CONCEPTUALISING RELATIONAL NORMALITY IN PSYCHOANALYTICALLY-INFORMED COUPLE PSYCHOTHERAPY

PIERRE CACHIA

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Abstract

A review of the psychotherapy literature highlighted an absence of publications exploring the conceptualisation of relational normality in adult couple relationships. This research set out to address this gap in theoretical and clinical reflection. The central aim was to contribute to an enriched understanding of the manner in which explicit theory-derived concepts and implicit notions of relational normality are applied in couple psychotherapy.

A qualitative design was adopted. Twenty-seven psychoanalytically-trained couple psychotherapists participated in one of the four focus groups used for data collection. Thematic Analysis led to the identification of three main themes namely: *Political*, *Indigenous* to psychoanalysis and *Non-native paradigms.*

The 'Political' theme refers to the discernment of who carries the responsibility to define relational normality. It captures the weighting couple psychotherapists give to their role and expertise, patients' views and experience as well as socio-cultural imperatives. Additionally, it highlights how their discernment is complicated by a degree of ambivalence. The second theme, 'Indigenous' denotes how psychoanalytic thinking is brought to bear in evaluating the quality of dynamic processes within and between partners, their psychic capacities and the genesis of difficulty. Participants concurrently maintained the view that sub-optimal states are normal. The third theme 'Non-native

paradigms' refers to ideas sourced from outside the psychoanalytic tradition highlighting the contribution made by statistical and medico-legal models of normality.

The main strength of this research lies in having recruited a sizable number of highly experienced couple psychotherapists. Limitations relate to the poor representation in terms of gender and ethnicity. This study recommends further research on factors influencing the consideration of the three identified themes. The research outcomes can also inform future training of professionals.

This study identifies how couple psychotherapists seek to move away from their initial, potentially biased appraisal of normality towards a sophisticated reflexive position. Holding rigidly to normative theory and personal belief is considered ineffectual. Conceptualising normality is not simply about discerning facts but involves the attainment of a sense of *dynamic equilibrium* between the multiple perspectives couple therapists contemplate.

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I dedicate this research to all the couples I have worked with throughout the past 20 years of clinical practice. Most of what I know professionally, I owe to them.

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To all,
A heartfelt Thank You.

Introduction

Chapter 1

> What constitutes the 'normal' mind, and whether such a thing can actually exist, are questions of considerable theoretical, and sometimes of practical, interest. (Jones, 1942, p.1)

The central aim of this study is to capture both the explicit and implicit notions of relational normality used by couple psychotherapists trained in the psychoanalytic tradition. Early in the history of psychoanalysis, the question of psychic normality was pondered upon with varying degrees of enthusiasm (Freud, 1966; Kaplan, 1967; Sabshin, 1967; Horton, 1971). However, the application of psychoanalytic thinking to couple psychotherapy has seen little consideration given to the conceptualisation of relational normality within this framework.

In clinical practice, some couples present with a wish for a return to 'normality' which is felt to be a missed desired state, while others seek to escape a boring 'normality' they find difficult to tolerate. The current research is inspired by the concern that, faced with such questions, failure to examine the concept of normality presents a real risk to the integrity of psychoanalytic work with couples. Practitioners may find themselves constrained by the normative dictates of their clients, culture, tradition, and statistical modelling.

Psychoanalysis itself has struggled to define psychic normality (Abrams, 1979, 1989). Additionally, shifting epistemological positions across the history of psychoanalysis has contributed to further, albeit enriching, uncertainty (Protter, 1996). Do couple psychotherapists take an empiricist position, or do they to take a more post-modern, humanistic and clinical narrative-led stance?

Rationale for the Research Focus

Psychic normality has long intrigued clinicians in the psychoanalytic tradition. Yet, in psychoanalytic couple psychotherapy where a central tenet is that 'the couple is the patient' (Ruszczynski, 1993), little has been written about relational normality. Indeed, a search on the PEP-Web database (Psychoanalytic Web Publishing), the largest online archive of psychoanalytic publications, with the full text of 59 journals dating back to 1918 (Psychoanalytic Electronic Publishing, 2019), conducted on the 10th of February 2019 for relevant search terms, highlights how absent this subject matter is from the literature.

The term *normal* appeared in the title of 173 publications while *normality* appeared in the title of 46 publications. A search for the terms *normal relationships* returned just one citation while a slightly wider search using the terms *normality / love* found six citations, five of which made reference to reviews of one book (Kernberg, 1995). In contrast, the term *normal* was found in within the text of some twenty-six thousand publication on the data base. This would suggest that while the term normality is frequently used, publications dedicated to examining the use of the term itself are very limited in number.

Defining what constitutes normal couple relating presents serious methodological, ethical, as well as, real political challenges but this does not diminish its relevance. A review of psychoanalytic theory including that emerging in the field of couple psychotherapy (presented in Chapter 2), indicates that this has in the large part emerged from an understanding of psychic dysfunction (Offer and Sabshin, 1974; Joseph, 1982).

However, relational normality is a far more complex phenomenon than the absence of problematic symptoms. Hence it is clear that there is a need for research into the conceptualisation of relational normality, as used in psychoanalytically-informed couple psychotherapy.

The Contribution to Conceptual Research

In thinking about normality, I have been drawn towards Leuzinger-Bohleber and Fischmann's (2006) work around conceptual psychoanalytic research as it allows the link between conceptual development to both intra and extra-clinical research activities. Research into how couple psychotherapists apply conceptualisations of normality benefits when it approximates Freud's 'Junktim-research' (1927, p.252). Freud views research into the psyche as being in 'conjunction with' or intrinsically linked to the therapeutic intra-clinical endeavour (Dreher, 2000). In this research, participant couple psychotherapists were invited to reflect about their intra-clinical experience and to illustrate their thinking with case material.

Moser (1992) describes a cyclic approach to development of psychoanalytic research as a way of linking clinical and extra-clinical research (including that derived empirically and from interdisciplinary sources) with ideas that emerge in clinical work with patients. He cautions that the 'formation of good concepts requires the representation of very complex process-systems, containing all individually possible relations to each other, which in number and variability seem endless'(Moser, 1992, p.38) and therefore a need to move beyond psychotherapists' personal 'mini-theories'.

Leuzinger-Bohleber and Fischmann (2006) assert that the 'process whereby clinicians deploy their implicit and explicit, private and official concepts in the clinical situation can itself be subject to psychoanalytic research' (p.1361). This study therefore fits the tradition of conceptual research in psychoanalysis which seeks the clarification of psychoanalytic concepts:

> …such research is both about the history of concepts, so as to trace a concept's origin and development, and equally about the current use of a concept, its classification, and its differentiation. In all that, conceptual research clearly is a constructive as well as a critical tool - one that may also prove useful in the assessment of other research activities. (Dreher, 2000, pp.3-4)

This research supports the understanding of the diverse ways couple psychotherapists conceptualise relational normality, and the manner in which they consider the myriad of biological and socio-cultural "facts" alongside their grasp of the couple's psychic reality (Skrine, 2001). It is hoped that this will allow the development of an understanding of how they are drawn and balances these diverse perspectives.

The findings provide insight into the epistemological position modern day psychoanalytically-informed couple psychotherapists adopt, and specifically, how they position themselves when conceptualising relational normality or its absence. Protter's (1985, 1988, 1996) model of epistemological developments in psychoanalysis will be presented in Chapter 2 when discussing the epistemological positions that the various conceptualisations of normality in the literature stem from. Psychoanalytic thinking has evolved away from the essentialist paradigm to a place where the intersubjective experience between psychotherapist and patient (or couple) are the primary source of a

more tentatively known truth. Clearly, the epistemological positions held by couple psychotherapists are likely to impact their conceptualisation of normality. It is probable, for example, that those adhering to the former position will assert that criteria for what is normal (or less so) can be more firmly ascertained than those occupying the latter positions.

Relevance to the Practice of Couple Psychotherapy

The conceptualisation of normality has clear implications for practice. Psychoanalytic theory has been accused of rather thoughtlessly incorporating societal norms as indicators of developmental normality. For instance, Cheuvront (2010) offers an insightful critique in his paper titled *Life-Long Coupled Relationships and psychoanalysis: Reconsidering Developmental Milestones and Measures of Normality in Clinical Practice* where he, rather cuttingly, points out that:

> Psychoanalysis has a history of having acted thoughtlessly and, at times, cruelly in the arbitration of normality. …Nowhere is this more evident than psychoanalysis' treatment of homosexuality. It took 30 years after New York City's Stonewall Riots, which for many marks the beginning of the gay civil rights movement, and 25 years after the deletion of homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1974), for the American Psychoanalytic Association to hold a formal panel at its annual meeting to acknowledge a shift in thinking about homosexuality (Lewes, 2001). (Cheuvront, 2010, p.30)

Considering this critique of the psychoanalytic tradition it is important that concepts used by practicing couple psychotherapists and what influences their application are better understood.

Mary Morgan, a respected practitioner and theoretician credited with having 'generated many of the most central concepts in psychoanalytic couples psychotherapy, especially in the neo-Kleinian and Bionian framework' (Schaefer, 2010, p. 56) views this research as likely to be of great interest to practitioners in the field (personal communication, September 2017). Psychotherapists often struggle with how to discern when dynamic psychic processes between a couple are excessively powerful and possibly symptomatic. Questions arise, such as: When is the manifestation of libidinal longings problematic or aggression being used to destructive end? Against which norms are couple psychotherapists to make their clinical judgements? Therefore, this suggests that couple psychotherapists would benefit from gaining an understanding of how their private and formal conceptualisations of normality influence their assessment of the couples they seek to help.

Additionally, this research sought to identify difficulties that couple psychotherapists face when conceptualising couple normality or when evaluating normative models (such as those relating to psychosexual development). Consequently, the results of this research are of interest to practitioner training programmes, providing an informed updating of their curriculum. Moreover, current couple psychotherapy services may use the findings of this thesis to ensure that identified challenges are addressed through staff support processes such as supervisory and Continued Professional Development (CPD) provision. Ultimately, the research outcome will benefit clients as it will contribute to a clearer understanding of how therapists manage ideas around normality, and potentially identifying restrictive or problematic applications in clinical practice.

Background to the Researcher

I am a qualified couple psychoanalytic psychotherapist trained in the United Kingdom. My previous training as a practitioner psychologist has to some degree grounded me in the normative scientist-practitioner model (Blair, 2010). Moreover, subsequent specialisation in Counselling Psychology, Gestalt and Systemic psychotherapies has led me to an appreciation of phenomenological and post-modern positions.

My interest in the field of *normatology* (Offer and Sabshin, 1991) emerged out of my own concerns that when assessing couples for psychoanalytic psychotherapy I had a myriad of conceptual ideas but no clear template of what a prototypal model of a normal couple looked like. Indeed, I wondered whether even if such a prototype could be defined, whether this might be useful, considering the uniqueness of every relational constellation I encountered in my work.

The Research Context

Couple psychoanalytic psychotherapy emerged in London, United Kingdom in what was to become the modern-day *Tavistock Relationships* (Scharff and Scharff, 2014). Recent research has highlighted the efficacy of this approach (Hewison, Casey and Mwamba, 2016) in improving relationship quality and partners' sense of psychological wellbeing. However, while:

> the psychoanalytic approach developed by Tavistock Relationships has had a worldwide impact… it is also true that 'deep' work with couples, which combines intrapsychic understanding with interpersonal dynamics, is not the

> dominate model of therapy with couples. Indeed, psychoanalytic treatment continues to face a crisis in many western countries as other approaches have risen in popularity. (Abse, 2019, p. x)

The current research recruited couple psychotherapists working or associated to a United Kingdom-based psychotherapy institution offering psychoanalytically informed couple psychotherapy. Participants were all sufficiently experienced so as to be well established in couple psychotherapy practice. Practitioners in this field refer to themselves as either psychodynamic (when registered with the British Association for Counselling and Psychotherapy) or psychoanalytic (when registered with the British Psychoanalytic Council). Throughout this thesis, participants will be referred to as couple psychoanalytic psychotherapists, couple psychotherapists or simply as practitioners.

Conclusion

Having introduced the goals and genesis of this research project, Chapter 2 will present the key theoretical ideas around normality in psychoanalysis, including normative aspects in the psychoanalytic couple psychotherapy literature, leading to the research questions that guided this study. The subsequent Chapter 3 will detail the research methodology, providing a rationale for the gathering of data through focus groups and its examination through Thematic Analysis (Braun and Clarke, 2006, 2013). Chapter 4 will present the results as a number of main themes and associated sub-themes illustrated and supported by verbatim quotes from the twenty-seven experienced couple psychotherapists who contributed to the study. These results will then be discussed in

the subsequent Chapter 5. The contribution the study makes to the research, theory and practice of psychoanalytically-informed couple psychotherapy will be highlighted. The strengths and limitations of the study are also discussed. The final Chapter 6 will conclude the work, providing a summary and final reflections.

The Concept of Normality in Psychoanalytic Theory

Chapter 2

Chapter Overview

This chapter will commence from an introduction of the field of couple psychotherapy, with particular emphasis on its emergence and establishment in the United Kingdom. Starting from the study of psychic normality in psychoanalysis, the chapter will then move on to the application of psychoanalytic thinking in couple psychotherapy and the normalities implied therein.

The term *normal* originated in the mid-17th century from the Latin 'normalis', the right-angle obtained using a 'norma', a carpenter's square. In the early 19th century, the current use of the term emerged as indicative of conformity or acceptance of standards related to group averages, freedom from disease and sound mental health (English Oxford Living Dictionaries, 2019). In psychology and psychotherapy, this more recent and somewhat more diffused meaning has been applied widely to particular mental states, individual patients and even populations. Specific research into how the term 'norma'-lity, that is what 'norma' is applied when thinking about relationships in couple psychotherapy, as far as I could ascertain, has not been undertaken or published.

The concept of normality has been somewhat neglected (Anna Freud, 1966; Kaplan, 1967; Sabshin, 1967; Horton 1971), as already evidenced in Chapter 1, when considering the limited number of publications focused on normatology to be found on PEP-Web. However, a number of key publications have made a significant contribution to our understanding of how this concept is applied in psychoanalysis. Offer and Sabshin first published their seminal work titled *Normality: Theoretical and Clinical Concepts of Mental Health* in 1966 (revised in 1974) and then, nearly twenty years later, published

another valuable study titled *Normality and the Life Cycle* (1984). In 1991, they edited a book with authors contributing diverse perspective on normality. In this latter publication, they called for the establishment of *normatology* as a specific field of research which they then believed was to become 'an important field of study in psychiatry and psychology in the future' (Offer and Sabshin, 1991, p.405).

Their work remains to be a uniquely comprehensive study of normality, providing an in-depth review of the development of thought in the field. Indeed, it has come to serve as a 'before and after' landmark in the study of psychoanalytic normality (Horton, 1971; Millon, 1991). However, Werkman (1970) criticises their work for being: 'one more of the many examples of writing that neglects the immense clinical and theoretical relevance of the concept of developmental tasks …ratings are difficult, tedious, and always somewhat imprecise, but they promise to free us from the intuitive and deductive morass' (p.179).

Central to Offer and Sabshin's (1974) analysis is the drawing up of two schemata. The first sums up their synthesis of the conceptualisation of normality across a range of scientific disciplines which they termed the *functional perspectives*. The second identified overarching trends in psychoanalytic thinking about normality.

Offer and Sabshin's Functional Perspectives on Normality

Offer and Sabshin (1974) examined a range of scientific disciplines including the medical-psychiatric, psychoanalysis, psychology, sociological, anthropological and the biological sciences. This led them to identify what they term *functional perspectives* which

encompass 'four distinct approaches encompassing all the complex definitions' (p.97) of normality across disciplines.

1. Normality as Health

The first perspective can be summed up as 'a healthy person is one who is reasonably free of undue pain, discomfort, and disability' (Romano, 1950, p.100). Offer and Sabshin (1974) argue that the:

> traditional medical-psychiatric approach, which equates normality with health and views health as an almost universal phenomenon. Many investigators have assumed behaviour to be within normal limits when no manifest pathology is present. …This definition of normality seems to correlate with the activity of the model of the doctor who attempts to free his patients from grossly observable symptoms. (p.99)

The authors point out that it is not only psychiatry that has advocated the idea of normality as equivalent to being symptom free. Significantly, they refer to Hsu (1961), an anthropologist who, in his book *Psychological Anthropology: Approaches to Culture and Personality,* suggests that normality and relational capacities are intrinsically linked with poor interpersonal relationships being the hallmark or symptom indicative of abnormality.

As early as 1932, Glover recognised that relational capacity seemed to be linked to normality. In his paper titled *Medico-psychological aspects of Normality,* he notes that 'the psycho-analyst has found himself compelled, owing to the nature of his case material, to include amongst the standards of *abnormality* not only bodily symptoms and psychic symptom formation, but various social inhibitions and degrees of maladjustment

in work and love' (p. 154). The definition of health and symptom had expanded to denote physical, psychic, as well as social phenomena.

The issue of normality as health is highly controversial. Leader (2011) cautions that:

> many people experience unbearable levels of suffering, this does not make them 'mentally ill', as there is simply no such thing as mental health. The more we explore the individual case, the more we find that the seemingly 'healthy' person may have delusional beliefs or symptoms that generate no conflict in their lives and hence attract no attention. (p.7)

In his hard-hitting *Normality does not equal Mental Health – The Need to Look Elsewhere for Standards of Good Psychological Health,* Bartlett (2011) argues that humans suffer from a resistance to 'the pathology of normality' (p.70). He suggests consideration of the experience of an extra-terrestrial observing our planet and realising that war, destructiveness and ecological devastation are a feature of human activity. Inflicting suffering on others seems gratifying and beliefs of different sorts are held on to with such conviction as to justify murder. Extreme behaviour, even criminal behaviour, cannot simply be designated as abnormal. This leads to a harsh critique of professions that equate normality with mental health:

> Psychological normality has …turned into a calcified, skeletal framework upon which psychiatry, much clinical psychology and social work, and the supporting mental health industry hang a rapidly growing collection of artificially constructed diagnostic labels that justify the *business* of providing mental health services. The equation of psychological normality with good mental health is implicit here, explicit there; it surfaces, and it goes below the surface; it is sometimes visible, at other times not; but it is never seriously questioned. (Bartlett, 2011, p.242)

2. Normality as Utopia

Offer and Sabshin (1974) assert that from:

> Freud's conception of normality as an ideal fiction, the "Normality as Utopia" view almost has become the trademark of the psychoanalyst. …Definitions of the ideal person differ considerably, but almost all psychoanalysts, either explicitly or implicitly, conceive of normality in terms of ideal functioning. (pp. 102-103)

In these authors' view, even when the importance of defining normality be denied, implicit functional reference models persist. These are applied when the psychoanalyst inquiries about which of their clients benefited most from treatment, how patients mature or grow through treatment or when trying to identify ideal analytic processes. The model of development and treatment is of itself often peppered with utopian idealism. This position is typical of those psychotherapies, not necessarily of a psychoanalytic perspective, that advocate self-actualisation and progress along maturational pathways as the end goal of therapy. This perspective will be discussed in greater detail further on in this chapter with regards to psychoanalytic theory.

3. Normality as Average

This approach draws on the concept of the statistically-derived normal distribution based on the 'mathematical principle of the Bell-shaped curve and its applicability to physical, psychological and sociological data (Offer and Sabshin, 1974, p.105). The authors point out that this perspective is difficult to reconcile with psychoanalytic theory which

attempts to account for the minutiae and the multicausality of psychic life and therefore sits uncomfortably next to more reductionist positions.

Verhaeghe (2004), Professor of Psychoanalysis at the University of Ghent, Belgium and author of *One Being Normal and Other Disorders – A Manual for Clinical Psychodiagnostics*, argues that:

> Psychic normality is understood in terms of average scores, standard deviation, and modal personalities. This implies that psychic characteristics can be mathematically calculated and then presented in the famous bell-curve of normal distribution: the normal group in the middle of the graph is the largest while the left and right sides are occupied by the smaller abnormal populations. (Verhaeghe, 2004, p. 7)

He concludes that even though it is objectively difficult to measure amounts of, for example, depression, this does not inhibit consideration of normality as average in clinical practice. He suggests that in the absence of objective measures, psychotherapists rely on their intuition and experience to describe, for example, 'A stronger than normal separation anxiety' or 'an excessive midlife crisis'.

4. Normality as Transactional Systems

This perspective, unlike the previous ones, does not have a static view of normality defined as particular states at specific points in time. It stresses the importance of 'change or process rather than a cross-sectional definition of normality' (Offer and Sabshin, 1974, p.110). Normality is viewed from the vantage point of temporal progression or 'process' (Gonzalez, (1987, p.286). Examples of such theorists might be

biologists subscribing to evolutionary theory where the unfolding of evolutionary development is more important that the hypothesised improved version of the organism under study.

