withdraw from the study at any point should you wish to.

If you would like to take part in the study, I will contact you by telephone to arrange an interview date. Please do not hesitate to contact me or my supervisor with any questions you may have about the project.

MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Appendix D

CONSENT FORM

I the undersigned voluntarily agree to take part in the study Being Aggressive: Kung fu practitioners experience of aggression

I have read and understood the Information Sheet provided. I am aware of the nature and purpose of the study, and of what I will be expected to do. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given if I did ask questions.

I understand that any data derived from an individual participant will be treated in accordance with the Data Protection Act (1998).

I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

I therefore consent to be interviewed about my experiences of aggression and give permission for the words from the interview and questionnaire to be quoted in the research, on the understanding that my identity will be protected.

Name of participant ............................................. Witness: ...................................
(BLOCK CAPITALS)

Signed ...........................................................................................

Date ...........................................................................................

On behalf of all those involved with this research project, I undertake that professional confidentiality will be ensured with regard to any written material or audio recordings made with the above interviewee. The use of any written material, audio recordings or transcribed material from the audio recordings will be for the purposes of research only. The anonymity of the above interviewee will be protected.

Name of researcher ...ROLY FLETCHER ............
(BLOCK CAPITALS)

Signed ...........................................................................................

Date ...........................................................................................
Appendix E

Background Information

Participant number:

Please mark the relevant box or write down your response to each question.


Q2. Sex: Male □  Female □

Q3. Ethnic Group: (From National Census 2001 questions)

White

British □
White Irish □
Other White Background □
If other please write in .................................................................

Mixed

White and Black Caribbean □
White and Black African □
White and Asian □
Other Mixed Background □
If other please write in .................................................................

Asian or Asian British

Indian □
Pakistani □
Bangladeshi □
Other Asian Background □
If other please write in .................................................................

Black or Black British
Caribbean □
African □
Other Black Background □
If other please write in .................................................................

Chinese or other ethnic group

Chinese □
Any other please write in .................................................................

Q4. Country of birth
England □  Wales □  Scotland □  Northern Ireland □  Elsewhere □
If elsewhere please name the country ..............................................

Q5. Religion
None □  Christian □  Buddhist □  Hindu □  Jewish □
Muslim □  Sikh □  Any other □ please write in .................................

Q6. Work

Are you currently working?
Yes □  No □
If yes:
Are you an employee □ or self-employed □
What is your occupation?.................................................................
What industry do you work in?.........................................................
How many hours a week do you normally work?.........................

Q7. What is your salary?
£0 - £15,000 □  £15,000 - £20,000 □  £20,000 - 30,000 □
£30,000 - 40,000 □  £40,000 - 50,000 □  £50,000 or above □
Q8. Health

Have you seen a medical professional in the last year?  No □  Yes □

If Yes – Was this related to your training or aggression?  No □  Yes □

Q9. Sexuality

Heterosexual □  Homosexual □  Bisexual □
Other □  Please specify

Q10. In your estimation, how long have you been training in Etheric Boxing

.............

Q11 How often do you train?

With teacher?..............................
With training partner?.....................
Alone?........................................

Q12. Was this your first experience of aggressive types of training?  Yes □  No □

If no, please give a brief history of your experiences below

(continue overleaf if necessary)
Appendix F

Interview Schedule

I am hoping to find out more about your experiences with aggression and so I'd like you to tell me about it. This is a chance for you to tell me the story of how you engage with aggression, starting from the beginning with all the circumstances that led up to it, what it is like and what has happened since. I'd like to remind you that if you wish to, you can stop the interview at any point without having to explain why.

a) So how long have you been training in this system?

b) And do you feel you've engaged with aggression, yours and other peoples, during this time?

So to clarify, because I know aggression can mean different things to different people, perhaps you could tell me what 'aggression' means to you...

1) What does aggression mean to you?

Prompts: what sort of images, thoughts, feelings spring to mind when you hear the word aggression

2) Thinking back to before you started training in this system, would you say that the meaning of aggression for you has changed since then?

If 'yes' explore what differences there are and how these manifest:
   What were the circumstances that led up to this change?
   How would you describe your training prior to this?
   How did you feel about that/how did that make you feel?
   What was it like for you?
   What happened after that?

Preamble: Now we have explored what aggression means to you, I'd like to hear what your actual experience of aggression is.

3) What is it like when you are aggressive?

Prompts: How do you go from being non-aggressive to aggressive?
          Does something trigger this change or can you chose to do that at will?
What triggers it?
How do you ‘turn it on’?
Does this differ between training and outside training?
what is it like emotionally, physically, practically
What does it look like physically?
Does looking aggressive differ from being aggressive?
Immediacy – what does this person look like in the room now?
What is your current state?
How does this compare with what they are saying?
How would they embody their aggression?
How does it make you feel?
Why do you think that happens
How do you train it?
System suggests 2 ways – alone and with partner – how does aggression relate to these different ways, how does it differ, how does it all link up?

4) And what is it like to have someone else’s aggression aimed at you?

Prompts: What does it feel like, emotionally, physically
  What does it look like
  How do you cope with that emotionally, physically
  What effect did that have on you (immediacy – how are they in the room now)
  How does this compare to what they are saying
  What support did you use if any?

5) How do you think people respond to you when they know that you can be aggressive?

Prompts: relationships with mates
  Family
  Girlfriends/partners

6) Looking to the future, how do you see this aspect of yourself developing?

7) I’d like to ask you whether there are any positives/negatives about developing your aggression that we have not already covered?

8) Finally, much public literature talks about aggression as a negative, and I was wondering what you made of that?
9) For those without your training, what would your advice be should people be struggling with issues relating to aggression?

10) Ok we're coming to the end of the interview, how are you feeling having talked about this?

Prompts: Would you like to explore that further?
What has been good/bad about helping with this research?

Right that concludes the questions I had. Is there anything else you would like to tell or ask me? Anything I have missed out or may not have understood?
[if 'yes' then explore, else finish]

Ok then I'll stop the tape now and the interview is finished. I'd like to remind you that your confidentiality will be protected by removing the names of people and places that may connect what is written in the report with you. The tape recorded interview will be kept in a secure place at all times and it will be put into written form as soon as possible after the interview. At the end of the project the actual recording will be destroyed.

Thank you very much for taking part and telling me about your experiences, it's been very useful. Do you have any other questions at all? Please feel free to contact me about the project later if you wish. Thanks once again.
Roly Fletcher
Department of Psychology – PsychD
University of Surrey

27 February 2007

Dear Roly

Reference: 98R-PSY-07
Being Aggressive: A proposal for an interpretative phenomenological analysis of kung fu practitioners experience of aggression.

Thank you for your submission of the above proposal.

The School of Human Sciences Ethics Committee has given a favourable ethical opinion.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the School Ethics Committee.

Yours sincerely

Dr Kate Davidson
Appendix H

Personal Reflection

My personal interest in aggression, martial arts, and the development of the self has been present from my undergraduate philosophy degree where I both studied kung fu in my spare time and endeavoured to gain an understanding of the development of the self through the works of Nietzsche, Collingwood, and Taoism. With hindsight I realize that at some level I was trying to address my own inability to engage with my aggression in some kind of healthy way, thus to relieve myself of my sense of anxiety, powerlessness, somehow being passive, and pushed around in social situations. When on my own, I often experienced the aftermath of these feelings as anger, sometimes even rage, but accompanied with a sense of impotence. I was unable to link up with my own anger in social situations. Like the participants in this study project, I think I too was afraid of my own capacity for anger and aggression, believing and judging it to be wrong.

