AN INTEGRATIVE APPROACH TO NARRATIVE THERAPY AND EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

BY

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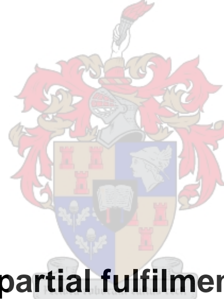

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"The learning of integration through practice involves, we believe, constant vigilance about what one is doing and why. Action, a particular intervention, should be followed by observation of what has happened and reflection on the process and outcome. This in turn may stimulate the therapist to find some answers to theoretical questions about what is involved in the process of change."

(O'Brien & Houston, 2000:18)

DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

Signature **Date**

ABSTRACT

As I engaged in a therapy journey with a single client, the possibilities for research on the integrative use of narrative therapy and EMDR unfolded. I investigated recent literature and realised that much had been written about narrative therapy as single approach to therapy within the postmodern paradigm. There was also extensive writing on EMDR and its integrative use with other therapies in assisting people who struggle with upsetting memories of trauma.

Since I was unable to find any literature to date on the integrative use of narrative therapy and EMDR, I realized that there was much to be discovered and learned on such an integrative research journey.

The client's experiences and descriptions of overwhelming emotional distress (as the problem in her life) during the process of integration was the main focus of this qualitative case study. During our therapy conversations knowledges were gathered and deconstructed. Video or tape recordings, photographs, work with clay, sketches, letters and other documents were useful in keeping track of the research journey. A reflecting team and the participation of the client's boyfriend contributed and enriched both the therapy and research journeys.

OPSOMMING

Tydens terapeutiese werk met 'n enkele kliënt het die moontlikhede van navorsing oor die integrasie van narratiewe terapie en EMDR vir my 'n werklikheid geword. Ek het onlangse navorsing bestudeer en besef dat narratiewe terapie as 'n enkele benadering tot terapie binne die post-moderne paradigma, al 'n geruime tyd lank nagevors is. Daar bestaan ook literatuur oor EMDR en die integrasie daarvan met ander terapeutiese benaderings in die ondersteuning van persone wat probleme ondervind met ontstellende herinnerings van trauma.

Aangesien ek tot op hede geen literatuur oor die integrasie van narratiewe terapie en EMDR kon vind nie, het ek vermoed dat 'n navorsingsreis op hierdie terrein verskeie ontdekkings en die ontginning van nuwe kennis moontlik sou maak.

Die fokus van hierdie kwalitatiewe gevallestudie val op die kliënt se belewing en beskrywings van oorweldigende emosies (as probleem in haar lewe) tydens die terapeutiese integrasieproses. Waarhede of kennis is tydens terapiegesprekke versamel en gedekonstrueer. Video- of bandopnames, foto's, kleiwerk, sketse, briewe en ander dokumente was waardevol om die koers van die navorsingsreis aan te dui. Insette en deelname van 'n refekterende span, asook die kliënt se kêrel, het beide die terapie- en navorsingsreise verryk en uitgebrei.

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CHAPTER ONE

MAPPING THE JOURNEY

1.1 INTRODUCTION

In my training and development as an educational psychologist, I was introduced to various forms of psychotherapy. Narrative therapy and Eye Movement Desensitization and Reprocessing (EMDR) are among these. Conversations with practising psychologists, supervisors, lecturers at the university and colleagues made me realize that although both of these had been found useful and effective in various therapeutic situations, they were strongly opposed by some on ethical, political and theoretical grounds.

I believe that we psychologists should continuously reflect on what we are doing; why we are doing it, as well as on the impact of our work with clients on their lives and our therapeutic relationship with them. In arguing for this view, Parker (1999:4) notes that we need to be intensely 'critical'[1] in deconstructing psychotherapy since it is difficult to separate one's own self perception, emotional connectedness and experiences from therapeutic practices. We need to be aware of this reality to avoid being misled **as to the nature of problems (Parker, 1999:3).

This study stemmed from my personal commitment to being an investigative, critical, reflective and responsible practitioner. Darlington and Scott's (2002:18) statement reflects the motivation for my research: "For some qualitative researchers the questions they explore grow out of a strong ideological commitment and the pursuit of social justice." Psychotherapy clients[2] have a right to be treated in a respectful, empowering and ethical manner. This is in line with the four fundamental principles Allen (2001:3) contends should underlie professional codes of conduct:

- *Respect for people's dignity and rights,*
- *Responsible caring,*
- *Integrity in relationships, and*
- *Responsibility.*

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[1] Parker (1999:4) describes the concept 'critical' as follows: *To be 'critical', then, does not mean finding the correct standpoint, but it means understanding how we come to stand where we are (e.g. Griffiths and Griffiths, 1992).*

[2] I use the term 'client' but some practitioners and authors prefer the term 'patient'.

My personal commitment to ethical practice led me to explore and reflect on a particular client's experiences during therapy involving the integration of narrative therapy and EMDR. Since I could not find any literature or other evidence of the effects of integrating these two therapeutic approaches, I realised that I would be shouldering a great responsibility in undertaking to integrate narrative therapy and EMDR. However, I believed that this therapeutic integration might be even more powerful and effective than a single therapeutic approach in assisting someone struggling with the memories of childhood trauma. I decided that it would be vital that my main guiding principle during the journey of integrating narrative therapy and EMDR be to treat the client in a respectful way that would be create opportunities for her empowerment.

1.2 QUESTION LEADING TO THE JOURNEY

Palmer (2003:338) contends that there is much to be gained from research on rather neglected areas such as feminist therapies. It would provide an opportunity to reflect on the complexity of therapy as such. My journey then would explore just that.

In preparing to reflect on the integrative therapy process of narrative therapy and EMDR, one question in particular presented itself: *What would the client experience during the process of integrating narrative therapy and EMDR?* Since I view the client's experiences and expectations as important determinants of the therapy process, I felt it was essential to focus on these aspects. This focus formed part of my reflections on the process of therapy integration and new knowledges that were consequently constructed.

1.3 MAPPING THE JOURNEY FOR RESEARCH

In my discussion of and reflection on this qualitative case study, I prefer to use the language of narrative therapy. This decision was influenced by the belief that language constitutes realities (Freedman & Combs, 1996:22). The conversations during therapy were also based on a narrative discourse (as described in 1.4.2), which is characterized by the use of metaphors (Morgan, 2000:21).

In this study I use the narrative metaphor of a journey to refer to the processes of exploration involved in the evolution of the research. The steps I took in *getting there* were similar to those involved in undertaking a journey. Therefore I use the terms *therapy journey* and *research journey*. Against this background, I also found it more useful to refer to *gathering knowledges* and *deconstructing knowledges* rather than using traditional scientific terminology such as *data collection* and *data analysis*.

1.3.1 Purpose of the journey

The purpose of this qualitative study was to reflect on the experiences of a female client, to whom I refer as Sonja (pseudonym), during the integrative use of narrative therapy and EMDR in therapy sessions. Part of my decision to integrate the two therapies arose from the fact that Sonja was a young woman who had experienced incidents of trauma early in her life and who had recently experienced overwhelming emotional distress. I hope that my reflections on her experiences will contribute to and encourage further research on practices of therapy integration.

1.3.2 Position within the research paradigm

Aspects of a postmodern paradigm form the basis of this qualitative study. Within this framework, I prefer to view knowledge about Sonja's experiences as contextualized and local (McLeod, 2003:71). This implies that knowledge is not "something out there", since it is shaped and affected by a person's personal experiences (Freedman & Combs, 1996:275). It also influences the position taken by the therapist or as Freedman and Combs (1996:277) put it, "In our interactions as therapists, we seek to ask **questions** rather than to interpret, instruct, or more directly intervene".

However, the dominant focus of this case study is based on therapy integration. My position of not knowing what Sonja would experience and how she would respond to this integrative approach to therapy reminded me of the fundamental goal of qualitative investigation: it is focused on discovering the meaning that people attach to particular words, actions and incidents (McLeod, 2003:73). According to Babbie and Mouton (2002:270), detailed descriptions of the actions of participants are the primary focus of the researcher, which necessitates effective methods for gathering knowledges. This will be further discussed in 1.5.2.

1.4 MULTIPLE KNOWLEDGES

1.4.1 Therapy integration

Earl J. Ginter (1996) suggests in an editorial that mental health professionals need to be aware of the importance of theory in their practices. According to him there are three support structures ("pillars") that define counselling:

1. contextually, it represents an **interpersonal medium**;
2. the importance of both **prevention and remediation**;
3. reliance on a **developmental perspective**.

The assumption can be made from this that an integrative approach should not imply an absence of theoretical foundation or theoretical relativism[3]. Palmer (1983:4) takes a similar line to that of Ginter in arguing for the necessity for a theoretical framework. This he sees as playing a central role in the therapist's understanding of the individual, theoretical knowledge. It supports the therapist in the therapeutic process ("journey") of exploring the client's problem in order to know and understand how human behaviour is modified, and it provides a foundation for treatment planning.

When it comes to the therapeutic integration of two or more approaches from different schools of theory, the motivation behind it would be a desire to explore *what can be learned – and how clients can benefit – from other approaches* (Prochaska & Norcross, 1999:459). McMahon (2003:113) explains that there are many possible forms of integration during therapy. For instance, there could be "an integration of two or more therapies or an integration of counselling techniques (the latter may also be called technical eclecticism), or an integration of both therapies and techniques" (McMahon, 2003:113).

In considering McMahon's view of therapy integration, I thought it necessary to take a closer look at the similarities and differences between **integration** and **eclecticism** as concepts to be understood in an integrative approach to psychotherapy. I found the following definition by Hollander (2000:32) provided the clarity I needed on these concepts: "*Eclecticism* is a process of *selecting out,* with the implication of taking something apart, whereas *integration* is the process of *bringing together*, with the implication of making something whole and new". Although there appears to be some measure of confusion over the uses of the terms as some sources tend to merge the two concepts, while others emphasise the difference between them, Hollander (2000:35) does not see this as a problem:

> A whole range of techniques may be compatible with a number of very different theoretical positions, and these can be employed within a framework for practice without necessarily compromising theoretical integrity.

1.4.2 Narrative Therapy

Narrative therapy originally developed as a political project from work done by Michael White and David Epston (Swan, 1998:31). The theoretical principles that underlie narrative therapy are postmodern epistemology, social constructionism, post-structuralism, and feminist theory.

In a postmodern context, therapy needs to be deconstructed, thus removing the therapist from a privileged position of scientific knowledge, power and certainty (McLeod, 1997:23).

[3] Definition by Ginter (1988:5) as cited in Ginter (1996): "One set of beliefs is no better than any other."

According to Payne (2000:32) the use of language and the outcomes thereof should be re-evaluated from a post-structural point of view. White (1997:224) refers to Foucault (1984) who contends that post-structuralist enquiry reveals practices (even in the name of psychological liberation) of the dominant culture and question these. Thus post-structuralist enquiry contributes to the deconstruction of perceptions – systems of interpretation and understanding (White, 1997:224).

Social constructionism, another important principle of narrative therapy, is emphasized through interaction between people (Payne, 2000:34). Social and cultural influences and norms are an integral part of social constructionism (Payne, 2000:34). To the social constructionist, meaning is frequently and continuously negotiated, thus social relationships determine reality (Gergen, 1999:236-237).

When people refer to a politically loaded term such as *feminism*, there appear to be many different understandings of this term amongst individuals. According to Carey and Russell (2003:87) poststructuralist feminism is based on the idea that women should be understood as a plurality, not a single group. They explain that between the 1980 and 1990s "feminists challenged the established categories of sex, class, race/ethnicity, and placed an emphasis on the multiplicity of meanings in regard to identity" (Carey & Russell, 2003:87).

While keeping the above-mentioned theoretical principles in mind, the therapist takes up a position of respectful curiosity to encourage the person to become aware of taken-for-granted stories and the ideas and beliefs which support them (Swan, 1998:32). In other words, the therapist does not try to solve a client's problems, but rather becomes interested in working along with the client to *thicken* alternative stories[4] that do not support or sustain problems (Freedman & Combs, 1996:15-16). However, Freedman and Combs (1996:17) also realise that in the process of co-authoring stories along with clients there is a possibility that the therapist's story could have both a negative and/or positive effect on the life of the client. The therapist should take care during therapy sessions not to reproduce the oppression, even of a different nature, that a client "has experienced at the hands of a dominant culture" (Freedman & Combs, 1996:18).

Payne (2000:8) emphasises the particular attention that White and Epston give to the choice of language since "language can blur or distort experience in the telling, can condition the ways in which we feel and act, or, on the other hand, be purposefully chosen as a therapeutic tool". This thought is in line with a postmodern, narrative, social constructionist worldview (Freedman & Combs, 1996:22):

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[4] **Alternative story:** The story that develops in counseling in contradiction to the dominant story in which the problem holds sway (Winslade & Monk, 1999:122).

1. *Realities are socially constructed.*
2. *Realities are constituted through language.*
3. *Realities are organised and maintained through narrative.*
4. *There are no essential truths.*

An overview of narrative therapy is provided by Payne (2000:10-17), who remarks that the practices he has outlined can be expanded, contracted, returned to or omitted by the therapist, based on her personal judgement, within a single session or over a sequence of sessions. The outline can be stated as follows:

- Telling of the *story* by the person: This story usually holds a *problem-saturated* description.
- Naming the problem: The therapist listens carefully to the person's description of the problem-saturated story and the way in which the person describes the problem. Together the therapist and client name the problem according to this description.
- Using externalizing language: These conversations can be described as "a way of speaking in which a gap is introduced between the person and the problem issue. The problem may be spoken of as if it is a distinct entity or even a personality in its own right rather than closely identified with the person. This way of speaking opens space for the relationship between the person and the problem to be articulated" (Winslade & Monk, 1999:123).
- Considering social and political issues: With social-constructionism in mind, the influences of society and culture should be explored.
- Relative influence questioning: This concept elicits two descriptions according to Payne (2000:13): "(a) The influence the problem has had and is having on the life of the person; and then, in contrast, (b) the influence the person has had and is having, on the 'life of the problem'".
- *Deconstructing* unique outcomes[5]: The process of deconstruction can be translated, according to Winslade and Monk (1999:122), as "[t]he process of unpacking the taken-for-granted assumptions and underlying ideas behind social practices that masquerade as truth or reality … It is less adversarial and more playful than critique or confrontation".
- Inviting the person to take a position: According to the individual's personal preference, the person chooses where he/she prefers to position themselves in relation to the

[5] According to Morgan (2000:52) "[a] unique outcome can be anything that the problem would not like, anything that does not 'fit' with the dominant story".

problem. The person's preferred position will determine how he/she will respond to the problem.

- Using therapeutic documents: These include letters, declarations, certificates, handbooks, notes from the session, tape recordings, lists, pictures, even music and song. These documents can be used to assist in the further exploration of alternative stories (Morgan, 2000:99).
- Continuing therapy: a process of *telling and re-telling* towards constructing an alternative story.
- Using *outsider witnesses*: people who are an audience to a person's telling and re-telling of alternative stories.
- Re-membering: The person is invited to consciously think about people who made a significant contribution to his/her life (Morgan, 2000:77).
- Ending therapy.

1.4.3 Eye-movement Desensitization and Reprocessing (EMDR)

In this study, EMDR was integrated with a post-modernist therapy. A psychologist, Francine Shapiro, developed EMDR in 1987 after experiencing the positive transforming effects of eye-movement on the perception of traumatic events (Appleyard, 2001:512). After conducting a case study and a controlled study (1989), Shapiro could back-up her hypotheses that eye movements (EMs) contributed to the desensitization of traumatic memories. Further case and controlled studies were conducted and in 1991 she changed the name of this treatment approach to Eye Movement Desensitization and Reprocessing (EMDR) "to reflect the insights and cognitive changes that occurred during treatment, and to identify the information processing theory that she developed to explain the treatment effects" (EMDR Institute).

Theoretically, EMDR relates to Braun's (1988) BASK-model, which focuses on behaviour, affect, sensation and knowledge, but also proves to have a clinical and theoretical tradition of cognitive therapy, as EMDR emphasises negative and alternative positive thoughts and beliefs (Allen & Lewis, 1996).

According to Francine Shapiro (2001:4) the biochemical balance of the brain's physical information processing system might hypothetically be upset by negative life experiences or trauma. "This imbalance prevents the information processing from proceeding to a state of adaptive resolution with the result that the perceptions, emotions, beliefs, and meanings derived from the experience are, in effect, *locked* in the nervous system" (Shapiro, 2001:4). EMDR enables the processing of trauma through bilateral stimulation (eye movements,

alternate tapping on hands, etc.). Allen and Lewis (1996) argue that the use of EMDR enables the person to revisit manageable quantities of the traumatic experience in order to think about and remember the traumatic incident(s) in ways that are less stressful and upsetting. In this way it is possible to create new associations of trauma through EMDR.

1.5 GETTING THERE

During the research journey important research methods included in-depth interviewing and observations made during therapy conversations since the choice of research methods used should enable the researcher to gather meaning from experiences (Darlington & Scott, 2002:3). Merriam (1998:6) points out that meaning is related to experience. She also mentions that perceptions of the researcher mediate meaning. This single-case study opened up the possibility of exploring Sonja's experiences and their meanings within an integrative therapy process.

A case study, according to Lindegger (2002:255), can be a source of rich, longitudinal information which is usually descriptive about the person or specific situations. McLeod (2003:99) refers to the flexibility of case studies when he states that "the researcher may not have, and may not wish to have, any control over the behaviour of the 'subject' of the study, or little control over the amount or type of data being collected".

This case study was mainly conducted within a postmodern paradigm with the aim of reflecting on Sonja's experiences during the integrative use of narrative therapy and EMDR in therapy sessions. Along the research journey it was of great value to consider how the client could benefit from a service (or not) in her own words, according to Darlington and Scott (2002:6), since a standard quantitative approach does not appear to be sufficient to determine that.

1.5.1 Participant/Client

The client, Sonja (pseudonym) referred herself to the Unit for Educational Psychology. Sonja was a young woman, aged 22. She reported difficulty in functioning at work, in relationships and part time studies due to unpredictable periods of overwhelming emotional distress. This made her an appropriate participant for this study.

1.5.2 Gathering knowledges

Sonja had weekly psychotherapy appointments with me at the Unit for Educational Psychology from May 2003. Before the integrated therapy was initiated, she had the opportunity to decide whether she wanted to take part in the research and was able to indicate her decision on a consent form.

Regular therapy contact sessions served as a basis for gathering knowledges. Narrative therapy and EMDR were used as the medium for conversations. Video or tape recordings of each session were made after Sonja had indicated that she would not mind these recordings being made. Together, Sonja and I discussed observations during therapy sessions and I found video recordings to be a useful source for personal reflection.

During this phase of the research journey the main focus was on how the process of therapy integration (narrative therapy and EMDR) would develop and how Sonja would respond to therapy integration.

1.5.3 Therapy conversations

- **Individual**

I prefer to talk about *conversations* instead of *interviews*. Conversations refer to our way of talking during the therapy journey in the process of gathering and deconstructing knowledges (Morgan, 2000:2-3). I see the reference to therapy conversations as reflecting the sincerity, genuineness and mutual respect during therapy. In our therapeutic conversations my first priority was to establish a relationship of trust between Sonja and me from the first session onwards. "Trust and rapport are crucial elements of in-depth interviews during qualitative research, if an individual is to share feelings and thoughts of past and present experiences" (Darlington & Scott, 2002:2). Sonja and I met weekly on the same day and at the same time. Our conversations and my observations allowed Sonja and me to explore the meanings of her experiences.

- **Reflecting team**

One reflecting team session was included in the therapy journey. An experienced consulting psychologist was invited to this session and spoke to Sonja about her life story while six postgraduate educational psychology students listened to the conversation. These students acted as an audience and had an opportunity to reflect on what they have heard during the conversation (Freedman & Combs, 1996:176-179). After Sonja and the consulting psychologist had listened to the reflection of the students, they continued their conversation, discussing what they had heard from the reflecting team. Sonja and I agreed in advance that I would be present throughout the reflecting team session, even when I did not take part in the conversation. This seemed acceptable to Sonja.