While several psychoanalytic theorists envisage development to happen across time and along a number of predefined stages or processes, they tend to define normality as points in time. Offer and Sabshin (1974) contrast these approaches with that of Erikson (1959) who 'defines normality in terms of the end product in an unfolding process over time…. For Erikson the process is clearly central to his thesis' (Offer and Sabshin, 1974, p.111). The relevance of process within the dyadic transactional system of a couple's relationship is of particular relevance to couple psychotherapy. Psychotherapists working with couples are afforded the unique advantage of being able to witness couple processes in vivo and consider their quality and evolution rather than simply appraise the resultant behaviour or result.

The Normal Psyche in Psychoanalytic Thought

The use of the term normal in psychoanalysis has given rise to much ambiguity, at times to the point of being considered a liability (Horton, 1971). Abrams (1989), in his paper titled *Ambiguity in Access: An Obstacle to Common Ground,* expresses the belief that 'in psychoanalysis, at present, some ambiguity borders on chaos, some controversy on open warfare' (p.3). He identifies a number of key areas in need of clarification and links the first of these, developmental theory, with ambiguous concepts of normality since:

> Psychoanalytic concepts of normality provide the foundation for differentiating disorders and designing approaches to their management.

> Isolating the components of mental development and accounting for how those components are usually brought together ease the task of distinguishing those disorders that are more likely to be responsive to psychoanalysis from those that are less. (Abrams, 1989, pp. 3-4)

The Major Trends in Psychoanalytic Conceptualisation of Normality

In their analysis of psychoanalytic theory, Offer and Sabshin (1974) identify three major orientations in thinking about the 'epigenesis of normal-neurotic behaviour' (p.27). They note that psychoanalytic investigation tends to depart from the investigation of pathological presentations and therefore normality emerges in the distinction of pathology and the non-pathological. In the Presidential address to the Institute of Psychoanalysis, Joseph (1982) suggests that this has led to a relatively impoverished understanding of normality:

> Often the literature contrasts *normal* with the neurotic, or *normal* and the psychotic, or, while describing, let us say, developmental stages, the statement is made that normal development would proceed in such and such a manner. …As psychoanalysts, we know more of pathology; we know more of the malfunctions of development; we know more of neurosis and psychosis then in fact we do of the normal. (Joseph, 1982, p. 3)

1. Psychoanalytic normality as an Ideal fiction

In *Mourning and Melancholia* (1917), Sigmund Freud considers variations in human reactions to loss and identifies mourning as a 'normal process' and melancholia as a more pathological reaction. According to Offer and Sabshin (1974), this normal-pathological dichotomy gave way to a more nuanced position when Freud was 'able to demonstrate the universality of unconscious conflict as reflected in dreaming process'

(p.29). He came to the conclusion that ‘a normal ego is, like normality in general, an ideal fiction’ (Freud, 1937, p.234). He elaborates further:

> Now every normal person is only approximately normal: his ego resembles that of the psychotic in one point or another, in a greater or lesser degree, and by its distance from one end of the scale and his proximity to the other we may provisionally estimate the extent of that which we have so indefinitely called the 'modification of the ego'. (Freud, 1930, p.390)

Other writers echo Freud’s position powerfully. Notably, Jones (1942) published *The Concept of a Normal Mind* in which he asserts the multi-faceted importance of furthering thinking about normality in spite of its elusive nature:

> What constitutes a 'normal' mind, and whether such a thing can actually exist, are questions of considerable theoretical, and sometimes of practical, interest. Even if we conclude that in an absolute sense no mind can be entirely and completely normal it is nevertheless worth asking what would be the attributes of such a mind. For, with such a standard before us, it would be easier to determine how far a given mind under treatment had progressed in the direction of normality. (Jones, 1942, p.1)

Jones makes a number of assertions that in many ways remain relevant today. He notes that psychotherapists make use of phrases to describe normality in a manner that suggest definitions had been established when in fact they are not. Amongst these are references to 'a mind functioning efficiently …a healthy mind …an organism well adapted to reality …a personality achieving its maximum of happiness …a personality in good contact with the social standards prevailing in the environment' (Jones, 1942, p.1).

Jones concludes that the definitions of normality he came across fall into two main sub-sets. Firstly, he identifies definitions focused around 'the criterion of happiness' and second, those centered upon 'adaption to reality'. He proposes that an advance in defining psychic normality was possible in upholding another idealistic view:

> The nearest attainable criterion of normality is fearlessness. …but we must be clear that we mean by this not merely manifest courage, but the absence of all the deep reactions that mask unconscious apprehensiveness. Where these are absent we have the willing or even joyful acceptance of life, with all its visitations and chances, that distinguishes the free personality of one who is master of himself. (Jones, 1942, p.7)

These models of normality attempt to define the ideal template, which Laing (1967) powerfully reminds us can only really be fictional in that 'What we call 'normal' is a product of repression, denial, splitting, projection, and other forms of destructive action on experience' (p. 23). In spite of the idealism of this vision of normality, it remains dominant in psychoanalytic thought (Offer and Sabshin, 1974).

2. Psychoanalytic normality as Optimal Integration

Offer and Sabshin (1974) credit Melanie Klein with providing one of the most comprehensive psychoanalytic descriptions of developmental normality. In *On mental health* (1960) which went into press soon after her death, Klein started off her paper by stating that a 'well-integrated personality is the foundation for health' (p. 237). She then proceeds to enumerate five 'elements of an integrated character: emotional maturity, strength of character, capacity to deal with conflicting emotions, a balance between internal life and adaptation to reality, and successful welding into a whole of the

different parts of the personality' (p. 237). These contributions, which remain important to the field of couple psychotherapy, are elaborated below:

i. *Emotional maturity.* This allows the individual to bear feelings of loss by accepting substitutes, the management of infantile phantasies, the capacity to enjoy pleasure, and relative freedom from envy and grievances.

ii. *Strength of character*. This is attained by the curtailing of infant's destructive impulses through the internalised experience of maternal care. Klein believes that the 'internalisation of good parents and the identification with them underlie loyalty towards people and causes' (p.237).

iii. *Capacity to deal with conflicting emotions*. The avoidance of conflicting emotions is problematic and undermining of a capacity to develop normal capacities.

iv. *A balance between internal life and adaptation to reality*. Klein is unequivocal: 'It is evident from my description that mental health is not compatible with shallowness. For shallowness is bound with denial of inner conflict and of external difficulties' (p.238). The required 'balance' depends on a capacity to know about and be able to cope with emotional pain (as in iii above).

v. *A successful welding into whole of different parts of the personality*. True to Klein's model of personality development, it is the interplay between different aspects of mental life, the impulses of love and hate that serve as the basis for mental health. This is achieved when all aspects are possible, but love predominates. Klein draws parallels with Freudian theory, noting

> that the internal process can be seen as involving destructive impulses and libido.

In concluding this paper, she offers a definition of normality that reflects the theoretical positions she had espoused:

> In a normal person, in spite of these conflicts, a considerable amount of integration can take place, and when it is disturbed for external or internal reasons a normal person can find his way back to it. Integration also has the effect of tolerance towards one's own impulses and therefore also towards other peoples' defects. My experience has shown me that complete integration never exists, but the more it has succeeded, the more the individual is able to have insight into his anxieties and impulses, the stronger will be his character, and the greater will be his mental balance. (pg.241).

Offer and Sabshin (1974) make no mention of Wilfred Bion's work. Given his significance in the development of couple psychoanalytic theory it merits noting that his work, like Klein's fits into the normative optimal integration trend. In a memorial meeting held in his honour in 1981, Hanna Segal spoke of how Bion's work built on Klein's contribution and 'explored the difference between the normal and abnormal development of the paranoid/schizoid position in particular in the normal and pathological use of projective identification' (p.5) She provides a distilled overview of his work, *A Theory of Thinking* (1962) where he elaborates how for 'thoughts to be contained, dealt with, and to become thinking, there must be a mental apparatus capable of containing and using them' (Segal, p. 6).

The views of Karl Gustav Jung, the founder of Analytical Psychology also align themselves with this trend. In *Basic Writings* (1959), he notes that:

> Individuation, is, to this extent, a natural necessity, insomuch as its hindrance, by the extensive or actual levelling to collective standards, involves a definite injury to individual vital activity… A plant which is to be brought to the fullest possible unfolding of its particular character must first be able to grow in the soil it is planted… Individuation is always to some extent opposed to collective norms, since it means separation and differentiation from the general and a building up of the particular – not a peculiarity that is sought out, but one that is already ingrained in the psychic constitution (p.260).

Thus, in Jung's psychology, integration is not simply about fitting into a specific environment but a more complex process in which individuation and collective processes are optimally adjusted. Myers (2013), in his paper *Normality in Analytical Psychology,* tells us that in 'Jung's view, "normality is a relative conception" …, a dynamic balance between the inner and outer worlds' (p.651). Jung claims that the main purpose of analytical psychology was indeed 'the better adaptation of human behaviour, and adaptation in two directions (illness is faulty adaptation)…to external life – professional, family, society – and secondly to the vital demands of his own nature…to bring it to the right pitch of development' (Jung, 1946, p.92).

Myers (2013) suggests that the perspectives offered by both Jung's and psychoanalysis agree about there being an 'average course of events' [Jung, 1936, p. 211] but diverge in a number of ways:

> While Jung recognised the role of inner conflict in creating neurosis …, he did not share Freud's view that normality was freedom from such conflict. Jones' ideal state of development, or Freud's "ideal fiction" …, corresponds to Jung's state of wholeness that is the final goal of individuation. Therefore, although the word normal is used in both psychoanalysis and analytical psychology, there are two separate meanings being used. Freud's "normal" equates to Jung's "individuation", and Jung's concept of "normal" can include a group that is opposite to Freud's—those who lack any significant development of consciousness … . Also, whilst Freud's normality is a fiction because it is unattainable, Jung says "the normal man is a fiction" … because there is no individual who is identical to the collective norms, i.e., that "every individual is an exception to the rule". (Myers, 2013, p. 651)

Significantly, Myers suggests that in modern analytic psychology, too much emphasis is being placed on individuation processes with the significance of collective processes being somewhat neglected. Considering the normal and the non-normal populations, he concludes that there is a need:

> to find the right balance between individuation and collectivity in a way that both serves society and meets each individual's needs and destiny. This requires a culture that values all parts of the collectivity-individuation spectrum, encourages individuals to find their natural place on it, and enables an ongoing progression whilst avoiding the problems of excessive one-sidedness, unconsciousness, and the analytic risks to the individual. Whereas neurotics are forced by their neurosis to become more conscious …, an increase in consciousness in normal people can only be pursued through a natural process of transformation within the individual [69]. …Whereas analytical psychologists tend to emphasise the ego-self axis, for the normal population the ego-persona axis is also very significant because of their direct involvement in collectivity. Yet neither axis represents a complete picture, so further development of the concept of normality in

> analytical psychology needs to be based on a healthy triangular relationship that affords value to all three. (Myers, 2013, p. 657)

Analytic psychology, as well as Kleinian and post-Kleinian theory, have played a key role in the development of couple psychoanalytic psychotherapy particularly in the United Kingdom (Ruszczynski, 1993; Hewison, 2004; Morgan, 2019). It is interesting to note that both Jung and Klein subscribe to the optimal integration schema with Jungian thinking providing focus on the inherent tension between intrapsychic and interpersonal/social processes. Klein, undoubtedly, is much more concerned with the intrapsychic world. In couple psychotherapy, the relevance of both dimensions is easy to appreciate, considering the interpersonal nature of coupledom.

3. Psychoanalytic normality as Adaptation within Context

Offer and Sabshin (1974) note that a number of theoreticians 'tend to emphasise the importance of cultural adaptation' (p. 43), compared to the likes of Klein and Jung. They refer to the often-quoted definition coined by Menninger (1945):

> Let us define mental health as the adjustment of human beings to the world and to each other with a maximum of effectiveness and happiness. Not just efficiency, or just contentment – of the grace of obeying the rules of the game cheerfully. It is all of these together. It is the ability to maintain an even temper, an alert intelligence, socially considerate behaviour, and a happy disposition. (p. 2)

Menninger's position seems distinctly less conflictual than that portrayed by Freud in *Civilization and Its Discontents* (1930). Freud tells us that 'Pathology has made us acquainted with a great number of states in which the boundary lines between the ego

and the external world became uncertain or in which they are actually drawn incorrectly.' (p. 66). His version of the normal psyche does not seem to allow for such serene adjustment with lingering internal conflict persisting over time:

> I should find it very understandable if someone were to point out the obligatory nature of the course of human civilisation and were to say, for instance, that the tendency to restriction of sexual life or the institution of a humanitarian ideal at the expense of natural selection were developmental trends which cannot be averted or turned aside and to which it is best for us to yield as though they were necessary of nature. …The fateful question for the species seems to me to be whether and to what extent their cultural development will succeed in mastering the disturbance of their communal life by the human instinct of aggression and self-destruction. (Freud, 1930, p. 145)

Krapf (1961) argues that the concept of adaptation allows for mental health to be defined accurately, as in his view:

> The psycho-analyst considers 'healthy' the reaction of a developing person to his conflicts if the individual in question shows himself capable of *flexible adaptation* which, while safeguarding his fundamental instinctual needs, allows him to tolerate the necessary frustrations (Jones) and the resulting anxieties (Glover), and if he is, in consequence, able to continue without hindrance the development towards mental health… (p. 444).

The term adaptation does not 'refer to the "mechanical" adaptation of a person to any sort of "reality". In fact, it is not this adaptation which is, in our view, the principal characteristic of mental health' (Krapf, 1961, p 444). The ability to retreat from reality and eventually gain mastery over one's environment is seen as indicative of normality

but this is clearly very different from Menninger's (1930) view of an adaptation that requires an accommodation of the environment.

Other Psychoanalytic Perspectives on Psychic Normality

While Sabshin and Offer (1974) provide us with a framework through which to view psychoanalytic normality, a number of other psychoanalytic theories depicting noteworthy conceptualisations merit consideration. While these conceptualisations may fit the trends schemata, they are presented independently because they represent particular interpretations on the notion of normality.

1. Normality as defence

In *The Concept of Normality,* Reider (1950) departs from a remarkably critical analysis of the 'popularization of psychiatry, psychoanalysis, and mental hygiene' (p. 43) which facilitated the identification of psychopathology. He then makes reference to the sociologist and demographer Davis (1938) noting that 'concepts of normality have become the morality of the mental hygienists, who subserve a class function' (Reider, 1950, p. 43).

Drawing on clinical observation, Reider describes what he terms 'pseudonormality' illustrating the phenomenon giving the example of a compulsive character who learning that rigidity is considered an undesirable symptom subsequently endeavours to display greater flexibility leaving the original difficulty untouched. Psychotherapy and related literature, one could argue, serve to arm patients to position themselves defensively,

either by the application of intellectual defences or by normalising all states as normal. Reider (1950) observed that:

> Standards of both normality and abnormality are perceived as threats. When abnormality is the danger, it is equated to instinctual wishes felt as dangerous… The psychoanalyst and the psychiatrist stand *in loco parentis* with an accusatory, 'You are not normal!' (p.48)

He concludes that it is clear that the concept of normality is value-laden:

> to a certain segment of our population the term has meaning as an extension and derivative of the concept of 'good'. In various ways acquaintance with it can be anxiety-provoking and anxiety-allaying. …In the main, when it is used successfully against anxiety it is seen as an additional layer of intellectual defence. (p.51)

Perhaps even more explicit is Gitelson's (1954) paper titled *Therapeutic problems in the analysis of the 'normal' candidate*. He discusses the analysis of a candidate in psychoanalytic training and argues that the analysis may be spoiled because:

1. Normality, a symptom, actually is not suffered as such. On the contrary, it is capable of earning social rewards of which the first is acceptance as a candidate. To no other symptom does such a large quota of secondary gain attach.
2. The defensive system is supported by the general culture and, besides this, is reinforced by the pre-analytic professional experiences of the candidate.
3. The analytic situation is contaminated and distorted by the adventitious external factors which interfere with the normal development of the transference. (pp. 179-180)

With modern day access to information and the popularisation of psychotherapy literature, it is hardly possible to encounter the therapy-naïve patient Gitelson seems to

wish for. Not only might a desire for normality serve defensive purposes but it may come to be considered pathological. Bollas (1987) uses the terms 'Normotic illness' or 'normopathy' which involve the complete abdication of self in favour of an other-defined normality. In *The Shadow of the Object: Psychoanalysis of the Unthought Known*, Bollas (1987) describes how for the normotic person:

> It is truly reassuring to become part of the machinery of production. He likes being part of an institution because it enables him to be identified with the life or existence of the impersonal…The normotic takes refuge in material objects. He is possessed of an urge to define contentedness through the acquisition of objects, and he measures human worth by means of collections of acquired objects. (p. 138)

In a latter paper titled *Psychoanalysis in the Age of Bewilderment*, Bollas (2015) wonders whether the world is entering a stage, in part thanks to the advent of social media, in which the 'normopath, or the normotic….is licenced to enter the world of the ordinary as long as individual idiosyncratic existence is ostensibly eliminated' (p. 96). Perceived normality is achieved at a great cost.

2. Normality as the Interplay between the Present and Past

In his paper titled *The Psychoanalytic Normalities,* Abrams (1979) asserts that because psychoanalysis is seen to be very much related to other human sciences such as psychology, sociology and biology, much confusion has arisen amongst psychoanalytic practitioners. He proposes that we may be better placed to judge psychoanalytic normality and integrate data from allied disciplines, if we think of 'two spheres of action - the sphere of the present and the sphere of the sequential' (p. 826). He believes that development takes place:

> in accordance with an innately determined sequence of expected phase emergences. The success of each emergent phase, however, depends upon the products of the antecedent ones, as well as the character of the stimuli available in the current areas of interaction and the mind's capacities to respond to them. (Abrams, 1979, p. 826)

Thus, the sphere of the present (synchronic) relates to our judgement of an individual's capacity to manage the interaction of psychology, physicality and the environment as these are encountered. The sequential sphere (diachronic) considers the past so as to capture the sequences of events and thus allows thinking about the genesis of the current presentation within the individual psyche. He argues that:

> Psychoanalysts assess both spheres. They assess the synchronic when judging a mind's effectiveness in achieving its task of engaging with, and harmonizing the psychological, the somatic, and the outside world at any moment in time. They evaluate the diachronic when raising such questions as, how has the past influenced the present equilibrium? And, what is likely to be the result of the products of the present integration when they are applied to the future? (Abrams, 1979, p. 827)

The vantage point offered by these two perspectives facilitate assessment of normality. If the mind is able to interact and manage psychic reality, physicality and the environment - meaning that it is able to fulfil synchronistic functions, then it is normal. In diachronic mode, normality or health become evident in the manifest application of the products of those synchronic activities to its ongoing development. The degrees and quality of normalcy or abnormality is determined by assessment of these two spheres, past and present.

Normality in Couple Psychoanalytic Theory

The idea of a normal couple is not one often encountered in psychoanalytic couple literature. Indeed, both the terms normal and normality are absent from the indices of Ruszczynski's (1993) review of the theory and practice of couple psychotherapy as practiced at Tavistock Relationships and the more updated compilation offered by Morgan (2019). The same holds true for Scharff and Scharff's Psychoanalytic Couple Therapy (2014). However, while explicit reference to normality is not easily encountered, implicit reference is not difficult to detect, particularly when examining the literature around the assessment of couples approaching treatment and the ending phases of therapy.

The Emergence of Couple Psychoanalytic Psychotherapy in Great Britain

The application of psychoanalytic technique to work with couples emerged in the United Kingdom (Hewison, 2004; Scharff and Scharff, 2014). Object relations theory with its interest in the analyst-analysand relationship provided fertile grounds for elaborating the nature of dyadic relationships and it was then a relatively easy leap to the application of this thinking to the adult couple relationship (Scharff and Scharff, 2014).

Hewison (2004) maintains that couple psychoanalytic psychotherapy 'is a clinical development of individual psychoanalysis and marital casework that was brought into being after the Second World War' (p.5). These psychoanalytic roots grew firm and have withstood the test of time. Indeed, in her recent book titled the *Couple State of Mind: Psychoanalysis of Couples and the Tavistock Relationships Model* (2019), Morgan defines the 'Tavistock Relationships model… as undoubtedly psychoanalytic' (p. xx) and indeed

practitioners could rightly be called 'couple psychoanalyst' (p. xx) even if the use of this nomenclature is avoided as it has limited appeal.