Within my family, I had the experience of growing up with a father who was 'robbed' of his power, becoming somewhat 'impotent' when I was 8 and he slipped on an icy pavement; an accident that resulted in many debilitating symptoms, eventually diagnosed as Multiple Sclerosis. I think my father always tried to protect me and the rest of the family from his own feelings at what had happened, and in response, I think I too tried to protect them from my own feelings of anger. Further, I think I (unnecessarily) attempted to 'step up' and become the 'man of the house' in a way that, whilst perhaps understandable, would never be possible for an 8 year old. Whilst this led to many frustrations for me surrounding my impatience at not being 'grown up enough', my impotence to help, and no where to express these feelings, I think it also led me to nurture my desire to rescue, help, alleviate, understand, and empathise. This is perhaps evident in my somewhat contrasting desire to become a counselling psychologist who helps, but also a counselling psychologist who writes about aggression, martial arts, and partakes in kung fu fighting in his spare time.

It is perhaps unsurprising then, that I take a strong non-pathologising stance towards aggression in this research and the literature review that preceded it, and attempt to explore how it can be made more accessible in a healthy and helpful way for clients (but also myself and those close to me). In addition however, I was interested in presenting participants perceptions of their relationships with friends, family and society at large. Although not consciously aware of this before, I believe this represents my own interest in how my aggression (or lack of it) affects my own perceptions and actions in relationships. Similarly, it also represents my interest in how my relationships (past and present) affect my ability to engage (or be unable to engage) with my aggression in a healthy/unhealthy way within those
relationships. Becoming aware of this has allowed me to begin to reflect upon my own capacities for aggression within my client work, and how able I am to engage with my clients aggression (generally or specifically at me) within our work when it arises.

However, the research raised far more material and was far more complex than I originally expected. This made it an extremely difficult and stressful task to decide what to include/omit to meet the word limit and deadline. I often found myself cursing and wishing that I had more time. As might be expected in this kind of research (no matter how much time available), I suspect that I have not done justice to the full range of participants subjective experiences. However, I do feel that this study has demonstrated that at least for these participants', expressing this particular type of aggression, within this particular context, a healthy engagement with aggression does seem possible. I therefore hope that my future research will go on to explore this possibility further.
Year 3: Have You Ever Wondered What It Might Be Like To Try And Cuddle A Tiger?
Towards a grounded theory of practitioners' non-pathologising experience of aggression

Supervised by Martin Milton
Abstract

Whilst human aggression is discussed widely in psychological literature, it is often addressed from the standpoint of positivistic science which suggests it is outside the control of the somewhat passive individual, who requires interventions to prevent or control it, implying that all aggression is pathological. Whilst this has its uses, it provides only a one-sided view, and contributes little to a fuller understanding of the experience of aggression. In order to begin to redress this, this study recruited and interviewed practitioners who were considered to work within contexts that allowed them to take a non-pathologising stance towards aggression. Data from semi-structured interviews with nine practitioners was subjected to grounded theory analysis. Accounts consistently attended to the bodily sensations, feelings and impulses that the experience of aggression, both own and other, engendered. The tendency to want to 'rid' aggression was associated with fear, anger, and an impulse to 'attack back'. Participants suggested the need to engage with these emotions, resisting the impulse to 'attack back', in order to be able to allow clients to bring their aggression, explore it, and engage with it in a constructive manner. In contrast to the current psychological literature, which suggests aggression is pathological and must be curbed; participants described themselves and their work as active in engendering aggression, and outlined the normality of it. This raises questions for practitioners' and clients in the need to acknowledge the impact of the wealth of pathologising psychological literature on the therapeutic relationship itself.
Introduction

Human aggression is found in many forms in everyday life and this is reflected in the wealth of psychological literature on the subject. However, a review of this literature (Fletcher & Milton, 2007) showed that the concept of aggression is both difficult to define precisely and, perhaps partly due to this, difficult to assess. There is theoretical conflict within positivistic science over how much effect biological or environmental factors have in causing it which leads to difficulties in measuring it quantitatively and thus producing any kind of standardised interventions.

Such causal models rest upon particular philosophical foundations, that result in the assumption that aggression is the result of 'causes' outside the control and awareness of the somewhat passive individual, and ultimately imply that all aggression is pathological in need of 'removal'. These assumptions therefore lead to a limited biological/environmental exploration of human aggression, focusing mainly on the overt extreme aggression, and thereby excluding the 'everyday' (perhaps more healthy) aggression of human interaction (Fletcher & Milton, 2007).

Despite these arguments, however, contexts underpinned by the medical model of health, such as the National Health Service (NHS), are still at risk of viewing clients' difficulties through the lense of diagnostic categories and attempting to intervene using standardised treatments that focus on 'symptom' change (Monk, 2003). This reinforces a view of human aggression as a (pathological) symptom in need of removal and clients referred through this route may be subjected to diagnostic categories and the implicit pathologising that comes with it, before they even reach the therapist.

In contrast, however, more recent phenomenological studies have demonstrated the potential value and meaning of human aggression for participants (e.g. Milton, 2005; Fletcher 2007). These findings therefore suggest a number of potential problems for the practitioner, within contexts such as the NHS, and/or reliant on the 'mainstream' psychological literature to inform his/her practice. If one ignores the possibility of other healthier expressions of aggression and attempts to 'rid' clients of their aggression, one risks becoming directive and limiting in what clients can explore and achieve. Clients, in turn, are 'labelled' as essentially passive (and pathological), further removed from others considered 'normal', and potentially left feeling helpless, hopeless, alone and afraid, rather than active, autonomous, and connected to others and their environments. They are denied the valuable opportunity to engage with aspects of themselves that are less comfortable or less socially acceptable, and therefore deprived of the potential that an engagement with this might bring in self-realisation (e.g. Fletcher 2007). It seems likely that such a therapeutic situation could well simply lead to further frustration and
aggression within the therapeutic relationship itself, rather than aid the client with their aggression issues. Therefore this research aims to address this by considering a more holistic engagement with human aggression.

Research Aims

Following an Interpretative Phenomenological Study (IPA) study undertaken last year (Fletcher, 2007), which explored the experience of aggression with martial artists, this study aimed to expand the research currently undertaken in this area in order to add to a more comprehensive exploration of human aggression through an exploration of how practitioners engage with issues of aggression.

There were therefore two principle aims to this research. The first was to specifically understand practitioners' perceptions of their experiences in engaging and 'attuning' themselves with human aggression, in a non-pathological manner, in order to provide clinicians with a deeper understanding of this area that is noticeable absent in the current psychological literature.

It was decided to target practitioners who work in contexts that might allow them to engage with aggression in a non-pathologising manner (e.g. private practice) and to avoid contexts, such as the NHS, where the context alone might make this more difficult.

The second aim of this research was to go beyond simple description however, to generate a practical theory which practitioners can actually apply in a meaningful and practical manner when engaging with aggression.

This has potential value for the counselling psychologist because it suggested ways of engaging with aggression related issues, without distancing themselves from their clients and limiting their clients' potential as is implied in the current psychological literature, but contributes to an exploration which can increase autonomy, sense of connection to self and to others.