1.5.4 Photographs and other documents

Photographs were taken of clay objects that Sonja had made during two separate therapy sessions. Other documents (such as letters, pictures, images, and diagrams) were photocopied, as Sonja chose to keep most of her work from therapy sessions in a

scrapbook, to take home. These served as physical reminders or evidence of steps she has taken on the therapy journey (Morgan, 2000:99; Payne, 2000:127).

1.5.5 Deconstructing knowledges

Deconstructing knowledges from conversations during the therapy journey helped me to reflect on the process of therapy integration and Sonja's experiences. Video/tape recordings, process notes, other documentation and observations were deconstructed according to codes that focussed on specific themes in Sonja's life story. As Babbie and Mouton (2001:283) note, thick descriptions are constructed from multiple sources of evidence.

1.6 COURSE OF THE JOURNEY

The study will be discussed in five chapters. Chapter One has provided some background information and outlined the research problem and purpose of the study. Chapter Two contains a review of the literature and attempts to discuss key concepts in appropriate detail, while the methodology is outlined in Chapter Three. In Chapter Four there will be a discussion of the implementation of the study. The last chapter will focus on findings and will provide a reflection of the research journey. Some suggestions will also be made for future research.

1.7 REFLECTION

This chapter was a starting point for my reflection on the research journey. My intention was to create a point of reference for the reader. I spoke about the question that led to the journey, as well as the purpose of it and position taken up by me as the therapist and researcher. A brief look was also taken at the literature on the therapies that were integrated during this study. In this way some expectations were constructed on the direction of this journey and how the journey was planned to unfold.

CHAPTER TWO

LOOKING THROUGH DIFFERENT WINDOWS

2.1 INTRODUCTION

There appears to be a rich source of knowledge within literature, which provides continuously developing perspectives on what people believe to be true or relevant to their field of study or profession. This chapter will give a general view of knowledge and research of existing literature about key concepts relevant to this *journey*. Drawing on the literature, I will discuss my understanding of an integrative approach to therapy. This discussion will also take a look through the *windows*[6] of narrative therapy and EMDR, as these two therapies were used in an integrative manner along this therapy journey. Both Narrative therapy and EMDR are different therapeutic interventions that developed in unique ways, from specific theoretical foundations and implications for practical implementation during psychotherapy.

I will attempt to deconstruct other important concepts with reference to this *journey* to ensure clarity and a common understanding of these concepts. The literature will enable me to shed some light on concepts such as postmodernism, social constructionism, and traumatic experiences in childhood.

2.2 INTEGRATIVE LANDSCAPES OF MEANING AND IDENTITY

2.2.1 A both/and approach

Integrative psychotherapy came into being with the advent of eclecticism in the early 1980s. A spectrum of diverse available therapeutic interventions by then already existed. The rapid development of an integrative approach to psychotherapy was aimed at utilizing the best of the various therapeutic orientations in the interests of more effective and efficient treatment of clients (Prochaska & Norcross, 1999:459; Corey, 2001:457). For Omer (1993) integration should be seen not as a "new theoretical idea", but rather as a way of organising and centring treatment, and of establishing better communication between therapist and client (Omer, 1993). Corey (2001:459) supports this view:

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[6] I found using the metaphor of looking through different windows useful in discussing knowledges from literature about narrative therapy, EMDR, therapy integration and other important key concepts. In my mind I have a picture of traveling in a train on this research journey. By looking through different windows on both sides of the train, one gets a variety of perspectives on the same area.

> One reason for the trend toward psychotherapy integration is the recognition that no single theory is comprehensive enough to account for the complexities of human behaviour, especially when the range of client types and their specific problems are taken into consideration. Because no one theory has a patent on the truth, and because no single set of counselling techniques is always effective in working with diverse client populations.

O'Brien and Houston (2003:20) express this concern when they refer to the various aspects of human existence that the therapist needs to keep in mind during psychotherapy. According to them, integration enables the therapist to recognize and value the *complexity of human beings* and do justice to the person who comes for therapy. They also point out that individual therapeutic orientations tend to focus on either behaviour, emotion, cognition or the body, in other words one of many psychological functions in a human being, thus artificially separating the organic whole (O'Brien & Houston, 2003:92).

It is useful to take a look at ways in which integrative therapy is discussed in the literature to gain more insight and a better understanding of its meaning. Corey (2001:457) talks about integrative counselling and psychotherapy as "the process of selecting concepts and methods from a variety of systems". Integration should happen gradually and systematically. He is convinced that knowledge (*study*) and practical experience (*clinical practice, research, and theorizing*) are necessary to produce an integrative perspective (Corey, 2001:468). Prochaska and Norcross (1999:458) refer to the "*integrative movement,* which seeks innovative methods of combining powerful processes and appropriate content from psychotherapy systems traditionally viewed as theoretically and clinically incompatible". Rather than playing one therapeutic orientation off against another, which might cause *mutual cancelling*, an integrative focus will balance contrasting theoretical elements of two perspectives to allow and create a surplus of movement (Omer, 1993).

However, some therapists might initially feel uncomfortable with an integrative focus as they view it from within different perspectives. Omer (1993) seems to be convinced that "[t]he integrative focus would not be acceptable to the more devoted followers of any extreme position in the spectrum of approaches". O'Brien and Houston (2003:12) show an understanding of this issue when they comment that therapy is conceptualized in different ways by different orientations as values significantly influence the perceived roles and actions taken by therapists. Corey (2001:463) confirms the fact that a person's philosophical assumptions and view of human nature would have an impact on what he/she perceives as *reality* and "direct your attention to the variables that you are 'set' to see".

A person's perceptions do not stand alone but are often shaped and influenced through social interaction. In reminding the therapist not to forget the client's position within society, O'Brien and Houston (2003:12) refer to Rycroft (1995) who said that clients are both

beneficiaries and victims in a society "of which they are both protected members and casualties". I believe that a therapist's values and philosophies play a role in an integrative approach to therapy. For instance, preconceived ideologies and perceptions might *blind* the therapist within a specific individual therapeutic approach to the potential that an integrative perspective holds. Seu (1998:212) makes the statement that *social dimensions of suffering* and *power dynamics* in the therapeutic relationship will be concealed if the focus of therapy is exclusively on the intrapsychic world. As therapists we need to be open to and informed about theories and techniques from various other orientations, in order to treat clients in just and highly effective ways at all times. Beutler and Harwood (2000:vii) argue that although an initial plan for therapy appears to ensure discriminating and differential treatment, it is essential to re-evaluate and make periodic changes based on the client's needs.

Integrative psychotherapy invites therapists of different individual orientations to adopt a more open landscape of identity[7] and to consider a *both/and* approach[8]. An integrative perspective is attainable if the therapist is willing to look for significant commonalities between seemingly opposing therapies that will contribute to a *rich alternative description* of integrative therapy, instead of staying focussed on stereotypes that separate them even further (Prochaska & Norcross, 1999:468). However, in a summary of the contributions and limitations of the various approaches, Corey (2001:481-484) reminds therapists that they must make calculated decisions when integrating various elements of different therapeutic approaches.

The emphasis on complementary characteristics and strengths of different therapeutic approaches does not imply that all therapies have equal value. As Phillips (1999) puts it, saying that we cannot declare one theory the best is not the same as saying that all possible theories are equal. O'Brien and Houston (2003:27) talk about the *dodo effect* in this regard, referring to the Dodo in *Alice in Wonderland* who declared that everyone has won and should get a prize. Within an integrative frame of reference, therapists need to develop a theory that they feel comfortable with; every theory has pros and cons.

As the therapist's personal experience progresses, it is necessary to refine and adapt his/her personal theory continually (Corey, 2001:459). O'Brien and Houston (2003:152) emphasise the importance of theory when they discuss the training of future therapists within an integrative approach to psychotherapy. According to them, theoretical knowledge should form the basis for training, but will not be of much value if student-therapists do not learn

[7] *Landscape of identity* refer to the possible meanings of an event for a person (Morgan, 2000:64)
[8] I use this term to emphasize that it is not about choosing between two alternatives, but rather considering the usefulness and applicability of both.

how to be with their clients: "What is required is reflecting *in* action as well as reflecting *on* action" (O'Brien & Houston, 2003:152).

In his article, Eagle (1998), who is convinced that psychotherapy integration is the best approach in cases of trauma intervention, reflects on a study where the strengths of both psychodynamic and cognitive-behavioural modes of intervention were integrated in a Wits trauma intervention model. According to him an integrative approach to trauma intervention aims at helping the client find relief from distress in an expansive manner (addressing internal and external functioning). Flexibility in implementation with regard to timing, emphasis and technique is usually associated with this (Eagle, 1998).

An integrative approach seems to have broader applications than the treatment of trauma. Corey (2001:457), however, mentions that the challenge for the therapist "is to find ways to integrate certain features of each of these therapies so that you can work with clients on all three levels of human experience". In line with this view, O'Brien and Houston (2003:156) argue that integration should always involve the following three basic principles during a therapist's training as well as throughout his or her professional life:

1. ***An academic, intellectual level of learning*** *about a broad range of existing theoretical models, rather than a single one. Such knowledge should be set alongside what is known through research*
2. ***A practical level*** *through direct work with clients, which is supported by adequate supervision and experiential training sessions and*
3. ***Personal development.***

(O'Brien & Houston, 2003:156)

According to Sue, Sue and Sue (2003:574), an integrative approach to psychotherapy is valuable and makes sense since a single theory or approach will succeed only partly in explaining and treating the complexities of human beings. When it comes to ethical ways of being with a person who seeks therapeutic help, it should always be inevitable to tackle problems systematically, usually in three or more stages:

> … the most probable factors determining a successful outcome to therapy are the personal qualities of both the therapist and client and the relationship between them, rather than the particular approach (McMahon, 2000:113).

2.2.2 The relation of eclectic therapies to integration

To me it seemed important to clarify any differences there are between an *integrative* and an *eclectic* approach to therapy, and how perceptions about each approach influence psychology and the therapeutic process.

Prochaska and DiClemente (1992, in O'Brien and Houston 2003:10) observe that people often have more positive associations with integration than eclecticism. Without attempting to play eclectic and integrative therapies off against each other, I list the summary made by Norcross and Prochaska (1999:464) of findings by Wolfe and Goldfried (1988) from a National Institute of Mental Health (NIMH) Workshop, and two studies by Norcross and Napolitano (1986) and Norcross and Prochaska (1988) to illustrate the differences between integration and eclecticism.

Figure 2.1: Differences between integration and eclecticism

Eclecticism	Integration
Technical	**Theoretical**
Divergent (differences)	**Convergent (commonalities)**
Choosing from many	**Combining many**
Applying what is	**Creating something new**
Collection	**Blend**
Applying the parts	**Unifying the parts**
A theoretical but empirical	**More theoretical than empirical**
Sum of parts	**More than sum of parts**
Realistic	**Idealistic**

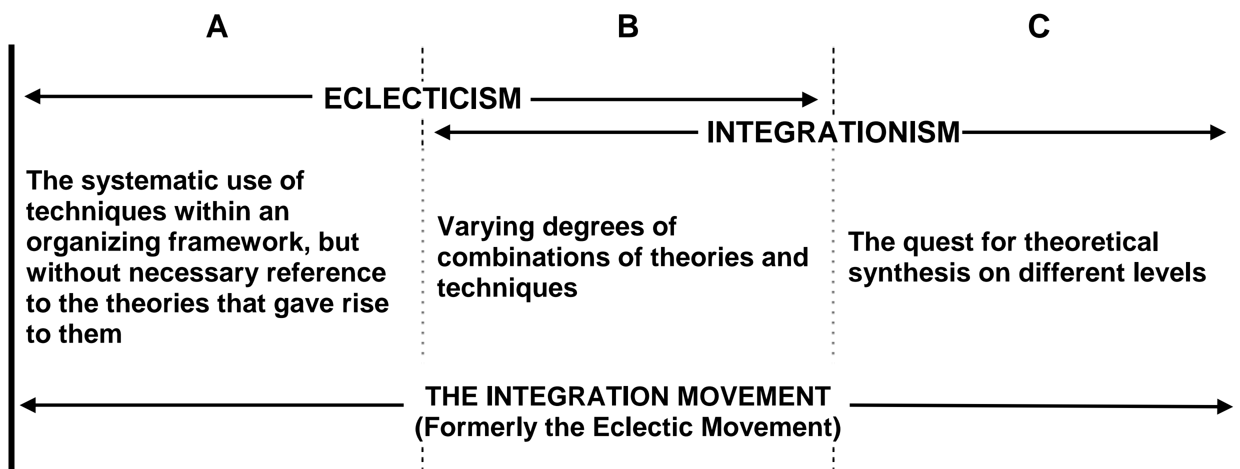
(Prochaska & Norcross, 1999:464)

In Figure 2.1 the contrast between an eclectic and integrative approach to therapy is evident. Eclectic therapists focus on choosing specific techniques from different therapies and combine these in their therapeutic sessions with clients. Empirical pragmatism appears to be the main characteristic of eclecticism. However, an integrative approach sees theoretical flexibility as important. As a result of therapy integration with theoretical flexibility, a new therapeutic approach is created through combining and blending some parts of different therapies (Prochaska & Norcross, 1999:464).

O'Brien and Houston (2003:10) believe that integrative and eclectic approaches each have a place and purpose in psychotherapy. They also argue that the effectiveness of a preferred treatment in all areas of the person's life should be the determining factor.

An illustration by Palmer and Woolfe (2000:34) clearly depicts the different uses of integration and eclecticism and the overlaps between them:

Figure 2.2: Eclecticism, integrationism and the integration movement



Psychotherapeutic integration that is *open* to "various ways of integrating diverse theories and techniques" has many guises, but according to Arkowitz (1997, in Corey, 2001:458) three of the most common ways of integration are *technical eclecticism*, *theoretical integration* and *common factors*. Corey (2001:458) explains that:

- *Technical eclecticism* is inclined to focus on differences and can be described as a collection of techniques from various approaches. The theoretical origin of techniques from different schools tends to be of less importance.
- *Theoretical integration*, as the term implies, puts a great emphasis on the creation of a conceptual framework from two or more theoretical approaches. Corey (2001:458) refers to Norcross and Newman (1992) when he indicates the assumption that theoretical integration will produce an outcome that "will be richer than either of the theories alone".
- The *common factors* approach attempts to identify *common elements* among various theoretical systems. All therapies have some common elements or *non-specific variables* although they have different theoretical foundations.

In their book ***Systems of psychotherapy: A transtheoretical analysis***, Prochaska and Norcross (1999:463) refer to their 1992 statement that theoretical integration will result in better outcomes. They emphasise that underlying theories as well as therapy techniques from different therapeutic schools are integrated during the process of *theoretical integration*

and that this process "entails a conceptual creation beyond a technical blend of methods" (Prochaska & Norcross, 1999:463). Omer (1993) describes an integrative focus as a *balanced mutuality* when two adversative theoretical orientations are seen as equally important when they are linked together. Prochaska and Norcross (1999:462) also elaborate on Corey's description of *technical eclecticism* and mention that it helps in deciding the most effective and efficient treatment for the specific person and problem – in other words, "predicting for whom interventions will work". With regard to the *common factors* approach, Palmer (1980:3) discusses a study done by Fiedler (1950) where he found that experienced psychotherapists from different orientations did similar things with their clients in practice. All these authors present a similar picture of the most obvious and important differences between common ways of integrating therapies.

In adopting an eclectic approach to therapy and its focus on the utilisation of different techniques from various orientations, it is important to heed the warning Omer (1993) issues that each problem will be matched with a different technique of intervention, which might cause therapy to be broken up in many disconnected interventions. I understand this as meaning that the client might have a fragmented experience of therapy, which could be frustrating or even time consuming. Since eclecticism covers a broad range of practice, the worst eclectic practice could be described as "haphazardly picking techniques without any overall theoretical rationale", which is better known as *syncretism* (Corey, 2001:458). Lazarus (1986 and 1996), as well as Lazarus, Beutler and Norcross (1992) indicate, according to Corey (2001:458), that *syncretistic confusion* would ensue if techniques from various sources are utilized without a sound and coherent rationale for all the choices.

Beutler (1983:6-7) adds another perspective to the eclectic approach and refers to research done by Strupp and Hadley (1979) as well as Strupp (1981b), which found the therapists did not really adapt their therapeutic approaches according to the different individuals who were consulting them. Thus therapists seem to find it difficult to take a totally objective stance when selecting techniques for eclectic intervention. Totton (2000:6) holds the view that most "therapists are *acting as citizens*, and putting their therapeutic skills and understanding at the service of a political goal to which they give priority". Palmer (1980:6) is convinced that the therapist needs to be flexible within an eclectic approach since human behaviour is very complex and changes happen constantly around us (in technology, social relationships, etc.).

While reflecting on psychotherapy integration, I became convinced that it entails more than just combining different techniques from various schools of therapy, as with an eclectic approach. An integrative approach to psychotherapy demands an *openness* to integrate diverse theories and "attempts to look beyond and across the confines of single-school

approaches to see what can be learned from – and how clients can benefit from – other perspectives" (Corey, 2001:458).

The journey goes on to the next window of knowledge that will focus on narrative therapy, as one of the therapies that was integrated during this study.

2.3 DECONSTRUCTING NARRATIVE THERAPY

Using the narrative metaphor leads us to think about people's lives as stories and to work with them to experience their life stories in ways that are meaningful and fulfilling" (Freedman & Combs, 1996:1).

2.3.1 Tracing its history

Narrative therapy results from work done by Michael White and David Epston, as mentioned in the previous chapter. The development of narrative therapy is viewed as an attempt to question traditional, essentialist, and foundational epistemologies of clinical practice (Amundson, 2001:175). Narrative therapy and discursive approaches are seen as emanating from a very important shift in psychotherapy in the power imbalance in therapy (Seu, 1998:213). According to Gergen and Kaye (1992), one of the greatest motivational factors that necessitated this shift "concerns the way in which the therapeutic process can be a hegemonic and subjugating process" (Seu, 1998:213).

Jill Freedman and Gene Combs (1996:22) describe the underlying theoretical perspective of this approach as "a postmodern, narrative, social constructionist world-view". In their view, such a worldview makes it possible to negotiate *power*, *knowledge* and "*truth*" in families and larger cultural aggregations. Further implications for therapeutic practices relate to four ideas on reality and "truth":

- *Realities are socially constructed.*
- *Realities are constituted through language.*
- *Realities are organized and maintained through narrative.*
- *There are no essential truths.*

(Freedman & Combs, 1996:22)

White (1995:37) does not consider narrative therapy to be an *approach* or a *world view*. It seems that in 1995 White himself was not sure whether it would be appropriate to describe narrative therapy as an epistemology or a philosophy, a personal commitment, a politics, an ethics, a practice, or even as a way of life, since all these appeared to be applicable to this

therapeutic approach. He warns that so much has been written lately *in the name of narrative therapy* which does not correspond with his understanding of its philosophical, ethical and political considerations (Prologue by White in Payne, 2000). This warning by White made me wonder whether narrative therapy could be multi-storied, and have different meanings and applications in different contexts. Whether it was possible that narrative therapy had developed in various ways from different philosophical, ethical and political considerations was another question that came to my mind. I also wondered which definition of narrative therapy I should consider as trustworthy, truthful and applicable to psychotherapy.

John McLeod (1997:x) writes that all therapies are in actual fact narrative therapies. He develops this point by saying that there is no narrative therapy, which implies one way of working. Rather, he explains that "if there is any common ground among narrative therapies, it lies in the intention to give the client every opportunity to tell his or her story, to really listen to these stories and to allow space for the telling of new or different stories" (McLeod, 1997:x).