Ruszczynski (1993) reports that in the post-war context increased societal concern about family breakups led the Family Welfare Association (FWA) to seek technical help from the Tavistock Institute of Human Relations (TIHR). The collaboration led to the creation of the Family Discussion Bureau (FDB) in 1948. Eventually the Bureau changed its name to Tavistock Institute of Marital Studies (1988). The name changed again to Tavistock Centre for Couple Relationships (2005) and then more recently to Tavistock Relationships (2016). Ruszczynski (1993) describes the organisation as 'catholic' because of the universality of its conceptual base having 'been influenced by Jungian thinking, by the work of the British object relations school (especially Balint, Sutherland, and Winnicott) and by the work of Klein and Bion' (p. 6).

Scharff and Scharff (2014) attribute the publication of *Marital Tensions* by Dicks in 1957 as marking the emergence of a clinically relevant technique with the 'integration of Fairbairn's theory of endopsychic structure and Klein's concept of projective identification' (p. 4). Work with couples allowed an understanding that a *joint marital personality* emerged in couple relationships that was in some ways more than the simple sum of the partners' personalities. This discovery remains a cornerstone of the approach, so that Ruszczynski (1992) was able to assert that the:

> focus of clinical interest, therefore, for the psychoanalytic marital psychotherapist is the *interaction* between the couple, rather than either or both of the two individuals who make up the marriage or relationship. In this sense, for the marital psychotherapist the patient is the marriage. (p. 35)

Having provided an overview of the development of couple psychoanalytic psychotherapy in Great Britain, a definition of the field would be most useful. Nevertheless, such a definition is not easy to come by. Lanman, Grier and Evans (2003) delineate rather succinctly the nature of the work typical of analytic work with couples:

> Psychoanalytic couple psychotherapists are concerned with aspects of couples' functioning that the couple initially may be unaware of. This form of therapy aims to facilitate change in the relationship between the partners. It focuses not simply on partners as individuals and not only on the conscious and rational level, but also on the interaction between partners that operates unconsciously, which, if not engaged with, can interfere powerfully with the possibility of lasting change. The approach considers a couple's relationship in terms of how the functioning of the two individuals can be perceived as fitting together to form one predominant joint mode of relating. (p.255)

More recently, Balfour and Morgan (2019) tell us that:

> the model of couple therapy developed at Tavistock Relationships works *in vivo* with the dynamics of the couple's relationship as this unfolds in their interactions when they are together with the therapist. This approach takes the couple's relationships itself as the patient, so to speak, without losing sight of the fact that this is made up of two individuals. (p.21)

Outside the United Kingdom, The Psychoanalytic Couple and Family Institute of New England offers a similar definition, reflecting the influence of family systems theory on the development of the field in the United States (Scharff and Scharff, 2014):

> psychodynamic and family systems theories to understand and work with the historic roots and current maintenance of dysfunctional relational patterns in

> the couple. We are further informed by recent neurobiological understanding of attachment, unconscious emotional communication and affect regulation. We consider each partner's current interpersonal behavior to reflect adaptations to the early home environment, in particular adaptive and defensive strategies developed to sustain connections to early attachment figures and to maintain a sense of one's self as loveable and safe. ...Emerging from the intersection of early relational schemas, the couple relationship develops into a reciprocally-reinforcing system that sustains the dysfunctional interaction patterns in the here and now. (The Psychoanalytic Couple and Family Institute of New England, 2013)

Having presented the emergence of couple psychoanalytic psychotherapy as a distinct discipline, the conceptualisation of normality in psychoanalytic thinking is now explored. This will pave the way for an exploration of the key concepts of couple psychotherapy and their contribution to an understanding of relational normality.

Assessment of Couples Approaching Treatment – Too normal or not normal enough?

Lanman (2003), in her influential paper titled *Assessment for Couple Psychoanalytic Psychotherapy*, tells us that couple therapists assessing a couple for therapeutic support 'extend the thinking about relating, which is employed by contemporary psychoanalysis, beyond the therapist–patient relationship, to include the relationship between the partners, to explore the unconscious 'fit' between their internal worlds (p.310)'. In discussing a specific couple presenting for treatment, she clearly judges couple functioning, engaged in symptom identification and considering developmental trajectories:

> Indeed, polarization between them can be understood as serving an unconscious purpose. For example, one partner is sometimes presented as

> the 'withholding', 'ill', depressed or 'impossible' one, while the other seems to be either carer, or victim, or both. …Looking for the nature of the unconscious 'fit' between the partners is crucial in understanding why a couple chose each other, and how defensive as opposed to developmental the relationship is, or could become. (Lanman, 2003, p. 310)

The normative element in real life couple assessment is perhaps nowhere as clear as when Lanman (2003) dwells on the need to think about mental health. While espousing the position that the couple relationship needs to remain the focal point of the assessment processes, the assessment of psychopathology is clearly considered vital. Lanman is unapologetic:

> Assessment with a view to psychotherapy needs to include making a 'psychiatric' judgement about ego strength, risk, vulnerability to breakdown or dangerous acting out. The limits to the level of psychopathology which can be worked with in psychoanalysis and psychotherapy are wide, and will vary from one agency to another. But wherever they are drawn, whatever the agency feels it can take on, it is important to know as well as possible what is being undertaken. (p. 318)

Lanman, Grier and Evans (2003) conducted a study into the assessment of couples which they published, titled *Objectivity in psychoanalytic assessment of couple relationships.* Their methodology involved couple psychotherapists rating assessment interviews and then rating the observed data across couple psychotherapy relevant criteria. One of their key conclusions supported their hypothesis that: 'It is reasonable to conceptualise states of mind in couples in terms of the concepts of paranoid-schizoid and depressive positions' (p. 258). This study, in view of the normative lineage of Kleinian theory, provides evidence of the prevalence of normative thinking in assessment processes.

Morgan (2010, 2014, 2019) also writes about 'first contacts' with couples at the start of therapy, often prompting her belief that in 'consultations with couples… a primary factor in containment is the therapist's couple state of mind and the way this is communicated to the couple' (p.17). The offer of containment and couple-focused interpretation by the assessing clinician is not to be mistaken as simple benevolence. In psychoanalytic assessment, interpretation has an evaluative function, as reminded by Hinshelwood (1991):

> There may be a danger in that my hypothesising about the deepest aspects of these patients, on one interview, will be regarded as much too speculative. However, the nature of psychotherapy is the intuitive production of hypotheses - they are for trying out with the patient. We do not work to build up evidence before making a hypothesis as in other forms of science; in fact the reverse, the process of therapy is to try out hypotheses with the patient. Our evidence comes from watching the fate of our hypotheses. The response to an interpretation is then the criterion for deciding whether to retain the hypothesis or abandon it. (pp.166-167)

Additionally, in a couple state of mind, the assessor is able to observe the couple's reactions of the presence of a third person and the symbolic process evoked by the thoughts and presence of the therapist. Morgan (2001) argues that when 'a relationship is functioning well, the relationship itself becomes the symbolic third' (pp. 19-20), which she links to a number of conceptualisations of couple functioning. These can all serve in the specific manner as templates against which such functioning can be thought of. She makes reference to Britton's (1989) neo-Kleinian 'third position', Colman's (1993) Jungian 'psychological container', 'creative couple functioning' (Morgan and Ruszczynski,

1998), as well as Ruszczynski's (1998) 'marital triangle'. It is interesting to note that from the vantage point of Offer and Sabshin's (1974) normality trends, Morgan (2001) is proposing that assessment against models of normality pertain to both the ideal fiction trend (when thinking about creative coupling) and that of optimal integration (consideration of Kleinian, post-Kleinian, and Jungian theory).

Assessing Couples Approaching the End of Treatment

Cachia and Scharff (2014) argue that when it comes to making clinical decisions as to when to bring the treatment of a particular couple to a close:

> Lack of perfection is not a reason to analyse a couple interminably. When we are disappointed in the outcome of treatment, our attitude can actually block progress. As Freud (1937) has said of the goals of individual psychoanalysis, "our aim will be not to rub off every peculiarity of human character for the sake of schematic 'normality' (Freud, 1937, p.250). (p. 323)

Drawing on Cachia and Scharff's (2014) work, Morgan (2019) lists factors or capacities that may indicate therapy with a couple can be brought to an end:

1. A capacity for concern for others
2. An ability to recover from setbacks
3. Some internal working through of 'unconscious blocks'
4. A reduction of narcissism
5. A capacity to deal with separation
6. The withdrawal of projections and reintegration inside the self
7. Better regulation of affect and sensitivity to partner's moods and feelings
8. Increased containment of the self and containment in relationships
9. More creative couple functioning
10. An establishment of a more creative internal couple - perhaps drawing on other internal couples as well as the internalised relationship to the therapist

11. A capacity to bear and mourn loss
12. Internalisation of the analysing function of therapy

The above list reflects the main trends identified by Offer and Sabshin (1974), where a carefully managed desire for an ideal state is implied in a number of criteria, such as those concerned with capacities for concern, recovery, separation and creativity. Optimal integration as a model for normality is implied in management for projective processes and containment of self. Normality as an adaptation to context is probably best represented in the capacity to mourn loss which a couple face at different points of their life together.

In contrast, Balfour, Clulow and Dearnley's (1986) study of a brief couple psychotherapy intervention draws up a number of criteria with the benchmark unreservedly formulated as ideal desired states. Significantly, while such stark idealism is not characteristic of clinical evaluation in couple psychotherapy, it does reflect the utopian model inherent to much psychoanalytic thinking:

1. Whether they had separated or remained together they should each have a conviction that what they have chosen to do is right, is accepted, and allows each to flourish.
2. Separated or united they must feel themselves to be appropriately separate people.
3. In their relationship with each other and/or others they must show the capacity to be sensitive to the whole range of feelings that maintain healthy relationships without fear of breakdown or other catastrophe. There should be an absence of idealisation and denial in maintaining the relationships.
4. They should be free of all symptoms and disturbances. (pp 138-140)

Normality in Ongoing Work with Couples

Couple psychotherapy theory has evolved to include a number of key concepts. These are discussed in turn, drawing out how they might relate to conceptualisation of couple normality, in light of the psychoanalytic heritage they draw from and the implied normative model they might espouse.

Hewison's (2004) audit of clinical concepts used in couple psychotherapy at Tavistock Relationships identified a number of key concepts that were actively applied to work with couples. The more frequently used concepts are listed here, as these provide a landscape of theoretical notions applied back then:

1. Projection
2. Couple Interpretation
3. Introjection
4. Countertransference to the couple
5. Marital fit
6. Transference from the couple
7. Bion's projective identification as communication
8. Bion's container/contained
9. Here and now interpretation
10. Paranoid and Depressive positions
11. Oedipus complex
12. Narcissism
13. 'Relationship' as object of therapy rather than either partner
14. Projective Gridlock

Significantly, Hewison' s research supported Ruszczynski's (1993) observation that theoretical orientations with couple psychotherapy (specifically at Tavistock Relationships) have always been somewhat pluralistic with practitioners utilising theories across a spectrum of psychoanalytic schools of thought. Most of these concepts are still widely used in couple psychoanalytic psychotherapy, as is evident in Morgan's (2019) recent writing, *The Couple State of Mind* which illustrates current practice at Tavistock Relationships. Drawing broadly on her account of concepts currently applied in the field

of couple psychotherapy, each of these are discussed below, drawing on additional literature, and reflecting on how these concepts express or imply normative underpinnings.

1. The nature of Transference and Countertransference in couple work

Scharff and Scharff (2014) note that transference and countertransference 'are as central to psychodynamic couple therapy as they are to individual analytic therapy' (p. 11). However, there is an important divergence in technique because of the unique focus on couple processes:

> Those aspects of the internal world that appear in the transference between couple and therapist, also, by definition, refer to the marriage. For whereas the individual therapist deliberately conducts himself in such a way as to reduce to the minimum the limitations of what can be brought into the transference, the partners in a marriage are continually defining between them the limits of what can be expressed within the relationship, such that "material" that is brought to the therapy is, in a sense, predefined. It bears the shape of, indeed is the psychic expression of, the couple interaction. (Colman, 1993, p. 73)

Clearly, couple psychotherapy has moved away from early reservations about the usefulness of transference and countertransference reactions and have come to appreciate the 'gathering of the transference' as an indispensable capacity (Morgan, 2019). This gathering is an essential diagnostic and assessment process in the treatment of couples.

For instance, Siegel (1997) asserts that the 'therapist may be pulled into a control struggle with one or both spouses, reflecting the couple's intrapsychic and interpersonal problems in this area' (p. 11). However, she takes a postmodern view of transference processes and notes that the therapist's position as the sole objective arbiter of what is happening within the patient needs to be critically evaluated. She notes that the 'relevance of culture and personal belief systems has been acknowledged in the analytic literature but only recently given full consideration' (p 12). Siegel considers a number of factors that may impinge on the quality of the transference reactions encountered in treatment and the manner these may come to be interpreted. These factors include:

i. social factors
ii. culturally determined values,
iii. religious beliefs and financial realities, as well as
iv. gender and
v. privilege inherent to the professional's position
vi. work setting
vii. personal aspects of therapist's life

She concludes that 'scrupulous honesty is needed in order to process and take responsibility for reactions and departures from the typical treatment stance' (p.14), and thus make adequate use of transference reactions in couple psychotherapy.

2. The couple as a Projective System

Freud described projection as a 'method of dealing with "internal changes" (wishes, impulses, frustration) which are unacceptable and get attributed to external causes' (Jaffe, 1968, p. 662). The understanding and valuation of projective processes has seen marked development in psychoanalysis. Morgan (2019) considers projective

identification to be 'a gift to those trying to understand the unconscious dynamics of a couple relationships' (p. 88).

Projective identification was originally described by Klein (1946) as a multi-stage process in which:

> (1) the projection of aggressively valenced thoughts and feelings within an object relationship where (2) the projector could subtly behave in such a way as to create the experience of the projected material in the object and (3) then exercise some control over the object and the projected material, (4) thereby having the opportunity to identify with the unacceptable thoughts and feelings while maintaining the illusion of not owning them. (Catherall, 1991, p. 147)

Central to Klein's thought is the idea that the material is not simply projected into the environment but is able to embed itself in an other. Significantly, in spite of the potential for destructiveness, Bion (1959, 1962, 1967) was able to understand that such processes also serve communicative functions, a view elaborated by Rosenfeld (1971) who distinguishes two forms of projective identification, namely that serving *communicative* and the other serving *evacuative* purposes. The difference between communicative and evacuative projection lies in 'the degree of violence in the execution of the mechanism' (Hinshelwood 1991, p. 184). In an ideal adult relational scenario, both types of projective identification lead to the recipient introjecting and usefully metabolising the projection (Scharff and Scharff, 1987).

The evacuative-communicative continuum relates to Kleinian and post-Kleinian theory development of capacity across the maturational process. Couple psychotherapists have

several ways of examining the quality of projective processes. They may draw on object relations theory (such as Meltzer, 1986) or Jungian theory (such as Colman, 1993) so that projective processes may be seen as symptomatic or symptom facilitating. For example, Morgan (2019) discusses work with a couple who sought help as they felt their relationship was in jeopardy. She identifies a type of projective identification that 'is not about communicating an unprocessed feeling, but about dealing with the anxiety that separated and difference bring and controlling and taking possession of the object' (p. 94). Both the quality of the projective process as well as its end result are assessed to be sub-optimal.

When couple psychotherapists consider unconscious projective, as well as transferential processes, they are looking at the couple as a transactional system. What they evaluate is not simply function at specific points. The quality of dynamic processes over time are clearly of central importance. A manifest behaviour, such as an honest admission of guilt, may through an appreciation of projective and transferential processes be understood by the couple therapist to be either destructive or creative.

3. Shared Unconscious Processes

> Unconscious phantasy, shared unconscious phantasy, shared defence and unconscious beliefs are all ways of understanding the unconscious life of the couple. The concept of fantasy while conscious is also of interest as couples often have conscious fantasies about their relationship which they are invested in but that aren't known about or shared by both partners. (Morgan, 2019, p. 54)

Tarsh and Bollinghaus (1999) attribute the notion of unconscious phantasy to Klein's work, believing that the infant's young mind 'gave raise to wordless kinds of imaginings' (p. 124). However, others (such as Hewison, 2014; Morgan, 2019) suggest that the roots of the concept can probably be traced much earlier to the works of Freud (1911) and similar ideas having been arrived at by Bion (1963) and Moiney-Kyrle (1971).

Unconscious phantasy can be thought of as mental activity encompassing both thoughts and feelings, seemingly linked up as stories, saying something about the world outside or within, as this is encountered and gives raise to experience (Hewison 2014; Morgan 2010, 2019). Isaacs (1948) contends that 'phantasy is (in the first instance) the mental corollary, the psychic representative, of instinct. And there is no impulse, no instinctual urge or response which is not experienced as an unconscious phantasy' (p.83). These phantasies remain unconscious in nature but may play a significant role in shaping a person's life. Psychotherapy aims to make these phantasies conscious, thus freeing the personality to develop more freely.

Dicks' (1957) reference to the *joint marital personality* introduced the idea that partners in a relationship develop significant intrapsychic links that greatly influence their life and specifically the manner in which they present in treatment. This understanding was further elaborated by subsequent authors:

> These processes of projection and projective identification (as well as the resulting introjection and introjection identification) are part of normal average human development and continue to be employed in all relationships. The mutual acceptance of the other's projection constitutes the unconscious attachment that the couple will have to each other and will

> consist of shared internal phantasies and shared defences. If too much of the personality is projected or if too little is found to be acceptable and so slowly taken back, these mechanisms can impoverish the personality, which has in effect disowned parts of itself. If this defensive posture is held too rigidly, the partners' shared phantasies and illusions and the shred defences will become defining and restricting of characteristics of their relationship. (Ruszczynski, 1993, p.9)

Shared unconscious phantasy and shared defence can therefore play a crucial role in bringing couples into treatment. 'The concept of shared unconscious phantasy is the heart and soul of psychoanalytical marital psychotherapy. It is the Holy Grail' (Tarsh and Bollinghaus, 1999, p.123). Morgan (2010) defines this concept as 'something significant in the psyches of the two individuals that is shared or that dovetails with the other's unconscious phantasy' (p. 39). Shared unconscious phantasy is therefore that which joins the couple on the unconscious level and may have originally actually brought the couple together but, in couples presenting for treatment, has become the unconscious link that holds them trapped in distress. The shared phantasies therefore relate both to the manner of the couple fit and the shared defences the couple employ (Tarsh and Bollinghaus, 1999; Hewison, 2014; Morgan, 2019).

In her paper, *The Dynamics of Marital Pathology*, Cleavely (1983) explains the manner in which the couple fit may become problematic:

> the interactive processes which we have discovered in working with couples in difficulty are to be found in all marriages and in all relationships. These processes are normal and healthy. They become pathological only in terms of degree and the rigidity in which the pattern of interaction is adhered to by both – consciously or unconsciously. (pp. 3-4)

Hewison (in press) has recently developed the idea of shared defence further by drawing on the work of Bollas (1987) and his concept of the normotic personality. In discussing work with couples displaying normopathy, he provides us with valuable insight into how couple psychotherapy seeks to address shared defence:

> Part of analytic work then, is to enable a more benign relationship between the self, in its many guises and qualities of experience, and the mind; to be helped to inhabit our self as it shifts and changes. The couple version of this benign relationship is where each partner has an active interest in the other's internal world – not as something to be threatened by and to control, but something that brings new life into the relationship, which can be used to develop the personality. (Hewison, in press)

Therapy is thus seen as supporting the development of a benign shared phantasy that is supportive of the couple relationship itself.

Morgan (2010) published a paper titled *Unconscious beliefs about being a couple* in which she introduces the idea of shared unconscious beliefs applying ideas developed by Britton (1998) to the couple relationship. These unconscious beliefs are conceptualised as being a particular category of unconscious phantasies that become stuck and immutable in the face of changing external reality (Morgan, 2019). In Schaefer's (2010) discussion of Morgan's (2010) paper, he notes that beliefs are part of our everyday life and are mostly benign, irrespective of their verity or otherwise. Only occasionally do these beliefs become indicative of pathological process and this largely emanates from the fact that they tend to be impervious of shift in the relational environment.

Abrams' (1979) two spheres of psychoanalytic evaluation provide a means of evaluating whether a particular phantasy is normal. The sphere of the present is that manifest in the shared phantasy enacted in the everyday life of the couple. In order to come to an understanding of this phantasy, the couple psychotherapist necessarily attends to the sequential. They look at the past and how the individuals within the couple dyad managed the relationship with their psychological and physical selves as well as interaction with the environment, human and otherwise. Following from Abrams' view, the couple may be considered normal if their life experience and the resultant synchronic reality, their shared phantasy, is fit for the purpose of sustaining coupledom. Fantasy like the unconscious processes is often unknown, at least to one party in the couple relationship (Morgan, 2019). Thus fantasies, while conscious to one, may impact the dyadic system without this being in shared consciousness. Hewison (2014) notes that the term is used by Jungians to mean imagination which they hold a central faculty of the human psyche. Interestingly, he also notes that Jung's definition of *archetypal image,* which can be considered as an internal image linking the psyche with soma, very much mirrors some understandings of unconscious phantasy.