Method

Methodology

In order to meet the aims of the research, a Grounded Theory approach (Glaser & Strauss, 1967) was used to analyse the data because it is specifically designed to go beyond simple descriptive methods to generate practical theory which is "clearly grounded in experiential
data" (McLeod, 1996. p71) that will "work when put into use" (Glaser and Strauss, 1967; p3).

Sample

The initial inclusion criteria for this study was left intentionally broad, to allow for the generation of a theory that describes and explains as much variety of experience as possible.

As discussed, due to the potential limitations of the NHS context, the only exclusion criteria used for this research were practitioners whose sole work was within the NHS. It was assumed that practitioners outside of the NHS may have more leeway to engage with a more holistic spectrum of human aggression and negotiate the issues that come with doing so.

Recruitment was through current professional contacts gained through my training, and participants who come forward via subsequent ‘snowballing’.

Participants were contacted by email and asked if they would be interested in taking part. Upon expressing their initial interest, participants were approached in person or by telephone by the researcher and sent an ‘Information for Volunteers’ pack (Appendix A) which included a Consent form (Appendix B) and a background information questionnaire (Appendix C). Upon return of the signed consent form, they were considered eligible to take part. A suitable time for interview was arranged and interviews occurred within a private distraction-free room.

In line with the Grounded Theory method, this research used a theoretical sampling method. Theoretical sampling proceeds by engaging with data collected in initial interviews and selecting further participants who can elaborate/challenge the theory that emerges from this cyclical process thereby allowing for the generation of a theory that describes and explains as much variety or experience as possible (Glaser & Strauss, 1967; Willig, 2001).

Thus, following the transcription and initial analysis of the first three interviews, further participants were recruited dependent on their ability to elaborate/challenge the emerging theory (this had implications for the interview schedule – see below). This process continued after each of the analyses of the subsequent interviews for the duration of the study. In some instances, this was a straightforward process, e.g. when one female participant spoke about her gender, another female, and male participant were sought in order to elaborate/challenge this. In other instances, such as speaking about fear, it was less obvious, and so, given the limited time available for the study, the researcher aimed to include participants from a range of theoretical backgrounds, age, trainings and gender, in order to capture as many experiences as possible.
Interview Schedule

The initial interview schedule was developed in collaboration with Martin Milton (supervisor) following out of previous research (Fletcher, 2007) and aimed to be broad, in order to explore participants' experiences of aggression (their own and others), both within their practices and outside of them. The aim of the interview was to elicit the subjective experience of the participants and a semi-structured interview schedule was used (Appendix D). This allowed the participants the freedom to speak freely and openly and hence "generate novel insights for the researcher", whilst enabling the researcher to "maintain control of the interview" and not stray from the original research question (Willig, 2001; p22).

In line with the methodology of Grounded Theory, after the analysis of the first three interviews, the schedule was adapted so that the researcher could use it to elaborate, test, and/or challenge the relevance of the emerging theory with subsequent participants. This process continued after the subsequent analysis of each of the following interviews. Although no new questions were added to the initial schedule, a number of prompts were added throughout the process, e.g. when asking about the experience of aggression, prompts were added to explore the role of perception (including gender as in the example above).

To aid this process the interview style was based around the principles of the counselling interview (Coyle, 1998), so that, should experience have elicited sensitive topics, it would have provided the interviewer with the tools to deal with the interviewee's distress whilst not losing sight of the research topic. This style allowed the researcher to include all reactions to the topic, considering them relevant and thereby not 'side-stepping' or avoiding them but encompassing them as part of the participants' contextual information surrounding the participants' experience.

All interviews were digitally recorded and then transcribed verbatim. Names and identifying data were changed in the analysis, to ensure the confidentiality promised in the consent pack.

Analytic Procedure

The approach used within this study was to analyse the content of the transcripts using the constructivist method of Grounded Theory described by Pidgeon and Henwood (1996).

Having transcribed initial interviews, the data was 'open-coded', descriptively labeling concepts in the text considered to be of relevance due to their quality (not their quantity) and noting links, similarities, and diversities between these. As the analysis proceeded, some of these concepts were integrated into higher-level analytic categories. Henwood and Pidgeon
(1996) suggest that the researcher use judgement to do this using a combination of “member categories” (p94) taken directly from the participant’s data, or into “researcher categories” (p94) which are theoretical ideas raised by the researcher not the participant. The links between the concepts under these categories will be tentative at this stage, in order to allow for fluidity based upon the analysis of other data.

This is an iterative process of moving between the analysis of the data and generating new data, in which concepts and categories were revised, redefined, expanded, divided, combined, and/or adapted as appropriate, in order to keep them coherent and grounded in the data, from which extracts were used to ground concepts and theory within the analysis.

Pidgeon and Henwood (1996) acknowledge the relationship between the researcher’s judgment and the text in this process, hence what is coded varied, dependent upon the interaction with participants, participants’ accounts offered and finally the interpretation of the researcher. The analysis therefore represents an inter-subjective, fluid process, aiming not to contradict the real world perceptions of the participants whilst facilitating a coding system that is as grounded (in the data) and coherent as possible, in accordance with Henwood & Pidgeon’s (1992) criteria for judging the quality of research in psychology.

This process ideally aims to work towards a point where data no longer produces any significant adaptations or additions, i.e. data saturation. However, given the limited time available for this study, this was not possible and this analysis should be read with this in mind.

**Situating myself in the research process**

As researchers are active in interpreting the participants’ material, it is ‘best practice’ to reflect on their role in the process, and how this impacts the study, e.g. the research question, the selection of participants, the analysis, and so on (Pidgeon and Henwood, 1996).

As a practising martial artist of 10 years, my own engagement in this process gave me some insider experience into engaging with aggression. In particular, it placed me in a position that held no negative view of aggression and helped me to draw out categories that were perhaps not obvious. Further, as a third year trainee Counselling Psychologist I was ideally placed to gain access to participants.

However this also introduced the risk that of bias in what was coded and introduced the need to ensure credibility as far as is possible. Thus self-reflective notes were kept throughout the project. In addition, all categories were grounded by examples from the interviews.
Ethical Approval

A description of the research was submitted to the School of Human Sciences Ethics Committee (SHS EC) who granted ethical approval (Appendix E).
Findings

Demographic Information

Due to the need to maintain confidentiality, the demographic information presented here is limited

In common, all the participants were white, identified their highest educational qualification as postgraduate degree/diploma, and had worked in both private practice and the NHS.

6 were female and 3 were male, between the ages of 40 and 82. Outside of their therapeutic practice, other roles included teaching, supervision, consultation, research, and management.

Within their organisational work, role titles ranged from senior therapist, to clinical lead, to head of service, and one participant identified as 'retired'.

Annual income ranged from the 15-25k bracket to 55k+ bracket.

Marital status ranged from single, to married, to divorced/separated.

All but one participant said they had undergone their own therapy. Number of times in therapy ranged from none to three. Length of own therapy ranged from 1 year to 10 years. One participant was currently undergoing therapy at the time of interview. Another had been having therapy 'on and off' for the last few years.

Accreditation of professional bodies included;
- British Psychological Society Division of Counselling Psychology
- British Psychological Society Division of Clinical Psychology
- United Kingdom Council for Psychotherapy
- General Medical Council
- British Psychoanalytic Council
- International Association for Analytical Psychology
- Nursing and midwifery council
- British Association of Behavioural and Cognitive Psychotherapy

Theoretical orientations included integrative, psychoanalytic/dynamic, systemic, and cognitive-behavioural.