Since my training was based on the narrative therapy developed by David Epston and Michael White (White & Epston, 1990; White, 1995 and 1997; Freedman & Combs, 1996; Monk, Winslade, Crocket & Epston, 1997; Winslade & Monk, 1999; Morgan, 2000; Payne, 2000), I will attempt to elaborate and discuss the rich historical and theoretical development of this particular therapy. It seems that initially both White and Epston were curious about the philosophical thoughts that supported and influenced their practices (Monk, 1997:7). Throughout the development of narrative therapy Michael White, Cheryl White and David Epston engaged in many conversations with each other to share their understandings of the narrative concept (White, 1995:13; Freedman & Combs, 1996:16; Monk, 1997:7; Payne, 2000:3).

During the late 1970s the writings of Gregory Bateson (1972, 1979) had a great influence on Michael White (White & Epston, 1990:2; White, 1995:11; Monk, 1997:7). Bateson, an anthropologist and psychologist, emphasises the fact that people are interpreting beings who try to make sense of the world. This implies that it is impossible to know objective reality since "all knowing requires an act of interpretation" (White & Epston, 1990:2). In this regard, White noted that many people submit to their problems and consequently seem to be unaware of their ability to use their own resourcefulness to reduce the effect of the problem in their lives (Monk, 1997:7). Bateson's demonstration of "how the mapping of events through *time* is essential for the perception of difference, for the detection of change" drew White's attention to the temporal dimension of therapy, which he perceived as often neglected in therapy generally (White & Epston, 1990:2). Thus a story in the narrative

metaphor can be viewed as a map but does not include every detail of the 'territory' of life that it represents (Freedman & Combs, 1996:15).

The work of Edward Bruner, an ethnographer, demonstrates that people try to understand and make sense of experiences by means of the stories they create (Monk, 1997:7). Bruner (1986) is convinced that "there are always feelings and lived experience not fully encompassed by the dominant story" (White & Epston, 1990:11). This view has been important in the development of narrative therapy since it implies that the stories people constructed about their own lives always have gaps. Only selected aspects of a persons lived experience are expressed in the performance of these stories, which are constitutive in the sense that they shape lives and relationships (White & Epston, 1990:12). White (1995:15) expresses his concern that the therapist should recognise his/her position in therapy and the degree of responsibility with regard to the real effects of altered or alternative self-narratives:

> … if in therapy we collaborate with persons in the further negotiation or renegotiation of the stories of persons' lives, then we really are in a position of having to face and to accept, more than ever, a responsibility for the real effects of our interactions on the lives of others (White, 1995:15).

Michael White's reference to the responsibilities of the therapist brings another important aspect into question: the apparently inseparable link between knowledge and power, and its role in therapeutic situations and in the broader society in which we live. Michel Foucault (1973, 1979, 1980, 1984) has probably had the greatest influence on 'developers' of narrative therapy (White, 1995:12). This French historian and philosopher's writings have powerful and wide-ranging implications for the therapeutic process (Monk, 1997:8). Monk (1997:8) remarks that a striking theme throughout Foucault's work is the processes of submission that become established in *professional practice*, especially in his analysis of the effects of power. "To Foucault power is knowledge and knowledge is power" (Freedman & Combs, 1998:38).

The existence of power relationships in society through racial, social class and gender interactions leads to the disempowerment of many people. It appears that *dominant narratives* in society in fact deprive many people of their voices in particular areas of discourse (Freedman & Combs, 1998:38). According to Foucault *dominant narratives* of our culture are often *internalised* by people so that they believe society speaks the truth of their identities (Monk, 1997:8; Freedman & Combs, 1998:39). Ablon (1985, in Seu, 1998:207) mentions that every person is aware of their self-judgements, though some might be more dependent on the opinion and approval of others. Therefore Michael White argues that every

person will always have "lived experience" which is not part of the dominant stories that have marginalized and disempowered those lives (Freedman & Combs, 1998:39-40).

Tina Besley (2002:126) also recognises the importance of work done by many poststructuralist theorists and the influence of Foucauldian themes on narrative therapy. A prominent focus falls on the importance of *language* and *meaning* in many social sciences, but does not appear to have been unexplored in psychotherapy until 1989 when Michael White and David Epston developed narrative therapy (Besley, 2002:126). It seems that Foucault had a major influence on the establishment of new ways of thinking about people and about therapy and counselling, especially with regard to power/knowledge relationships, and the roles of language and meaning (Besley, 2002:127; Seu, 1998:205).

According to Seu (1998:205), Foucault was convinced that external coercion leads to internal regulation through discourse, as the person keeps watch over him/her self. In this regard Foucault also argued that certain discourses reproduce power relations. This argument followed as an oppositional view against explanations by psychoanalysists that people's actions should be understood "through an inquiry into the unconscious mind and their intrapsychic conflicts of the person" (Seu, 1998:204). Rather than empowering a person, such practices tend to put the therapist in an expert position on knowledge about the person's self (Seu, 1998:204). Foucault gradually became more interested in the techniques which legitimise power and their work in subjecting our bodies, governing our gestures and dictating our behaviours, thus different powers of external forces and powers of internal regulation (Seu, 1998:205).

Power positions are often connected to political issues. I would like to focus briefly on the political implications of narrative therapy. In the first chapter I referred to Swan (1998:31) who argues that narrative therapy originally developed as a political project. Besley (2002:135) describes the inherently political nature of therapy as "an activity or set of principles inscribed by power relations". In the introduction to his book ***Psychotherapy and politics***, Totton (2000:2) defines his view of politics in the field of psychotherapy. He explains that questions such as, *What is 'human nature'? What behaviour can be seen as normal and expectable, what sorts as abnormal and unacceptable?* and *What is the meaning and purpose of human existence?* place psychotherapy in a political sphere.

Totton (1997a) perceives psychotherapy practices as "overwhelmingly to the left of the political spectrum", but mentions that there needs to be a balance between liberalism and conservatism. He seems to be convinced that therapy is indeed a politically reactive activity (Totton, 1997a, in Totton, 2000:4). Phillips (1999:35) commented that "… we no longer enjoy the comfort Freud experienced in his one-size-fits-all approach to the unitary narrative. … It

is clear, however, that no therapist approaches the patient in a completely neutral frame of mind". Thus narrative therapy should be seen as a lifestyle and a political project, according to Besley (2002:135). This involve respectful listening and speaking as a means of producing different ways of the 'self' with its basis and orientation strongly Foucauldian (Besley, 2002:135).

2.3.2 Skills and knowledges of Narrative Therapy

In his discussion of ideas informing narrative therapy, Martin Payne (2000:19) takes a closer look at the possible meanings of the term *narrative*. He describes "accounts", "stories", and "narratives" as interchangeable terms in this therapy and says that they all refer to the *very act of being 'told'* (Payne, 2000:19). However, it is necessary to keep in mind that a narrow definition might be counterproductive and tend to oversimplify the full meaning of narrative in counselling and psychotherapy (McLeod, 1997:53). Michael White (1995:14) remarks that "we live by the stories that we have about our lives" and that these stories really *shape*, *constitute*, and *embrace* our lives. Narrative therapy is not just about people's life stories, but about the real effects of these life stories on their existence. John McLeod (1997:53) points out that *retrieval of meaning* lies at the heart of narrative therapy. Alice Morgan (2000:5) explains the meaning of stories for the narrative therapist as follows:

Stories consist of:
* events
* linked in sequence
* across time
* according to a plot.

For her, "[t]he way we have developed these stories is determined by how we have linked certain events together in a sequence and by the meaning we have attributed to them" (Morgan, 2000:6).

The stories people tell when they come to therapy can metaphorically be referred to as showing a map (Payne, 2000:45). An important aspect of narrative therapy is that people are seen and understood as separate from their problems (Morgan, 2002:2). Naming the problem, therefore externalising and separating it from the person, supports the "belief that a problem is something operating or impacting on or pervading a person's life …" (Freedman & Combs, 1996:47). White (1995:22-23) comments that externalising conversations enable people to *experience an identity that is distinct or separate from the problem*. It comes down to a belief that the problem is not the person, and the person is not the problem. Externalisation invites a different perspective on the problem, and according to White (1995:23) new possibilities for action are opened up: "… People say they experience this

process as freeing, or as opening up new possibilities. So, I think it introduces a lot of hope" (White, 1995:23-24).

Deconstruction of the problem usually goes hand-in-hand with externalising conversations (White, 1995:24). This involves asking questions to 'take the problem apart' (Monk, 1997:8) or can be described as a process of 'unpacking' (Freedman & Combs, 1996:57). Deconstructing the problem will give the client an opportunity to explore the situation from different angles (Monk, 1997:8):

> Deconstructive questioning invites people to see their stories from different perspectives, to notice how they are constructed (or that they are constructed), to note their limits, and to discover that there are other possible narratives (Freedman & Combs, 1994b in Freedman & Combs, 1996:57).

At this point the position and role of the therapist come under scrutiny since good listening seems to be of utmost importance. Kaye (1996) argues that therapy should take 'not knowing' as its starting point (Seu, 1998:213). However, Seu (1998:214) is concerned that the therapist in a 'not knowing' position may mask the ideological function of hiding issues of power in a therapeutic relationship. It appears to be "a device for avoiding our responsibilities as therapists by claiming that we can somehow lift ourselves out of history and material conditions" (Seu, 1998:214).

However, Payne (2000:25) argues that there can be no 'expert knowledge' about human life since we are "too changing, variable, unique, multi-faceted, uncertain and complex for 'certain' definitions and conclusions …" Freedman and Combs (1996:44-45) refer to Anderson and Goolishian who have written extensively about the importance of a 'not knowing' position for the therapist. They explain that a 'not knowing' position does not attempt to deny the fact that therapists have particular training and knowledge in their field of work. Therapists' 'knowing' lie in the process of therapy, for the content and meaning of people's lives fall outside these parameters. Therefore, asking curious questions from a 'not knowing' position can clarify the therapist's assumptions and invite clients to question their own assumptions. This can have a very therapeutic effect in itself.

Morgan (2000:vi) takes the view that people also contribute in significant ways to the development of skills and knowledges of narrative therapy practices. She also reminds us that the therapist should realise and acknowledge that "people have many skills, competencies, beliefs, values, commitments and abilities that will assist them to reduce the influence of the problems in their lives" (Morgan, 2000:2). McLeod (1997:53) points to another value that the use of story has: information about "action, purpose, identity, feeling, intentionality, and the world within which the storyteller lives" is conveyed in every story a

person tells. An awareness of these should assist the therapist and client in identifying and exploring the meaning of 'clues' to unique outcomes.

'Clues' within a narrative therapy context can be described as possible starting and linking points for the development of a parallel story (alternative story) to the problem-saturated story which the person has told (Payne, 2000:75). These 'clues' will only be accepted as unique outcomes if they offer significant meaning to the client (Payne, 2000:76). White and Epston (1990:56) remark that it is helpful to review the person's life history as an invitation for the person to recall occasions when the problem had little or no effect. Viewed from this perspective, it seems that history plays an important role in the process of rendering an alternative story through unique outcomes and exceptions (White, 1995:26). Therapists also need to keep in mind that people's lives are multi-storied (White 1995:27). This implies that there will always be other stories, apart from the dominant stories, about our lives. These *other* stories are called sub-stories by Michael White (1995:27).

This re-authoring of an alternative story gradually takes shape when people recall sub-stories of their lives. People are gradually invited to formulate and tell a different or unfamiliar (alternative) story in response to questions that the therapist asks about unique outcomes (Payne, 2000:77). Focussing on unique outcomes invites the person to tell sub-stories, which are experiences that stand outside their dominant stories. White (1995:28) agrees that sub-stories "really provide a point of entry for re-authoring work".

The therapist and client are co-authors of the alternative story. While the therapist continually asks curious questions about sub-stories and parts of experience that have been neglected, the client brings descriptions to these questions (White, 1995:28; Payne, 2000:119).

Payne (2000:118) emphasises the importance of questions during narrative therapy, since it invites people to break away from the dominant (problem-saturated) stories of their lives. Questions provide the opportunity for both therapist and client to explore experiences and their meaning. Morgan (2000:61) states that "landscape of action questions involve inquiries not only into the details of the particular unique outcome but also into any other actions and events that may be linked to the unique outcome". Landscape of meaning questions invite the person "to reflect on the meanings of the events or unique outcomes that they have described" (Morgan, 2000:61). Landscape of action and landscape of meaning (also called *landscape of consciousness* by White, 1995:31) questions help to explore the effects of the problem, but also invite the person to reflect on events and experiences that most accurately portrays his/her preferences, e.g. characteristics of motive or of belief (White, 1995:31).

The client's responses to landscape of action and landscape of meaning questions will open up a different, alternative story or narrative (Morgan, 2000:69). *Rich or thick descriptions*[9] are created by exploring the person's personal skills, commitments, beliefs and values (Morgan, 2000:69). The person's rich descriptions are valuable for framing an alternative story. During re-authoring conversations the alternative story will be *thickened out* as the therapist and client together explore occasions when personal abilities and qualities had a positive effect in a difficult situation or contributed to desirable effects (McKenzie & Monk, 1997:109). Referring to the point made by Bruner (1990), Freedman and Combs (1996:195) make the suggestion that *thicker and more multi-stranded* stories should be authored through the search for many past events that strengthen the alternative story.

In thickening the alternative story, White (1995:33) argues the importance of inviting and encouraging clients to involve other significant people in their lives in the preferred developments of their lives. He states, "… this is powerfully authenticating of these developments" (White, 1995:33). Once identified, these *significant others* act as audience to observe and acknowledge the steps the person are taking to decrease the influence of the problem on his/her life. The sharing of stories tends to join people together (Roberts, 1999:11), since the stories that others have about a person have a very strong influence on the development of the person's own story (McKenzie & Monk, 1997:110). This emphasises the value of an audience that will appreciate and acknowledge the preferred developments in the person's life (White, 1995:33; McKenzie & Monk, 1997:110).

There are many ways to recruit an audience. McKenzie and Monk (1997:111) mention that letters can be useful in recruiting an audience when they are written together by the therapist and client, and sent to significant people (who will appreciate, acknowledge or value the person's efforts in producing change) in the person's life. White (1995:34) supports the notion that letter writing and other types of documentation are often effective at engaging others.

Therapeutic documents, i.e. letters, statements, certificates, creative writing, pictures, music or songs, etc. can all be invaluable physical reminders of new knowledges, perspectives and preferred changes a person has taken and are evident reminders of an alternative story (Morgan, 2000:99; Payne, 2000:127). White and Epston (1990:77-187) give many examples of and discuss *a storied therapy* through letter writing. Apart from narrative letters, they refer

[9] According to White (1997:15) a cultural anthropologist, Clifford Geertz (1973) introduced *thin* versus *thick descriptions*, terms borrowed from Gilbert Ryle. White (1997:15) explains that *thick descriptions* are those "descriptions of person's actions … that are informed by the interpretations of those who are engaging in these actions, and that emphasise the particular systems of understanding and the practices of negotiation that make it possible for communities of persons to arrive at shared meaning in regard to these actions".

to letters of invitation, redundancy letters, letters of prediction, counter-referral letters, letters of reference, letters for special occasions, brief letters including post session thoughts, therapist's requests for information, engaging persons who decide on non-attendance, recruiting an audience, and so forth.

This leads to the assumption that a therapeutic document can be described as a record of competencies rather than the description of problems and symptoms (McKenzie & Monk, 1997:113). It is also important that documents should only contain information that the client experiences as important (Morgan, 2000:85).

Another way of *teaming up* against the problem is through the contributions made by an outsider witness group. Team members can create a sense of 'linking' or 'joining' with the client through sharing ways in which the person's story *resonates* in their own lives (Payne, 2000:166). It is an attempt to decentre the therapist in the therapeutic process (White, 1997:101). This sharing should, however, not be so focussed on the team members that it becomes self-focussed or moralizing (Payne, 2000:166). Rather, as Michael White (1997:101) states, it is always "the responsibility of other group members to respond to this recounting and re-living in a way that re-centres the agenda, the concerns, and the lived experience of the person seeking consultation".

Yet another way of strengthening the alternative story through social connections is the re-membering of conversations. Morgan (2000:77) emphasises that re-membering conversations is not just a process of recalling, but one that invites the person to consciously think about people who he/she wants to be associated with their lives (Morgan, 2000:77). These conversations are a way of engaging others, through reflection, as witnesses to changes and achievements (Morgan, 2000:118; Payne, 2000:214). Re-membering conversations decentre the therapist as the client identifies persons in his/her life (both those alive and those who are no longer living) who will support and assist him or her through their relationships with the client (Payne, 2000:214).

Within every conversation, discourse[10] plays a significant role. Language constitutes reality and has far reaching effects across social interaction (Seu, 1998:203; Freedman & Combs, 1996:28). Language affects the way a person views the world, but also what the person sees in it (Freedman & Combs, 1998:28-29). That is why a therapist needs to be aware of the ideological functions and implications of language, as well as possible dangers of postmodernism in psychotherapy (Seu, 1998:203). Potter and Wetherell (1987) believe

[10] The term **discourse** is used to indicate "any utterance longer than a sentence" (Reber & Reber, 2001, s.v. 'discourse'). Freedman & Combs (1996, 42-43) refers to Rachel Hare-Mustin, who defined **discourse** as "a system of statements, practices, and institutional structures that share common values…The ways most people hold, talk about, and act on a common, shared viewpoint are part of and sustain the prevailing discourses."

language to be *an ideologically charged social activity*, since it legitimises or challenges, supports or ironises, endorses or subverts whatever is spoken about (Parker, 1997:290 in Seu, 1998:205). Through discourse people convey to each other that which is seen as normal and true (Seu, 1998:204). Harlene Anderson and Harry Goolishian (1988:378) explain that "language does not mirror nature; language creates the nature we know" (Freedman & Combs, 1996:29). A change in language is, therefore, necessary to bring about change in any area of life, for example change of belief, relationship, feeling, or self-concept (Freedman & Combs, 1996:29). With reference to the work of Jacques Derrida (1988), a philosopher, Freedman and Combs (1996:29) emphasise that language is continually changing, which implies that meaning is derived from "the word in relation to its context". This insight underlines the need for people within the narrative therapy frame of reference to negotiate the meaning of words.

Often it is useful to speak of a problem metaphorically, since it is possible to externalise metaphors in conversations (Morgan, 2000:21). The use of metaphorical description makes the choice of language even more important. As mentioned before, care should always be taken to privilege the person's description of the problem and its effects (White & Epston, 1990:48).

Alice Morgan (2000:4) attempts to summarize narrative therapy in practice when she describes it as "a respectful, non-blaming approach … which centres people as the experts in their own lives". Narrative therapy assumes that people have many skills, knowledges and competencies which make it possible for them to bring about preferred change in their own lives, once they realise that they have a separate existence from the problem (Morgan, 2000:4). There is no blue print for a narrative therapy session since there are many possible directions that conversations can take (Morgan, 2000:4). However, the emphasis should be on genuineness, a willingness to ask questions and respectful curiosity (Morgan, 2000:4). There is also a point during narrative therapy when the therapist should step back.

It is when people think, speak and act more often in different ways, and recognise some of the *purposes, values, beliefs* and *commitments* that support their alternative life stories that the therapist has less to contribute to the person's life (White, 1995:20). At this point, the steps the person has taken and the changes that have occurred should be celebrated to bring therapy to an end and to "discharge the therapist" (White, 1995:20). Phillips (1999:46) observes the challenge of narrative therapy as an attempt to "loosen the sense of inevitability that is carried by the narrative of one's past so that the chapters that extend into the future are more under the authorial control of the patient".

2.3.3 Invitations to responsibility

> *Far from despair, the idea that each of us recreates reality with each encounter fills me with wondrous hope, empowerment and community connection. If there is no absolute truth "out there" to create pristine "expert systems" that can somehow solve our problems mathematically … [i]f we accept that when we enter into dialogue we* ***both*** *change; if it is true that we* ***co-create*** *reality, which in turn creates us – then we are called to a new kind of community. If I can only ever be part of the creation I must act humbly. I'd take that over being a goddess …* (Maureen O'Hara,1995:155, in Freedman & Combs,1996:264).