4. Narcissism and Shared Psychic Space

It is not surprising that couple psychotherapists consider very carefully the impact narcissistic impulses have on couple relationships because of the creative as well as the disruptive potential of these processes:

> The germs of the distinction between libidinal and destructive narcissism can be found in the history of the development of the concept. From its beginning two themes have run in contrapuntal fashion through the discourse on clinical narcissism. One theme is of narcissism as a defence

> *against* adverse object relations; the other theme is of narcissism as a manifestation of basic *hostility to* object relations. (Britton, 2004, p. 479)

The implication of this view is that the quality, purpose and process in which and through which narcissism becomes manifest in couple relationships serves important normative and evaluative functions because of its anti-couple potential. While discussing a couple he had seen, Bagnini (2014) writes about:

> the witch's brew of inseparability and fusion brimmed with fits of exploitation and rage at being unfulfilled but stuck together… .They were so engorged at an asymbolic level that therapy could not provide a transactional experience for development pf observing egos. (p.187)

While narcissism is not always destructive, in this case, not only did its manifestation undermine couple functioning but effectively neutralised the therapeutic experience.

James Fisher (1999), a significant figure in couple psychotherapy, tellingly titled his book *The uninvited guest – emerging from Narcissism towards marriage*. Fisher uses the term marriage to 'emphasize the passion for and dependence on the intimate other' (p.1) and narcissism to mean:

> a type of object relating in which there is an intolerance for the reality, the independent existence of the other. Narcissism in this sense is in fact a longing for an other, but a longing for an other who is perfectly attuned and responsive, and thus not a genuine other at all. (p.2)

In Fisher's view, narcissism is clearly symptomatic and not normal with marriage being the antidote for this affliction. Marriage itself can therefore be considered an ideal fiction in which the sharing of psychic space can happen in serenity to the benefit of all.

Such a reality is never fully achieved but what it represents is valued and hoped for nonetheless.

5. Psychic Development in Couple Relationships

In *Normality and Pathology in Marriage*, Ekstein (1977) places the developmental process within the couple relationship at the centre of the idea of psychological marriage. This lengthy quote is merited due to the relevance of his contribution to this research:

> …borrowing from Freud and Erikson, is that notion that marriage has to be understood as an epigenetic development. Each phase of marriage from courtship onwards, or even long before courtship, is part of the epigenesis of marriage. …Searching for the object, and the ability to approach the object, to maintain a relationship with the object, to let go, not to swallow the object, not to be swallowed by the object - all this, is of course, part of the whole growth process towards marriage. Early relationships to parents, siblings, teachers, and friends are precursors of marriage that help people develop these abilities.
>
> When a couple comes with a marital conflict, we must always ask ourselves what capacity for marriage these two partners possess. Where are they on the epigenetic scheme, and what is the crisis that they bring us?
>
> According to the epigenetic scheme a developmental maturational process takes place in the process of marriage. Developmental and maturational aspects are equally important. During different phases of marriage entirely different tasks develop. …It is Erikson's basic notion that whatever is experienced as a conflict is also a task; our aim is to turn the conflict into a task for the patient. (pp.36-37)

Ekstein discusses difficulties around specific developmental tasks in some details and then concludes his paper on a somewhat upbeat note. He believes that psychoanalysis is increasingly interested 'with establishing a framework by means of which to understand normal tasks…Marital counselling is not simply a process that deals with sick, disturbed people, but a process useful for normal people during problems of crisis' (p. 42).

Otto Kernberg, author of *Love Relations: Normality and Pathology* published in 1998, dwells on the management of aggressive drives in close relationships, viewing development as a maturational process where normal love is a mature love. He states unambiguously:

> I propose that two major developmental stages must be achieved in order to establish the normal capacity for falling and remaining in love: a first stage, when the early capacity for sensuous stimulation of erogenous zones…is integrated with the latter capacity for establishing a total object relation; a second stage, in which full genital enjoyment incorporates earlier body-surface erotism in the context of a total object relation, including a complementary sexual identification. (Kernberg, 1974, p. 743)

Morgan (2019) draws together thinking about the impact of psychic development across the lifespan on couple relationships. She argues that:

> Psychic development, stimulated by physiological developments and the response of the environment, has for many a natural trajectory towards being an adult intimate and creative couple. Couple therapists encounter couples for whom these developments have been halted, restricted or rejected. The couple who present may be in a committed relationship, perhaps with children, but are more like two friends, two siblings or a mother-baby couple. While for some, this might be the relationship they

> choose to have, others feel that they can't become the sexual, adult, intimate couple they want to be. (p. 127)

Morgan traces the developmental journey from infancy to adolescence and the eventual emergence of the adult 'creative couple' (Morgan, 2004, 2019; Morgan and Ruszczynski, 1998). The adult well-functioning couple is seen to have its genesis in the very start of life. The baby's relationship to its caregiver is the prototypal dyadic relationship. Difficulties in early relationships are hypothesised to result in problematic adult relating. Cleavely (1993) argues that:

> perhaps it is not so much what happens to us as children that is so significant to future development, but how what happened is managed – whether there is someone there to catch you. Part of the purpose, perhaps, behind the compulsive need to repeat a past experience, to relieve it, is to get in touch with "the original failure of the facilitating environment" (Winnicott, 1974). (Cleavely, 1993, p.58)

Post-Kleinians, particularly Britton (1989), have been influential in the development of theory in the field of couple psychotherapy. The successful working through of the oedipal process allows a relative ease with triangular relationships. The infant excluded in some manner from the parental couple, perhaps because of the sexual nature of their relationship, can maintain a sense of being loved. Thus, the infant, later the adult, is able to know they are apart but linked to their love object. The centrality of oedipal processes needs to be understood in the light of the fact that is never fully resolved and is encountered at different stages of the life span (Balfour, 2009). The significance of this developmental perspective is evidenced in that the Tavistock Clinic book series published *Oedipus and Couple* (Grier, 2005) exploring this developmental paradigm in

relation to couple psychotherapy. However, developmental theory has not been without its critics, precisely because of the normative developmental pathways often implied therein. This critique is discussed at some length here as it is of relevant to couple psychotherapy, having led to the pathologisation of a number of relational constellations.

In *The Temptations of Normality: Reappraising Psychoanalytic Theories of Sexual Development*, Schwartz (1999) considers the concept of the '*normal'* to be 'one of the more chilling concepts in psychoanalysis, or in psychology for that matter' (p. 560). He is particularly concerned around notions of epigenesis and 'argues that developmentally orientated theories of sexuality rest on a set of interlocking assumptions that are highly questionable from the scientific, epistemological, and political points of view' (p. 554). He considers developmental models as 'myths for the modern age' (p. 556) which become a pseudoscience, distracting psychotherapists from Bion's (1970, 1977) injunction to approach all work with patients without memory or desire. Schwartz terms the habitual reliance on causal developmental theory and hypothesising as developmentalism which he explains:

> By developmentalism, I do not refer to the assertion that experiences in childhoods affect adult personality and that they often provide adult-life with ideational and affective content around which neurotic as well as adaptive processes are organised. Developmentalism, as articulated by Freud, modified by numerous psychoanalysts and psychologists…asserts much more. It claims that universally, that it is a feature of our species, very particular and special things happen, *must* happen in the course of human life…for its most valued features to be achieved…the structure of human beings and the patterns of behaviour typically seen at different points in the

> life cycle reflect their prewired predisposition to move towards these developmental goals. (pp. 557-558)

For instance, Cohler (2000) notes that while 'being gay has become "virtually normal"' (p.222), the situation in psychoanalysis is somewhat complex precisely because of the legacy of developmental theory:

> Contemporary perspectives on understanding the course of gay lives, as more generally within psychoanalysis, focus less on experience-distant epigenetic and biological formulations of the "cause" of same gender sexual orientation, and more on the experience-near meaning for the analysands of their alternative sexual lifeway. Clearly, there are many pathways leading to the same gender sexual orientation. …Psychoanalysis has been mired from the outset in the effort to "explain" homosexuality, although not heterosexuality, as the outcome of either immature or psychopathology in personality development. Efforts by those within psychoanalysis concerned with personality development…continue this tradition of founding explanations for presumably normal gay lives paradoxically as the outcome of a deviant or psychopathological condition. Even though well meaning and seeking to show that same sex desire need not be regarded as itself evidence of psychopathology, it is difficult to view homosexuality in adulthood as "normal" when founded on circumstances in early life which are deviant or psychopathological. (p. 241)

Couple psychotherapists applying normative developmental models are not necessarily engaging in what Schwartz (1999) terms as developmentalism. However, it is clear that avoiding such rigidity while appreciating the impact of personal histories and maintaining sensitivity to idiosyncratic developmental pathways of their patient couples and the individuals that constitute them, is not an easy task.

6. The Couple Psychotherapist's Couple state of Mind

Morgan (2001) coined the term 'couple state of mind' to denote the disposition the psychotherapist must maintain in order to offer optimal conditions for couple psychotherapy to flourish:

> Much more than keeping both partners in mind. It is about keeping the *relationship* in mind. Interpretations are usually directed at what the couple create together. The therapist will be searching for some preliminary understanding of the area in which their shared anxieties and unconscious phantasies lie. These are often to do with the meaning of being in a relationship itself. (p. 18)

Morgan believes that this position can only be maintained when the practitioner has developed a capacity for thinking, specifically a capacity to link emotionally laden thoughts and feelings, that is, to maintain a state of 'reverie' (Bion, 1960, 1963, 1965) to the material the couple present. Moreover, since the therapist is necessarily engaged in a triangular relational space, the resolution of Oedipal anxieties (Freud, 1900, 1909, Klein, 1927) must be sufficiently attained as to allow for manoeuvrability on the part of the psychotherapist.

Training in couple psychotherapy is a rigorous and multifaceted process. Hewison (2004) noted that when the initial two-year training program was set up with the establishment of the Tavistock Marital studies Institute this consisted of 'clinical work with a senior staff member as a co-therapist, clinical case discussions and theoretical and technical seminars' (p. 64). Later, the requirement for personal psychotherapy was introduced. All these components or, variants of them, are still part of current training programmes in couple psychotherapy. The insistence that trainees have their own individual therapy

throughout the duration of their training stems from an appreciation that management of transferential and projective processes is challenging. Indeed, ongoing supervisory consultation is a feature of post-qualification professional life.

Couple psychoanalytic theory does not simply have a particular training pathway but, perhaps more importantly, a specific set of capacities that are the desired outcome of the training and need to be maintained through the subsequent supervisory support. Tarsh and Bollinghaus (1999) admit that the hope of capturing the 'Holy Grail' leading to the couple's recovery through the capture of the couple's shared unconscious is a somewhat 'romantic view' (p. 123), an ideal fiction held in the psychotherapist's mind. Developing a greater capacity to maintain a couple state of mind is likewise a normative ideal, applying an understanding of what optimal dyadic processes look like.

Relational Normality in Context

The relationship between notions of psychoanalytic normality and societal norms has always been problematic to untangle. As early as 1942, Ernest Jones found himself in agreement with critique levelled against psychoanalysis' reliance on:

> an unthinking acceptance of the normality of the social environment… to achieve a comprehensive judgment in psychology one needed to analyze the so-called 'normal' as well as the obviously neurotic, and that to judge the latter by the standard of the former might well introduce serious fallacies in the generalizations formulated. (p. 1)

Additionally, he contends that 'there is nothing in the method of psycho-analysis itself that binds the theory to any preconceived conception of normality in the average human

mind' (p. 2). More recently, Cheuvront (2010) points out how psychoanalysis has at times continued to collude with social convention:

> Over 100 years of psychoanalysis have given us a number of striking examples where social customs and traditions have been incorporated into our clinical theory and practice, hen adopted as developmental milestones and measures of normality. Two examples that immediately come to mind are ideas about the relative immaturity of women as compared to men (Freud, 1937), and the pathologizing of homosexuality.
>
> …Psychoanalysis has a history of having acted thoughtlessly and, at times, cruelly in the arbitration of normality. …Nowhere is this more evident than psychoanalysis' treatment of homosexuality. It took 30 years after New York City's Stonewall Riots, which for many marks the beginning of the gay civil rights movement, and 25 years after the deletion of homosexuality from the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1974), for the American Psychoanalytic Association to hold a formal panel at its annual meeting to acknowledge a shift in thinking about homosexuality. (pp. 38-39)

Psychoanalysis' failure to strive for a clear, unbiased development of its theoretical foundations is most pronounced when dealing with sexual minority groups or behaviours and this, of course, has serious ramifications for the couple psychotherapist. In discussing open and polymorphous relationships, MacCann (2017) suggests that there is a need for practitioners to 'question their own pre-existing assumptions and to build a more accepting therapeutic container' (p. 57). He lets us into how he finds himself:

> revisiting aspects of theory that underpin couple psychoanalytic practice: namely ideas about the unconscious couple fit, the notion of the relationship itself acting as a container for the couple, the defensive use of splitting when the going gets tough. In revisiting the theory, I began to wonder how best to

> employ these concepts in therapy whose relationship is open or where one of the partners has wishes to make it so. (p. 45)

McCann concludes that couple psychotherapists, attentive to the historical record tainted with the pathologising of various expressions of human sexuality, must not be too attached to particular positions. The literature suggests that couple psychotherapists are supported to heed Bion's (1967) advice to be 'without memory or desire'. This is another ideal fictional norm defining psychotherapeutic normality. This normality is of value as Bion's 'counsel works well as a spur to theoretical humility, and wisely cautions against clinging inflexibly to intrusive agendas' (Pariser, 2013, p. 129).

The Evolution of Psychoanalytic Thought, Epistemology, and Normality

Psychoanalysis knows its birth to Sigmund Freud whose background in the biological sciences of zoology and anatomical research is well-known, while his credentials in philosophy are less often referenced (Allison, 2017). The young Freud studied philosophy at the University of Vienna under Franz Brentano who came to define himself as a 'godless medical man and empiricist' (Freud, 1874, p.70).

In spite of Freud's lineage, the epistemological status of psychoanalysis has shifted considerably as the field of epistemology itself underwent significant development. It is therefore not surprising that rather more recently, Protter (1996) poised the question:

> Does our future lie with the empiricist harder sciences, to be justified according to clear-cut criteria; or is psychoanalysis more akin to the interpretive, humanistic disciplines, to be judged by a different set of standards? (p. 533)

While a detailed exposition of the complex epistemological debate surrounding psychoanalytic thinking is beyond the scope of this project, a summary of the ensuing positions is presented, as these have direct relevance to how psychotherapists and couple psychotherapists in particular, think about concepts of normality.

Protter (1985) suggests that the developments which have taken place in the 20th century around the theory of knowledge have had a profound impact on psychoanalysis. These led to a movement away from a 'metapsychology, to a refocusing on the features of the actual communicative encounter between analyst and patient' (p. 209). Protter provides a schema for these developments which help map out the trajectory psychoanalysis has taken with the move away from empiricism, towards what he describes as schema focused on *clinical contexts* and *clinical text*. In Protter's exploration, psychoanalysis moved along a number of positions which he referred to by the theme that dominated each period. Each of these positions provides valuable schema sketching the developments in psychoanalysis over time.

Correspondence-Essentialism

The positivist-empiricist stance in psychoanalysis represented a search for immutable truth or the hidden essence in the hope that logical interpretation or rigorous scientific investigation would lead to an accurate account of reality. The empiricist view of science maintains that meaning can only be found in the observation of fact with the relationship between the observed and observer being unambiguous (Stern, 1985).

Allison's (2017) critique of Freud's epistemological stance claims that he laboured to convince readers that his theories are 'legitimately drawn from innumerable observations' (Freud, 1914, p.17) and are independent of his influence or indeed, to some degree, of philosophical and literary precursors. Clearly, Freud was eager to establish psychoanalysis as an empirical science, but some would argue that his success was limited in this regard. In his later works, he started to see 'the reciprocal determination between subject and object as a condition for productive analysis' (Allison, 2017, p.101) which one can consider to be a deviation from the empiricism that dominated the science of his day.

Considering the often ambiguous conceptualisation of normality across the history of psychoanalysis, one suspects that the concept was never established with the clarity or certainty that would satisfy the essentialist position. However, echoes of this view of reality can be found across the reviewed literature. For example, both Krapf's (1950) assertion that 'mental health can be defined in quite rigorous terms' (p. 444) and Klein's (1960) statement that a 'well-integrated personality is the foundation for health' (p. 237) have an air of certainty and permanence characteristic of this position.

In the field of contemporary couple psychoanalytic psychotherapy, the continued application of normative models of psychic development as discussed earlier, suggests that the correspondence-essentialism paradigm is not entirely dead. Equally, Lanman's (2003) emphasis on the need to assess the pathology status in terms of 'making a 'psychiatric' judgement about ego strength, risk, vulnerability to breakdown or dangerous acting out' (p. 318) is reminiscent of this stance.

The Clinical Context

Truth in the essentialist position is about capturing reality as if this is unrelated to time, space and context. Anti-essentialist movements sought to contextualise reality in both social space and time as well as language. The humanistic-existential trust which spearheaded these anti-essentialist developments:

> is reflected in the post-Freudian upsurgence of self-in-relation psychologies as a counterpart to biological drive views. But even under the umbrella of Freudian drive psychology, efforts have been made by various thinkers to purge its mechanistic metapsychology and replace it with a clinical theory of intentions and reasons. (Protter, 1996, p.538)

This clearly corresponds to a pragmatic view of psychoanalysis in which, Stern (1985) suggests 'the relationship between observation and theory is highly ambiguous, deeply influenced by the norms and social structure of the particular science in question' (p. 205). In line with this position, he concludes that:

> the community of patient and analyst tries to understand how and why the patient has come to be this particular person. Their acceptance of the impermanence (since truth may change) and imperfections of their work makes no less satisfying to them their discovery of words that fit experience closely…Given two sincere participants, psychoanalytic constructions are no less likely to be "made up" than theories of any other kind. (p.206)

Balfour and Morgan (2019) view couple psychotherapy to involve interpretation of what happens '*in vivo* with the dynamics of the couple's relationship as this unfolds in their interactions' (p.21). While this might be understood as the psychotherapist taking an empiricist observer-observed stance, the subjective nature of the psychotherapists'

position is now more fully acknowledged. Hewison (2008), reflecting on a clinical account, concludes that:

> The commentaries on a piece of clinical material from couple therapy shows us how hard it is to say that any movement or sequence of events in a consulting room is a 'clinical fact' that can survive the shift from one therapist to another… after all, what I see as a clinical fact may not be what you see. We cannot have portable galvanometers and stopwatches… (no page number)

The Clinical Text

A subsequent development reflecting a hermeneutic position where, Protter (1985) suggests, psychoanalytic truth is found in the appreciation of the personal narrative emerging in the therapeutic encounter. The 'main feature of this theme is the narrative sphere of analytic time; in particular, how the "pull of text" or narrative affects the knowing of (and by) the patient. As the patient unrolls his 'life story' there is a pull to make some kind of sense, shape and form out of this' (p.219). Adherents to this view believe that whether an immutable truth exists at all is less pertinent to the work of psychotherapy than empiricists or social constructivists suggest.

Chapter Summary and Conclusion

This chapter has examined psychoanalytic normality illustrating that the struggle to define psychic normality has been present since the genesis of psychoanalysis and is indeed ongoing. While the number of publications dedicated to this matter remains relatively limited in number, the practicing psychotherapist is, nonetheless, left with a

number of conflicting ways of conceptualising psychic normality. Concepts are nowhere as definitive as the right angle marked by the carpenter's 'norma' or square.

Furthermore, no publication dedicated to relational normality was identified in the field of couple psychoanalytic psychotherapy and yet, it is clear that models of normality imported from the main corpus of psychoanalytic literature, permeate couple psychoanalytic theory. The literature provides no clarity as to how couple psychotherapists conceptualise relational normality and the epistemological position they maintain.

The central aim of this research stemmed from a desire to address this lacuna in the literature. The study sought to identify the explicit and implicit notions of relational normality used by couple psychotherapists trained in the psychoanalytic tradition. It aims to understand to what degree they are conscious of using psychoanalytic models of normality, as well as perhaps others not pertaining to the psychoanalytic tradition. The research was inspired by the concern that failure to examine such notions presents a real risk to the integrity of psychoanalytic work with couples.

This thorough analysis of the literature therefore led to the formulation of the four research questions guiding this study, namely:

1. How do couple psychotherapists conceptualise relational normality when working with their couple-patients within the psychoanalytic model?
2. What other frameworks and ideas are applied in considering normality?
3. How do cultural influences and personal biases impact therapists' conceptualisation of relational normality?