Within private practice, average length of therapy ranged from 20 sessions to 6 years.
Preferred length of therapy offered by these participants ranged from 24 weeks, time-limited to open-ended depending on context and need. One participant said that it was 'impossible to say'.
Data Analysis

Within the analysis three full stops are used to indicate where material has been omitted (viz ...), and material within square brackets has been added by the researcher for clarification.

*Figure 1 - The Aggression Model*

Figure 1 diagrammatically represents a suggested theory of the processes of aggression and how these interact with each other, which emerged from the theoretical coding of participants' experiences.

The theory suggests that the experience of aggression, and one's responses to it are influenced by one's perception of the situation. As can be seen in Figure 1, following the unbroken lines, responses to aggression are characterised by fear, anger and the desire to 'freeze' or 'attack' back. The theory suggests that these responses may result in returned aggression from the other, thus creating a circle or spiral of perpetuated conflict as each party attempts to deal with the 'attacks' of the other.

The centre of Figure 1 diagrammatically represents a multi-faceted process which interrupts this cycle of 'attacking', leading to the expansion of possibilities for one's own and another's selves.
The experiences of aggression alongside these processes are outlined below.

**Fear, Anger, Freezing and Attacking**

The theory of aggression that emerged from this analysis suggests that, unless 'interrupted', aggression between people tends towards a cyclical process of perpetuated conflict, as each person attempts to deal with the 'attacks' of the other.

As can be seen from Figure 1, it is suggested that this is due to aggression and the response to this aggression by the other persona, both being underpinned by similar processes, characterised by anger (seen on both the right and left hand side of Figure 1). Nancy, for example, said, aggression is "the expression in words or action of somebody's feelings of anger".

This anger was accompanied by various bodily sensations, such as "an ache in my throat" (Sally) and "physical tension...in the chest" (Jeremy), and by somewhat vicious impulses, such as "the impulse to throw something...Or kick something" (Jeremy) or the desire to "strip somebody to pieces with my tongue and absolutely shred them" (Ellen).

Whilst it seemed that these impulses were generally curbed, e.g. "common decency stops me" (Ellen), there was a need to direct such anger, sensation and impulses outward as aggression (following the direction of the arrow on the left hand side of Figure 1). Graham summed this up by saying that aggression was "a painful, difficult feeling...[that I feel a] need to get rid of". For the participants in this study this tended to be verbally, e.g. Michael said "I'm aware particularly from feedback from others that I get very irritable".

In doing so, however, it consequently impacts upon others (Figure 1, right hand side). It can be seen that the experience of receiving this aggression triggers very similar processes to those previously described. Again these included bodily sensations, e.g. "my heart go(es) thump, thump, thump" (Carly), and emotions such as fear and anger:

These emotions also have outward expressions. Fear seemed to result in the inability to do anything, which Ellen described in detail saying:

"I remember just absolutely just freezing, thinking "fuck, what do I do?" [laughs] and I did nothing ... because I just thought, "I can't do anything" and he came to punch me and he punched the umm, he came right up to me and punched right by the side of my face and into the wall ... I think my urge is just to freeze... there's nothing you can do in that, in that
moment of umm real, real aggression... I kind of almost remember feeling almost glued to the spot

Anger often results in more vicious impulses, e.g. "I could kick the door once he's left the room...I feel like screaming. I feel like, you know, just swearing at him. I feel like exploding" (Sally).

Anger also led to the desire to 'attack back'.

Kirsty exemplified this saying, "if I do feel attacked...Well I'm more likely to attack... I'm not having this and you know I'm not taking that as an attack, I'm going to just hold my ground here and give as good as I get".

The theoretical model reflects that we have the potential for both fear and aggression in response, as Ellen said, "[I] want to kind of either crumble or attack back". However, as indicated by the directional arrow in Figure 1, one can see that it is anger and 'attacking back' as a response that can feed the cyclical system that perpetuates further aggression.

Perception of the Situation

The analysis suggested that underlying this cyclical system were certain perceptions/assumptions regarding the nature of aggression and how best to deal with it.

Firstly, as Graham noted, there is a perception that aggression is negative; he said "I suppose in modern parlance we use aggression as a rather negative... with negative connotations...completely disproportionate to umm to what is happening in reality".

This then leads to the further assumption that aggression should not be allowed, e.g. "none of us want to be tolerant of that" (Ellen), and therefore that those who perpetrate it should be blamed and punished. Jeremy argued this, saying "[they] seem only to want to attribute blame whenever something happens...And therefore have some sort of justice...It's very much a sort of 'eye for an eye, tooth for a tooth' sort of mentality", which in itself is a form of 'attack', and is per se a precursor to further aggression.

These perceptions therefore directly affect the processes involved in being aggressive and in responding to it, thereby further contributing to the cyclical pattern described above.

As a result of considering aggression to be negative, and in an attempt to avoid the 'blame' and 'attack' that follows, it can be tempting to suppress and/or disown one's own potential for
aggression. Sally described this process as being "[out of] touch with...their anger...keeping [it] separate; splitting".

Whilst this strategy may offer the individual the 'illusion' that they are not aggressive and therefore not at risk from retribution, it does not break the aggression cycle, because the effects of the aggression are still perceived by the other and responded to accordingly. Patricia pointed out, "often I'll have the affect even though it's missing in the patient".

Participants referred to this as 'passive' aggression, which might emerge as, e.g. "resistance...moaning about things, not engaging" (Kirsty) and "withholding ... themselves, within relationships and so forth ... they don't give you a lot back" (Carly).

This strategy distances one from others considered blatantly aggressive and appears advantageous in that it further adds to the 'illusion' of not being aggressive or not part of a group considered to be aggressive, i.e. Ellen argued, "[it is] certainly getting rid of our own aggression if we lump it into somebody else... all these yobs that carry all our aggression".

However, this strategy fails in that, by disowning one's own capacity for aggression, one is left feeling bereft of the ability to 'attack' back. Patricia argued this saying "if we didn't feel aggressive or angry... we'd be exposed to all sorts of bullying".

As illustrated in the model (both sides of Figure 1), if one is unable to engage one's anger and 'attack', fear is the only option, and the focus of which can become 'groups' that 'carry all our aggression'. Ellen exemplified this saying, "we're all quite frightened of that... that's how it's seen, it's out there you know, there's these yobs and it's not safe to walk the streets".

Graham also pinpointed this, "we're bombarded with this notion that umm, that a group at a certain age that are out of control and um a threat to society and undermining the standards and values of our society".

As Patricia argued, this seems to simply intensify fear about the aggression of others, "[it] has created this idea that there's more violence now than there ever was".

Jeremy explained this process further, "What flashes through your mind at some level is that in the paper at lunchtime or on the news last night someone was seriously damaged ...what jumps into mind is the worst possible scenario... [and] the emotional response I have [therefore] is not commensurate really with the level of risk I might be...The risk is probably zero".
This further perpetuates the aggression cycle outlined in Figure 1: the fear of aggression 'out there' increases, which is accompanied by a feeling of greater powerlessness ('freezing') due to the decrease in one's perceived capacity to mobilise one's own anger and aggression in response.