Ethical codes are there to protect various partners in the therapeutic relationship (the client, the therapist and the professional body), but these codes also fall under the authority of the legal code of the country in which they operate (O'Brien & Houston, 2000:73). Narrative therapy, like other therapeutic approaches, must adhere to these ethical codes. One of the aspects that make narrative ways of working different from other approaches is the fact that relationships have two-way implications, since they foster "membership in new communities and new life stories for both therapists and the people who consult with them" (Freedman & Combs, 1996:265).

Narrative therapy is not unproblematic. It could appear to be an oversimplified therapy based on stories (Freedman & Combs, 1996:38). It is also true that in many contexts stories are often used to influence, deceive or mislead others (Roberts, 1999:21). It is therefore incumbent on narrative therapists to ensure that their practice is ethical so that the value of their work can be seen.

Many stories that are told in therapeutic conversations have a clear link with discourses in our wider social context (Freedman & Combs, 1996:38-39). Narrative therapy is not about the random telling of stories, but focuses in an ethical way on the stories that people tell themselves, and others and the stories by which they live, and its history in various contexts (Freedman & Combs, 1996:38-39). These stories are based on the client's own account, descriptions, knowledges, purposes, values, skills and competencies.

Ethical codes make an appeal to narrative therapists in the first place to work in respectful, non-blaming, responsible ways with people who consult their assistance (Morgan, 2002:2). Thus a practitioner of narrative therapy will treat people as the experts of their own lives. Payne (2000:45) emphasises that the problem-saturated story at least deserves respect and belief. Unfortunately respect of diversity is often seen as having political overtones (Amundson, 2001:182).

People's life stories often unfold and are told when the therapist asks purposeful, curious questions during narrative therapy conversations. Amundson (2001:178) cautions that the

utility of an idea can not determined in terms of the comfort or rhetoric nature of it. Thus the therapist continually needs to *generate experience* through questions asked rather than being focused on the gathering of information (Freedman & Combs, 1996:113).

Martin Payne (2000:68) remarks that the ethics of externalisation bothered him for a long time since externalisation of the problem could make it possible to influence a person without his/her knowledge. His way of overcoming this problem has been to insist that the narrative therapist should always negotiate naming of the problem in every therapeutic situation before externalisation. In that case the client is not forced to do anything so externalisation is transparent Payne (2000:68).

It also appears to be important for narrative therapists to clarify their understanding of the difference between effectiveness and efficacy in therapy (Amundson, 2001:180). "Facts about what works/does not" explains *efficacy* according to him, whereas "real world or contextual considerations" would explain *effectiveness* (Amundson, 2001:180). These two concepts seem to be important when considering the purpose of therapy. Amundson (2001:181) insists that the purpose of narrative therapy should be as co-created and collaborative as possible for every client, though utility should be privileged.

When asked what he would refer to as *limitations* of narrative therapy, Michael White identified only his personal limitations (White, 1995:38). A narrative approach to therapy necessitates personal reflection, reading and conversations with the persons who seek assistance, as well as with other therapists, to explore and develop/reduce personal limitations in a way that will benefit the work and clients (White, 1995:38). To me reflection on and awareness of my own beliefs, values, assumptions and affect seem an invaluable means of contributing to ethical practice.

I would like include a thought by McLeod (1997:138), which for me encapsulates narrative therapy:

> … a constructionist narrative therapy…entails a different stance toward therapy, a stance that foregrounds a sense of persons as social beings, living in and through a culture and its stories. This stance has implications for a number of domains of therapeutic endeavour: training, research, ethics and, ultimately, the very nature of psychotherapeutic helping.

Moving on from the discussion and deconstruction of narrative therapy and its implications on the therapeutic relationship, the next window will give a view of Eye Movement Desensitization and Reprocessing, referred to as EMDR.

2.4 DECONSTRUCTING EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

2.4.1 Tracing its history

Francine Shapiro (2001:315) attributes the birth of EMDR to a *chance observation* by herself in a park, during her psychology training in 1987 (Greenwald, 1998:279). As she was walking, "her eyes spontaneously moved rapidly from side to side" (Greenwald, 1998:279). Some upsetting thoughts she was having seemed to disappear (Shapiro, 2001:7). According to Shapiro (2001:7) the spontaneous, rapid movement of her eyes in an upward diagonal resulted in the previously disturbing thoughts becoming less valid and upsetting.

Consequently Shapiro's discovery led to the development of a standard procedure of EMD (Eye Movement Desensitization) in the same year (Shapiro, 2001:8). She was curious to see what the result of EMD would be under controlled conditions and whether it would succeed in alleviating people's problems that stemmed from traumatic memories (Shapiro, 2001:8). Initially EMD was presented as a single-session *cure* for people who suffered from post-traumatic stress disorder (PTSD) symptoms (Greenwald, 1998:280).

The continued refinement of the initial procedures, as well as Shapiro's evaluation of many more case studies (done by trained therapists), led to her decision in 1990 to change the name of the procedure from EMD to Eye Movement Desensitization and *Reprocessing* (Shapiro, 2001:13). The changed name (EMDR) emphasises a more integrative information processing paradigm (Shapiro, 2001:13). The use of EMDR is specifically intended to help persons to integrate *new desirable self-statements,* but simultaneously to create an opportunity to rapidly desensitize traumatic cues (Shapiro, 2001:26). Shapiro (2001:26) points out that cognitive reassessment or restructuring of memories is an important component of EMDR treatment. This includes "the elicitation of spontaneous insights, and an increase in self-efficacy, all which appeared to be by-products of the adaptive processing of disturbing memories" (Shapiro, 2001:16). The change of name, therefore, is not unrelated to investigations into the validity and efficacy of this approach since it originated (MacCluskie, 1998:116). Ricky Greenwald (1998:280) points out that although there has been great excitement, there have also been uncertainties and controversy about EMDR in many circles (psychologists, scientists, etc.). One of the main issues being that there seems to be little published information on the theoretical foundation of EMDR (Lohr, Tolin and Lilienfeld, 1998:147). There seems to be a need to clarify the underlying mechanisms of EMDR in order to explain how this approach really works (Greenwald, 1998:280).

According to Kathryn MacCluskie (1998:130) Shapiro made a statement in 1995 in which she observed that penicillin was used as a drug many years before scientists were able to

explain its curative mechanism. This explains her stance on EMDR. Although EMDR lacks a solid theoretical base, Shapiro (2001:16) defends her position by stating that therapists "need the most useful clinical heuristic we can provide". She seems confident that within the next decade more clarity about the underlying mechanisms of EMDR will be provided (Shapiro, 2001:16).

With the critique by Lohr *et al.* (1998) in mind, I found the summarised version provided by the EMDR Institute Database (2003) interesting. It emphasises that further research is necessary to prove the hypothesis that EMDR enhances information processing (EMDR Institute Database, 2003).

This Accelerated Information Processing (AIP) model was developed in an effort by Shapiro (1995) to describe and determine the possible effect of EMDR (EMDR Institute Database, 2003). The AIP model is based on her hypothesis relating to the inherent information processing system within every person which allows experiences to be processed in a way that learning takes place (EMDR Institute Database, 2003). It appears that when a person has experienced trauma or stress during the developmental period, the information processing system may become unbalanced (Shapiro, 2001:15).

In such a case EMDR has proved to be effective in activating and maintaining a dynamic state in the information processing system (Shapiro, 2001:15). This allows for change of information and proper resolution through the means of therapy. According to Shapiro (2001:316) the AIP model can be compared to a therapeutic road map that draws together physiological concepts of network activation as well as reorganising emotional information in a better way. However, (Shapiro, 2001:56) recommends that therapists remain flexible when using this model as a clinical road map.

Shapiro (2001:316) in her own words describes the process in terms of the AIP model as follows:

> This means that the stored memory of an event is brought to consciousness, relevant information needed to experience and remember it in a healthy manner becomes incorporated.

Although still little is understood about neurobiology, Shapiro (2001:15) points out that *desensitization, spontaneous insights, cognitive restructuring, and association to positive affects and resources* are not primarily part of the adaptive reprocessing, but may be seen as by-products.

Shapiro (2001:316) argues that the psychological foundations of all psychotherapies should only be considered relatively in the light of "the infancy of neurobiology". According to her the efficacy of the procedures carries much more weight than the present inability to understand

and therefore to explain the neurobiological mechanisms (Shapiro, 2001:316). She also mentions that salient features of most major psychological modalities have been integrated in this model (Shapiro, 2001:316). Various elements are combined in the structured EMDR protocols and contribute to the complexity of this approach (EMDR Institute Database, 2003). Shapiro (2001:317) also refers to some of the contributing therapeutic orientations which include psychodynamic therapy (free association), experiential and feminist therapies (client-centred approach) and behaviour therapy (standardized protocols that focus on present stimuli and conditioned responses). These contributions are valued within this integrative form rather than in isolation, since people respond in different ways to different elements of EMDR (EMDR Institute Database, 2003).

Thus EMDR in itself seems to embrace an integrative approach to psychotherapy. And it has shown that it can deliver positive outcomes in psychotherapy and trauma treatment of people from a variety of populations (Shapiro, 2001:11).

2.4.2 Skills and knowledges of EMDR

I think that it would be helpful to examine the eight phases that make up EMDR first. Each phase is described as an essential part of EMDR treatment (Shapiro, 2001:69). The eight phases are utilised independently of the number of EMDR sessions and included phases in different sessions will vary from one client to another (Shapiro, 2001:69).

In Figure 2.3, the eight phases of EMDR are presented in the form of a diagram. These eight phases are deconstructed below the figure.

Figure 2.3: The eight phases of EMDR

Phase 1: Client History and Treatment Planning

Shapiro (2001:91) cautions that EMDR is not suitable for all clients. Thus, information about a person's present functioning (*personal stability*) and circumstances is important when deciding whether EMDR would be the most effective means to assist a person with his/her presenting problem (Shapiro, 2001:70). It seems necessary to ensure that the client will be able "to deal with the high levels of disturbance potentially precipitated by the processing of dysfunctional information" (Shapiro 2001:70). In this regard, aspects that are important about the person's history and need to be evaluated include possible physical factors (such as age, or pre-existing heart or breathing problems) and dysfunctional behaviours, symptoms and characteristics (Shapiro, 2001:70; 93-104). If EMDR is found to be suitable for the

specific needs of the client, the therapist sets up a treatment plan and determines which specific targets will be reprocessed (Shapiro, 2001:70).

Phase 2: Preparation

During the second phase of EMDR the therapeutic relationship is emphasized (Shapiro, 2001:71). A relationship of trust, honesty, common goals and a therapeutic alliance must be established as a means of ensuring greater therapeutic effectiveness (Shapiro, 2001:122). Time is spent to explain the process and possible effects of EMDR (Shapiro, 2001:71). This is also an opportunity for the client to talk about any concerns or questions about the process with the therapist (Shapiro, 2001:71). At this point relaxation techniques as well as safety procedures are initiated so that the client can utilize them should high levels of disturbing material emerge during the session (Shapiro, 2001:71).

In many ways client expectations are shaped by their understanding of the theory and procedure of EMDR (Shapiro, 2001:129). Shapiro (2001:71) states that any concerns about secondary gain issues must be addressed before trauma reprocessing begins, since these issues will have a detrimental effect on the therapeutic process and outcomes. In Phase Two the exploration of metaphors is also seen as important by Shapiro (2001:71) since they may contribute to the successful reprocessing of traumatic memories. It is also a good idea to assess whether the client is comfortable with eye movements and to establish a stop signal that the client may use at any time (Shapiro, 2001:124).

Phase 3: Assessment

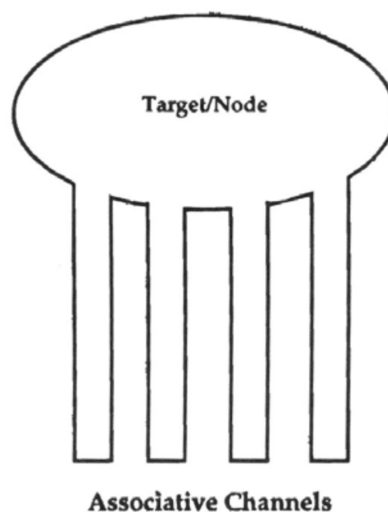
Now the focus moves closer to the identified target memory (an upsetting or traumatic memory) and the components that it is made up of (Shapiro, 2001:72; 132-133). A baseline response needs to be established right at the start of this phase. This *baseline response* is obtained when the person is asked to explain to the therapist what happens or what image he/she gets when thinking of the incident. However, clients should be told and assured that they need reveal only what they desire to the therapist, since the processing of traumatic information is more important than explanations of every detail. With the memory identified, the person will be asked to think of an image that represents the incident or a traumatic part of it. The next step will be to identify a negative cognition about the self (a negative self-belief or self-statement) that is related to the traumatic memory. Then the person also needs to identify a positive cognition about the desired self and rate the validity of this positive cognition on a 7-point Validity of Cognition (VOC) Scale (Shapiro, 2001:136-139). The emotion(s) experienced when the person thinks about the image and negative cognition related to the disturbing memory need(s) to be identified as it/they will shift and change during processing. At this stage the level of emotional disturbance will be measured on a 10-

point Subjective Units of Disturbance (SUD) Scale and the client will be asked to indicate any physical (body) sensations that are experienced (Shapiro, 2001:72; 139). Now the baseline measures should be clear.

Phase 4: Desensitization

The previous phases should have prepared the client for the accelerated reprocessing (Shapiro, 2001:144-150). Now, during the fourth phase, the client's negative effect can be addressed (Shapiro, 2001:72). This implies that the focus is on reducing the person's level of disturbance to 0 or 1 on the SUD Scale. Thus, to desensitise disturbing material, all the dysfunctional information that is stored in different channels of association with the target event needs to be processed. I include the figure below to demonstrate in a very basic way how processing of information in all the channels connected to the traumatic target memory, is necessary for desensitisation:

Figure 2.4: Channels connected to the traumatic target memory



(Shapiro, 2001:151, figure 9)

All responses from the client in between sets of eye movements or any other form of appropriate external stimuli are included in this phase. Sets of eye movements (or other stimulus) are repeated by the therapist until the client reports a minimized level of disturbance or emotional distress, indicating 0 or 1 on the SUD Scale. This desensitisation phase is considered as only one part of the reprocessing, since other dimensions of reprocessing is continued in the following phases (Shapiro, 2001:72).

Stage 5: Installation

Once the measure on the SUD Scale is down to 0, the positive cognition that the client identified earlier on (Phase Two) can be installed. The process of installation means that the

original negative cognition is replaced by positive cognition (Shapiro, 2001:73). This indicates a sense of positive self-assessment with regard to the target memory and is evidence of positive integration (Shapiro, 2001:160-161). Sets of eye movements (or other relevant external stimuli) are made while the client simultaneously focuses internally on the relevant positive cognition and the target memory. When sets of an external stimulus are given, clients usually experience how positive images, thoughts and emotions become stronger, more true and vivid as the opposite appears to happen to the original negative cognitions. These sets are continued until the person feels more confident and certain about the positive cognition, and is able to report the VOC measure on a level 7 (Shapiro, 2001:73). Shapiro (2001:161) indicates that a rise of the VOC level might be prevented by blocking belief, which will have to be reprocessed as a new target memory.

The installation phase is viewed as one of the most important facets of EMDR treatment since it emphasises the strengths of the person according to his/her own positive self-assessment (Shapiro, 2001:74). The treatment process can move on to the next phase when a level 7 on the VOC Scale is maintained after a few additional sets.

Phase 6: Body Scan

Following the full installation of the positive cognition, Phase Six will give an indication of any remaining unprocessed information associated with the target memory (Shapiro, 2001:74-75). In this phase the client mentally scans his/her body while focussing on the target memory and positive cognition in his/her mind. If any unusual or residual physical sensation is mentioned, this should be targeted with more sets of eye movements (or other relevant external stimuli) (Shapiro, 2001:162).

The body scan phase of EMDR treatment may point out important areas of further tension or remaining unprocessed information, sometimes due to resistance (Shapiro, 2001:163, 75).

Phase 7: Closure

Time planning of every EMDR session seems vital to ensure there is enough time to close each session properly (Shapiro, 2001:75, 164). Closure will ensure that the client leaves the session in a secure, safe and stable condition, whether or not reprocessing is complete. Consequently guided visualization or other relaxation techniques are useful tools which clients can also utilize at home when necessary. However, keeping a journal or log of any disturbing or negative thoughts, dreams, memories or situations that occur during the following week will help the client to gain cognitive distance from them. These incidents can then be discussed and targeted in a follow-up session. Often clients also experience new insights during the week between sessions which are worth writing down and sharing (Shapiro, 2001:166-167).

Phase 8: Re-evaluation

Strange as it may seem, the last phase mentioned here should actually be implemented right at the beginning of each EMDR session (Shapiro, 2001:75-76). Re-evaluation allows the client to share anything from her journal or log book with the therapist and to re-access previously processed targets to assess treatment effects. If there appear to be new or still unresolved target memories, these need to be addressed.

Since EMDR therapy is most useful for people who suffer from memories of a traumatic experience, the contexts for treatment might differ according to circumstances. According to Greenwald (1998:283) these range "from single-session treatment following a disaster or critical incident, to frequent or occasional use in the context of long-term treatment with a chronic trauma victim". Not only do the contexts differ, but individual differences are also varied and influence each session uniquely (Greenwald, 1998:283).

Apart from all these differences, therapists often find that people have difficulty in talking about a traumatizing or abusive incident (Roberts, 1999:19). This appears to stem from fears of what others would think of them or how they would react towards them if it were to be revealed. Though a person might seek help from a therapist, it cannot be assumed that the person will be willing to change (O'Brien & Houston, 2000:107). Intrapsychic processes like open-mindedness or defensiveness are evident of a person's willingness to receive therapeutic assistance with whatever troubles him/her. These are realities that an EMDR therapist often has to face.

Shapiro (2001:260) also mentions that survivors of trauma frequently carry feelings of guilt about and a sense of responsibility for abuse. Consequently they find it very difficult to understand boundaries in relationships with others.

Thus, it is important to keep in mind the early life experiences of trauma that have been stored at the time of the incident, have often not been sufficiently processed at that point. Shapiro (2001:17) attributes a person's present emotional and behavioural reaction which are consistent with these earlier disturbing event(s), to the negative affect and beliefs that are associated with these memories of trauma. It appears that these inappropriate emotional and behavioural reactions are due to inadequate assimilation of information at the time of the traumatic incident (Shapiro, 2001:17).

Considering these realities, EMDR should be used along with other therapeutic approaches in a discerning way (Greenwald, 1998:285). Since elements of different psychotherapies are integrated within EMDR with the intention of treating the client as a whole person (Shapiro, 2001:45), the development of an overall treatment plan for every client by the EMDR trained therapist is crucial (Greenwald, 1998:285). According to Shapiro (2001:53) all psychological

modalities agree "that information is stored physiologically in the brain". This seems to be a definite common factor, which implies that major components of most psychological approaches are represented when healing occurs.

Thus, when a client is assisted during EMDR treatment, the intention is to enable insufficiently processed material to become fully integrated into a more adaptive perspective. This changed perspective will contribute to the person's reacting in more appropriate and empowered ways (Shapiro, 2001:251).

When eye movements were initially used in EMDR, Shapiro (2001:8) observed that most people found it difficult to keep moving their eyes for any length of time since their eye muscle control was not that well developed. Therefore she started moving her fingers back and forth while the client had to follow them with his/her eyes.