4. How does training support development of thinking around relational normality?

The following chapter presents the research methodology devised to address this research question. It details the rationale for selecting focus groups as the data gathering method of choice as well as the design, procedure and use of Thematic Analysis in making sense of the gathered data.

Methodology

Chapter 3

Chapter Overview

This chapter presents the methodological approach adopted for this study. It departs with a discussion of the development of the research questions and research design. Presentation of the research participants' demographics is followed by presentation of the data gathering and data analysis procedure. Ethical and epistemological considerations conclude the chapter.

The Research Questions

The research questions for this study were developed in response to the identified lacunae in knowledge in the field of couple psychoanalytic psychotherapy. Four guiding questions were formulated:

1. How do couple psychotherapists conceptualise relational normality when working with their couple-patients within the psychoanalytic model?
2. What other frameworks and ideas are applied in considering normality?
3. How do cultural influences and personal biases impact therapists' conceptualisation of relational normality?
4. How does training support development of thinking around relational normality?

The questions aim to capture both explicit and implicit conceptualisations applied by couple psychotherapists. Considering the lack of literature about normality in this field, it is possible that attention to implied normative references may be rather important. The operationalisation of the research questions in the focus group schedule took this into consideration.

The Research Design

This is a qualitative study designed to capture rich data by harnessing the interactive nature of focus group data collection. Thematic Analysis is applied to identify the manner in which couple psychotherapists conceptualise normality.

Rationale for Methodological Choice

The choice of a qualitative design follows Caswell's (2013) emphatic statement that the approach is ideal when there is a need to 'study a group or population, identify variables that cannot be easily be measured, or hear silenced voices' and when there is a need for 'a complex, detailed understanding' (p. 48). Additionally, Wimmer and Dominick (1991) believe that both the aims and philosophy underlying qualitative and quantitative research are complimentary but different so that 'whereas quantitative researchers thrive for breadth, qualitative researchers strive for depth' (p. 139). This study aims at achieving an in-depth understanding of the challenges and dilemma participants experience in the process of conceptualising normality.

The potential benefit of including a quantitative component to this research was carefully considered. In spite of the fact that survey research may suffer from limited ecological validity because of the inherent cultural, linguistic and psychological presuppositions (Cicourel, 1982), and reliance on a stimulus-response model (Mishler, 1986), adding a quantitative component provides a valuable additional dimension. Jick (1979) suggests that such a design could 'uncover some unique variance which otherwise may have been neglected by a single method' (p.603).

In discussing the use of mixed methods research in counselling psychology, Hanson, Creswell, Plano Clark, Petska and Creswell (2005) note that some researchers have argued the philosophical paradigms supporting quantitative and qualitative methods are essentially irreconcilable (Smith, 1983) while other have argued that this not necessarily so (Reichardt and Cook, 1979). There is now a growing sense of consensus that 'multiple methods may be used in a single research study to, for example, take advantage of the representativeness and generalisability of quantitative findings and the indepth, contextual nature of qualitative findings' (Greene and Caracelli, 2003).

However, while the benefits of mixed methods were contemplated, the selected qualitative design was considered sufficient for the purposes of a Professional Doctorate (Smith, 2015).

Rationale for Method of Data Collection

The Focus group was the method of choice as it is supportive of participants' efforts to identify and articulate concepts that might be somewhat ill-defined. The methodology is considered to be ideal when it comes to drawing out a wide range of views, perspectives and understandings around an issue (Wilkinson, 2000; Underhill and Olmsted, 2003; Braun and Clarke, 2013). Morgan and Krueger (1993) suggest that focus groups are advantageous in a number of situations that are relevant to this research:

1. *When there is a gap between professionals and their target audiences,* and the researcher (or other professional) would benefit from 'a clear view of how others think and talk' (p.16). The focus group exposes the researcher to the diverse subjectivities within the group, thus alerting the researcher to

personal biases imposed by one's life experiences and cultural stereotypes. Considering the subject matter of this research, this is of great relevance ensuring that both the researcher's and participants' points of view are challenged by the multiplicity of perspectives likely to emerge in a group conversation.

2. *When investigating complex behaviour and motivations.* Morgan and Krueger (1993) succinctly capture what the researcher hopes to achieve in supporting a creative group interaction:

> ...many of the behaviours we might wish to understand are not matters of conscious importance to research participants...as they hear others talk...by comparing and contrasting, they can become more explicit about their own views. In addition, as they do express their own feelings and experiences...other participants make them aware of things that they had not thought about before. (p.17)

In researching the conceptualisation of normality, the focus groups allowed for implicit and informal ideas to be expressed. In particular, when participants presented clinical narratives, these were likely to evoke a variety of emotional and technical responses from the group that are of value to this research.

3. *To learn more about the degree of consensus on a topic,* or in other words to gain an understanding of the range of opinions present within the focus group. Since the available data about relational normality, as thought about by couple therapists, has never been researched, the focus group allowed the researcher to gain insight into the sets of circumstances that led to one response rather than another, or indeed to the same response but for different reasons.

4. *When there is the need of a friendly research method* that is respectful and not condescending to target audience, allowing for a sense of safety (Vaughn, Schumm and Sinagub, 1996). This is very important when researching clinically relevant concepts so as to ensure the tone of the research is explorative rather than evaluative. In this context, the focus group allowed a group of peers to talk about their thinking and their clinical work within a receptive and interactive space.

While individual interviews could have been used, 'the thing that distinguishes focus groups is the presence of group interaction in response to researchers' questions' (Morgan and Krueger,1993, p.15). Participants are offered the experience of feeling supported and empowered when participating in a cohesive group (Goldman, 1962; Peters, 1993). The group process uniquely facilitates the emergence of attitudes and opinions through the interactive nature of the setting (Morgan, 1988) and encouraging a greater degree of spontaneous expression of opinion (Butler, 1996). Kitzinger (1994) suggests that disagreements amongst group members stimulates the expression of dissident views that widen the range of opinions expressed thus enriching the data. Individual interviews would have also been less attractive to participants because psychotherapists generally appreciate a discussion of their practice, since this is seen as a means for furthering professional development. Indeed, some participants reported that the focus groups served as a valuable continued professional development (CPD) event.

The quality of focus group data is dependent upon a number of other considerations connected with the very nature of the group itself. 'Holding separate sessions with homogenous but contrasting groups is believed to produce information in greater depth than would be the case with heterogeneous groups' (Knodel, 1993, p.40). Group size is also an important consideration. Typically, the focus group consists of eight to twelve respondents (Stewart and Shamdasani, 1990) such that the moderator can capitalise on small group interactions to pursue the research goal. Furthermore, Braun and Clarke (2013) note that recommendations for sample size vary but their experience indicates that a smaller number of participants per group (of between three and eight) allows for a richer discussion. Smith (2015) suggests that for a Thematic Analysis study at Professional Doctorate level the ideal number of focus groups lies somewhere between 3 and 6 groups. Four focus groups were established, each consisting of between 5 and 8 participants with a total of 27 couple psychotherapists all meeting the inclusion criteria for the study.

Additionally, Sim (1998) suggests that while focus groups cannot provide data that allows for empirical generalisations based on probabilistic representations, they do offer some potential for theoretical generalisation. Sim argues that focus groups may allow for:

> the data gained from a particular study provide theoretical insights which possess a sufficient degree of generality or universality to allow their projection to other contexts or situations which are comparable to that of the original study. The researcher sees the parallels, at a conceptual or theoretical level…not one based on statistical representativeness. (p. 350)

Vicsek (2010) agrees that theoretical generalisations are possible but adds that focus groups allow for other types of generalisation, specifically:

1. *Tentative incidental generalisation* inferred from identified commonalities shared amongst research subjects. The argument is not based on statistical evidence and is not conclusive by hypothesis supporting. For example, Vicsek (2004) reporting on a study exploring insecurity in a particular population, argued that the 'the fact that there were strong convergences amongst many of the groups and similar clusters of opinion appeared again and again in the groups, supports the assumption that the results have significance beyond their particular situated location' (Vicsek, 2004, p.307). The possibility of this data gathering method allowing for the development of hypothesis about the process of conceptualisation of normality is of significant value.
2. *Variation-based generalisation* identified by Smaling (2003) which allows for an appreciation of variation in a population. Focus groups provide insight into the breath of concerns, perspectives and aspects of a phenomenon and the existence of these can be generalised to the population (Puchta and Potter, 2004). Vicsek (2010) cautions that this does not mean that who set of phenomena in a given population can be identified through focus group research.
3. *Existence generalisation* allows for simple generalisation about the existence of a phenomenon or opinion in the wider population but not its distribution. In researching the conceptualisation of normality, the identification of more

marginal perspectives may be uniquely important if, for example, this represents ethically problematic positions).

4. *Analogical generalisation* refers to the transfer of conclusions from one case or group to a similar case or group. Smaling (2003) identifies six criteria in assessing analogical generalisation namely, (i) the relative degree of similarity, (ii) relevance of similarity to conclusion, (iii) support by means of variation, (iv) the relative plausibility of the conclusion on its own, (v) support by means of variation, and (vi) empirical and theoretical support.

The Research Participants

Participants were selected from current staff members working with the clinical service of a couple psychotherapy serviced in the United Kingdom. Three essential criteria were set:

1. Participants were required to be qualified at least 2 years prior to the start of the study via a psychoanalytically -informed couple therapy training pathway;
2. Participants were required to be registered members of an established professional body (specifically the British Psychoanalytic Council or the British Association for Counselling and Psychotherapy); and
3. Participants were required to be in clinical practice seeing at least three couples in regular weekly therapy.

Potential participants were sent an invitation via an email by the lead researcher to which both the Participant Information Sheet Information Sheet (Appendix A) which

included the consent form, and Participant Demographics Information Sheet (Appendix C). An insert within the organisation's monthly staff bulletin was also created, inviting participants to contact the lead researcher.

Participant Demographics

Twenty-seven psychotherapists participated in this research with four focus groups having seven, five, seven and eight participants respectively. Twenty-three of the participants were female and four male, with 60% being over the age of 55 and only two participants being 45 or younger. This stark disparity in the numbers reflects the gender representation within the profession itself with, for example, only about 19% of couple psychoanalytic psychotherapists listed on the British Psychoanalytic Council's 'find a therapist' online search facility, being male (British Psychoanalytic Council, 2019). All except for two participants identified themselves as heterosexual and all but four of the participants identified themselves as white. Nearly 70% have been in long-term relationships spanning 20 years or more.

The research participants were very experienced with two thirds having been practicing in the field for over 9 years and many for much longer with one participant indicating that they had worked with couples for over 40 years. Only three participants had less than 4 years of post-qualifying practice. Sixteen participants (60 %) had completed the Masters level couple psychoanalytic course at Tavistock Relationships, while the rest had completed psychodynamic training, either at postgraduate or Masters level. Details of each participant's demographic characteristics is provided in the following Tables 3.1 to

3.4, representing each of the four focus groups. Pseudonyms are used throughout to ensure anonymity.

Table 3.1: Participant Demographics of Focus Group 1

Participant	Charlotte	Rachel	Natalia	Linda	Hannah	Dawn	Sandra
Gender	Female	Female	Female	Female	Female	Female	Female
Age	56-65	46-55	46-55	46-55	56-65	66+	56-65
Years in relationship	21+	21+	21+	21+	21+	21+	21+
Ethnicity	White	Mixed	White	White	White	White	White
Sex orientation	Hetero	Hetero	Hetero	Hetero	Hetero	Hetero	Hetero
Level of qualification	PgDip	Masters	Masters	Masters	Masters	Masters	Masters
Years of Experience	9+	9+	9+	5-6	9+	9+	9+
Professional Registration	BACP COSRT	BPC BPS	BPC	BACP	BPC	BPC	BPC
Specialisation	Couple dynamic, Psycho-sexual, Counselling	Couple analytic, Child therapy, Adult therapy	Couple analytic	Couple analytic	Couple analytic	Couple analytic	Couple analytic, Adult analysis

Table 3.2: Participant Demographics of Focus Group 2

Participant	Riya	Catherine	Ian	Marie	Victoria
Gender	Female	Female	Male	Female	Female
Age	26-35	66+	66+	46-55	66+
Years in relationship	--	21+	21+	21+	21+
Ethnicity	Asian	Mixed	White	White	White
Sex orientation	Hetero	Hetero	Hetero	Hetero	Hetero
Level of qualification	Masters	Masters	Masters	Masters	Masters
Years of Experience	9+	9+	9+	2-4	9+
Professional Registration	BPC BPS	BPC	BPC	BPC BACP	BPC
Specialisation	Couple analytic, Clinical psychology	Couple analytic, Counselling	Couple analytic, Individual therapy, Social work	Couple analytic, Couple dynamic, Individual therapy	Couple analytic, Individual therapy

Table 3.3: Participant Demographics of Focus Group 3

Participant	Eva	Isabel	Trisha	Greta	Grace	Amelia	Oliver
Gender	Female	Female	Female	Female	Female	Female	Male
Age	56-65	56-65	56-65	46-55	46-55	46-55	46-55
Years in relationship	21+	11-15	11-15	16-55	21+	21+	21+
Ethnicity	White	Mixed	White	White	White	White	White
Sex orientation	Hetero	Hetero	Hetero	Hetero	Hetero	Hetero	Homo
Level of qualification	PgDip	Masters	PgDip	Masters	PgDip	PgDip	Masters
Years of Experience	9+	9+	9+	5-6	5-6	5-6	9+
Professional Registration	BACP COSRT	BACP COSRT	BPC	BACP	BACP	BACP	BACP UKCP COSRT
Specialisation	Couple dynamic, Group Counselling	Couple dynamic	Couple dynamic, Individual therapy	Couple dynamic	Couple dynamic	Couple dynamic	Couple dynamic, Psycho-sexual, Individual therapy

Table 3.4: Participant Demographics of Focus Group 4

Participant	Evelyn	Traci	Abigail	Camila	Lydia	Ian	Leah	Harry
Gender	Female	Female	Female	Female	Female	Male	Female	Male
Age	56-65	66+	56-65	36-45	66+	56-65	46-55	56-65
Years in relationship	21+	11-15	21+	11-15	21+	21+	16-20	6-10
Ethnicity	White	White	White	White	White	White	White	White
Sex orientation	Hetero	Hetero	Hetero	Hetero	Hetero	Hetero	Hetero	Homo
Level of qualification	Masters	Masters	Masters	Masters	Masters	Masters	PgDip	Masters
Years of Experience	9+	9+	9+	7-8	9+	7-8	2-4	2-4
Professional Registration	BPC BACP UKCP	BPC FPS	BACP UKCP COSRT	BACP	BPC	BACP	BACP	UKCP COSRT
Specialisations	Couple analytic, Individual therapy, Systemic therapy, Social work	Couple analytic, Individual therapy	Couple dynamic, Psychosexual, Individual Therapy	Couple dynamic	Couple analytic, Individual counselling	Couple analytic	Couple dynamic	Couple analytic, Psycho-sexual, Systemic therapy

Materials

The practice of couple psychotherapy is a complex and dynamic issue that requires the moderator to be both sufficiently skilful and informed. Ten to twelve well-developed questions are often adequate for a two-hour focus group interview (Krueger, 1993). Offer and Sabshin's (1974) four functional perspectives of normality, namely normality as health, utopia, average and process, served as the framework for the development of the focus group schedule. Additional questions were devised to tap into participants' reactions to being invited to contribute to this research and to explore whether they felt that their professional training had sufficiently addressed their thinking about relational normality.

The Focus Group Schedule

The focus group schedule consists of an introductory question followed by a set of eleven questions, some of which had a number of prompts as shown in Table 3.5. The question sequence was structured in such a way as to facilitate the development of the group discussion. Initial reactions to the subject matter amongst potential participants at the recruitment stage indicated that they were intrigued and even surprised. The introductory question was therefore fashioned to capture this more emotive response. Question 1 then invited participants to consider their clinical practice, inviting them to discuss how they conceptualise normality in this setting. The four subsequent questions explored whether participants conceptualise normality in terms of Offer and Sabshin's (1974) functional perspectives. The functional perspectives allowed participants to explore conceptualisations of normality beyond those used in psychoanalytic thinking.

Question 6 then invited couple therapists to reflect on how they assess or judge both the quality of interaction they witness between couples and the nature of the affect they experience in response. The next two questions investigate how participants manage their biases and whether they are aware of how this impacts their thinking about couple normality. The following question seeks to gather participants' reactions to a somewhat provocative and critical appraisal of normative thinking in psychoanalysis, while the final question seeks to gather the reaction of participants to having participated in the focus group experience. The focus group schedule, including the detailed guidance provided for the facilitators, is found in Appendix B.

Table 3.5: Focus Group Schedule Questions

Introductory question:

In working with couples, couple psychotherapists seek to address their need for something to change. Can I ask you to reflect for a moment and then share with us what you believe you are helping couples achieve? Is it some form of so called 'normality'?

Q1: What ideas do you associate with the notion of normality in couple relating when seeing couples in your practice?

- *Prompt 1: does psychoanalytic thought provide you with an adequate framework to consider normality?*
- *Prompt 2: does couple therapy help couples achieve normality and, if it does, what does that look like? What are you working towards, normality or some other end state?*

Q2: Normality has been conceptualised in terms of a lack of manifest symptomology - that is, using a health/disease framework. To what extent is this true?

Q3: Some would say that normality is not achievable. Is normality a utopian notion?

Q4: Is normality about being average, about avoiding extremes?

- *Prompt 1: Is there any conflict between your position around normality and that related to measures of individual and relational well-being (e.g. the CORE Clinical Outcome Measure (CORE-OM) and the Couple Satisfaction Index (CSI) for those working at [organisation]. Is normality about being outside the measure's clinical range?*
- *Prompt 2: how do these tools influence your thinking about normality, if at all, and is this consistent with your analytic framework?*

Q5: Normality can be seen as related to process with psychoanalysis, for example, suggesting that some developmental processes are normative in nature. Does this apply to thinking about couples?

- *Prompt: What particular theories do you find relevant here and do you normally refer to them in thinking about normality or a lack of it?*

Q6: The couple therapist is often required to witness couples in a state of relatedness, that is, to see how couples behave in vivo. Do we think about normality as we observe the couple and ourselves in the clinical situation?

- *Prompt 1: can particular ways of relating be considered more or less normal?*
- *Prompt 2: Are the therapist's feelings a reliable gauge of the couple-patient's normality status?*

Q7: Therapists can allow their own individual and cultural biases to impact their observations and their thinking as to how 'normal' a particular aspect of couple relating is. To what extent do you find yourself struggling with such matters in clinical practice?

- *Prompt 1: London is a very diverse city. Do couples define normality in ways that surprise you?*

Q8: What do you think are the dangers inherent to thinking or failing to think as to how notions of normality impact couple therapists?

Citation: *Cheuvront's (2010) paper titled Life-Long Coupled Relationships and psychoanalysis: Reconsidering Developmental Milestones and Measures of Normality in Clinical practice highlights the importance of thinking with clarity about normality in psychoanalytic practice. He asserts that psychoanalytic theory has at times, rather thoughtlessly incorporated societal norms as indicators of developmental normality, thus diminishing the value of other pathways towards normality in whichever way that might be conceptualised. Attention to impact of "cultural" normality in couple relationships is therefore very relevant to the practice of couple psychotherapy.*

Q9: To what degree would you consider this statement to be true?

- *Prompt 1: What measures do you take to limit such biases and/or limitations?*
- *Prompt 2: Considering what you have said and heard today, would you think that your training focused sufficiently on considering normality in relation to coupling?*

Q11: I would welcome any final concluding thoughts you might wish to share.

- *Prompt 1: Has participating in this forum been helpful?*
- *Prompt 2: Is there anything that needs clarification before we conclude this meeting?*

Demographic Information Sheet

Participants were asked to complete a form collecting information about their personal and professional lives. The following data was collected:

i. Gender
ii. Age
iii. Length of longest personal couple relationship
iv. Ethnicity
v. Sexual orientation
vi. Highest professional qualification in couple psychotherapy
vii. Other professional qualifications in psychotherapy and allied disciplines
viii. Years of experience working with couples
ix. Registration with professional bodies
x. Specialisations (couple, individual, group or child psychotherapy)

The full demographic information sheet can be found in Appendix C.

Hardware used in Data Recording and Processing

The focus groups were recorded using professional grade audio recording equipment. Two machines were used so as to insure against data loss. The data was then downloaded onto the researcher's laptop, stored in an encrypted folder and the original recordings were deleted from the audio recording equipment. Access to the laptop is protected by biometric security.

Data Gathering Procedure

Four focus group meetings were conducted on the basis of detailed procedural guidelines which included the interview questions and instructions for both the lead and assistant facilitators. The researcher served as the lead facilitator and was able to

employ his previous experience in conducting all four research focus groups. The assistant facilitator had an excellent knowledge of the institution in which the study was conducted and was chiefly responsible to managing the logistical aspect of the events. She also actively supported the facilitation of the group process when the need arose. The use of an assistant moderator is considered important to enhancing quality control, enriching subsequent analysis, and improving the handling of focus group logistics (Krueger, 1993).