Out of the awareness of the individual, however, anger, aggression and 'attacking' back are mobilised and dispersed in the disguise of attributing 'blame' and 'justice'. Unfortunately, these mechanisms for dealing with aggression and keeping it out of awareness can fail. In such instances, if one is without the awareness and/or ability to channel such aggressive energy elsewhere, one can be immediately confronted by one's own aggression, causing such distress that it is impulsively discharged as an 'attack' in an attempt to 'rid' oneself of it.

Nancy talked about this saying, "aggression type problems that we were dealing with were of the very explosive kind where the feeling is there and they act on it instantly and they've done it before they can err...you know get a grip of themselves".

Again such actions can feed into the cycle of aggression bringing the possibility of an 'attack' back and consequent a perpetuation of this cycle.

As illustrated, the processes involved in the aggression cycle both perpetuate it, and tends to operate, at least partly, outside of the awareness of the individuals involved. It is therefore very difficult for those within such a cycle to begin to see it for what it is, understand it, and break out of it.

**Breaking the cycle**

For those wishing to break out of this cycle, however, this study suggested that therapy may offer an exit through an engagement with someone, the practitioner, who is able to remain outside it and bring the processes involved into awareness, so that they can be investigated and ultimately dealt with more constructively.

As Graham suggests, “they're struggling with it or they want me to sort of help them struggle with it...Sort of thinking together and I mean, one of us doing the thinking now but I'm hoping that you will at a later stage together”.

Nancy exemplified this using a clinical vignette.

“Eventually there was a bit of a pause, I decided it was time to intervene so I said Tom, or Dick, or Harry, what ever his name was, “have you ever wondered what it might be like to try
to cuddle a tiger?" So there was a short pause while he considered this unlikely proposition
and then I went on, “because that's what it's felt like a bit today and of course we understand
that you've been terribly hurt, umm so you're not going to let anybody get near enough to hurt
you again but they've all been reaching out because they really would like to help you, they'd
like you to join in and if you stop to think about it, they've all been hurt too because that's why
they're here, so it's quite brave of them to have gone on trying and perhaps you'd like to think
about that because I think it's quite important.” And we got quite shortly after that to the end
of the Community meeting and we all went and gathered around him and took him away for
coffee and that was err a a err a way of losing his err aggression, his anger. Umm which
turned out quite well on that occasion”.

In order to achieve such therapeutic results, however, this analysis suggests that therapeutic
practitioners need to engage in their own processes to help them keep outside the cycle of
aggression in order to be able to support their clients.

Moving to the middle section of Figure 1, a multifaceted process is now outlined which details
how this is achieved for both therapist and client.

Surviving Anger without 'Attacking' back

In order to create a therapeutic space within which the practitioner and client can begin to
examine the client's issues with aggression, this analysis proposes that the practitioner resists
his own aggressive urge to 'attack' back as aggression becomes apparent in the room.

As Graham said, "[it as a] misunderstanding [that] people can still believe that punishment and
um and meeting aggression with aggression, meeting aggression, negative aggression with
negative aggression is going to somehow...resolve the situation but it doesn't".

If the practitioner is able to achieve this, the client is therefore not 'blamed' or 'punished' for
bringing their aggression into the room, and the practitioner can address it. Sally said,
"sometimes I will acknowledge somebody's anger and that can sometimes help to dissipate
it”.

Furthermore, the practitioner can openly invite it, as Sally suggested saying she could,
"encourage[s] them to have those murderous fantasies or whatever...It's probably quite
healthy to have those... and I often say to patients ‘you know, those are just thoughts”.

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In doing so, it is proposed that the client is supported through an experiential process where he can feel, perhaps for the first time, that it is safe and retribution free, when his aggression is acknowledged and revealed to him, thereby making it possible for it to come into awareness and consequently be examined.

It is therefore crucial that the practitioner confronts the aggression of another impartially and finds ways to deal with the anger and impulses that accompany any potential personal response to this.

Kirsty said “I find it useful to have a quite simplistic, non-fixed view really if I possibly can” and Ellen echoed this out stating, “I think a huge part of our work is somebody withstanding an awful lot of umm horrific, aggressive, angry, disappointed attack...[it’s] bearing it, not reacting but taking my own stuff somewhere else so that I can be supportive”.

Patricia summarised this saying, “our own capacity to deal with anger, or our own perception, relationship with it and that can include gender, families, the whole lot [becomes] an issue”.

This seems to necessitate a process in which clients can accept and explore their own potential for aggression while practitioners must distance their own to a later safe haven.

Participants suggested that the use of their own supervision and therapy as such safe spaces to take their aggression were supportive of this. Sally said, “you do need supervision to help you to separate that without kind of losing it”, and Graham said, “I suppose the [psycho]analysis gives you the container for aggression... in a way that supervision may not” (Graham).

Thus the model suggests that practitioners must engage with their own capacity for aggression in order to resist the urge to ‘attack’ back if and when aggression presents with their clients, using the support of their supervision and own therapy. In doing so, this creates a space outside of the cycle of aggression, free of the possibility of retribution, within which the therapist may be able to support the client in acknowledging and ultimately exploring their aggression, thereby breaking the cycle.

*Surviving Fear without Freezing*

It has been suggested in this model, that the consequence of facing the aggression of another and resisting one’s impulse to ‘attack’ back leads to the experience of fear.

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1 For ease of reading the male personification has been used where it can also refer to either sex
Carly noted this saying, "I think that that can feel quite umm difficult as a therapist because you have to sit with it, which can be quite anxiety provoking".

As has also been shown in the model, this mirrors the experience of the client who may also be finding it extremely difficult to openly acknowledge his personal aggression due to the fear that accompanies it. Ellen points this out saying, “clients [who] come and they're terrified...[because they think] there's this taboo that if they're angry, it's negative...they're thinking that anger is wrong”.

Similarly to the importance of surviving anger whilst resisting the urge to 'attack' back, the analysis highlighted the importance of the therapist surviving this fear without succumbing to the impulse to 'freeze' and become powerless.

As Ellen argues, "if you can't manage it ... [they] will pick up that it's not a safe place to go...they're all watching how you're going to handle that... I act as if it's not bothering me in the remotest whereas inside of me is absolutely shit scared...[in order that we might become able to] look at it and not be afraid of it".

Therefore, the practitioner, although perhaps fearful, must overcome any ‘freezing’, and remain encouraging of the need to acknowledge aggression. As Kirsty demonstrated, “I'll come straight back into the room like ‘what’s going on here?’”.

Participants acknowledged however, that they required their own support in maintaining this ability and again outlined the importance of clinical supervision. For example, Carly said, "I think it's important to reflect on it with somebody else, I think that's where clinical supervision is really helpful...I think it facilitates sort of interrupting some of those cycles that are getting played out and being able to look at what's going on in the room”.

Similarly Kirsty said, "If I feel frightened with somebody, I take that seriously... you have to track your process don't you... I absolutely stop on that or go straight to supervision".

Thus, in a similar process to that detailed for surviving anger, linked to resisting the urge to 'attack' back, the model suggests that practitioners must engage with their own capacity for fear, using the support of their supervision, to be able to resist the urge to ‘freeze’ when aggression presents. This appears to be a requisite if they are to effectively continue to acknowledge the aggression of their clients.
The Need to Address Perceptions

The model shows how in the process outlined, a space is created where client and practitioner can begin to acknowledge and explore the client's aggression, free from the practitioner's responses such as ‘attacking’ or ‘freezing’.