Although, from the start, eye movements were considered to be an important element of EMDR (as the term indicates), it is now recognised as only one of many external stimuli that can be utilised as *dual attention stimuli* during EMDR treatment (EMDR Institute Database, 2003). A preferred external stimulus, for example eye movements, hand-tapping or auditory stimulation, is used to focus a client's attention externally. Simultaneously the person is expected to focus on internal distressing material (EMDR Institute Database, 2003). Thus the client's information processing system is activated by dual attention stimuli (Shapiro, 2001:xiv).

Frank Corrigan (2002:8) refers to this ability to focus one's mind as *mindfulness*. He describes mindfulness as "the ability to observe and describe mental states during the experience of them with the ability to choose to apply the focus of consciousness away from the feelings". Consequently, Corrigan (2002:14) hypothesises that the activation of the *anterior cingulate cortex* during EMDR results in the transfer of memories from *emotional paralimbic systems* to *episodic memory systems*. In that case, the efficacy of EMDR is mediated through bilateral stimulation. Appleyard (2001:512) explains in less complex terms that altering stimulation contributes to enhanced information processing between the right hemisphere (associated with emotions and nonverbal information) and left hemisphere (associated with language and meaning of experiences). Thus it appears that traumatic memories can be reprocessed effectively when bilateral stimuli activate this process (Corrigan, 2002:14).

During the reprocessing of traumatic memories, the person might experience an abreaction. Thus, every therapist who is trained and makes use of EMDR during therapy sessions, needs to be knowledgeable about abreactions. Shapiro (2001:172) describes her understanding of abreactions as follows, "… the re-experiencing of stimulated material at a

high level of disturbance". She cautions that it could occur during the integrative processing of emotional and cognitive material at any time, with any target (Shapiro, 2001:172). It is emphasised that an abreaction should never be forced on the client or suppressed by the therapist (Shapiro, 2001:172). If an abreaction appears, it should be accepted as part of the person's processing of dysfunctional information (Shapiro, 2001:172).

2.4.3 Invitations to responsibility

As with narrative therapy, and for that matter any psychotherapy, ethical implications of EMDR need to be considered. Shapiro (2001:xii) seems to be very aware of the possible implications and consequences with regard to the use of EMDR, and research and training in EMDR.

In a short article by Melissa DeMeo (1996), mention is made of limited research studies that question the efficacy of EMDR. As I understand it, the EMDR Institute is not blind to this issue, and they themselves frequently suggest elements or areas for further research and development (EMDR Institute Database, 2003).

On the other hand, though, I found quite a few research articles on EMDR as a therapeutic approach in psychology. Carlson, Chemtob, Rusnak, Hedlund and Muraoka (1998:4) refer to EMDR treatment of chronic combat-related PTSD[11] and the differing results obtained when compared to controlled studies, with regard to positive effects (Shapiro, 1989), mixed effects (Boudewyns *et al.*, 1993; Pitman *et al.*, 1993) and negative effects (Jensen, 1994). Carlson *et al.* (1998:4) point out that EMDR does, however, have strong support for treating traumatic memories ("although not for combat-related PTSD") according to research by Wilson, Becker and Tinker (1995).

Other researchers (Devilly, Spence & Rapee, 1998:436) have highlighted the apparent *methodological flaws* in research by Shapiro (1989). According to them, Acierno, Hersen, Van Hasselt, Tremont and Meuser (1994) found some shortcomings such as "a small sample size, lack of diagnostic clarity, lack of standardized measures, an inadequate control condition and therapist demand effects".

In another part of the article, Devilly *et al.* (1998:449-451) reflect on their own research findings on the efficacy of EMDR treatment. A sample of war veterans who showed symptoms of PTSD took part in the study. The researchers concluded that eye movements (or any other from of external stimuli) do not have a primary influence on the processing of traumatic information. Yet another conclusion drawn was that improvements in the war

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[11] PTSD is a commonly used abbreviation for *post traumatic stress disorder*.

veterans who formed part of the study as compared to the control groups were not statistically significant.

In response, Shapiro (2001:xii) argues that further research is necessary and valued in the EMDR context. However, Shapiro (2001:xv) also mentions that EMDR has already been established as "a standard and effective treatment of psychological trauma" by the International Society of Traumatic Stress Studies (who have evaluated controlled research done by independent task forces).

Though continued further research is still imperative to ensure the client's best interest, it cannot be gainsaid that therapists need to have a life-long commitment to learn and develop more skills to enable them to serve clients in the best way possible. In this regard, adequate training is very important if a therapist wants to make use of specific methods or techniques (Shapiro, 2001:xii).

It is also vital to get the client's informed consent for EMDR treatment (MacCluskie, 1998:132). According to Welfel (1998) informed consent indicates that the therapist has provided the person with treatment options to address the presenting problem (MacCluskie, 1998:132). Reber and Reber (2001:352) give a more comprehensive explanation of the term *informed consent*:

> Permission given by a participant to carry out a research or medical procedure when the consenting individual is provided with complete information about the procedure including:
>
> (a) the nature of the procedure;
>
> (b) the potential known risks and benefit;
>
> (c) any alternative procedures that are available; and
>
> (d) acknowledgement that such consent is voluntary.

The above definition and its implications for EMDR are implicit in Shapiro (2001:71), which points out that during the preparation phase the client needs to be informed about emotional disturbance which might be experienced during or after EMDR sessions. MacCluskie (1998:132) agrees that the client has a right to know about the experimental and controversial nature of this treatment, which obviously includes a discussion of the advantages and disadvantages of EMDR. Another aspect of informed consent implies that alternative treatments should be suggested if it appears that the person is not benefiting from the attempted therapy (MacCluskie, 1998:132). The necessity for informed consent is even greater in the case of legal proceedings (Shapiro, 2001:99).

Another ethical consideration, as well as an invitation to the therapist to be responsible, is the need to recognise and treat each client as an individual (Shapiro, 2001:88). The fact that each person is unique and different implies that people's needs would vary continuously (Shapiro, 2001:88). According to Shapiro (2001:88), "The effectiveness of EMDR depends as much on the quality of the journey as on the designated destination".

Therefore, when the client has an abreaction during an EMDR session, it remains the therapist's first priority to ensure the client's safety (Shapiro, 2001:173). However, unconditional regard and support for every client by the therapist should be evident at all times (Shapiro, 2001:173).

Invitations to be responsible during EMDR treatment are in some way also directed at the clients. Shapiro (2001:276) notices that clients are empowered when therapists allow and encourage clients to come up with their own answers, rather than provide answers. During the process of EMDR it is assumed that the client would "progress as far as possible on their own" (Shapiro, 2001:276).

2.5 DECONSTRUCTING OTHER KEY CONCEPTS

For the purpose of this study, I believe it is necessary to deconstruct specific concepts that influenced the research journey. In this way I attempt to explore the understandings of these concepts as presented in the literature.

2.5.1 A postmodern / post-structuralist perspective

Although there was some evidence of it beforehand, postmodernism only really came to existence in the 1970s according to Payne (2000:22f), questioning modernism, its predecessor, with "a spirit of dissatisfaction, disbelief and challenge …". In a postmodern context, therapy needs to be deconstructed, thus removing the therapist from a privileged position of scientific knowledge, power and certainty (McLeod, 1997:23). When this happens, McLeod (1997:23) states that the telling of personal stories by the client, which is at the heart of therapy, will become central.

Freedman and Combs (1996:28) contend that postmodernists claim that people's language *constitutes* their realities (their worlds and beliefs). Language does not exist by itself, but comes into being through the interactive sharing of information as people view their realities, especially within their communities. Modernists, however, use language to connect objective (real) and subjective (mental) worlds. This implies that the language used to describe external reality is seen as giving an accurate reflection of internal representations (Freedman & Combs, 1996:28).

The main themes associated with traditional, modern and postmodern cultures are illustrated in the table below:

Figure 2.5: Traditional, modern and postmodern therapy approaches

Traditional	Modern	Postmodern
• Collective, family-oriented way of life	• Individualistic	• **Awareness of 'relational' self**
• Self defined in terms of external factors: importance of 'honour'	• Autonomous, bounded self: importance of 'dignity'	• **Fragmented, 'saturated' self**
• Belief in religion	• Belief in science	• **Belief that knowledge is socially constructed**
• Moral certainty	• Moral relativism	• **Search for moral frameworks**
• Static society	• Commitment to 'progress'	• **Fear of anarchy and chaos**
• Localised forms of political control	• Nation state	• **'Global village'**
• Agricultural work	• Industrial work	• **Information processing work**

(McLeod, 1997:3)

Thus the differences between these three worlds are recognised on many different levels (McLeod, 1997:4). These changes, according to McLeod (1997:4), occur at the level of social organisations, institutions and ways of communication. But also at the level of the individual person the sense of *what it is to be a person* is shaped through relationships, belief and affinity frames of reference, and the economic system in which you find yourself from birth.

A question that arose for me was why therapists need to know about these philosophical debates and changes. McLeod (1997:4) sheds some light on this in his statement that therapy is influenced by, but has also made a contribution to and had an influence on the changes from traditional to modern, and consequently to postmodern perspectives. Paolo Bertrando (2000) also cautions postmodern therapists not to lose sight of the positive contributions and characteristics of modernist theories and practices.

In explaining some of the implications of a postmodern perspective, Payne (2000:20) suggests that people live their lives through the stories or narratives they tell. A person's concepts and beliefs are shaped through these stories, and influence the way the person understands his/her life and world.

Bertrando (2000) has a different point of view of postmodernism and the use of narratives in therapy. He argues that stories are present in the individual's consciousness. Thus *the*

stories people tell exclude the unconscious foundations that contribute to their understanding of the world and their behaviour in the world (Bertrando, 2000).

Post-structuralism is usually mentioned in discussions of postmodernism. It appears to be an important aspect of postmodernism (Payne, 2000:32). According to Payne (2000:32) the use of language and its outcomes should be re-evaluated from a post-structuralism point of view. White (1997:224) refers to Foucault (1984) who said that post-structuralist enquiry reveals practices (even in the name of psychological liberation) of the dominant culture and question these. Thus post-structuralist enquiry contributes to the deconstruction of perceptions – systems of interpretation and understanding (White, 1997:224).

In a summary of post-structuralism, Payne (2000:222) expresses his empathy with many therapists who experience levels of discomfort. He mentions that post-structuralism will challenge "dominant humanist assumptions, underlying traditional therapies, of the 'will to truth', the 'repressive hypothesis' and the 'emancipation narrative'" (Payne, 2000:222).

As therapists, working from a post-structuralist perspective, assist people in re-examining their lives, 'richer' and 'thicker' descriptions of their lives and relationships can develop when the focus of therapy is on their own knowledge and experience. In this way 'truths' are not only accessible to people in positions of power or 'experts' (Payne, 2000:34).

However, Seu (1998:216) is convinced that a post-structuralist deconstruction is not an adequate psychotherapy tool, although it is necessary to make people aware of many different narratives of their lives. The problem with a post-structuralist deconstruction appears to be that the therapist still needs to decide which narrative will suffice (Seu, 1998:216).

When one considers a postmodern perspective, with post-structuralism as one of its aspects, the position and responsibilities of the therapist come into question. Bertrando (2000) argues that not everyone can be a postmodern therapist since it requires adopting a particular position. He rather describes postmodernism as, "… an inevitable consequence of our existing in the present conditions of living".

As a result, the postmodern therapist needs to re-examine his/her own position frequently. Seu (1998:216) reminds therapists to be constantly aware of our own prejudices and ideology, as we stand with our clients against their problems. She is convinced that the therapist can never take a neutral position since the positions of the client and therapist is continuously negotiated throughout therapy (Seu, 1998:216).

From a post-structuralism point of view, therapy is characterized by decentring by the therapist, which should be an ethical commitment (Payne, 2000:222). Since postmodern

therapists appears to invite a re-examination of power relations and the expertise associated with power, there tends to be a greater focus on moral and political ideology than on a clinical perspective, according to Amundson (2001:181). Though, Payne (2000:222) remarks that a decentred therapist position is one that limits the therapist's position of power during therapy, and contributes to transparency and a more open, honest therapeutic relationship.

Both Bertrando (2000) and Seu (1998:215) also raise some concerns about a postmodern stance. According to Bertrando (2000) the postmodernist cannot prescribe a postmodern perspective, since that would imply theoretical prejudice while postmodernism question general theories. In reference to Habernas (1987a, 1987b), Seu (1998:215) makes the following statement, which gives pause for reflection:

> To me the fundamental choice is whether we think there is a complete absence of basic reality, replaced by a never-ending stream of equally valid constructions of reality, or whether we want to hang on to a basic belief in the existence and importance of a core self, a core reality, without neglecting the fact that the various readings and accounts of it are always culturally and historically constructed.

2.5.2 Social constructionism

Based on René Descartes' work *The Discourse on Method*, the assumption is made by Kenneth Gergen (1999:221) that it takes social coordination to create meaningful language. People need each other to create meaning, but Gergen (1999:221) observes that through this meaning making process, alternatives are thus potentially eliminated. This interaction between people is emphasised by social constructionism, since social and cultural influences and norms form an integral part of social constructionism (Payne, 2000:34). To the social constructionist, meaning is frequently and continuously negotiated, thus social relationships determine reality (Gergen, 1999:236-237).

In psychology, social constructionism emphasises social and cultural influences on behaviour, rather than "theories of assumed 'inner' damage or pathology" (Payne, 2000:35). According to Payne (2000:35) social constructionists propose that acceptable norms by our culture and other people determine or 'construct' a person's view of reality. As a further result, social constuctionist psychologists argue that "the concept of a single definable core 'self' " should be questioned since it is a "Western 'humanist' social construct" (Payne, 2000:36).

Since societal norms appear to have such a powerful effect on a person's perception of reality, a constructionist position will also question values and personal ethics (White, 1995:14). However, Gergen (1999:233) warns against the perception that constructionism opposes values. He argues that strong commitments tend to blind people to alternatives

possibilities and make then deaf to alternative voices. Rather, constuctionism invites people to be aware and to experience a spectrum of possible relationships with others (Gergen, 1999:235).

2.5.3 Traumatic experiences as a child

> *The child trapped in an abusive environment is faced with formidable tasks of adaptation. She must find a way to preserve a sense of trust in people who are untrustworthy, safety in a situation that is unsafe, control in a situation that is terrifyingly unpredictable, power in a situation of helplessness.* (Herman, 1992:98 in Mash & Wolfe, 2002:386)

As a child, my client Sonja, experienced many situations at home that had a traumatic impact on her life. A traumatic experience can be described as *sudden*, *horrifying* and *unexpected* (Lewis, 1999:6). When a child experiences a situation as intense and frightening, a feeling of helplessness and an inability to cope may overwhelm the child (Lewis, 1999:6). This indicates that a traumatic event will not be familiar and consistent with a child's normal experience, according to Lewis (1999:6). One, unexpected event or many incidents over a period of time may cause trauma (Lewis, 1999:8).

However, the same stressful event in a family does not have the same effect on every child involved (Lewis, 1999:6; Mash & Wolfe, 2002:380). Since children will respond in different and unique ways to traumatic experiences (such as abuse, neglect, and family violence), it is impossible to try to make predictions that characterise the likely effects of trauma. Consequently, children who are frequently exposed to outbursts of anger and aggression in their family, experience a continuous challenge to adapt successfully (Mash & Wolfe, 2002:380).

These necessary adaptations a child should make appear to be influenced in many ways, according to Masten *et al.* (1999), on the child's "makeup" and available support (Mash & Wolfe, 2002:380). This apparent 'ability' of some children to experience success in the face of difficult circumstances and traumas is referred to as resilience by Lewis (1999:10). These children who seem to cope are also sometimes referred to as "survivors of adversity" (Hughes, Graham-Bermann & Gruber, 2001:68). However, a child's resilience does not guarantee that 'all is well' because some children might show deficits or psychopathology symptoms only much later (Hughes *et al.*, 2001:68).

According to Hughes *et al.* (2001:84) support through strong bonds with other systems than the family promote resilience in a child. Lewis (1999:12) also considers that "a close, loving relationship with a supportive, available caregiver" leads to resilience. Support and care from any adult, especially if a child's parents are unable to cope with the situation, will make the child less vulnerable to trauma (Lewis, 2001:12). Schools can be positive and empowering

organisations that play an invaluable role in promoting resilience through effective management and opportunities for children to also develop emotionally and behaviourally (Hughes, 2001:84; Lewis, 1999:12).

Mash and Wolfe (2002:391) found that experiences of trauma disrupt and damage many significant memories and experiences from childhood. Though, later in life the effects of the trauma might turn into a chronic emotional experience of pain (Mash & Wolfe, 2002:391). In an attempt not to think about or deal with unpleasant memories and current stressors, some teens and adults turn to substance abuse for temporary relief (Mash & Wolfe, 20002:391).

I find it both incomprehensible and fascinating that children often do not perceive their parents as abusive when they shout or scream at, hit, or mortify them (Mash and Wolfe, 2002:388). Instead, there appears to be a strong emotional bond of loyalty according to Wekerle and Wolfe (1996), which is based on those times when the parent is perceived as a source of connection, knowledge and love by the child (Mash & Wolfe, 2002:388).

However, if a child were to be frequently exposed to rejection and inconsistent parenting, there would be a strong likelihood that the child's representation of the parent would take the form of an unavailable and dangerous person (O'Brien & Houston, 2000:50). O'Brien and Houston (2000:50) point out that the quality of attachment between a parent and child is usually determined by various factors such as the age of the child and how the parent perceives the child's individual characteristics. It seems to me that if a parent and child have relative strong ties, then a person might only realize the nature and effects of childhood trauma for the first time as an adult.

Experiences of trauma during childhood could have effects that are carried into adulthood by an individual. Rossman (2001:35) defines this long-term impact of exposure as "impact that could be in the areas of an individual's cognitive, social, emotional, or behavioural functioning and is assessed when time has passed". As such, a person who experiences rejection or inconsistent parenting might believe that during childhood that he/she was unworthy of the parent's attention (O'Brien & Houston, 2000:52). Early exposure might also hold a child back from developing necessary social and behavioural skills which are important in adulthood. If a child who experienced trauma responds in a defensive or avoidant manner to any reminders of the trauma it will prevent the person from developing key skills such as social comparison skills, empathy and perspective taking (Rossman, 2001:49). Rosmann (2001:53) also values the findings of Wolfe, Wekerle, Reitzel-Jaffe and Lefebvre (1998), who found that people who were exposed to physical abuse or adult domestic violence showed significant signs of interpersonal wariness and hostility, but that they were also inclined to perceive others with a negative attitude.

During therapy with survivors of abuse it is important to appreciate, acknowledge and respect the needs and wishes of the client, since these have been ignored during childhood (Walker, 1998:70). It is assumed by most therapists that childhood experiences have a direct relation to how a person presently perceives him/herself in relation to others (O'Brien & Houston, 2000:103).

2.6 REFLECTION

In consulting various sources of literature, I was able to deconstruct the meaning of an integrative approach to therapy, as well as an understanding of narrative therapy and EMDR. This alternative story embraced an integration of narrative therapy and EMDR as an empowering alternative to therapy in re-authoring traumatic experiences form childhood.

I view this therapeutic integration based on knowledges from both schools of therapy as empowering. Within a postmodern, post-structuralist framework, integration could open up new possibilities to therapeutic intervention.

In the following chapter there will be a focus on the practical aspects of this research journey on therapeutic integration of narrative therapy and EMDR in my work with Sonja.

CHAPTER THREE

GETTING THERE

3.1 INTRODUCTION

I prefer to use the metaphor of a journey (as mentioned in Chapter One) to describe the implementation of this study. The sections of this chapter will serve as guidance on the route of this research journey.

The therapy journey started off in May 2003 and continued for six consecutive months. In our weekly therapy sessions during this time, Sonja shared many reflections and experiences from her life.