Researchers such as Morgan and Krueger (1993) suggest that too much emphasis on moderator skill is counter-effective. They propose that a sufficient level of competence in handling group dynamics is essential but that 'in reality, it may be more than merely feasible to find a good moderator from within the research team, it may in fact be preferable to do so' (p.5), particularly when the moderator requires familiarity with the research area under investigation.

Both facilitators sought to keep in mind Zeller's (1993) advice that:

> the effective user of a research design finds ways simultaneously to capitalise on the opportunities and to avoid or mitigate the risks. One of the major opportunities of focus group research is the exploration of sensitive topics... The burden of setting an agenda which will both capitalise on the opportunity and mitigate the risks falls on the moderator. (p.167)

Furthermore, Zeller (1993) suggests three strategies for effective focus group research:

1. *Capitalising on the methodological principle of reactivity in the screener questionnaire*. In the initial process of recruitment of focus group members, it is

normal procedure to utilise a screener questionnaire that asks for relative demographic data such as age, gender and level of education. To capitalise on the principle of reactivity, the questionnaire should also include material that will alert group members to the subject to be discussed in the focus group sessions. In this way, in the time between the reception of the screener questionnaire and the focus group session itself, members had the time to react to the fact that they are to be asked to deluge details about a specific aspect of their thinking and practice. Members will then be able to participate in the focus group interaction having already had the time to formulate opinions and reactions. Zeller (1993) argues that "our information about their reflected self-appraisal will have more fidelity to what they really think if they have some time to put their thoughts together" (p. 169). The focus group interaction then allows these thoughts both condensed and challenged. In this study the Participant Information Sheet (Appendix A) provided a description of the research area indicating that it was simultaneously both relevant to practice and absent from the literature. This information sheet stimulated interest in the study leading to inquiries being made to the researcher as to why the particular research area had been chosen.

2. *Capitalise on the communications principle of self-disclosure in the introductory comments.* Self-disclosure can take place at a number of levels. The moderator has to be aware that an optimal range of self-disclosure exists and has to guide the group towards avoiding either inadequate (superficial) or excessive (too detailed) self-disclosure. The moderator must have a number of group leadership skills available such as empathy, probing, blocking and modelling to help achieving this

objective. Moreover, the moderator needs to establish an adequate interpersonal relationship with the group and create an atmosphere of openness by modelling self-disclosure of one's own experience which Zeller (1993) suggests 'must be appropriate but higher than optimal' (p.174) such that group members are made comfortable to share intimate, private details. In keeping with this strategy, the facilitators positioned themselves as fellow couple psychotherapists intrigued by the complexities of conceptualising relational normality. Additionally, facilitators invited participants to be open about their dilemma and uncertainties as well as clinical material that had challenged their conceptualisation of normality.

3. *Capitalise on the social psychological principle of legitimisation in reactions to participants' comments.* The moderator must carefully emphasise the importance of participation and the legitimate right of all members to express their own personal beliefs and realities, even if they are unique and non-conformist. This is required both initially and as the interactions between group members intensify. Zeller (1993), however, points out that the moderator must also undertake 'legitimation of non-participation' (p.178) such that individuals who are threatened by being asked to disclose detail about a particular event will not be excessively pressured. However, while legitimising non-contribution, those who resist self-disclosure need to be offered alternative opportunities to explore their experiences such as commenting about what others have said. The use of group facilitation skills supported lively group processes across the four focus groups. The lead facilitator paid attention to more silent group members to ensure their views enriched the research findings. However, most participants needed little

support to express their views, probably because group discussions are standard feature in their professional lives.

Prior to the start of the group, the facilitators read through the Participant Information Sheet and ensured all consent forms were signed and completed demographic forms were collected. Facilitators encouraged participation from all group members while guiding the group through the emerging conversation in a way that loosely followed the interview protocol. As each question was addressed, the lead facilitator ticked it off on the focus group schedule and then moved on to the next question in a manner that respected the flow of conversation within each group, while aiming to meet the interview schedule goals. In closing the group session participants were debriefed, again reminding of their right to withdraw their contributions, in part or in full, as well as the provision for support as outlined in the participant information sheet, which also served as the debrief sheet (Appendix XX). Each group ran for a duration of 90 minutes.

Time Frame for Conducting the Study

Ethical approval by the Tavistock Relationships (Appendix D) and the University of East London (Appendix E) was granted in September 2017 and January 2018 respectively, following which a pilot study was conducted. The four focus groups were originally planned to take place in the first two months of 2018 but recruitment of couple therapists was challenging. The study sought to attract some of the busiest and most senior practitioners in the field of couple psychoanalytic psychotherapy practitioners in London, rather than simply meet minimal participant criteria. The groups were eventually run between mid-March and the end of April 2018 with the last one having to

be postponed by a couple of weeks due to poor turnout. The allowance of several weeks between each session date was specifically designed to give potential participants a choice of days/times.

The Pilot Study

A pilot study was conducted with three practitioners and a co-facilitator so as to test the efficacy of the focus group schedule. This trial was deemed successful with only minor adjustments required. The printing of the demographic questionnaire was modified from double to single sided as the former led to one participant not completing the forms. Additionally, a note was added to the facilitators' guidelines to ensure that all forms were checked for completeness on receipt. The interview protocol was changed so that the format of the bullet points used now allowed questions to be ticked off by the lead facilitator as they were asked. The questions were easily comprehensible and proved effective in gathering the desired data.

Data Analysis Procedure

Thematic analysis was conducted in line with Braun and Clarke's (2006, 2013) six-step process (Figure 3.1). This approach complemented the research questions, by allowing a psychological framework to be integral with the method of deductive thematic analysis, while permitting for themes to emerge from the participant accounts using inductive coding (Fereday and Muir-Cochrane, 2006; Joffe, 2012).

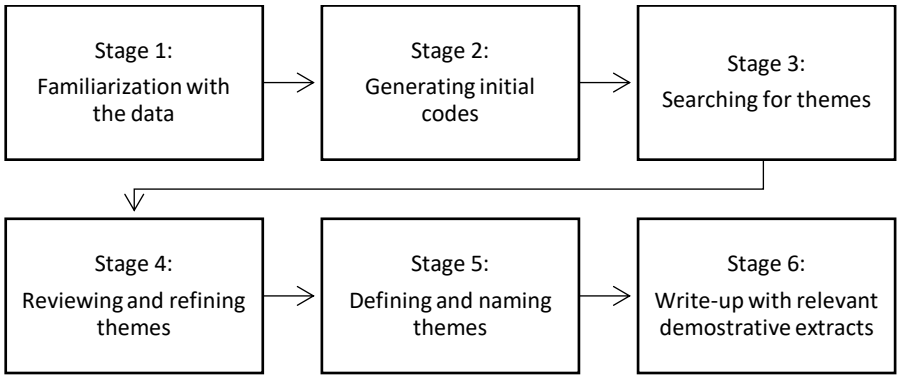

Figure 3.1. Six phase method based on Braun and Clarke's (2006) Thematic Analysis

The deductive element of this applied qualitative research thus implemented the epistemological position of critical realism where different people are accepted as not sharing the same singular reality (Decoteau, 2016). In line with fundamental psychoanalytic understanding, this position acknowledges that individuals are moulded by their past experiences and contexts, which shape their perceptions. Consequently, different individuals do not undergo and understand experience in a homogenous manner (Braun and Clarke, 2013; Fletcher, 2016).

In the process of data analysis, the primary researcher immersed himself in the data by repeatedly listening to each recording and taking on responsibility for the transcription process. The reading of the subsequent texts facilitated an in-depth familiarity with the participants' contributions (Braun and Clarke, 2006), while an appreciation of the diverse positions expressed by attending psychotherapists, supported the maintenance of the necessary accuracy of the coding process (Vaismoradi, Jones, Turunen, and Snelgrove, 2016).

In line with Braun and Clarke's (2013) recommendations, the data was coded manually with the researcher seeking to achieve data saturation at which point no further meanings or perceptions emerge from the data set. Codes were generated, identifying features of the transcript as data relevant to the aims of the research were developed. The subsequent cross-examination of the coded transcripts allowed the identification of resemblances and variances across the coding which gave raise to the emergence of the predominant themes and sub-themes. Attention to latent meaning was given priority, which supports the identification of any underlying assumptions expressed by participants (Braun, Clark, and Terry, 2015), in relation to their thinking about normality.

Rationale for using Thematic Analysis

All data was subjected to Thematic Analysis which is a flexible and useful research tool allowing the interpretation and study of participant understandings (Vaismoradi, Jones, Turunen, and Snelgrove, 2016). One of its main strengths is adaptability to diverse contexts, research questions and epistemological positions, being 'compatible with both essentialist and constructionist paradigms' (Braun and Clarke, 2006, p.78). This made Thematic Analysis well suited for this research as the data was likely to reflect the participants' different epistemological positions with regards to psychoanalytic theory (Protter, 1988, 1996). Moreover, it is in keeping with the stated critical realist stance espoused by the researcher.

Qualitative approaches are generally well suited to address research questions with a limited research base (Joffe and Yardley, 2004). However, Thematic Analysis is

considered particularly suitable when theoretical basis or conceptual framework is not well developed (Braun and Clarke, 2006). Thematic Analysis' focus on patterns across the data set rather than on an individual detailed level of analysis allowed an appreciation of differences and commonalities in the conceptualisation of normality across the four focus groups.

Alhojailan (2012) argues that Thematic Analysis is appropriate when there is a need for:

(i) data-faithful interpretation of collected data

(ii) use of both deductive and inductive approaches

(iii) analysis of phased data, and

(iv) coding and categorising.

Thus, for example, while Grounded Theory is similar to Thematic Analysis in a number of ways, since the data gathering and data analysis elements are inseparable in the former, it would not have been suitable for this study which relied on multiple data sets. Additionally, Grounded Theory is less compatible with the researcher's critical realist stance which presumes a high degree of familiarity with the research topic (Hoddy, 2019). Thematic Analysis has been criticised as being descriptive rather than interpretative (Pope, Mays, and Popay, 2007), but Braun and Clarke (2006) argue that the extraction of themes provides a degree of analysis.

The choice of a hybrid approach to thematic analysis, allowing both a data-driven inductive approach (Gioia, Corley, and Hamilton, 2013) as well as deductive analysis (Fereday and Muir-Cochrane, 2006; Joffe, 2012) was well suited for this research. The

researcher gave form to the focus group schedule informed by concepts and theory already available in the professional literature in the fields of psychoanalysis and couple psychotherapy (reviewed in Chapter 2). This allowed a rigorous and enriched data collection process (Fereday and Muir-Cochrane, 2006; Braun, Clarke, and Terry, 2015). The subsequent coding process used an inductive approach in which literature was not consulted during the coding process, allowing for a subjective idiosyncratic interpretation of participants' subjective point of view (Joffe, 2012).

Reliability and Validity

The validity of the study was ascertained by ensuring that all participants met the research criteria. Indeed, all participants were trained, qualified and registered with appropriate professional bodies as indicated in Tables 3.1 to 3.4. Additionally, all of them had several years of clinical experience with many having worked at very senior levels within their profession.

The reliability of the research findings was supported by consistent discussion with the supervisory team. Both supervisors separately reviewed the coding process and emergent themes and sub-themes. Additionally, the material was reviewed by a qualitative researcher working in a field unrelated to couple psychotherapy.

Ethical Considerations

This research was examined and approved by the Ethics Board of Tavistock Relationships as the research was conducted in part-fulfillment of the requirements of the Doctorate in Couple Psychotherapy offered by the organization (Appendix D). The two supervisors overseeing this project were both experienced psychotherapists with a clear understanding of the nature of psychotherapeutic discourse and the type of dilemma the research protocol was likely to evoke. The research was then submitted to the University of East London Research Ethics Committee for approval (Appendix E).

Throughout the recruitment process, the researcher ensured that the nature of the study was clearly presented to potential participants. The subject matter and the fact that the research involved the use of focus groups was detailed in all recruitment materials and in the Participant Information Sheet (Appendix A). The right to withdraw from the study at any point in time was clearly stated in the printed material and participants were reminded of this right at the start and closure of all focus group meetings. Additionally, the closing question of each focus group provided an opportunity for participants to discuss any outstanding matter and perhaps seek or provide clarification.

While no adverse outcomes were envisaged since this research did not involve vulnerable individuals and all participates were experienced in discussing clinical matter, provision was nonetheless made for post focus group support. The lead researcher offered to be available for debriefing and support and, for those who might have

preferred to talk to someone independent of the study, the contact details of a qualified counselling psychologist familiar with the nature of the research and the interview protocol was made available. None of the participants requested this support and no undue distress was reported.

All data was de-identified and pseudonyms used in transcripts. When quotations from participants' contributions in the focus groups was felt to risk compromising their confidentiality they were consulted, and a solution agreed. Identifying details referring to participants' patients, places of work and other biographical details were randomised. Participants were consulted. Data was held securely as required by the UREC guidance.

The Researcher's Epistemological Position

Lyons and Coyle (2016) acknowledge that 'the repertoire of psychological research has undergone a remarkable change over the last few decades' as 'British Psychology developed an openness to qualitative work and a growing recognition of the contribution that qualitative research makes to a rich and broad research profile' (pp.9-10). They note that Freud used qualitative case studies as a way of testing his theories and the method remains highly valued in the field of psychotherapeutic psychology even if the type of inferences made have changed with some movement away from earlier positivist positions. Creswell (2013) suggests that characteristic of current qualitative research is the acknowledgment that writing in a distant and omniscient manner is no longer satisfactory. Researchers need to discuss both their background as well as the epistemological stance they adopt.

My own position with regards to psychoanalysis and psychological theory in general has been heavily influenced by my professional training as discussed in Chapter 1. It remains firmly located in the realm of critical realism, somewhere between the relatively straightforward discernment of positivism and the modulated knowing of relativism. Hoddy (2019) maintains that critical realist research is aimed at:

> Developing causal explanations that map the components of social phenomenon across stratified layers of reality, spelling out what the relevant objects, structures, mechanisms and conditions are to that phenomenon. (p. 113)

Using Protter's (1985) schema, which has been elaborated in Chapter 2, my central paradigm for psychoanalysis centres around the theme of *clinical context.* In other words, I sit more comfortably with Stern's (1985) description of pragmatic view of psychotherapy where:

> There is a natural world external to us…but our sense data and the ideas based on them bear no simple relation to it. Furthermore, the natural world is complex enough, is composed of so many interlocking strata, that no single understanding of phenomena is adequate. This is especially true of phenomena so dazzlingly complicated as social and psychological events… These views incorporate the constructivist contribution of the paradigmatic view, but reject the irrationality of pure self-reference. (p. 205)

Lyons and Coyle (2016) helpfully provide a schematic model of research epistemology which I expand to include parallels with epistemological positions within psychoanalysis itself, as defined by Protter's (1985) model:

Realism	Critical Realism	Relativism
If a researcher has applied their research approach rigorously, they can be confident that their findings map on the reality they are exploring.	A researcher should take care in moving beyond the realities of the participants and make claims about a reality that exists independently.	A researcher should ask how we come to build up versions of reality and should treat findings as versions of reality rather than as revealing realities independent of how we know them.
⟷		
Correspondence-Essentialism	**Clinical Context**	**Clinical Text**
Psychoanalysis provides the tools for the analyst to accurately discern the structure and process of the client's psyche.	The clinical situation allows for an understanding of the client to be achieved but this is not independent of the cultural and temporal contexts in which such understanding emerges.	Psychoanalysis is a hermeneutic discipline allowing the construction of valued but transient interpretations.

Figure 3.2: Mapping epistemological positions in research and dominant epistemological themes in psychoanalytic thinking, following Lyons and Coyle (2016) and Protter (1985).

Chapter Summary and Conclusion

This research was conducted with the hope of advancing an understanding of how normality is conceptualised when couple psychotherapists encounter intriguing relational phenomena in their work with couples. In the next chapter the research findings will provide insight into the views expressed by the twenty-seven participants analysed in line with the methodology outlined in this chapter.

Analysis and Interpretation

Chapter 4

Chapter Overview

This chapter presents the findings resulting from the analysis of the focus group data. The identified themes and subthemes extracted through Thematic Analysis are supported by excerpts taken from transcripts across each of the four focus groups. This chapter is organised in three main sections dedicated to each of the three identified themes, each section departing with an overview of the theme and concluding with a brief summary.

All participants are referred to by a pseudonym and all quotes have been carefully scrutinised to ensure that any reference to clinical and patient material safeguards confidentiality. Where necessary details have been deleted or altered.

Emergent Main Themes and Subthemes

Thematic analysis led to the identification of three main themes that permeated the discussion amongst participating psychotherapists, namely:

(i) *Political* - referring to considerations as to who defines relational normality;

(ii) *Indigenous* - referring to the use of psychoanalytic models in considering this normality; and

(iii) *Non-native paradigms* – referring to how ideas sourced from outside the psychoanalytic tradition come into play.

The following table gathers these themes, their related sub-themes and the collated codes arranged in order of their prominence across the four transcripts. Each of these

themes are later explained, using direct quotations illustrating views expressed across the four focus groups.

Table 4.1. Themes, subthemes and codes derived from Thematic Analysis

Themes	Subthemes	Codes
1.0 Political (who defines normality?)	1.1 Therapist responsibility	1.1.1 Complexity of clinical judgement
		1.1.2 Maintaining the therapeutic position
	1.2 Ambivalence	1.2.1 Struggle with ambiguity of concept
		1.2.2 Fear of damaging patients
	1.3 Client-centric normality	1.3.1 Centrality of meaning (for clients)
		1.3.2 Normality sought after by clients
	1.4 Socio-cultural	1.4.1 The polymorphic nature of normality
		1.4.2 Holding context in mind
2.0 Indigenous (pertaining to the analytic)	2.1 Quality of Dynamic Processes	2.1.1 Intra-couple
		2.1.2 Intra-clinical
	2.2 Sub-optimal as Normal	2.2.1 Dystopian relationality
		2.2.2 The conflicted psyche
	2.3 Capacity	2.3.1 Management of personal process
		2.3.2 Interpersonal maintenance
	2.4 Genesis	2.4.1 Personal developmental journeys
		2.4.2 Relationship histories (couple and transgenerational)
3.0 Non-native Paradigms (non-analytic)	3.1 Central Tendency	3.1.1 Providing a cut-off point
		3.1.2 Psychic normality outside the norm
	3.2 Medico-legal	3.2.1 Health
		3.2.2 Legal

Theme One: Political

Theme Overview

Psychotherapists participating in this research were very much preoccupied with who defines normality. An acute awareness that clients often inquire from therapists as to what constitutes normality exists alongside concern about the power this confers to the therapist. Participants seemed to sit rather uncomfortably with the awareness of the power differential inherent to their role.

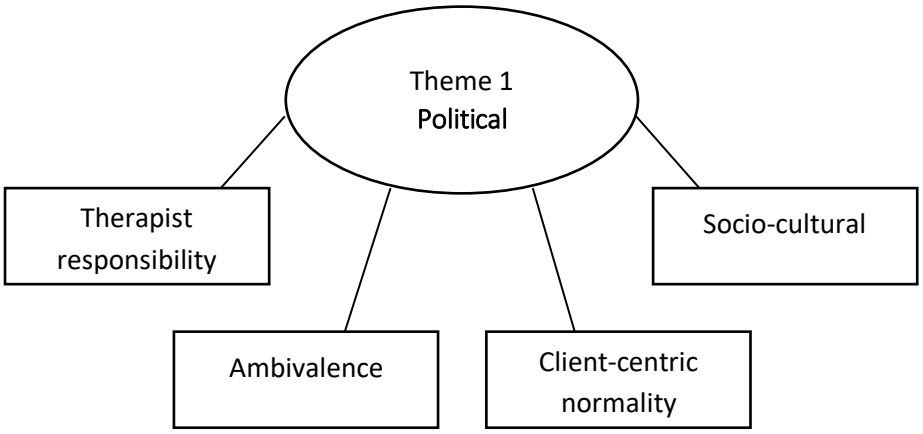

Figure 4.2. Thematic map for Theme 1

Thinking about this political dimension is further complicated by awareness that therapeutic discourse takes place in a space immersed in a myriad of socio-cultural imperatives. Couple psychotherapists, like their patients and couple-patients are not immune of their impact. This all contributes to the rather ambivalent relationship towards the conceptualisation of relational normality.