By allowing the client to present his aggression in such a manner, the practitioner takes a stance that challenges the assumption that aggression is negative. As Kirsty said “I actually don’t think there's anything wrong with being aggressive [laughs]...[it] is all part of the rich tapestry really”.

In challenging this assumption however, the exploration of possible negative consequences is not denied but the differences between this and the internal processes of the individual are highlighted, thus implying that it is the behaviour, not the individual or their aggression that may be regarded as 'negative'.

Ellen summarised this saying "it's not wrong, it's how it might be expressed maybe, you know and they get them into difficulties but the feelings aren’t".

This then allows opens up the possibility of a space within which examination of how a client has habitually associated certain aggressive feelings with certain behaviours can occur, to allow the emergence of other forms of behaviour with less negative outcomes.

Sally summarised this saying, “I suppose it’s trying to understand what it is and then kind of thinking backwards and being able to bring about some kind of change to whatever it is that feels so unbearable that they have to put a brick through the window”.

Rather than simply 'labelling' the client as aggressive, this introduces the importance of considering context in any such exploration. Ellen pointed out saying, “there’s all sorts of aggression... Contextual as well isn't it?”

Three pertinent examples given by participants demonstrate this.

Graham pointed out that, “aggression is one of those very necessary instincts that umm can be a life preserver... sometimes it is necessary to respond to the environment aggressively”;

Patricia said that within familial relationships arguing that what may be acceptable in an adult intimate relationship, "[which is] a relationship of equals in a way ...could be quite frightening if it was a parent and a child";
And Jeremy provided an example using the context of an organisational hierarchy. He said "I think that depends a lot on the position you hold... I'm using the hierarchical relationship, that the person who's lower in the hierarchy is more likely to feel intimidated...If someone higher up, whereas someone higher up is going to feel less intimidated, even though the situation might to an observer be equally intimidating".

Participants suggested that through this process, clients can eventually gain greater choice about how they engage with and express their aggression.

Nancy compared it to electricity, saying "in nature where it's completely uncontrolled, it takes the form of lightning, fork lightning or sheet lightning you know and ...it can nearly kill you...on the other hand if you channel it and put it through cables, you have power and heat and light and you can do fantastic things with it. Well anger's a little bit like that, if it's uncontrolled, it's a bit like the lightning and if you can channel in it a useful way it can be terribly handy stuff".

**Expanding Possibilities**

As the practitioner maintains an accepting, non-judgemental stance throughout this process, the client begins firstly to acknowledge and then be able to make changes to his attitude to aggression.

It is hoped that in doing so the therapeutic relationship is strengthened as the client begins to realise he will not be 'labelled' as different from the practitioner for their aggression, thus aligning the two in a common struggle with aspects of their humanity.

Whilst this is beneficial to the ongoing work, it also facilitates an understanding between practitioner and client that everyone has the capability of showing aggression emerges (Sally: "I know we're all capable of doing it") and the only difference is in the individual's personal expression of it.

This then creates the possibility to engage and channel one's aggression into activities beyond those demonstrated in Figure 1. As the broken line at the top of Figure 1 indicates, this expands possibilities allowing for a different kind of engagement with current activities, or the beginning of completely new behaviours as one enters into a process of creatively using the energy that has been freed up.

Some of the examples participants suggested demonstrated the expansion of such possibilities included:
Politics: "you look at the Parliamentary debates... [it's] about, you know, really using your wits to attack and receive and heightened your argument to actually hopefully in the end [laughs] get you know a shift for the greater good" (Ellen).

Sport: Graham noted that "of course sportsmen umm are trained to... unleash their aggression at a particular point... and actually use their aggression to its limits, to the limit accepted by the rules of the game".

And intimate relationships: Jeremy pointed out that "the majority of people in ordinary relationships up and down the country get pretty bloody angry with each other [laughs] and things get thrown and broken and...hit occasionally and I just think that's...that's part of, part and parcel of intimate relationships...love and hate go together...You know when it's people are sort of working out their love and hate...In ordinary ways... it's part an parcel...of life" to which Patricia concurred, "you'd have a fight with someone [that's] part of the fun isn't it, you chuck something [laughs] and then you make up afterwards, there's a bit of, that's kind of controlled aggression which is, where I don't think I've ever experienced the kind of uncontrolled aggression where sort of hurtle something at someone that might really hurt them".

Summary

The analysis of the data obtained in this study suggested that aggression, both own and that of other people, tends to be underpinned by anger, bodily sensation, and impulses to 'attack', or 'freeze'. This tends towards a cyclical process whereby two people 'attack' back when they feel they are being 'attacked'.

Underpinning the urge to 'attack' back is the perception that aggression is negative and therefore must not be tolerated. This results in the individual trying to suppress/deny his own aggression in an attempt to distance himself from others judged as 'aggressive'. Ultimately, however, this is only an illusion, and the individual's aggression is nonetheless expressed in the disguised form of attributing 'blame' and punitive style 'justice'. This in itself is a perpetuation of the aggressive cycle.

Those wishing to escape this cycle can be aided within the therapeutic encounter if the practitioner can resist being caught up in his own version of the aggressive cycle with the client. In order to achieve this, the practitioner must allow, or even encourage the client to bring his aggression, whilst resisting his urge to 'freeze' or 'attack' back. This slowly challenges the assumption that all aggression is negative and will be penalised, allowing the
client to begin to acknowledge his aggression, looking at how it is usually expressed, and considering how he would like to express it in a way that would be more helpful.
Discussion

This study aimed to extend the research in the area of human aggression, exploring the experiences of practitioners who attempt to engage with it in a non-pathologising manner, in order to produce a localised theory.

Certain valid points of interest arose from the study that contrast with the majority of the published literature which tends to view aggression as caused by factors outside the control of the individual thereby implying that the individual is somewhat passive, suggesting standardised interventions that deem it to be pathological and grouping clients with others inappropriately.

The theory that emerged from this study suggests that this in itself can be perceived as a 'disguised' form of 'attacking' aggression on the part of clinicians and policy makers, that risks disempowering and distancing clients ('freeze') and/or perpetuating further aggression as they 'attack' back, leading to a cycle of 'attacking' aggression that ultimately helps no one.

The present study suggests a way of working with clients that encourages an engagement with aspects of the self that are less comfortable or less socially acceptable. In doing so clients become less disempowered as they become aware of their active role in the process, and their ability to 'tap' into the valuable resource of aggression to help them negotiate alternatives once their assumptions have been revealed.

By acknowledging that all aggression is mitigated by one's perceptions, this suggests that it is important to recognise that aggression is not simply 'negative', but that the outcome of aggression is influenced by personal and social understandings, including the relationship that the therapist forms with the client. Hence, it was emphasised that the practitioner must avoid bringing normative judgements, or attempting to 'rid' the client of their aggression, but rather must engage with it in a non-critical manner.

However, actively 'engendering' aggression in this manner is a difficult and uncomfortable process for both client and practitioner, bringing them face-to-face with their own fear and anger. This highlights the need for practitioners to engage in their own personal process of engaging with these aspects of themselves if they are to make therapy worthwhile for themselves and the client. This is supported by other more phenomenological studies that have begun to view aggression in this light (e.g. Milton, 2005).