3.2 MAPPING THE JOURNEY FOR RESEARCH

3.2.1 Purpose of the journey

One of my first priorities during this study was to determine what I wanted to explore during the research journey. I realised that Sonja's tellings and her descriptions of experiences during therapy in many ways would be a reflection of the integrative therapy process. Since I believe it to be my responsibility to treat clients in ethically fair ways, focussing on her experiences was of great importance. This ethical commitment motivated me to continuously ask curious questions focussed on: *What were the client's (Sonja's) experiences during the process if integrating narrative therapy and EMDR?*

In keeping with narrative therapy and EMDR, our therapeutic conversations were an exploration and deconstruction of Sonja's life experiences. These rich descriptions of her experiences contributed to our exploration of an alternative, preferred story of her life. Sonja's experiences guided the process of integrating narrative therapy and EMDR, and were also evident of change, growth and development. The research journey opened up opportunities to reflect on her interaction during therapy and the influence her participation had on the therapy process.

Sonja and I were not the only persons interacting about her life and experiences during the therapy journey. The reflecting team contributed a different perspective on Sonja's experiences through their participation. I assumed that documenting all the experiences and changes that Sonja spoke about would enrich her alternative story and my personal reflections on the integrative therapy journey.

3.2.2 Position within the research paradigm

In Chapter One I mentioned that this study was based on my personal commitment to be an investigative, critical, reflective and responsible practitioner. A remark by Darlington and Scott (2002:18) reflects my motivation: "For some qualitative researchers the question they explore grows out of a strong ideological commitment and the pursuit of social justice".

The professional codes for psychologists emphasise the responsibility of psychotherapists to treat clients in respectful, empowering and ethical ways (Allen, 2001:4). Bound by and committed to these codes, I viewed continuous reflection an inevitable part of the research process. My personal values and an awareness of my responsibility in the client-therapist relationship also determined how I positioned myself during our therapy conversations on the journey.

From a postmodern perspective, I could not take a position of power, certainty or scientific knowledge in this qualitative study. Rather, my focus was on describing instead of evaluating the therapy process and my personal reflections. According to Payne (2000:32), post-structuralist enquiry, an aspect of the postmodern paradigm, contributes to the deconstruction of perceptions. These perceptions can be described as systems of interpretation and understanding (White, 1997:224).

Considering interpretation and understanding, I found it helpful to view knowledge about Sonja's experiences as contextual and local, in line with most qualitative researchers (McLeod, 2003:71). This emphasises the fundamental goal of qualitative investigation: "… to uncover and illuminate what things mean to people" (McLeod, 2003:73). According to Babbie and Mouton (2002:270), detailed descriptions of the actions of participants are the primary focus of the researcher, which necessitates effective methods for gathering data.

Important research methods include therapy conversations with and observations made of a client during these conversations, since only then would the researcher be able to construct meaning from experiences (Darlington & Scott, 2002:3). Merriam (1998:6) seems to have a similar view on meaning that is related to experience, but she also notes that perceptions of the researcher mediate meaning.

My research may be described as a qualitative single-case study with elements of a post-modern paradigm.

Babbie and Mouton (2001:640) define a case study as follows:

> A case study is an intensive investigation of a single unit. This unit can vary: from individual people, families, communities and social groups, organisations and institutions, events and countries.

In his description of a case study, Lindegger (1999:255) states that it can be a source of rich, longitudinal information that is usually descriptive about the person or specific situations. Merriam (2002:178-179) provides more detail:

> Qualitative case studies share with other forms of qualitative research the search for meaning and understanding, the researcher as the primary instrument of data collection and analysis, an inductive investigative strategy, and the end product being richly descriptive.

Case studies open up possibilities of considering different and new perspectives (or *ideas* and *hypothesis*) as these might develop from "careful and detailed observation" (Lindegger, 1999:255). In considering different and new knowledges or perspectives on a case study journey, there is an exploration of multiple variables with a significant focus on the client's interaction with her context. This contributes to a more thickly described understanding of the person's perspectives and behaviour and "the influences of multilevel social systems" on her life and experiences (Babbie & Mouton, 2001:281). McLeod (2003:99) refers to the unpredictability of case studies when he states, "the researcher may not have, and may not wish to have, any control over the behaviour of the 'subject' of the study, or little control over the amount or type of data being collected."

The way the researcher positions herself strongly influences the research process. By giving rich and colourful descriptions of the case study, the researcher attempts to investigate new possibilities based on what was learned during the case study. The reader is then in a position to decide what knowledges from the case study will be useful in his/her own context (Merriam, 2002:179).

These knowledges about case studies in general contributed to my construction of this case study of my therapy work with an individual person. The case study I undertook provided an opportunity for thorough reflection on shared experiences, constructed knowledges and observations during the therapy journey. Rich, thick descriptions lead to an understanding of the person's experiences and the therapy process.

3.3 GATHERING KNOWLEDGES

The main means of gathering knowledges was Sonja's experiences during the integrative therapy process. Sonja had weekly therapy appointments with me at the Unit for Educational Psychology (Stellenbosch University). In a consent form she voluntarily gave her permission for her experiences and story to be shared with other people and used if they would contribute to different ways of understanding and doing therapy. After our last therapy conversation she gave permission to me to share our work with other professionals.

For the purpose of this research journey, regular therapy contact sessions served as a basis for gathering knowledges. There appear to be multiple ways of gathering knowledges in a case study. Different ways of gathering knowledges based on the research question are described and recommended by Babbie and Mouton (2002:282). These involve a variety of different conversation and observation situations, gathering knowledges from various informants (participants).

One of the many ways of gathering knowledges involves careful and thorough observation. During a case study these observations lead to the emergence of new ideas and hypotheses (Lindegger, 1999:255). I took note of any physical reactions that Sonja showed during therapy conversations and would ask about its meaning for her. I also asked her to tell me more about the meaning of symbols that she used during conversations and other activities (making of clay objects or drawings).

Qualitative ways of gathering information also involved weekly therapy conversations that Sonja and I had. My first priority during the therapy process was to establish rapport and trust from the first session onwards. Darlington and Scott (2002:2) point out that trust and rapport are crucial elements of in-depth conversations during qualitative research. These therapy conversations implied that the researcher had to guide the conversation in a general direction by asking relevant questions, in no specific set or order (Babbi & Mouton, 2002:289). Narrative enquiry into aspects of the problem-saturated story that Sonja told was made possible through curious questions. This developed as an exploration and deconstruction of the problem-saturated story, which would open up the possibility of an alternative preferred story. Narrative discourse, as discussed in the previous chapters, was used during therapy conversations, specifically at times when narrative therapy and EMDR were integrated. According to Darlington and Scott (2002:2):

> … research methods such as in-depth interviewing and participant observation are particularly well suited to exploring questions in the human services which relate to the meaning of experiences and to deciphering the complexity of human behaviour.

Contextual variables relating to the client and the setting necessitate detailed descriptions on the part of the researcher, since context also shapes interaction (Babbie & Mouton, 2002:282; Darlington & Scott, 2002:96). I was able to gather detailed descriptions from observations, field notes, video recordings, photographs of activities, written work and drawings, which reflected what happened and what Sonja experienced during therapy sessions.

With the permission and full knowledge of Sonja, video or tape recordings of each session were made and kept. The video recordings were also a useful resource for my personal

reflection after each session. I took photographs of the clay objects that Sonja made during two separate therapy sessions. Other documents (such as letters, pictures, images, and diagrams) were photocopied, since Sonja chose to keep most of the work she created during therapy sessions in a journal which she took home with her. These documents proved to be important physical evidence of her experiences and reflections.

3.4 PARTICIPANTS IN THE JOURNEY

3.4.1 Client

Sonja (pseudonym) decided to come to the Unit for Educational Psychology at the Stellenbosch University at the beginning of May 2003. She wanted to talk to someone about things that had troubled her and have had an effect on her general functioning. She was an Afrikaans speaking young adult, 22 years of age, who described herself as fit and healthy at that time. She worked as a managing assistant at a gym. Although her career was time and energy consuming, Sonja was also doing a part-time correspondence course in Public Relations. Her partner was a full time student at the university and shared his flat with her.

3.4.2 Therapist

When Sonja came to the Unit for Educational Psychology, I had been doing the master's course in Educational Psychology for four months. Since the beginning of 2003 I had been introduced to and trained in narrative therapy. My training in narrative therapy continued throughout the rest of the year. During April I had also attended level one training in EMDR at Stellenbosch University.

Along with my theoretical training it was recommended that, as a trainee psychologist, I should invest in my personal development by attending personal psychotherapy sessions. I had only recently started visiting a psychotherapist on a regular basis. At that stage Sonja and I met as she was referred to me for therapy. She was my first client for therapy. In a way I expected that this therapy journey with Sonja would bring about growth and enrich my life and professional development, although I also realised that taking up a position as therapist for the first time would bring about many challenges.

3.4.3 Reflecting team

Various literature on narrative therapy suggests the value added to therapy when a reflecting team takes part in therapeutic conversations, since clients are empowered by these practices (White, 1995:172-198; Freedman & Combs, 1996:169-193). During our eleventh session, I suggested inviting a reflecting team. After we had discussed how it could enrich our conversations as well as her preferred, alternative story, Sonja agreed to invite a

reflecting team to one of our sessions. Fellow post-graduate students, who were doing the same course as I had been doing, volunteered to be reflecting team members.

The team members contributed to the therapy process by their acknowledgement of problems that Sonja was talking about. They shared their fascination with certain of the more neglected aspects of their own lives – which might be considered as unique outcomes to further develop the alternative stories of their own lives. They also positioned their own responses within the context of their personal experiences, imagination, purposes, curiosity and values (White, 1995:180).

3.4.4 Consulting therapist

Since I had never before been part of a reflecting team therapy session, I invited an experienced psychologist to act as consulting therapist[12] to lead the conversation with Sonja and team members during the reflecting team session. The arrangements were made only after Sonja had agreed to speak to the consulting therapist during that particular session.

3.4.5 Outsider witnesses

Payne (2000:16) describes *outsider witnesses* as people who are considered to be an audience of the person's telling and re-telling. Sonja's boyfriend, Roelof (pseudonym), appeared to be the first and most important outsider witness in Sonja's life. She invited Roelof to her last therapy session and shared with him the telling and re-telling of her life story.

3.5 THERAPY CONVERSATIONS

3.5.1 Individual

The therapy journey was characterised by many different individual therapy conversations. Working within a postmodern paradigm, I elected to use a social constructionist perspective during our individual sessions. According to Terre Blanche and Durrheim (1999:153) a constructionist approach to therapy conversations recognises specific linguistic patterns, such as *typical phrases, metaphors, arguments and stories*. Babbie and Mouton (2002:289) elaborates on individual conversations:

> A qualitative interview is essentially a conversation in which the interviewer establishes a general direction for the conversation and pursues specific topics raised by the correspondent. Ideally, the respondent does most of the talking.

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[12] The therapist involved was our narrative therapy supervisor, who had been using narrative therapy for many years.

From these individual therapeutic conversations meanings are co-created and constructed between the therapist and client (Terre Blanche & Durrheim, 1999:153). An acceptance and understanding of people's stories are created through a process of deconstructive listening. Deconstructive listening allows the listener to check his/her understanding and make sure that it fits with the speaker's intended meaning (Freedman & Combs, 1996:46-47). There appears to be a move from deconstructive listening to deconstructive questioning, since the latter invites people to view their stories from a different perspective and to construct them differently (Freedman & Combs, 1996:56-57).

3.5.2 Reflecting team

Another way of talking and reflecting on Sonja's life story involved inviting people as outsider-witnesses to witness the conversation between Sonja and the consulting therapist (Morgan, 2000:121). The outsider-witnesses or reflecting team, consisting of postgraduate educational psychology students, were oriented towards *joining* with Sonja, *supporting the development of new narrative, and facilitating deconstructions of problem-saturated descriptions* (Freedman & Combs, 1996:173).

This particular orientation helped reflecting team members to make a positive contribution to conversations during the therapy process.

3.6 PHOTOGRAPHS AND OTHER DOCUMENTS

> *… a document carries meaning independently of what its author's intentions were: it is simply a point of intersection for social meaning (or discourses) and is no more distant from what 'really happened' or what somebody 'really felt' than an interview.*
>
> (Terre Blanche & Durrheim, 1999:153)

The quotation above describes a social constructionist way of understanding and gathering meaning from documents during research. According to Merriam (2002:13) written, oral, visual or cultural artefacts are various forms of documents that open up new possibilities for understanding and constructing meaning.

Not only do documents have a value in the meaning-making process, but they also serve as evidence of steps the client has taken during therapy (Payne, 2000:127; Morgan, 2000:99). By documenting significant achievements or commitments, we try to prevent intentions and/or accomplishments from getting lost. In this way alternative stories can be thickened and continued (Freedman & Combs, 1996:222). Documents can also serve as a way of inviting other people into a *community of concern* or an audience. This allows people to share their alternative stories and contributes to a better understanding of the meaning making process in the person's life.

3.7 DECONSTRUCTING KNOWLEDGES

In a case study, the process of deconstructing knowledges that were gathered on the research journey necessitates some understanding of the multidimensionality of these knowledges. This understanding can be created by describing the context and conditions of various patterns of phenomena (Babbie & Mouton, 2001:283).

McLeod (2003:102) emphasises that an understanding of a case study relies on the researcher's ability to hear and understand meaning as revealed by the client. In an attempt to make thorough observations and have better understanding of Sonja's experiences during the integrative therapy process, I decided to transcribe video recordings of our therapy sessions. These transcriptions helped the further deconstructing of knowledges in a systematic and thorough way (Darlington & Scott, 2002:143).

A typical example of the way in which I conducted transcriptions of therapy sessions, follows:

Dag/Datum/Sessie/ Video posisie	Persoon	Gespreksinhoud	Kodering
Maandag 2 Junie 2003 SESSIE 3	*E:*	Sit gerus, hoor. ...Nou hoor hierso, is jy dalk lus dat ons sommer met die brief begin vandag? Wil jy daaroor praat?	
VIDEO 1 01:52 tot 02:43	*S:*	Ek weet nie... Ek het nou maar net gedink...jy het mos gesê ek kan miskien...en toe't ek maar net gedink, wel, ek vergeet vinnig goed, so...(glimlag)	
	E:	(lag)	
	S:	...ek moet maar neerskryf.	
	E:	Het jy bietjie gehardloop? Jy klink vir my bietjie uit asem...	
	S:	Ja. Ja, ek was besig met 'n kliënt, toe't ek seker so 5 minute voordat ek hier moet wees, het ek klaargekry. Toe't ek gou gehardloop.	
	E:	Ooo...	
	S:	Dis mos darem nou nie ver nie, so...	
	E:	Hoe gaan dit by die werk?	
	S:	Ag, dit gaan baie goed. Dis mos nou stil op hierdie stadium, almal begin nou vir die eksamen...	
	E:	Ek kan nogal dink. Julle het seker baie studente wat kom, né...	
	S:	Hm... So dit raak mos nou maar stil. En veral oor die vakansies is dit soos in doodstil daar. Maar dan kry mens kans om al die werk in te haal, so mens hoef seker nie te...	
	E:	Het julle baie ekstra werk?	
	S:	Weet jy, um... Ja, maar ek dink ons hele, um... ding gaan nou ge-outomatiseer word, so baie van die ekstra werk gaan wegval. Maar ons is nog maar 'n nuwe gim, so... Ek bedoel, um...	

Qualitative ways of deconstructing knowledges includes looking for themes during conversations, signs of development and change, the use of metaphors, and expressions of thoughts, emotions and traumatic experiences. According to Babbie and Mouton (2003:283)

clear conceptual categories are needed, to provide a focus, given the *amount of data collected* during case studies. Since knowledges were gathered within a post-modern paradigm during narrative therapy in this study, I will discuss how the deconstruction of knowledges according to *categories* of Sonja's problem-saturated story, unique outcomes (such as skills and knowledges), values and commitments, as well as alternative accounts of her life story as they emerged along the journey (see Addendum 2). In this way there will be a focus on specific areas of her life and experiences. My motivation for choosing this approach to the deconstruction of knowledges gathered during the therapy journey was influenced by Epston and White (1992:13):

> The gift of therapy is balanced by the gift of consultancy. We consider this reciprocity to be of vital importance in reducing the risk of indeptedness and replacing it by a sense of fair exchange.

In this qualitative case study, the deconstruction of knowledges relies in many ways on reflections by the client and therapist on personal experiences and on the therapy process. Video/tape recordings, process notes and other documents from our therapy sessions contributed to the process of deconstructing knowledges.

3.8 CONSIDERATIONS FOR ETHICS AND VALIDITY

On approaching the research journey, I had to rethink the ethical dimensions of this work. Durrheim and Wassenaar (1999:65) strongly contend that the purpose of ethical research planning is to ensure the protection of all participants in terms of their rights and welfare. They suggest three ethical principles: *autonomy* (this implies that participants will have voluntary and informed consent, the freedom to withdraw at any time and the right to be anonymous in any publication), *nonmaleficence* (this implies the researcher needs to consider possible risks and harm that might be inflicted on people because of their participation) and *beneficence* (this implies that there needs to be benefits to doing the research). There are other important imperatives. Babbie and Mouton (2001:527), for instance, refer to the researcher's accountability to society in conducting research. This accountability requires the researcher to work in ways that are socially responsive and responsible. This point is also emphasised by Kotzé and Kotzé (2001:viii) who argue that research should bring about transformation in societies on the basis of ethical and ecological ways of being.

On the journey with Sonja, I had to ensure that she was informed about her rights and that she freely participated in all therapeutic activities. There seemed to be no apparent risks to her participation on this research journey. I also had to consider the possible contributions the journey would make to her life and to the development of therapeutic integration.

The validity of a qualitative case study, and more specifically this research journey, should also be considered. According to Babbie and Mouton (2001:123), the term *content validity* embraces the range of meanings that might be implied by the use of a specific concept. Critics might argue that a case study would offer many limitations, such as the validity of knowledges, the difficulty of testing causal links and of making generalizations based on a single case study (Terre Blanche & Durrheim, 1999:256). However, working within a post-modern paradigm, it is the reader, not the researcher, who decides what knowledges will be useful in other similar situations (Merriam, 2002:179). This necessitates rich descriptions by the researcher, to enable readers to decide whether they want to make use of knowledges constructed during case studies. Merriam (2002:179) refers to Erickson (1986) who argued that "the general lies in the particular", which implies that knowledges constructed during a specific situation, might be useful in similar contexts or situations.

On qualitative research validity, David Silverman (1993:94-95 in Babbie & Mouton, 2001:124) emphasises the importance of constructing "a deep mutual understanding" during conversations between the researcher and client. This perspective also has a place within a post-modern paradigm. The process of deconstructing knowledges could contribute to greater understanding of how Sonja conceptualised and made sense (found meaning) in her world.

3.9 REFLECTION

At this point in my reflection on the research journey, I have shared how the journey was mapped and how it gradually unfolded. It was important for me to consider ways I would go about to gather knowledges from the therapy journey. I also had to think about deconstructing these knowledges in order to be able to construct rich reflections on these. In this study I had to consider whether my preferred ways of conducting research would honour Sonja in an ethically just manner. This also reflected upon my personal commitment to therapy and research.

In the next part I will focus on describing the journey that Sonja experienced and what we spoke about during therapy integration. The journey begins as I reflect on the unknown territory that Sonja and I intended to explore. I will share how the therapy journey unfolded, first by focussing on the problem-saturated route that Sonja had experienced. Thereafter I will describe how values, commitments, skills and knowledges took the journey on an alternative, preferred, and richly descriptive route.

CHAPTER FOUR

THE JOURNEY

4.1 INTRODUCTION

In the previous chapters of my thesis, there was a focus on the planning, structuring and course of the research journey. There was also reflection on existing knowledges about the therapies that were integrated during the therapy journey. In this chapter I will take a closer look at the therapy journey that was undertaken and will attempt to give rich and thick descriptions of how the journey unfolded. There will be a strong focus on Sonja's experiences during the journey, as well as on the process of integrating narrative therapy and EMDR.

4.2 THE EXPLORATION OF AN UNKNOWN TERRITORY

Before unfolding the journey that made an exploration of the unknown territory of this client's life story possible, I would like to underline again that all the names of people used in this case study are fictitious.