Sub-theme 1.1: Therapist Responsibility

There was a degree of consensus across all focus groups that concepts of normality feature strongly in both therapists' and patients' minds. Indeed, one participant suggested that psychotherapy itself implies an issue around normality because of the clear difference in the positions of the professional and patient or couple. Reflecting on his sense of feeling that he was not part of the in-group while attending a psychotherapy conference, he drew parallels between his experience and that of his patient-couples:

> they can be left feeling terribly shamed and humiliated by virtue of the questions we ask, what we go for, what we choose to ignore? Because they might be coming with a parental or, sort of authoritative transference to us, and even though we are not using the word normal, we are thinking in some particular way that actually implies abnormal. All the things we have been saying and even unconsciously, maybe as well, relating to them as other, as something that's less than…
>
> (Harry, Focus Group 4)

Couple therapists expressed an acutely sensitivity to the risk inherent to the patient position and the defining of normality seemed to exacerbate their concern. Responsibility for the participants was not simply a requirement of their professional status but also seemed to emanate from a deep humanism, perhaps even an identification with their patients. All participants would have had a requirement to undergo extensive psychotherapy themselves, as part of their own training, so that identification is facilitated by an intimate knowledge of what it means to be a patient.

Code 1.1.1: Complexity of clinical judgement

It was clearly evident from the manner in which focus group participants struggled when attempting to articulate their positions and the dilemma thinking about normality brought up, that this task is challenging even for the experienced psychotherapist. Clinically, normality is a very complex matter with multi-layered ramifications. Rachel in Focus Group 1 spoke of how thinking about normality does not sit comfortably with her. On reflection she realised that interpretation itself, considered to be the cornerstone of psychoanalytic therapeutic intervention, departs from being drawn to some feature in the couple's presentation:

> …I think I am finding myself captured with an actual couple experience. It is easier for me to relate to this concept when I think about a couple experience about what is normal, and I think I would then go as far as to say that every interpretation, not every, but… may be guided by some sort of running thought of what would be, I wouldn't say normal but there is some, there is some sort of idea as what would be the usual. I think it's hard for the couple. If the couple feel like it's usual for them but if something feels to be unusual or not comfortable, or problematic then we start to interpret that. So, actually we interpret… interpretation may be led by the couple's own experience of normality, of whatever, I don't know if normality is the right word. It doesn't feel right again.
>
> (Rachel, Focus Group 1)

This psychotherapist's sense of being burdened with the responsibility this inevitability confers is evident here. Additionally, there is a degree of discomfort around the term itself which will be discussed at a later part of this chapter. Suffice to say that when something does not fit the 'usual' presentation, this may become the therapist's point of focus. In response to Rachel's statement above, Dawn then shares some thoughts about

what therapists may know", namely the presence of trauma and other features of the client's mental life. This then leads to a crucial dilemma: while something that 'is not OK' may emerge as a focus of intervention and be seen as problematic, is it responsible to label this as abnormal or is there a better way this can be framed?

> Dawn: But, but the couple will bring their internal world into the consulting room and into the relationship, you know, whether different attachments and experiences, you know, traumas…
> Rachel: But they come with an experience that something is not OK.
> Dawn: That's right but because this has been part of their experience and what they have accumulated, you know, in the course of life and then they create something together which, you know we might think as a way of trying to manage something and, you know, that may involve enactments. I think it's so difficult then to, you know to…so there may be a lot of denial and then, and you are trying to help the couple to think about something that is difficult that you as the therapist think is really important. At the same time what they have created in terms of the couple dynamic is not abnormal, I mean it is the creation of the dynamic between them.
>
> (Focus Group 1)

The inevitable evaluation of patients and patient-couples against the norms provided by the corpus of psychoanalytic theory and clinical expertise led to a degree of consensus that clinical judgement is an integral and unavoidable part of treatment in Focus Group 4:

> Lydia: Where we focus our interpretations, what do we pick up? With every minute of every session you've got a million options, haven't you? Where you focus your attention and just by focusing on X rather than on Y, you make a value judgement, don't you? You are saying, this is noteworthy and that is not…
> Evelyn: Yeah, it's unavoidable…

> Lydia: It's unavoidable, isn't it, and we wouldn't call it, we make value judgement by using normality, but we are using a framework that guides us.
> Traci: We might be using a framework. Perhaps, it's just, I still don't like the word normal but perhaps we are using, I agree what you say about a framework and a value judgement, in so far as we want to focus on this particular thing because we think it is important. In that moment it's the important thing we want to bring to the couple's attention. I wasn't making a point about values as much a point about calling something normal.

Later, the theme was developed further as the discussion in this focus group unfolded. Concern about the impact designating a feature in the patient's presentation as worthy of exploration and therefore identified as potentially normal or otherwise, emerged strongly:

> Lydia: But I think there is a problem inbuilt in that, isn't there, because for me to understand what it is like to be bisexual, for me to understand what it is like to be schizophrenic, I have to explore it with the patient…
> Evelyn: Yesss…
> Lydia: …and the moment you try to explore it you are saying something about normality, aren't you? And you are running the risk of the patient feeling that you are making a judgement.
> Harry: Normal in the sense that you are not by virtue…, or you might be, that's the other thing, you could be, but you are still exploring it because their meaning of it might be very different from your meaning of it.
> Lydia: …what it means for the person you are working with, don't you?
> Harry: yeah, yeah…
> Lydia: But if they are very, very aware of not being normal then you are faced with resistance which might feel quite intrusive and judgemental.

Contrasting positions were evident in relation to therapists' grasp of what is normal. While Sandra (Focus Group 1) spoke of 'beginning to wonder whether the notion of

normality is rather primitive …and very limiting because things are so complex', others suggested that couple psychotherapists have a fairly straightforward sense of what normality entails:

> Ian: Yeah, I need to try to get some understanding and I use, I guess, the frameworks I have for understanding couple relationships, to get some understanding of what gets in the way of people treating each other well basically. There are lots of norms that come into defining well and healthy ideas…
>
> Catherine: And also, what triggers a particular sort of relating because you can see when you have a couple in front of you, sometimes they can relate to each other in a way which is quite free-flowing, without edge and sometimes they resort to this very rigid, very familiar defensive relating so I guess you are sort of trying to gauge how much there is of that and how much there is of something healthier. I guess I would be, sort of working trying to help them trying to understand what triggers the more psychotic type relating.
>
> Ian: So, in that sense we all have an idea of normality because we all have an idea of what's psychotic, for example. So presumably, we all recognise and will be concerned with severe psychotic happenings in the room.
>
> (Focus Group 2)

Clinical judgement is complicated by the therapist's own biases and life experiences. Rachel, in Focus Group 1 shared how having detected something she found worrying in the patient's narrative or manner, led her to make what she viewed as clinically valuable considerations. However, once again, the possibility of finding herself judging patients as abnormal or otherwise sits uncomfortably with her:

> I suppose what I find helpful, this might be garbled as I am thinking it through as I say it. When someone presents me with something that I'm worried about, for instance, excessive drinking or sexual behaviour which I think is not helpful, it often helps me to think that, surely the point here is not what

> they are doing or what I think about it. Is, is this a defence against something else? I mean, it sounds a bit obvious, isn't it, but nevertheless, in that way, I think psychoanalytic thinking helps me and, I hope helps the people I work with to think: yeah, we are not going to judge this, we are not going to say this is right or wrong or normal…
>
> (Rachel, Focus Group 1)

The nature of therapeutic work, particularly when couples are very distressed, taxes therapists' abilities to managing their responsibility of maintaining a professional stance. Personal feelings which might get in the way of thinking, including the process of applying the appropriate theoretical and technical knowledge in their possession, must be carefully held back:

> Victoria: Where I find that most challenging is when working with divorce and separating couples because it is not unusual for couples to be in such a distressed state that they will be very cruel to one another. So, how to think about that, about that being maybe an effort to detach whilst in a strange way remaining attached, but through a very destructive mechanism, if you will. And what people will do to, and with one another, I certainly have to suspend quite a lot of, you know, my own distress in being a witness to that.
>
> Ian: You'd be aware, hopefully aware, aware of what we feel and think, it's just not necessarily, just haphazardly or instinctually acting on it.
>
> Victoria: Yes, that's right. Really challenging the whole concept of feeling and thinking at the same time.
>
> Ian: Yeah. No easy task.
>
> (Focus Group 2)

This bracketing of feelings can only be achieved through fostering a high degree of reflexivity and awareness, including of the lacunae in one's knowledge. Eva goes as far as

to suggest that an awareness of the limitations inherent to psychoanalytic thought needs to be borne in mind:

> Eva: But isn't this the point where awareness comes in, and clearly you are aware and able to think about this? I think it is tricky when we have people who come from cultures that we are really quite unfamiliar with and we can be very aware that maybe different norms, and even the psychoanalytic theory, may not really fit so well. But we can really expect our clients to educate us about their cultures – that's not their job, isn't it? We'd have to get very aware of not knowing.
>
> (Focus Group 3)

In response, another participant somewhat hesitantly spoke of how working with a black patient left her unsure as how to apply her frame of reference and fearing she might fail to meet the patient's needs:

> Amelia: I have a particular issue … with a black patient of mine. A man, who [details deleted] I have been seeing for a number of years and he is very upset about the question whether psychoanalysis has anything to offer black people. Now the work we do is the work I would do with any of my patients. Of course tailored to what he brings [details deleted] and when I say to him "what am I not getting, what is it the therapy here isn't reaching for you, sort of, a black man?" He says, "Oh no I didn't mean about here it is in general". In a sense that might be a projection, might be part of the problem. It is problematic for me because I can't see what I can't see if you know what I mean. So, yeah, that's a real challenge for the work.
>
> (Focus group 3)

Clearly, no apologies are being made for a desire to know, a desire to be in a position allowing understanding of, a discernment of what might be troubling the patient. Firstly, this desire to know is directed in relation to the therapeutic relationship itself. The

therapist is clearly considering the patient's disclosure as a projection, a reflection of emergent feelings towards the therapist. Secondly, there is a desire to grasp what is troubling this man at a deeper level, as the participant's disclosure above suggests that years of seeing this client has allowed her to gather much information about the hardships he experienced and yet this did not feel wholly satisfactory.

Code 1.1.2: Maintaining the therapeutic position

The complexity inherent to maintaining a therapeutic disposition when considering relational normality meant that conversations across the four focus groups, rather naturally, led to exploration of what supports clinicians' capacities to grapple with the pull exerted by personal bias. There was a strong consensus that training, particularly the requirement for personal therapy and clinical supervision, go a long way in preparing clinicians to grabble with the sort of dilemma faced in practice. However, a few somewhat dissident voices express reservations as to whether these matters are sufficiently addressed in training.

In Focus Group 4, participants reflected on how psychotherapy can by its very nature imply abnormality. This can happen on an unconscious level, but it is also manifest in a more concrete manner in 'how we dress, how we set the room, the kind of language we use, what, who we hang round' (Harry). When the researcher inquired as to how professional training helps them manage this reality, the response was similar to that expressed across the four groups:

Traci: I think in one's personal therapy…

Evelyn: And supervision, I'd say, as well.

Lydia: in supervision, yeah…

(Focus Group 4)

When facing complex feelings towards patients, psychotherapists seem to find that having had their own training psychoanalysis or therapy continues to support their capacities for discernment:

> But I suppose coming back to counter transference, if we started to feel with a particular couple that this wasn't normal, mmm, and it hadn't been something we'd had with other couples or we'd experienced, or that, we'd be thinking, is that me or is that coming from them? Is this a projection of their own feeling that what they are actually in, engaging in is abnormality? I mean, I suppose it does comes back to your own analysis and counter transference and really knowing what you're feeling so that if you are feeling that something is not normal you can differentiate whether this feeling comes from you or whether this is a counter transference, a projection from them, their feeling in whatever they are engaging in is not normal.
>
> (Hannah, Focus Group 1)

While there seemed to be consensus about the importance of these well-established training components, Lydia (Focus group 4) noted a degree of variability in the practice of couple psychotherapy and potentially in how concepts are applied:

> But, but, I've got quite a bee in my bonnet about that, that a lot of our training is so highly theoretical, we are actually not very good at translating how that works out in the consulting room, in terms of our normative values or in terms of what we think is normal practice, normal therapy. We all think

> of ourselves as ordinary, normal therapists, don't we? And we are all going to be very, very different in the room from each other. But actually, we don't talk about that.

She then proceeds to provide valuable insight into the supervisory process and how this might impact thinking about normality. This senior clinician provided valuable insight into the supervisory process:

> Lydia: But as a supervisor, I have to say, what I find most rewarding as a supervisor, is to work for a long time with a supervisee because you begin to know what their normal is. So, if supervisee X criticises the woman first, I know this is odd because usually she's on the side of the male. So, you get to, you find out what people's particular ways of positioning themselves in the room is and you read the material accordingly and that's what my supervisor does for me, but this is unusual for you… and we need more of that, don't we? We need to actually know what our own normal is in all its limitations and its abilities and…
>
> Evelyn: And hopefully that will evolve as well as you develop, that's the point, isn't it? That it's dynamic.
>
> Lydia: Yeah, once a supervisee says: I've done it again, haven't I?! I'm slightly on the side of… that's all you can look for.
>
> (Focus Group 4)

A sense of the supervisor's excitement at the supervisee's emergent capacity to register their own biases in relation to the patient-couple is clear. Significantly, Lydia does not suggest that supervision allows for a truly objective evaluation of reality but rather that it facilitates the development of the capacity to thinking about one's biases while considering the clinical picture.

Clearly, a similar degree of reserve about the possibility of personal therapy eliminating the tendency of therapists to be influenced by 'their gender, their sexuality, their, any other identifying feature' (Hannah, Focus Group 1) led to the following rather cynical exchange about the desired but unachievable bias-free state of mind. Making reference to Freud's (1925) thinking about the 'tabula rasa' and Wilfred Bion's (1967) injunction to abandon 'memory' or 'desire' the following exchange ensued:

> Dawn: but, but that perhaps that is what is meant by full analysis, that if you…
> Hannah: I was following on from that...I was curious…then what? You're a blank piece of paper?
> Dawn: No blind spots, all sorted!
> Charlotte: Even suspended attention…
>
> (Focus Group 1)

While achieving a state of perfect objectivity is improbable, participating psychotherapists seemed adamant about the value of reflective practice. In Focus Group 1, Natalia spoke of how when a couple or individuals present in a problematic manner, the experienced therapist might still find themselves thinking 'oh, I don't know…' implying that they question the patient's normality. Asked as to what might inform such judgement, the difficulty with managing the impact of the therapist's own emotional reactions emerged as a significant concern:

> Sandra: But is it not one of the things we have to go through, as a couple therapist? To always, all the time to challenge ourselves to think? And it is partly about working with the countertransference, isn't there? I think it is probably quite important here, that you know, is this maybe that I am finding this difficult and, and can I think about that and really still listen to the couple who are saying that this is what it means to them? Not what it means to me,

you know… and that, seems to me that, this is something we are doing all the time even without consciously thinking about it.

Hannah: I think it is very important, isn't it?

(Focus Group 1)

This led to another participant speaking of how crucial personal therapy was in developing self-awareness and reflexivity which in turn facilitates the management of emotions. Again, this participant, reflecting on her own senior role within the profession, illustrates the importance of insight through the experience of supervising a trainee:

Dawn: I was thinking, that takes us back to our own personal therapy or, or analysis, to have an understanding of, not necessarily, well our blind spots, also our limitations. You know, someone just emailed me today, someone I supervise on the private practice. Mmm, I am seeing her on Thursday, but she never emails between sessions, but she wrote. She said, I want to have your views, because, she said, I think I am not going to be very good working with this couple because they seem so rigid. And I thought there was something so healthy about that because you know, because there is insight and that she was using someone else to think about her. That she was using someone else to think about this rather then, lasso, cut it off, let's say… that she was thinking about them, difficult couple but doesn't matter really, the kind of reflective process about, you know, where we are ourselves in relation to a couple.

(Dawn, Focus Group 1)

Experienced psychotherapists are themselves keenly aware of the need to monitor and think about their experience with patients, if they are to maintain a reflexive stance, particularly when in touch with difficult feeling states:

> It was also a feeling of defeat that somehow, we weren't going to get very far with it. There was a sort of feeling of not being able to…, I mean, this person was suicidal as well, kept making suicide attempts, my feeling was, it's just a horrible proximity to something so… so anti-life, so destructive…
>
> (Catherine, Focus Group 2)

When asked what helps in such situations the participant spoke of finding:

> lots of support in the opportunity to talk about these things and to get other views, reminders of, for example, countertransference… in discussing with other people who I guess are interested about things in a particular…, to understand the meaning of something rather than come to judgement.
>
> (Catherine, Focus Group 2)

This fear of inflicting a judgment that might not support therapeutic outcome is further complicated when the couple fear being judged even before therapy is embarked upon. Hannah (Focus Group 1) spoke of an ongoing struggle with managing preconceived ideas about what is normal in couple relationships when inviting a couple to think about the fact that their 12-year-old son shared their bed. The therapist wanted to explore this matter in light of their ongoing relational difficulties. The couple made a determined defence of their behaviour by making reference to their expertise in the field of anthropology:

> Well I suppose I was thinking about that couple…the couple that had the child in the bed and I was sort of thinking about, because in a way I was about to say, before I was thinking that there is something about analytic therapy training, about having one's own analysis, that challenges you constantly about normality. You challenge yourself about normality and it is, I suppose, about trying to understand something about the couple. If you have your notions that things are normal or abnormal, well then you can't do that! And I remember with that couple really challenging myself because

> they used it a lot in the therapeutic work… It was a cultural norm and they listed the countries where it was a cultural norm to sleep with this, to have the child in the bed. And he was 12 at this stage.
>
> (Hannah, Focus Group 1)

This illustration of how a benign explorative stance held by the therapist can be inhibited if normative thinking takes hold too firmly. Additionally, there is the risk that this provokes a defensive stance in the couple. In Focus Group 3, reflecting on the difficulty of stirring away from normative thinking, some participants noted that psychoanalytic theory tends to bias thinking towards psychopathology and that this was reflected in their training:

> Eva: Training mainly focuses on abnormality.
> Amelia: Well I suppose you could see this as CPD (*Continued Professional Development*) really.
> Greta: Well maybe in the training, the encouragement to be always curious, because you then learn about a different normality.
>
> (Focus Group 3)

Additionally, academic training components aimed at challenging normative views are reported to be somewhat limited:

> Oliver: Mostly doing your own therapy whether that's as a result of your training or going into training because of your therapy, that can get you at least bring to the surface what your 'id' normal are if you like and bring them more 'ego' normal.
> Trisha: I am thinking back to our training, think it was when we were discussing things like difference, cultural difference, diversity, when we had input on that that there was an explicit challenge to the kind of normative thinking that, that was almost in relation to people who we already see as

> other. So maybe sexual minorities or ethnic minorities and so on. But in terms of the mainstream, I don't think that challenge was particularly explicit.
>
> (Focus group 3)

An interesting suggestion emerged in Focus Group 4, that rather than promoting a broad curriculum around normative thinking, the crucial task of training is that of creating a space, a culture that is inductive of thought:

> But actually, all the stuff about political correctness and all of that has stopped people, trainings, address the things that are really different. In our training we had, I think, one seminar on homo…, same sex couple, there was one on race. That's not enough but it's something about creating a culture where people can feel they can talk about these things without being shamed.
>
> (Evelyn, Focus Group 4)

In contrast to the critique of training as being somewhat economical when it comes to teaching around diversity and related areas, others proposed that personal psychotherapy was the key. In Focus Group 1, this was seen as the primary tool in helping trainees overcome resistance to develop a more open-minded curiosity:

> Mmm, I think that is what we do in our therapy, in analysis, that's the works of a training analysis. That you have while you're training, that's where you are exploring your own psychic resistance and your own limitations in relation to the training and what it throws up and in relation to the training couples…
>
> (Dawn, Focus Group 1)

Asked whether personal therapy might be thought to replace formal teaching in this area, the primacy of the former in supporting the capacity to think openly was emphasised:

> Dawn: Isn't that why we have training analysis?
> Linda: and supervision
> Natalia: But I think analysis is really the corner stone of it because it is really in supervision one can be more compliant.
> Dawn: …but in the counselling training you do have, what's it called, the self-awareness, self-reflective groups and I also, that sounds so interesting and so potentially helpful. We have not had that in our training, it's much more confined to our training, to our individual analysis.
>
> (Focus Group 1)

In contrast, participants in Focus Group 3 contemplated the possibility that institutional culture within psychotherapy organisations might limit or restrict greater open-mindedness:

> Isabel: But I think in a way it's almost inevitable that whatever training you do it will be subject to some sort of institutional bias. In that, if you've got a training that trains you to challenge then you're got your qualification you can look at what is out there…
> Grace: But as individuals we have to do that don't we, we get to go to CPD with other organisations not just [name of organisation].
>
> (Focus Group 3)

Eva summed this up eloquently as 'there is a kind of orthodoxy, an organisation creates its own orthodoxy, its own language, its own attitudes'.