The theory that emerged from this study considered aggression mainly from the perspective of a one-to-one therapeutic situation, however, given the current focus in political, legal and
media circles towards certain social sub-groups believed to be the perpetrators of aggressive crime, it is suggested that this research has wider implications for policy makers outside of health care circles.

The practitioners within this study stressed the need for the support of personal therapy, supervision, and (it is assumed) a degree of willingness and motivation on the part of their clients to even begin to address some of these issues. The task of tackling aggressive issues at a social level seems all the more difficult when one considers that no such equivalent therapeutic 'niceties' seem to exist at that level. However, it is suggested that taking the 'easy' option and striving to simply 'eradicate' aggressive crime through punitive means, risks making the situation far worse, strengthening divisions within society, and leading to greater fear and anger.

Limitations

My previous engagement with aggression may well have influenced the selection of participants, the questions asked, and the shape of the emerging analysis in a manner that limited the depth of the theory produced. In order to moderate this, reflective notes were kept throughout the process but in order to give greater credence to these findings, it is suggested that the report would greatly benefit from an independent inspection from another researcher in the future.

Given the limited time available to produce the initial findings for this report, it is further acknowledged that theoretical saturation was not completed. This report must therefore be considered a 'work in progress' that would benefit from the further development/challenges that might be found through further interviews. This is not to throw doubt on the usefulness of the theory as it currently stands but to acknowledge that its generalisability and richness would be improved by the additional perspectives that further interviews could offer, perhaps particularly including participants from within other social, cultural, employment and geographical locations.
References


Dear volunteer,

You have been given this information sheet because you are a therapeutic practitioner and you also expressed an interest in taking part in this project. In my research I am interested in finding out about people's own accounts of their experiences of aggression and how this affects them and their work and life. I am writing to ask if you would help by allowing me to interview you and by sharing your particular account of engaging with aggression with me. The project has received ethical approval from the University of Surrey.

I am in my third year of training in Counselling Psychology and I have a particular interest in people's experience of aggression, what it is like to be aggressive and what it is like to have other people's aggression aimed at you. It is hoped that the research will ultimately improve psychological understanding of the role that aggression plays in people's lives. My supervisor for this project is Dr. Martin Milton. Martin is a senior lecturer at the University of Surrey.

The purpose of the interview is to allow you to talk freely about your experiences of aggression. Whilst I will ask you some questions, I will also be aiming to arrive at an accurate understanding of your account so there will be plenty of opportunity for us to talk about aggression as broadly as you may want to consider it. Whilst this may make the interview feel informal there are some important formalities that you should be aware of and these are listed below:

- You may decline to answer particular questions
- The interview will be tape recorded
- I will use some of what you say in the recorded interview in my research report
- The research report will be read by my supervisor and examiners
• The research report may be put forward for publishing, meaning that it could be read by anyone

Your confidentiality will be protected by removing the names of people and places that may connect what is written in the report with you. The tape recorded interview will be kept in a secure place at all times and it will be put into written form as soon as possible after the interview. At the end of the project the actual recording will be destroyed.

You do have the right to stop the interview and/or withdraw from the study at any point should you wish to.

If you would like to take part in the study, I will contact you by telephone to arrange an interview date. Please do not hesitate to contact me or my supervisor with any questions you may have about the project.
Appendix B

CONSENT FORM

I the undersigned voluntarily agree to take part in the study Practitioners Being with Aggression: Towards a grounded theory of practitioners's non-pathologising experience of aggression

I have read and understood the Information Sheet provided. I am aware of the nature and purpose of the study, and of what I will be expected to do. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given if I did ask questions.

I understand that any data derived from an individual participant will be treated in accordance with the Data Protection Act (1998).

I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

I therefore consent to be interviewed about my experiences of aggression and give permission for the words from the interview and questionnaire to be quoted in the research, on the understanding that my identity will be protected.

Name of participant ..........................................................

(SIGNATURE)

Signed ....................................

Date .....................................

On behalf of all those involved with this research project, I undertake that professional confidentiality will be ensured with regard to any written material or audio recordings made with the above interviewee. The use of any written material, audio recordings or transcribed material from the audio recordings will be for the purposes of research only. The anonymity of the above interviewee will be protected.

Name of researcher .................................

(SIGNATURE)

Signed ...................................................

Date ............................................................................................

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Appendix C

Practitioners Being with Aggression: Towards a grounded theory of practitioners's non-pathologising experience of aggression – Background Information

1) How old are you? [ ]

2) What sex are you?
(Please tick)

Male [ ]
Female [ ]

3) What is your highest educational qualification?
(Please tick)

None [ ]
GCSE(s)/O-Level(s)/CSE(s) [ ]
A-Levels [ ]
Diploma (HND, SRN, etc.) [ ]
Degree [ ]
Postgraduate Degree/Diploma [ ]

4) Is your work as a therapist your only work?

Yes [ ] (Go to question 5) No [ ] (Go to part b)

b) What other work do you undertake?
(Please tick)

Teaching [ ]
Supervision [ ]
Consultation [ ]
Research [ ]
Management [ ]
Other (Please specify) ________________________________
5) Do you only practice in private practice?

Yes [ ] (Go to question 6) No [ ] (Go to part b)

b) What other settings do you practice in?
(Please specify)__________________________________________

6) If you work within any sort of organisational setting, what is your rank within the organisation?
(Please tick)

Junior therapist [ ]
Senior therapist [ ]
Head of service [ ]
Honorary appointment [ ]
Other (please specify)_____________________________________

7) What is your annual income?
(Please tick)

Up to £15K [ ]
£15k--£25k [ ]
£25k--£35k [ ]
£35k--£45k [ ]
£45k--£55k [ ]
£55k+ [ ]

8) To which of the following ethnic groups would you say you belong?
(Please tick)

Bangladeshi [ ]
Black (African) [ ]
Black (Caribbean) [ ]
Black (Other) [ ]
Chinese [ ]
Indian [ ]
Pakistani [ ]
White [ ]
Other (please specify)______________________________________
9) Please state your city/county or residence? ______________________

10) What is your current marital status?
(please tick)

Single   [   ]
Married  [   ]
Divorced/Separated  [   ]

11a) Have you been in psychotherapy yourself?

Yes   [   ] (please go to part b)   No   [   ] (please go to question 12)

b) When did you have psychotherapy?

First therapy  From (month/year) ______/______  
Until (month/year) ______/______
Second therapy  From (month/year) ______/______  
Until (month/year) ______/______
Third therapy  From (month/year) ______/______  
Until (month/year) ______/______

(If you have been in therapy more than three times, please supply the dates of subsequent experiences)

12 a) Are you accredited with one, or more, or the therapeutic professional bodies?

Yes   [   ] (please go to part b)  
No    [   ] (please go to question 13)

b) Please indicate the professional body/bodies that has accredited you.
(please tick)

BPS Division of Counselling Psychology  [   ]  
BPS Division of Clinical Psychology  [   ]  
United Kingdom Council for Psychotherapy  [   ]  
British Association for Counselling  [   ]  
Other (please specify)  __________________________
13) Length of time since accreditation?

(If you are accredited by more than one professional body, please give details of all accreditations)

14) What is your therapeutic orientation?
(please tick)

Integrative/eclectic [ ]
Cognitive-Behavioural [ ]
Psychoanalytic/dynamic [ ]
Humanistic [ ]
Existential-Phenomenological [ ]
Systemic [ ]
Other (please specify) ____________________________

15) Average length of therapy you provide?