Sonja and I met for the first time at the Unit for Educational Psychology during her lunch hour, as this was the best time of the day for her to get away from work. Monday lunch time became our regular appointment time. Our conversation during the first two psychotherapy sessions gave me an opportunity to get to know Sonja as well as her description and understanding of problems that troubled her life. I encouraged her to ask any questions that she might have about me or the therapy process and to say if our way of talking about the things troubled her.

In my decision to work from a post-modern perspective, I preferred to take in a *not knowing* position in my conversations with Sonja. She was the expert of her own life and had unique life experiences. In this sense I chose to view knowledge as being *local*, not *universal*. Together we explored her life stories through my asking questions out of respectful curiosity and Sonja sharing her memories and knowledges (ways of thinking) about her own life journey.

In many ways the journey was initially unclear to both of us. Neither of us knew exactly how the journey would unfold. However, there was some likely direction from the start when Sonja and I talked about the hopes that she had for the therapy process. Sonja told me that

she wanted to be capable of understanding herself in a better way and to become less emotionally upset through little things that sometimes went wrong at work or in other settings. I explained that together we could explore the problem (we spoke about it as *overwhelming emotional distress*) in a narrative way. Sonja also identified strategies, resources and skills (unique outcomes) that had previously been useful in her life in other situations, and we considered whether they might also be helpful in her current problem situations.

4.3 A PROBLEM-SATURATED ROUTE

Right from the first therapy session, Sonja told her problem-saturated story to me by describing her experiences of overwhelming emotional distress and insecurity in different life settings (at work, home, in town amongst friends, etc.). These problems stood in opposition to her hopes for therapy. During our first conversation she shared her hopes:

S: *Ek verwag nie 'n kits oplossing nie. Ek wil net weet ... hoe om ... vir myself dinge beter uit te redeneer.* [I don't expect a quick fix. I just want to know ... how to ... think about things in a better way.]

And later: *... Ek ... vind ... dat ek ... verskriklik vinnig emosioneel raak as 'n klein dingetjie verkeerd gaan ... Ek wil net weet dat ek op die einde van die dag ... net ... die, sê nou maar die gereedskap hê ... die 'tools' hê om net ... dit net self vir my te kan uitwerk en te keer dat ek rêrig emosioneel raak ... oor goed waroor mens nie veronderstel is ... om rêrig omgekrap te raak nie. Net om 'n sterker mens te wees, basies.* [I ... find ... that I ... suddenly become emotional when little things go wrong ... At the end of the day I just want to ... just ... the, lets say get the tools to just ... be able to work things out for myself and to prevent myself from becoming really emotional ... about things that you are not supposed to ... be so upset about. Just basically to be a stronger person.]

When I saw Sonja for our second therapy session, she reflected on her initial hopes of what therapy would offer. At this point I was still struggling to use externalizing language when talking about the problem:

S: *"Ummm … Ek weet nie rêrig presies hoe om dit … ja, um … ek weet nie hoe om dit te sê eintlik nie. Die rede … daar's nie rêrig een rede nie. Dis 'n hele … dis maar net hoe ek voel en hoe ek optree, en ...* [Ummm ... I don't exactly know how to ... yes, um ... I don't know how to put it. The reason ... there isn't really one reason. There are many ... it's just how I feel and how I behave, and ...]

E: *So sou jy sê dis jou gevoelens en jou optrede?* [So, would you say it's your feelings and behaviour?]

S: *En my reaksie teenoor goed wat met my gebeur.* [And my reactions when things happen to me.]

Sonja seemed to be more relaxed once the conversation was not directly focused on her. She told me about her family and elaborated about health problems that several of her family members had been struggling with. Figure 4.1 depicts the different health problems in Sonja's family. Problems with alcohol abuse and depression contributed to family conflicts and estrangement.

Key to Symbols used in figure 4.1.

➢ Alcohol abuse

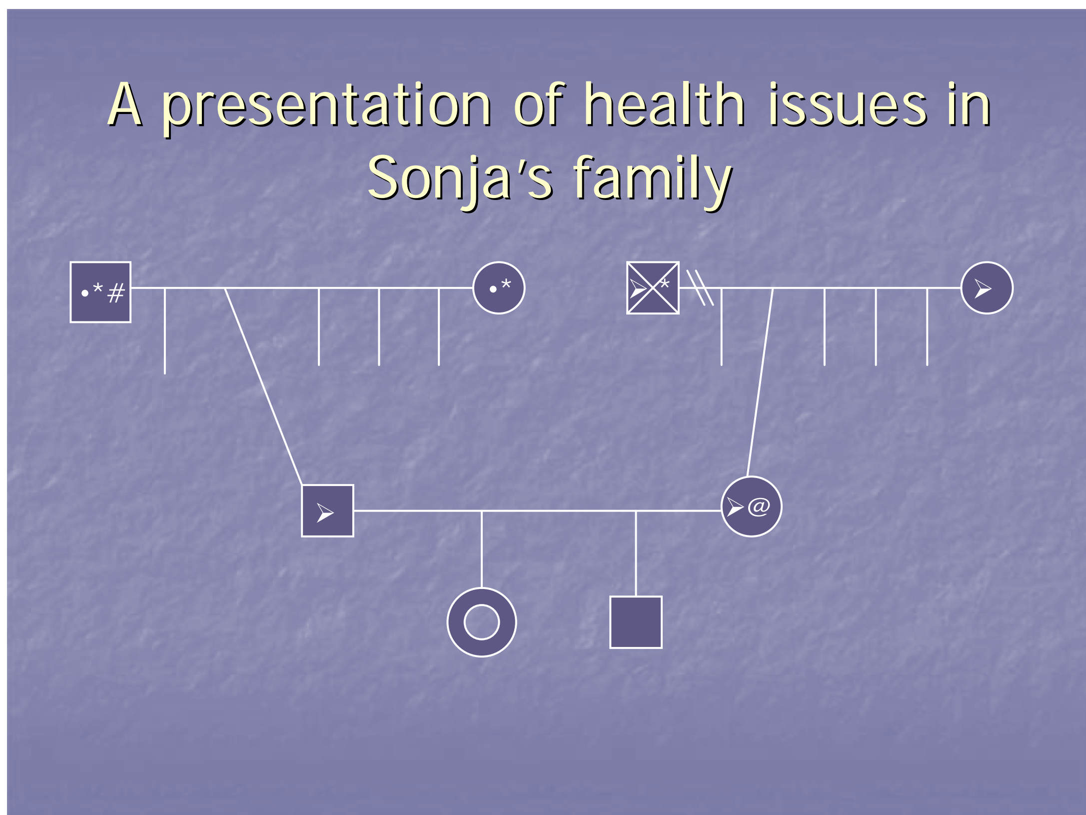
• Heart problems

∗ Diabetes

@ Depression

Cancer

Figure 4.1: A presentation of health problems in Sonja's family



She said that she remembered having a happy pre-school childhood. She also had some good memories of her mother at that stage. During our second therapy session I once asked her how she would describe her relationship with her mother, since she mentioned that Roelof's mom was more like a real mother to her. Sonja replied:

> "*... sy's nie 'n slegte ma nie, sy's ... Daar is nie rêrig een* ('n verhouding) *nie.*" [... she's not a bad mother, she's ... There isn't really one (a relationship).]

Sonja took time to describe how different her relationship was with Roelof's mother:

> "*Kyk, sy was die ma wat ek wou gehad het ... omdat my ma nooit daar was vir my nie ... Um. Ek dink die feit dat ... verstaan ek kon haar ook help want ... want Roelof se pa is dood toe hy mos die eerste keer oor Engeland toe is ... En sy was ook maar alleen gewees, so ek was baie dae by haar gewees ... En, net omdat ek weet sy sou na my luister. Ek kon net gaan praat en ... sy sou geluister het ...* "
>
> [You see, she was the mother that I always wished for ... because my mother was never there for me ... Um ... I think the fact that ... understand, I could help her as well because ... because Roelof's dad died while he was over in England for the first time ... And she was also very lonely, so I spent many days with her ... And, just because I knew that she would listen to me. I could just go to talk to her ... she would have listened.]

According to Sonja, things at home started changing during her primary school years. Her mother (Riëtte) had trouble with depression and started drinking. Riëtte had to be hospitalised more than once. Sonja remembered how her father (Pierre) often threatened that he would leave his wife. He then demanded that Sonja and her brother choose who they would prefer to stay with: Pierre or Riëtte. However, he never carried through his threats on divorce. Depression and alcohol affected Riëtte's life in such a way that she was not able to work any longer. When Pierre's private business collapsed, Sonja's family faced great financial problems since Riëtte often had to be hospitalised.

Sonja's relationship with her mother gradually worsened. She blamed her mother for everything that went wrong at home, since she perceived her mother as never being available to her brother (Pieter) and herself. She remembered with tears of sadness how her mother said that she hated her (Sonja), how she chased her out of the house and told family and friends that she was a bad person. Initially Sonja cried and was very angry about everything that had happened at home, but during her high school years she realised that it was better to avoid going to her parental home by staying over at friends. At school Sonja was able to live the life she chose and she took part in the activities that she enjoyed doing.

When Sonja finished school, her parents wanted her to go to university. But instead, she decided to go overseas. In England she had an Australian boyfriend, who wanted her to move back to Australia with him. After about a year in England Sonja returned home and completed a personal trainer course in Cape Town. She finished her six months training in four months, since she attended day and evening classes simultaneously. Then she went to Australia, but in the end she stayed there for only about 3 months. According to Sonja, the immigration regulations of the country made it very difficult for her to immigrate to Australia. She saw things as not working out for her the way she thought they would. Eventually she broke up with the Australian and returned to South Africa.

About two months after returning from Australia, Roelof and Sonja started going out. She had a very different experience of a relationship with a man with Roelof. Sonja told me that Roelof was very different from her previous boyfriends. She mentioned that she felt a stronger person in her relationship with him than with previous boyfriends. She explained how the previous boyfriends had made her feel inferior to them . However, in her relationship with Roelof she felt that he accepted her as she was and loved her unconditionally. Sonja had eventually moved into a flat with Roelof and started working at a local gym.

Initially Sonja said that she was worried about "inappropriate" emotional reactions at work. In deconstructing these emotional responses, she agreed that it would be useful to speak of these emotional reactions or responses as *overwhelming emotional distress*. In further exploration and deconstruction of *overwhelming emotional distress*, Sonja realised that confrontation situations (e.g. at the gym, at home, or in other social settings) usually triggered this response.

4.4 VALUES, HOPES AND COMMITMENTS

In the exploration of Sonja's life story, she often spoke about her reactions and ways of dealing with specific incidents or situations. My asking about her intentions or purposes at the time, invited her to reflect on her values and beliefs, hopes and dreams, her principles for living as well as her particular commitments. Carey and Russell (2003:65) refer to Michael White, who prefers to talk about these 'qualities' as ***intentional*** *states of identity* rather than ***internal*** *states of identity*. It is of greater value to explore the intentions, hopes, values and commitments that motivate a person to react in a specific way, than to label a person as having internal states (e.g. resources, strengths or qualities, as well as deficits or deficiencies).

Conversations about Sonja's intentional states of identity surfaced every now and again throughout the therapy process. One such intentional state appeared to be Sonja never turning up late for a therapy appointment. When I mentioned this observation to her, she

confirmed that she saw it as good manners to turn up on time and that being on time was very important to her since she did not want people to wait for her as she disliked waiting for others.

During therapy Sonja spoke of her avoiding situations of confrontation. She appeared to 'worry' about others' well-being, especially after situations of confrontation. Sonja described this 'worry' as a commitment to caring for others. She generally valued relationships in situations where she experienced mutual trust. She also spoke about times when she resisted the expectations of others in order to do what she thought was best for herself and her own future.

She carried hopes and dreams in her heart about her future, which she started turning into action. She was committed to hard work and success in her career. This appeared to be one of the reasons why she managed to complete school successfully, and was promoted at work within a short period of time.

Time and effort seemed to be of no consequence when she was spending them in meaningful ways on someone/something that was important in her life. Sonja also valued justice in her relationships with others and gradually put this value into action. Her recognition of the roles others played in her life was one of the ways in which she demonstrated the value she accorded to justice.

Identifying these values, hopes and commitments helped to thicken out her preferred, alternative story.

4.5 HELPING STRATEGIES

Various helping strategies that had been useful to Sonja in the past were documented in different ways. The writing of therapeutic letters was very useful in documenting the helping strategies that Sonja spoke about during the therapy session. At other times, Sonja documented these strategies on a white board or she would symbolise some of the strategies she found helpful through the medium of clay or drawings.

Sonja told me that she realised that some strategies had been useful in the past when overwhelming emotional distress had threatened to take charge of her life. Talking to Roelof about the situation helped, as well as taking a walk or just allowing herself to cry in a place where she felt safe. She also thought that allowing herself the time to do what she enjoyed and wanted to do could help to limit the effect and appearance of overwhelming emotional distress.

Referring customers to the appropriate staff was another strategy that she had previously used and found helpful in situations when she did not have all the information. Sonja

ascribed her promotion at the gym to the fact that people had recognised that she was working effectively, purposefully, enthusiastically, competently and as a result probably realised how committed she was to her work.

According to Sonja, Roelof supported and encouraged her to stand up for herself, her commitments and beliefs. The fact that she knew he was standing by her by supporting and understanding her was very helpful. (**was the most helpful)

4.6 THE INTEGRATIVE USE OF EMDR AND NARRATIVE THERAPY DURING SESSIONS

During one of my supervising conversations with Professor Newmark, we discussed the ways in which traumatic memories from childhood still affected Sonja in the way she spoke about her life and experiences of overwhelming emotional distress during therapy sessions.

In our second session, Sonja referred to her relationship with her mother, which, according to her, had deteriorated since entering primary school. At this point she had mentioned an incident that stood out as the turning point of her relationship with her mother. She spoke about the incident as follows:

> *"Ek … dink … die keerpunt het gekom toe … um … ek eendag iets gebreek het in die badkamer. Dit was 'n porselein-dingetjie. Um … En ek was baie bang sy vind dit uit en ek het dit vasgesit met wondergom. En toe sy die middag by die huis kom, toe sien sy dit, en toe begin sy alles in die badkamer en die huis breek. Sy het alles begin stukkend gooi. En ek het nie verstaan wat gaan aan nie. En dit was een van haar eerste uitbarstings gewees. En van toe af …*
>
> *… En van toe af het dit net al erger begin gaan."*
>
> [I … think … the turning point came when … um … I one day broke something in the bathroom. It was a little porcelain thing. Um … And I was really scared that she would find out and I glued it together with glue. And when she returned home that afternoon, she discovered it, and she started breaking everything in the bathroom and house. She started smashing everything. And I did not understand what it was all about. And this was one of her first eruptions. And since then …
>
> … And since then things became worse.]

Following this session, I wrote a therapeutic letter to Sonja in which I reflected on our conversation. When Sonja was reading the letter at home, she experienced a physical reaction in her body while reading about what we had spoken about.

> *"Maar ek dink die ding wat my die m… toe ek die brief gelees het wa… een plek wat eintlik my keel laat toetrek het, is hier waar jy geskryf het oor…um…o, toe ek hierdie dingetjie gebreek het."*
>
> [But I think the thing that… when I read the letter that… one reference that made me feel asthmatic, is here where you wrote about…um…oh, when I had broken this thing.]

This incident appeared to be the first of many traumatic childhood experiences that Sonja had locked away in her memory. Sonja also spoke about her experiences of guilt as a child, referring to the incident of breaking something in her mother's bathroom, as well as various other occasions when her mother told her that she was the reason for all the conflict between her (Sonja's) parents.

At first her way of coping with the emotional impact of experiences of trauma at home was to cry. But by the end of her primary school years she chose instead to ignore both the situation at home and her feelings about it. According to Sonja, experiences from her childhood seemed to hold her 'prisoner' in a way that she made her feel insecure and anxious in relationships and situations of confrontation. As Roberts (1999:19) explains, "The individual believes his [her] experiences to be so unacceptable to others, or risk such negative reactions, that they are held with fear and shame, concealed, or hidden. Silencing seems part of all traumatizing or abusing experience". Sonja described situations of confrontation which she experienced recently and her worry:

> *"... dat ek dit nie uit my kop uit kan kry nie, want ek voel net heeltyd daar's ... alles is nie reg soos wat dit moet wees nie. Ek weet nie rêrig hoe om dit te beskryf nie. As so iets met my gebeur ... ek kan dit net nie uit my kop uit sit en vergeet daarvan nie."*
>
> [... that I can't get it out of my mind because all the time I just feel that there's ... everything is not as it should be. I don't really know how to describe it. When something like this happens to me ... I just can't put it out of my mind and forget about it.]

Roberts refers to Mollica (cited in Roberts, 1999:19) who found that story-telling was at the heart of effective treatment of trauma, whatever the orientation of the individual therapist. Narrative Therapy opened up opportunities to talk about traumatic experiences in Sonja's life. As a means of expanding these conversations, as well as ensuring development and healing from the traumatic experiences of Sonja's childhood, I told her about EMDR and why I thought this therapeutic technique might contribute and further enrich her alternative story.

The fifth and six sessions opened up the conversation about EMDR and we spoke about why I thought it might be helpful in dealing with traumatic experiences which appeared to still have an influence on her life and thoughts about herself. In the following sessions we explored the incident when Sonja broke a porcelain ornament in her mother's bathroom, as well as associated traumatic incidents through the use of EMDR techniques. EMDR allowed Sonja to deconstruct her problem-saturated story and thicken out the alternative story of her life experiences.

4.7 DECONSTRUCTING KNOWLEDGES

In Chapter One of this thesis, I referred to Winslade and Monk's understanding (1999:122) of deconstruction during narrative therapy as a way of viewing, thinking and talking about personal perspectives (ideas and assumptions) from different angles. The process of deconstructing knowledges was a collaborative action between Sonja and me during the integrative therapy journey. Addendum 5 was included as an example of the process of deconstructing knowledges.

4.8 AN ALTERNATIVE, RICHLY DESCRIPTIVE ROUTE

The integrative therapy process of Narrative Therapy and EMDR allowed me to get to know Sonja apart from overwhelming emotional distress, which previously appeared to have quite a strong grip on her life. Freedman and Combs (1996:1) reminds us that the narrative metaphor leads to meaningful and fulfilling life stories. Integration of traumatic experiences through EMDR also contributes to a more adaptive life perspective which allows a memory to take its place as a functional part of the client's overall life history (Shapiro, 2001:316).

Sonja spoke of times when her courage and perseverance helped her through difficult times. Her perseverance was evident in her completing school successfully, keeping contact with her mother and caring about her despite many disappointments and hurt in their mother/daughter relationship, her determined efforts to immigrate to Australia, her hard work end dedication at the gym, and many other situations. Although her parents had other plans for her future, Sonja showed the courage to do what she believed was right for her at the time when she had finished school. Her courage was also evident in her attempts to restore her relationship with her mother during the June 2003 holiday, as well as the occasion when she confronted Roelof who had slipped up on his duties at home. Sonja also took some courageous steps in going overseas and to Australia by herself. Courage and perseverance was also evident in the therapy process, especially at the time when she was willing to take part in an outsider witness session attended by unfamiliar people.

Along with these acts of courage and perseverance, Sonja carried dreams for her future in her heart. In her personal life, she spoke about the kind of mother she wanted to be for her

children one day. Sonja had high expectations for her career as well. She was working towards promotion at work, as well as keeping an eye and ear open to more promising career opportunities. Sonja also invested in further education by following a correspondence course in Public Relations.

With regard to her work and studies, Sonja spoke about her dependability and dedication at work. This was evident in the fact that she was usually on time for work or any other appointments, her taking initiative at work in designing a more effective and practical supervising system, as well as her accepting responsibilities and the consequences that went with it.

Sonja chose to live a life of hope and focused on possibilities of the future. She chose not to give up when things at home were in turmoil. She made a plan to "survive" acts of emotional abuse against her, by staying over at friends when necessary, during her school years. When things did not work out for her in Australia, she returned to South Africa, but did not give up on hope. Instead, Sonja decided to explore a career as personal trainer in Cape Town, and later in Somerset West. All these and many other occasions that Sonja spoke about, were evident of this seemingly unquenchable hope in her life.

4.9 LOOKING BACK ON THE JOURNEY

The therapy process journey, many changes happened in Sonja's life. She did not experience overwhelming emotional distress again during the eight months of therapy. However, our conversations about overwhelming emotional distress opened up conversations about confrontation and her experience, thoughts and feelings about it.

After the second session of integrative EMDR/narrative therapy, Sonja had a dream in which she stood up to the enemy. She had experienced these dreams of herself being confronted by an enemy quite often before and was never before able to protect or defend herself. Previously she had dreamed that she would run away. This time the dream was different and she thought that our conversations during these sessions might have contributed to this positive change in her dreams.

Sonja also reported other changes in her life during our therapy journey. She experienced how sadness, worry and insecurity gradually moved away to make space for inner strength and self-confidence. Eventually Sonja was also able to identify and establish her personal *Support Team* that consisted of people who knew Sonja apart from the problem. These people were important to Sonja, since they encouraged her and showed that they cared about her.

Sonja celebrated the end of the journey by making a clay image during our final therapy session. The clay image was very different from the one made by her a few months earlier on. The earlier figure was kneeling down, with its arms folded protectively around it, eyes closed and head covered. The figure she made during our last session was also in a kneeling position, but this time its arms were stretched out above its head, as if in praise. The figure's hair was tied in a ponytail and had a smile on its face (see Addendum 1).

4.10 REFLECTION

The therapy journey started off on a problem-saturated route. Along this route Sonja's values and commitments were reflected in her tellings. A deconstruction and exploration of unique outcomes were the start of Sonja's construction of a preferred alternative story. Sonja's experiences and reflections influenced the process of integrating narrative therapy and EMDR, which guided this therapy journey.

Now that the telling of the journey has been completed, I will share my reflections on the journey in the following chapter.

CHAPTER FIVE

REFLECTIONS ON THE JOURNEY

5.1 INTRODUCTION

At the start of this research journey, I stated my commitment to becoming an investigative, critical, reflective and responsible psychotherapist. As part of this intention, I will now discuss my personal reflections on this therapy journey and the ways in which I have constructed meaning from the research question that focused on what Sonja experienced during the integrative therapy process.

5.2 WINDOWS OF KNOWLEDGES

Reflecting on the way in which Sonja and I spoke about her problem-saturated and alternative stories during the integrative therapy process made me realize that knowledge and first hand experience were inseparable. On this journey I experienced the importance of developing an integrated theoretical perspective through relevant reading and thinking, actual counselling (Corey, 2001:487) and supervision. A continuing openness to various theoretical schools of therapy seems to be necessary in order to develop an individually fitting personal approach to therapy (Corey, 2001:487). This appears to be a never-ending process required in the psychology profession.

Corey (2001:487) views integrative therapy as an art that has to be mastered for a therapist to know the appropriate time and method in a particular therapeutic intervention. Being new to the field of psychotherapy, I initially relied greatly on regular supervision, specific training and relevant literature on narrative therapy and EMDR. Aware of my responsibility and ethical commitment, I had to consider carefully whether my integrative approach to therapy with Sonja would assist her in dealing with the problems she spoke about. In the course of this research journey, I gained skill in the art involved in and the appropriate use of the integration of narrative therapy and EMDR.

5.3 THE JOURNEY

5.3.1 The route

The therapy journey started off on a problem-saturated route. The metaphor of a train journey helped Sonja to recognise that there was more than one window available to view the landscape on both sides of the train as we travelled along the track of her life

experiences. On this route Sonja seemed to accept that she could not erase negative experiences from her past, and she started realising that she could decide how she wanted to remember these. She also seemed to begin to value other seemingly insignificant experiences in her life journey. The possibility of looking through more than one window at the same time took the therapy journey in a new direction. This was the route of a richly descriptive alternative story.

5.3.2 The client

I experienced Sonja as a very challenging client to work with. She often appeared tense, sitting on the edge of the chair, rubbing her neck, or scratching her arm. Her sadness, hurt and worry revealed itself and tears ran freely down her cheeks as she spoke about past experiences and the damaged relationship with her mother. Sonja came across as being reserved and I had to ask many curious questions to encourage her to elaborate on what she experienced emotionally, cognitively and physically.

In contrast to these challenging aspects, I also perceived that Sonja entertained a great measure of hope for her life. This hope made it possible for her to talk about her dreams and plans for her future. In both her professional career and personal life she took steps and made choices that originated from this hope. Her courage was also evident in the way she approached many challenging situations in her life, such as her endeavour to change her poor relationship with her mother and to speak to a colleague about her unacceptable behaviour at work. It was important for Sonja to find healing and gain a positive perspective on her life. Her courage helped her to talk about difficult and hurtful times that still had an influence on her life, and even to accept the challenge of talking about herself in the presence of outsider witnesses.

Sonja did experience significant change and healing along the therapy journey. This was evident in our conversations, through the clay objects she had made and her drawings as well as in a letter she wrote and handed to me during our last conversation (Addendum 7).

5.3.3 Questions that led to the journey

The main question that gave rise to the research journey focused on what Sonja had experienced during the therapy process when narrative therapy and EMDR were integrated. Her experiences and needs directed the therapy process. It was her description of experiences, such as intense fear in situations of confrontation and memories of childhood trauma that led me to integrate EMDR with narrative therapy. These experiences as well as the integrative therapy process influenced each other. It is impossible to speculate on what she might have experienced and spoken about if therapy conversations had been based only on a single approach.

I could not find any recent literature on the internet or in libraries where narrative therapy and EMDR had been integrated. From my training in EMDR and further research, I knew that this approach had been successfully integrated with other modalities. Therefore, I considered why an integration of EMDR and narrative therapy could not be possible and effective. Theoretical flexibility of both approaches seemed to lead naturally to a blend or combination of these particular therapies and opened up the possibility of creating a new approach to integrative therapy.

Another question I had was whether the integration of EMDR and narrative therapy could contribute to the therapy process in a way that could strengthen and enrich Sonja's alternative life story. In many ways, Sonja's tellings of her changed experiences of situations at work and of childhood memories, as well as the development in the clay figure she created, were a reflection of the thickening of her preferred alternative life story.

5.3.4 Purpose of the journey

The purpose of the research journey was to explore the integration of narrative therapy and EMDR in the case study of Sonja's therapy process. This involved a strong focus on Sonja's experiences during the entire therapy process.

The integration of narrative therapy and EMDR allowed an exploration and deconstruction of Sonja's life experiences. These rich descriptions contributed to our exploration of an alternative, preferred story of her life. Through this way of talking about her life, Sonja shared that she experienced greater understanding, as well as different ways of thinking about incidents and experiences from her past. She also experienced change, growth and development in her life.

In doing research about this specific therapy journey with Sonja, I had a chance to look back and think about the therapy process of integration. I realised more than ever how much Sonja's experiences guided this process of integration.

5.4 CONSTRUCTED KNOWLEDGES AND LIMITATIONS OF THE JOURNEY

My personal reflections on this case study alerted me to exciting new possibilities for therapeutic integration based on this integrative approach to narrative therapy and EMDR. These possibilities for further research and study appear to be endless and should be encouraged in the interests of providing psychotherapy clients with the best care and assistance possible.

On a personal level, this journey had a great impact on my development as psychologist. Through continuous reflection, supervision conversations, and further reading and research, I was able to gain confidence in what I was doing. These opportunities for reflection also

encouraged me to be aware of my ethical responsibility in my ways of talking and being with Sonja.

The question could also be asked whether the outcome of this therapy process would have been any different had EMDR not been integrated with narrative therapy. This will remain an open question. If I were given the chance to do a similar study, I probably would make similar decisions and suggestions along the therapy journey. I would again elect to integrate narrative therapy and EMDR because of the way in which the therapy process developed while working with Sonja. Next time, however, I would be more confident that I was effecting the integration in a responsible, respectful and ethical way.

In considering practical limitations, I have to mention the fact that I had to change our therapy location three times. These changes were due to circumstances beyond my control since there was reconstructive work being done in the building where we met for therapy sessions. As a beginner psychologist, I was strongly affected not only by the practical arrangements, but also my personal insecurities about doing therapy during the first few sessions. Therapy was new to me: on a personal level, our therapy journey ran parallel to the personal journey I was experiencing as a beginner psychologist. O'Brien and Houston (2000:27) refer to "the interaction between client, therapist and technique" that is important to recognise during therapy and when considering the outcome thereof.

5.5 POSSIBLE FURTHER RESEARCH OPPORTUNITIES

This case study has opened opportunities for further exploration of integrating therapies. The integration of EMDR and narrative therapy in this study resulted in positive effects on Sonja's life perceptions on this journey. This suggests that further research on the integration of EMDR and narrative therapy with other clients on a larger scale would be valuable.

Another opportunity for exploration may be an investigation of similar therapy integration with clients who struggle with problems related to past traumatic experiences.

My reading during my research journey suggests that no significant research had previously been conducted in South Africa or other countries on the integration of these specific therapies. This opens a new field of research. Furthermore, my reflections on this journey have made me recognise the value of supervision and discussion groups among professionals. Such shared experiences encourage and enrich responsible and respectful approaches to integrative therapy in training and professional practice situations.

5.6 FINAL REFLECTION ON THIS RESEARCH JOURNEY

The following metaphor from a poem by John Donne resonates with my understanding of an integrative approach to therapy:

> … diverse approaches to clinical practice and various perspectives on what it means to be human gather on a hill, link hands and try to arrange themselves in some form of fluctuating, useful harmony. Instead of climbing to some mythical height from which to look down upon the 'savages/barbarians', narrative might form even bigger circles to 'bring them in' (Amundson, 2001:184).

I found the experience of therapy integration during this specific case study challenging, nerve-racking and exciting. At the same time the therapy and research journey made me realise the power and potential of therapeutic integration. This case study may be seen as indicating that integration of seemingly contrasting therapeutic modalities is possible and can result in positive and enriching outcomes.

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ADDENDA

ADDENDUM 1

PHOTOGRAPHS OF CLAY FIGURES MADE BY SONJA ON THE THERAPY JOURNEY

Clay figure made by Sonja on 4 August 2003. Her description:

"Dis 'n voutjie wat haarself vashou. Sy't 'n doek om haar kop ... Ek hou baie van beelde van vrouens wat nie perfek is nie, wat 'n tipe 'claok' aanhet. Roelof se pa het sulke beelde gemaak. Ek geniet dit om met klei te werk."

Clay figure made by Sonja on 10 November 2003. Her description:

"Die beeldjie se naam is MY LIFE – OPSTAAN EN STERKER !"

ADDENDUM 2

LIST OF CODES USED FOR DECONSTRUCTING KNOWLEDGES

CATEGORIES	COLOUR CODES	THEMES IN LIFE AREAS	CODES
Problem-saturated story	Violet	Overwhelming Emotional Distress (crying)	OED
Values and commitments	Blue	Insecurity	INS
Skills and knowledges	Red	Frightened	FRI
Preferred alternative story	Green	Caring	C
		Anger	A
		Frustration	FRU
		Standing up (assertive)	SU
		Survival	SUR
		Motivation	MOT
		Traumatic Experience	TE
		Perseverance	PERS
		Guts	GS
		Powerlessness	POW
		Trustworthy	TRU
		Responsible	RES
		Fairness	F
		Honesty	HO
		Punctuality	PUNC
		Efficiency	EFF
		Enthusiasm	EN
		Competence	COM
		Devotedness	DE
		Sadness	SAD
		Blame	BL

ADDENDUM 3

EMDR PROTOCOL

ADDENDUM 4

EMDR CONSENT FORM

CONSENT FOR EYE MOVEMENT DESENSITIZATION AND REPROCESSING TREATMENT

I have been advised and understand that Eye Movement Desensitization and Reprocessing (EMDR) is a new treatment approach that has not been widely validated by research. I have been informed that initial studies have shown EMDR has produced promising results in reducing anxiety and in reducing post-traumatic stress symptoms, such as intrusive thoughts, nightmares and flashbacks. I have also been advised that, although there are currently no known serious side effects to EMDR, there is minimal data as to its efficacy and safety.

I have also been specifically advised of the following:

1. Distressing, unresolved memories may surface through the use of the EMDR procedure.
2. Some clients have experienced reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including a high level of emotional or physical sensations.
3. Subsequent to the treatment session, the processing of incidents/material may continue, and other dreams, memories, flashbacks, feelings, etc. may surface.
4. Before commencing EMDR treatment, I have thoroughly considered all of the above, I have obtained whatever additional input and/or professional advice I deemed necessary or appropriate to having EMDR treatment, and by my signature below I hereby consent to receiving EMDR treatment.

I consent and submit myself to EMDR treatment.
My signature on this Acknowledgement and Consent is free from pressure or influence from any person or entity.

Signed at ___________________________ on the ___ day of ________________ 20......

______________________________ ___________________________

Signature Witness

ADDENDUM 5

EXAMPLE OF TRANSCRIPTION AND CODING

Dag/Datum/Sessie/ Video posisie	Persoon	Gespreksinhoud	Kodering
Maandag 29 September 2003 SESSIE 12 VIDEO 4 01:26 tot 02:52	*E:* *S:* *E:* *S:* *E:* *S:* *E:* *S:* *E:* *S:*	Jy't vir my oor die telefoon gesê dat daar iets was wat jy graag... O, um... ...met my wou gedeel het. Dit was nie dat ek dit soseer neergeskryf het nie, maar dis net iets wat ek opgelet het van 'n paar drome wat ek nou al gehad het. Hm... In die verlede... altyd in 'n droom... as... ek... in die moeilikheid was (onhoorbaar)... of ek was, moet ek myself probeer verdedig, dan kon ek glad nie. Ek het glad nie krag gehad nie. Ek kon nie iets aan enige iemand anders doen nie... so... dit was nie dat dit 'n probleem was nie... (Onhoorbaar.) Ja, dit was net dat ek het dit altyd opgemerk. Ek het nie krag gehad om iemand weg te stamp of daai persoon... Hm... En nou, die laaste drie keer dat ek sulke drome gehad het, het dit net skielik verander. Nou kan ek basies... Dit voel of ek meer... krag het in 'n droom om self	 FRI INS POW POW A COM

		(onhoorbaar)... En dit het my net	GS
		opgeval.	SUR
		Meer krag om jouself...?	
	E:	Te verdedig of...	
	S:	Te verdedig...	COM
	E:	Ja.	
	S:	...Daar iets anders?	
	E:	Nee, dit was basies dit. Dis net... dis	
	S:	nogal 'n groot verandering, want	
		ek kon nog nooit dit... rêrig doen	
		nie.	
		Is dit amper iets soos om vir jouself	
	E:	op te staan?	
		Ek wil so dink, ja.	
	S:	So...so...	
	E:	Dis as... sê nou maar... Dis vir	
	S:	myself... Sê nou maar iemand val	
		my aan of iets... ek het niks krag	
		gehad om enigiets daaraan te	FRI
		doen nie. En nou kan ek eintlik	POW
		die persoon wegstoot of	
		wegstamp of... en ja... Dis nogal	SUR
		'n verandering.	GS
		En is dit vir jou 'n... 'n positiewe	SU
	E:	belewenis of...	
		Ek sou so sê...	
	S:	...hoe ervaar jy dit?	
	E:	Dit het my altyd gep... nie gepla nie.	
	S:	Ek het net gewonder hoekom...	
		ek bedoel, ek het nooit rêrig in	
		my drome... nog nooit vir myself	
		kon opstaan nie. En die laaste	
		paar keer het dit wel anders	

		uitgedraai, so...	
		En hoe sal jy dit	
	E:	beskryf...(onhoorbaar)?	
		Dis 'n goeie... dis goed...	
	S:	As jy nou...	
	E:	Dit voel positief.	
	S:	Voel jy positief?	MOT
	E:	Ja.	
	S:	Is daar nog enige iets wat jy... Jy't	
	E:	nou spesifiek vir my vertel van	
		die drome, maar... iets anders wat	
		dalk in hierdie twee weke... vir	
		jou opgeval het?	
		Um... Net dat ek 'n paar situasies by	
	S:	die werk hanteer het, um... Ek het	
		nogsteeds op my senuwees	
		gevoel en alles, maar ek het tog	C
		wel... met *staff*... waarvoor... ek	
		moes mee praat as hulle iets	RES
		verkeerd doen, het ek dit alles	TRU
		gedoen... En uh... dit het alles	
		oraait uitgewerk. Ek bedoel, ek	PERS
		was bietjie *upset* gewees en so,	DE
		maar nie...	
		Soos in konfrontasie-situasies?	
	E:	Ja, dit was 'n konfrontasie-situasie,	
	S:	en dit het op die einde heel *okay*	
		uitgedraai, um... Ja...	
		Wat was vir jou anders as die vorige	
	E:	kere?	
		Iemand maak die deur oop en toe.	
	>		

	S:	Ek sal nie sê ek was anders nie... Ek was nogsteeds gestres en alles, maar ek het dit gedoen. So...	GS PERS
	E:	Ek gaan net die deur sluit... Ekskuus, Sonja. Dat ander ons nie kan pla nie. Daars-hy. Ja? Ekskuus...	
	S:	Nee, ek sal sê ek het omtrent steeds dieselfde gevoel, maar ek het dit darem ten minste hierdie keer reggekry om... met hulle te praat... En...	
	E:	Was dit dalk iets anderster in jouself gewees?	
	S:	...Ek weet nie. Net die feit dat ek dit moet doen. Ek sal nie sê dit het my nie gepla of ek was nie gestres of iets nie... Ja, ek was nogsteeds maar...	RES EF TRU
	E:	Steeds gestres en steeds gepla?	
	S:	Ja... En... na die tyd... is dit nogsteeds vir my moeilik om met... sê nou met die meisie te praat as ek... as ek weet sy's nog 'n bietjie *upset*, maar daar's niks wat ek daaraan kan doen nie. So...	C
	E:	So wat was anders van... van die konfrontasie-situasies hierdie afgelope twee weke? Want jy't nou gesê daar's iets anders, né?	
	S:	Stel dit so! Ek... ek het nie gehuiwer om dit te doen nie... maar miskien...	RES F

	E:	Daar was minder huiwer?	
	S:	Ja. Maar... dit het nogsteeds nie vir my maklik gevoel nie.	
	E:	*Okay*... Is daar iets waarmee jy vandag wil begin...Sonja?	C
	S:	Um... Nee, ek het nie rêrig nie... Um... Ek het gewonder of mens se... mens se drome mos... kan deel wees van... wat mens dan op die oomblik ervaar? So... is daar miskien 'n rede dat ek nou begin anderster droom? Of...	
	E:	Wat dink jy?	
	S:	Ek weet rê...	
	E:	Hoe ervaar jy dit?	
	S:	Wel, ek het die drome as 'n positiewe ervaring ervaar, so... Is dit nie 'n vorm van positiewe verandering nie?	GS SU
	E:	En dit wat jy op die oomblik elke dag in jou lewe ervaar... Dink jy... dit kan dalk 'n invloed op jou droom hê?	
	S:	Dit mag miskien, ja. Um, ek voel nog nie heeltemal sterk nie, maar dis seker maar (onhoorbaar)...	INS POW
	E:	Wat van dat ons vandag begin met een van daai beelde wat jy miskien in jou droom gehad het... in 'n droom gehad het?	
	S:	*Okay*...	

ADDENDUM 6

PROCESS NOTES OF AN INTEGRATIVE SESSION OF EMDR AND NARRATIVE THERAPY

ADDENDUM 7

A LETTER WRITTEN BY SONJA AT THE END OF THE THERAPY JOURNEY