16) Preferred length of therapy that you provide? (Time limited, Open ended, etc)
Appendix D

Interview Schedule

I am hoping to find out more about your experiences with aggression and so I'd like you to tell me about it. This is a chance for you to tell me the story of how you engage with aggression, starting from the beginning with all the circumstances that led up to it, what it is like and what has happened since. I'd like to remind you that if you wish to, you can stop the interview at any point without having to explain why.

   a) So I see you've been practising for [see demographic info] years and you work [see therapeutic orientation on demographics]?
   b) And do you feel you've engaged with aggression, yours and other peoples, during this time?

So to clarify, because I know aggression can mean different things to different people, perhaps you could tell me what 'aggression' means to you...

1) What does aggression mean to you?

Prompts: what sort of images, thoughts, feelings spring to mind when you hear the word aggression

Do you think your colleagues would see it the same or differently?

2) How has this come up in your work?

What were the circumstances? (depression, anger, fear, rage, anorexia, ocd?)
How did you feel about that/how did that make you feel?
What was it like for you?
   Freezing?
   Attacking?
What happened after that?
How was it embodied?
What did you make of it?
How did you work with it?

3) And has aggression come up in your life outside of work?
4) And what is it like to have someone else's aggression aimed at you?

Prompts: What does it feel like, emotionally, physically

What does it look like

How do you cope with that emotionally, physically (fear, anger, gender, support, prejudice)

What effect did that have on you (immediacy – how are they in the room now)

Freezing?

Attacking?

How does this compare to what they are saying

What support did you use if any?

5) Ok so now we've talked about the aggression of others, what about your own aggression?

How did/do you know when you are feeling/being aggressive

How do you deal with it

What do you do with it

Are you involved in any combat sports

Have you been in a fight

What does it feel like

How is it embodied

6) How do you think people respond to you when they know that you can be aggressive?

Prompts: relationships with mates

Family

Girlfriends/partners

Colleagues

Gender

7) I'd like to ask you whether there are any positives/negatives about aggression that we have not already covered?

8) Finally, much public literature talks about aggression as a negative, and I was wondering what you made of that?
Professional and cultural
What about cultural differences?
Would your answers change depending on context (work/non-work)
Prejudice?
Attacking?

9) For those who might be struggling with issues relating to aggression, what would your advice be?
   Supervisees
   Peers
   Friends
   Family/children/parents

10) Ok we're coming to the end of the interview, how are you feeling having talked about this?

   Prompts: Would you like to explore that further?
   What has been good/bad about helping with this research?

Right that concludes the questions I had. Is there anything else you would like to tell or ask me? Anything I have missed out or may not have understood?
[if 'yes' then explore, else finish]

Ok then I'll stop the tape now and the interview is finished. I'd like to remind you that your confidentiality will be protected by removing the names of people and places that may connect what is written in the report with you. The tape recorded interview will be kept in a secure place at all times and it will be put into written form as soon as possible after the interview. At the end of the project the actual recording will be destroyed.

Thank you very much for taking part and telling me about your experiences, it's been very useful. Do you have any other questions at all? Please feel free to contact me about the project later if you wish. Thanks once again.
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Appendix G

Personal Reflections

Like many of my childhood peers, I can remember running around with toy guns, reading comic stories about the army, and generally playing at war and fighting. At this young age the realities of violence and aggression seemed like simple fun, and I had not yet encountered the more difficult emotions that accompany it. My parents tell me that they were convinced that I was heading for a career in the armed forces like both my grandfathers before me. Thus my personal interest in aggression, albeit a somewhat naïve one, stretches back almost as far as I can remember.

However, when I was eight years old my father slipped on an icy pavement; an accident that resulted in many debilitating symptoms, eventually diagnosed as Multiple Sclerosis. Shortly thereafter, my maternal grandmother lost her struggle with cancer and died, and my grandfather moved in with us. Looking back I now realise that I perhaps perceived these men a somehow more vulnerable and less powerful. At the same time, my mother, out of necessity, rose to the challenge, taking over the household, becoming, in my opinion, more empowered than ever before. With hindsight I realise that perceiving my male role models as ‘crumbling’ around me, whilst perhaps understandable, made it more difficult for me to maintain my own sense of personal potency. I believe I then developed strong feelings of envy, and the resulting anger, towards the women of my household who, from my perspective, seem to have become empowered by the situation. Slowly my academic marks began to fall, and I became prey to bullies in my social life. All of this seemed extremely ‘unfair’ and distressing, and would often result in angry, aggressive outbursts towards my family, and fighting in the school playground. However, none of this made me feel any stronger or more powerful, and as one might expect, it drove me further away from my family and friends.

Following my own experience of therapy at the age of eighteen, I was able to improve my academic marks, I took up martial arts, and my friendships, although still not always easy, seemed stronger. I was no longer bullied. I was able to go onto study for my undergraduate degree. Whilst more empowered, something still did not feel ‘right’. I still felt ‘weak’ and ‘powerless’ within myself and was still drawn towards a proactive personal investigation into aggression. In my undergraduate philosophy degree I became particularly interested in the work of Nietzsche and his ideas around the human struggle for power within relationships. I also studied eastern philosophy, in order to support my martial arts training. Later, I was also drawn back to the world of therapy, personal and the course, with the vague idea that this might help somehow, even though I was unable to say exactly what was ‘missing’. Naturally my research interests on the course then centred on aggression.
As I conducted this year's research I was able to recognise in myself the cyclical processes of aggression that emerged out of the data. I thought back to my own adolescence where I felt 'powerless' and 'attacked', but was now able to recognise my own 'attacking' stance towards those around me. Although not so consciously aware of it, I believe my preference for carrying out such research has partly been my own attempt to bring my own role in these aggressive cycles into my awareness such that I might break free and regain my own sense of potency by claiming back the energy bound up within it. Becoming aware of this has allowed me to reflect both on my relationship with myself, with my friends and family, and within my client work. This began a difficult process, particularly in my client work, of continually assessing my own position towards my clients such that I am neither preventing them from bringing their aggression, nor am I 'attacking' them for doing so. The importance of supervision and therapy, alongside support from friends and family has become of even greater importance to me this year, and I am grateful for all the help they have offered.

However, the research also raised difficulties for me. The interviews provided far more data than I originally expected and could do justice to within the short time-limit available. I felt under far more pressure when having to make theoretical decisions about who to interview in a manner that would do justice to the emerging theory and wondered how much my own struggles with this topic were influencing this or leading me to miss other data. I often found myself wishing for more time and for more of my supervisor's time, and feelings of fear, anger and powerlessness all formed part of my experience at various times. Interestingly, I also found myself feeling far less powerful in my martial arts training, losing confidence in my ability, becoming more afraid of getting hurt, and actually receiving a couple of painful yet fairly minor punches that I would previously have stopped. My fear is that this study, and therefore 'I', have not been powerful enough, i.e. that it will not break the cyclical pathologising aggression that is the trend in current psychological circles. I also suspect that, to those who disagree with it, it may well be perceived as an 'attack' that simply perpetuates further 'attacks' back. However, I do feel, at a personal level, and I hope ultimately at a wider professional/social level, that this study does bring to awareness a different way of perceiving and working with aggression that leads to the possibility of greater empowerment for those who engage with it.
List of published papers

Publication 1 – a shortened version of my first year literature review


Publication 2 – a shortened version of my second year research project