Focus Group 2 allowed for a discussion of an aspect of orthodox practice promoting patients' self-reflexivity, when a participant disclosed that rather than answering questions about normality, he finds himself addressing the question back to the patient:

> Yes, I was thinking earlier that when somebody asks me 'what's normal' I'd be interested in why they are asking that question and also, what have they

> been used to in their lives? You know, they've got a sense, they must have had the question for a reason and as I'd say they've got a background, and they've got… Does normal mean what I have been exposed to or does it mean something else?
>
> (Ian, Focus Group 2)

Riya felt that inviting patients to reflect on their motives could not replace reflexivity on the part of the couple psychotherapist. This allows awareness as to whether normative frameworks are held too rigidly:

> I was really happy that actually, you stepped back to question your own way of understanding because what I had assumed was that we look at a couple like this through our typical concepts. We'd understand it as she's struggling to separate or, you know, those sorts of ideas and understand it more like that. Rather than step back and thinking more what the cultural meaning is. So, I wonder whether we still… (pause)… what I am saying is, the framework we use is still based on our, the framework we clearly internalised inherent in our work but actually the difference is how tightly we hold on to that. Because what you have been demonstrating actually is a flexibility in how strongly you might make that link when you are formulating.
>
> (Riya, Focus Group 2)

Thus, the rigid application of technique or theory is seen to limit the flexibility required to engage more fully with the couple's experience and maintain a therapeutic position in thinking about relational normality.

Sub-Theme 1.2: Ambivalence

Focus group members struggled with their mixed feelings and somewhat contradictory ideas around adopting and using a definition of relational normality. For example, Lydia in Focus Group 4 tells us:

> …But the more we are talking, the clearer it is we all have a normal in mind. We don't call it normal, we call it: are they in the paranoid schizoid? Are they in the depressive position? Can they love between? How rigid is the projective system? How much of a phantasy-determined couple are they? We do have our own way of normality in finding it.

However, this apparent clarity around how couple functioning is judged is juxtaposed against much agonising around normative thinking and related judgements. Lydia shared her dilemma:

> …I try not to think about normal and then you go through your cases and do! However hard you try not to judge or not to have a sense of what a couple ought to be. There are many, many moments when you say: ah, do I need to say something about this? My normal is somewhere breached and I do take a position and I question, am I right to take a position? I had a couple quite a while ago where sexually stuff happened. She would wake up and find her husband penetrating her and I thought: can I afford not to take a position vis-a-vis this? I put it back to what's the couple's normal and what do the couple feel about it, but we do have reactions to what our couples do and don't do?
>
> (Lydia, Focus Group 4)

Code 1.2.1: Struggle with the ambiguity of concept

Uncertainty about the meaning and application of the term in psychotherapy settings was a dominant theme in Focus Groups 1, 2 and 4, and to a lesser degree in Focus Group

3. Many expressed surprise at the choice of research focus and admitted they had not thought about relational normality much at all:

> I suppose what came to my mind is that I really never thought about, eh, what's normal. I mean, that's not a concept that would immediately come to mind, eh, it made me think that perhaps, I think more in terms of, well, what creates strength in a couple relationship, you know, what creates a degree of happiness and how a couple can manage. I thought if, it seems so complicated to start thinking about normality. Mmm, because I think, you end up having to define something which to someone else might be perfectly reasonable or ordinary. I was thinking in terms, in terms of cultural, eh, socio-economic layers of normality and, you know, how difficult it is to put one's finger on something…you know, we live in an age of identity politics and kind, mmm, it's so much about me, having to find ways of expressing, express oneself in terms of sexuality, cultural expression and so on, and I think, again, it sort of widens the whole spectrum of what, what might, we might think of as normal.
>
> (Dawn, Focus Group 1)

Some participants expressed a very cautious view towards thinking about normality. Leah (Focus Group 4) spoke of how 'we as therapists tend to stay away from the word normal because there is so much relativity attached to it…and that somehow doesn't go with analytic thinking'. She suggested that: 'we can talk about schizoid, depressive position etc. because there is more of an agreeable definition. When we come to normal we know it's so relative, it' difficult to work with it…'. It is as if this participant was somewhat oblivious of the fact that the theoretical concepts made reference to, relate to normative developmental theory. Deviation from the prescribed pathways dictated by these theories is likely to be viewed as symptomatic or abnormal.

In Focus Group 2, Ian expressed reservation about the subject matter of the research:

> I am not sure I find it relevant to the clinical work. …I was surprised that you had said that there was a lot written on it, normalcy, in term of individual psychoanalysis but not in terms of couples. If it were important then surely every concept of normality found in individual psychoanalysis could be thought of as we're treating the couple relationship. If there is an idea of normality for the individual, surely that can be adapted, can have its form in terms of couples. But, so I am surprised that if it was important in psychoanalysis there hasn't been much written in couple work…

Reflecting the position expressed by Leah earlier, this participant suggested that developmental models relate to health and are therefore not to be thought of as normative in nature:

> Ian: The developmental models are very important, but I relate those to health, what is happening, what has happened and what is happening that stops people from having a better quality of relationship given the values that I have as to how people should treat each other or what a creative, what a healthy relationship is, what's getting in the way. In that sense I find developmental models very important to think about - all of them, not just one.
>
> Riya: So, when you are looking at normality, you were just saying, you know, are you looking patient-led or which way are you looking, are you looking patient-led or therapist-led, or the interaction between the two? Because I think there is a distinction here between, as you are saying, what you would regard as healthy might contribute to your work but equally there is what they regard as normal something around, you were saying earlier, about how they understand the use of the term.
>
> Catherine: No, they think we have a concept of normal…
>
> Riya: but they have one as well. I guess what is getting me rather puzzled is thinking: Which way in? How are we looking at that, are we looking from our

> own generated idea of it? From our trainings, our backgrounds, or are we thinking in terms of our interpretations of what they see as normal or is it the marriage between the two?
>
> (Focus Group 2)

Furthermore, the above introduces the notion that evaluating how people treat one another is a criterion which some therapists use in thinking about the functionality of a couple relationship. Ian elaborates further:

> As far as I am aware I do not think in terms of normality. I think in terms of how people are treating each other, how they are treating other people, mmm, what's the quality of the relationship?

It is intriguing to note that the notion of health (and ill-health), acceptable behaviour (and less acceptable forms of behaviour) are not thought of reflecting notions of normality but are somehow juxtaposed against the notion as if completely unrelated to it. Clearly, the above conversations underline the centrality of the political issue as to who has the right to define what is to be deemed normal.

Psychotherapists indicated that they are generally less interested in evaluating the normality of a particular relationship or behaviour, and would rather expand the couple-patient's experience of self and other:

> Hannah: You know if, if you are working with somebody, you know, a young person and they have extreme pain I guess we would think that's not normal.
> Natalia: You are immediately into a fertile area. Otherwise it is quite a barren land, normal, abnormal.
> Charlotte: So, is that the kind of difference? In a way, between the idea of a definition of a dot in space, something that is specific like the

> medical and legal and the continuum thing where people can then actually expand from a very narrow idea to something a bit broader that fits, feels less constricted, you know, easy to…
>
> (Focus Group 1)

This ambivalence is amply illustrated in the following exchange that took place in Focus Group 2. Riya reacted to the group's concerted move away from looking at how practitioners might come to apply normative ideas but exploring how patients might think about this matter:

> I'm really glad that you are looking at this, particularly couple psychoanalytic work because it's almost a question that we see in the systemic world or in social psychology and particularly that type of bias that we might hold. It is interesting hearing us immediately thinking about what a couple might regard as normal and less about the judgement that we might hold when we classify as normal or not. I wonder whether it's our, whether it's our avoidance to do that? Perhaps a belief that we don't need to think that, but I definitely do think that we hold some idea of what we would probably think, what normal would be for each couple that we have in the room but are less aware of what that might look like and whether that might come from. Because I do not think that it's entirely in line with just the training, just about the idea of what we might think of as a "good enough" internalised containing object, I think it certainly comes from other ideas and more biases that we hold but can often be masked as "isn't this what all couples should be doing?" - I think what you are looking at is really fascinating actually.
>
> (Riya, Focus Group 2)

Later, this same participant started to wonder why the notion of normality sits so uncomfortably with practitioner psychotherapists. She suggested that perhaps this

relates to defence from the anxiety around assuming responsibility and executing judgement, leading to this exchange:

> Catherine: And what is it that we resist about the idea of normality? Because, I was thinking, that we are party to some social conditioning, just what makes us react like, cos I react quite strongly to the idea of norms and… surely, I am not trying to get people to be, fit a particular mould. But in some ways, I guess I am - in terms, in terms of healthy functioning. I have some idea about what I would like to help people achieve.
> Ian: it's crucial, we need to, don't we?
> Riya: Well there you shot yourself in the foot with the word normality, you know. I think that is what we are all struggling with, going to what Ian said - I think if you used another word, bias or judgement or values or something like that, I think that gives us the freedom to work with it, because otherwise we are all jarring on this normality thing. Is it our defence, I don't know?
>
> (Focus Group 2)

Some participants even seemed to wonder whether this ambiguity reflected a limitation on their part, some form of inflexibility:

> This may just be my stubborn inflexibility but, I can see if a couple says 'is this normal?' they could also say 'is this healthy' could be a very similar question but, to me, I do not find the concept of, to me, if it is normal, there is pathological and I don't think, not that I don't have a sense of what might be disturbed, but I don't think in the guts of the work in terms of normality, I think in terms of how, as I said times, how people are treating each other, the quality of the experience of their relationships.
>
> (Ian, Focus group 2)

In an attempt to avoid emotional ambiguity inherent to assigning normality or otherwise to a couple or individual patient, thinking in terms of health and symptomology is presented as a valid option. Significantly, and seemingly unbeknown to this participant,

any discussion of health, by its very nature, involves the application of a normative framework.

Code 1.2.2: Fear of damaging patients

The ambivalence displayed by psychotherapists did not simply stem from worries about how best to define and think about normality but also from an ongoing concern that the use of applying a normal/not normal dichotomous classification can prove harmful to patients. In Focus Group 4, Camila spoke of how she found contemplating normality in psychoanalysis stigmatising. She then proceeds to suggest that perhaps:

> psychoanalysis invented 'good enough' to get rid of normal… I am curious why you are bringing normal back because we have been working really hard to avoid this? And 'good enough' seems good enough to describe something that is either average or not worrying as much, or well, yeah, good enough.
>
> (Camila, Focus Group 4)

The discomfort with the term itself sits alongside concerns about stigmatisation. Significantly, the participant ends up in a circular argument moving away from abnormality but then potentially returning to it when considering what failure to be 'good enough' might look like.

Later in the same group, Traci elaborated a bit further noting how 'normal is bringing a value judgement. Of course, it is that case that we have our values'. When the facilitator noted that some aspects of psychoanalytic developmental theory were normative in nature, even if psychotherapists may shy away from labelling divergence from such models, this elicited another heart-felt emotive response:

> Harry: …pathology, developmental. Arrested development of course was a term levelled against queer people in terms of their development. I mean, I can't think about this, what we are talking about today, without the whole process of othering and if you look at that literature, who's doing the othering, who is in a position to other, who is the other? And of course if we go back to your point, couples are also having transferences to us… it is really hard to separate out what we might think we are doing and how that is experienced by the other. You know, they might feel we are shaming them or pathologizing them or abusing them or whatever.
>
> Lydia: Curiosity can feel really intrusive, can't it? Being curious about something the couple think is normal, then you are intrusive, you are questioning. Are you critical? Question mark!
>
> (Focus Group 4)

The above highlights both the ethical sensitivity of these practitioners, as well as their political alertness. There seems to be a clear sense that pathologising, shaming and abusing belong to the same undesirable categories of actions that psychotherapists wish to avoid inflicting on their patients.

Personal accounts of the damage being labelled as abnormal were shared, indicating that psychotherapists do not simply relate to their patients on an ideological level but through a process of identification. In the following account, both the patient and the senior psychotherapist (who was previously a trainee social worker) are judged, labelled and subsequently managed in a restricting manner. Another participant draws the conclusion that perhaps conformity to group social norms can serve as a working definition of normality:

> Harry: But aren't we also talking about one's guilt of not fitting in, of difference? I am just remembering in my head when I was training as a social

> worker, I did a placement in [detail deleted] …it was a sort of weekly meeting with the psychiatrist and the patients and we were all in this meeting and this woman was telling people she was going home for the weekend and the psychiatrist in the meeting said: 'you are not going home, you're not normal'. And she said: 'In what way am I not normal, doctor?' And he said: 'You hear voices and you talk inappropriately' and I heard myself saying as a tiny, little social worker, 'what's normal?' Ahhh, God! I was banned from seeing any of his patients. I showed him up in public, so I have had this terrible aversion for normality, I was being abnormal, I didn't know my place!
>
> Traci: You were not subscribing to norms in our society…. Then perhaps we have a definition!
>
> Evelyn: Yeah
>
> (Focus Group 4)

Significantly, in Focus Group 2, Victoria spoke of her pride in being on the council of the British Psychoanalytical Council when this organisation drew up a statement officially revising the historical pathologising of homosexuality within psychoanalytic circles. She then reflected that this change in position 'makes me think that what we might be struggling with now, I wonder what people will be struggling with, about, as they try to work out a way to live together'. The risks of continuing to apply pathologising labels on particular behaviours remains a real possibility to be kept in mind. As Eva in Focus Group 3 noted, the use of normality as categorisation depends on 'whether we believe you can shoe-horn people brought up now with all the forces and factors, and so on, coming to bear on them, into models which applied a 100 years ago, 90 or even 50 years ago.'

Adding further complexity to discussions, it was noted that clinically thinking about normality can at times offer some relief to patients. The following narrative seems to

oscillate between appreciation of the clarity, even relief, that exploring the patient's notion of normality is seen to bring, and the concern about the ill effects of psychological labelling:

> I had a different path in mind and mine came from, I don't want to sound particularly pretentious, Foucault and thinking about the abnormal and the way there is, this came up actually this week maybe because I was thinking about this, came up. A couple I have been seeing for 4 years said, oh, something wasn't normal, and we had a discussion around normal in terms of descriptive statistics, distributions and things like that and how an evaluative layer gets put on that. And it was actually quite helpful to take out some of the sting out for her, feeling that something wasn't normal. But then I suppose there is also that, for me, there's the question of who decides what's normal in that evaluative sense and sometimes some of the ways dynamic theory, analytic theory is used can be quite othering and that can be quite othering. I was thinking of Freud's letter to an American mother and the, about homosexuality, saying it's no advantage although recognising the social cost of that. Saying, in effect, it's not a psychic problem, it's a problem of society, so it's interesting that maybe what we bring into the room, even if we try to leave it outside can, be quite challenging.
>
> (Oliver, Focus Group 3)

In contrast with the potential of labelling patients as inferior bearers of stigma, participants in Focus Group 3 discussed the importance of appreciating their capacities:

> Grace: Also, when I am looking at their normality or their experience as well as looking at the presenting problem, issues that are coming up etc. There must be a point when I ask them what is working for them as a couple. What works, what, and that's always…
>
> Eva: what are the good bits…
>
> Grace: What are the good bits, yeah, I try not to label it as so good but it's interesting. Also, what they draw on within themselves, get them in touch

> with some of the developmental stuff, the creative stuff that Mary Morgan will speak about…there is a sense of aspiration as well, within the relationship, alongside the issues.
> Eva: So, there is capacity…
> Grace: Yes, yes…

When the facilitator somewhat provocatively suggested that perhaps in offering psychotherapy to their patient-couples, therapists were working towards some concept, some conceptualisation of normality, the response was both sharp and highly emotive. The following except illustrates this reaction:

> When you ask it like that I get a siren going off …it's just, I just think, Nooo! Making good little people who are going to be fed into this late industrial capitalist machine is not the role of psychotherapy. It's more, for me, it's a more liberator-y thing and freeing things up and that may be how I am positioned as a privileged white male that I can do that, don't know but you see a lot, definitely there is a liberator-y impulse in Lacanian theory but also in Latin America where a lot of interesting stuff is done where… and I come into it from a trajectory of queer theory and an understanding of the damage caused by medicalised psychiatric and analytic power. How that can cause all sorts of problems.
>
> (Oliver, Focus Group 3)

The keen awareness of the dangers poised to patients by the inequality of the therapeutic relationship was evident, and generally something that all participants seemed very much sensitised to. In this therapist's appeal, one can discern a desire for the democratisation of the therapeutic process, relating to how political notions of normality can be felt to impact the less powerful.

Sub-theme 1.3: Client-centric Normality

Many participants expressed the belief that an understanding of normality must depart from the clients' meaning-making processes and is largely to be client-led. Epitomising this position, Riya in Focus Group 2, spoke of how this might happen:

> So actually, do we adjust our understanding of normality based on the couple we have in front of us and how far they can go? Because actually, as you say, many of them will want to keep many of the features and really not be able to work through a lot and yet we still see that as a good-enough piece of work.

Psychotherapists apply psychoanalytic theory to get hold of 'what is getting in the way' of the desired therapeutic outcome which in this case is defined by the patient's goals for treatment:

> I think that fits with the sense, the theory helping, helps me to think about what is getting in the way to these people getting things to work in the way they want them to work. So, it's assessing against their own aspirations, hopes and so on, which may vary obviously but what's getting in the way of them achieving that.
>
> (Eva, Focus Group 3)

The position expressed here is somewhat paradoxical. On one hand, it is the therapist who discerns, aided by analytic theory, what is hindering the process towards the end goal but, on the other hand, is not informed by this knowledge as to what the goal of treatment might be. The latter is seen to be wholly the patient's responsibility.

While there was some degree of consensus that sensitivity to clients' beliefs was crucial, the degree with which the clients' position is to be taken as providing the reference line for assessing normality was contested and seen as complicated by a number of factors.

Code 1.3.1: Centrality of clients' meaning

Considering the meaning clients attribute to normality is seen to be a valued avenue for psychoanalytic investigation. At times participants seemed to be considering the clients' notion of normality not as establishing some norm to be respected but rather as a verbal symbol of something that needs to be opened up and understood. This is made rather explicit in Focus Group 1:

> Rachel: …what comes to mind is a case I worked with, she was constantly, in the beginning, in the initial consultation, she was constantly in the first 5, 6 sessions saying "it's not normal, it's not normal what's going on here and then he goes to speak about it with his mother and then he goes to speak about with his father and that's not normal and then he is going that and that is not normal" and it was essential to start saying that it seems like it is so important what's normal and what's happened. "And my friend, her husband he come home at 5 o'clock and that's normal" … so that's why I am thinking that the experience of what is normal was so important for this couple and then down the line, suddenly everything became possible.
>
> Natalia: Because you hinged it with meaning, otherwise it is just a word denuded of any meaning. But once you enlarged from the word normal, abnormal…you are immediately into a fertile area. Otherwise it is quite a barren land, normal, abnormal.

Participating psychotherapists seemed to be universally intrigued by the manner in which clients come to think about normality both on a personal level and in discerning

the state their partner and relationship might be in. This quote from Focus Group 2 is a good example:

> … it's not unusual for people to use the word normal. You know, I want to be normal, he's not normal, it's not normal. Yeah, I do say, what does that mean to you? You know, I do ask people what that might mean for them.
>
> (Victoria, Focus Group 2)

This curiosity is not simply about where the client or couple locate normality, but also why the question itself comes to mind. Thus, Ian in the same focus group spoke of how:

> when somebody asks me what's normal? I'd be interested in why they are asking that question and also, what have they been used to in their lives? You know, they've got a sense, they must have had the question for a reason and as I'd say they've got a background, and they've got… Does normal mean what I have been exposed to or does it mean something else?
>
> (Ian, Focus Group 2)

Along these same lines, Eva in Focus Group 3, spoke of how in considering normality:

> the theory …helps me to think about what is getting in the way to these people getting things to work in the way they want them to work. So, it's assessing against their own aspirations, hopes and so on, which may vary obviously but what's getting in the way of them achieving that.

Eva seems to be suggesting that theory can be used to provide a framework facilitating the achievement of desired therapeutic goals in a manner that does not impinge or provide a view on the psychological value of these client-led objectives.

Paradoxically, Eva later affirmed that 'it's up to them to say if they are Ok or not. They probably wouldn't come and be paying to see us if they felt ok'. However, the participant then seemed to recall that clinically 'you do sometimes get couples who can't work out what the problem is. ...They still seem unhappy, but they do not know what's the problem.' This type of presentation seemed to jar with ideas she had expressed and led Trisha to respond rather emphatically to the apparent dilemma by admitting that she does 'think we make judgements on what we think is normal'. A number of group members expressed their agreement with this admission.

True to the psychoanalytic tradition, Lydia in Focus Group 4, spoke of how the overt and conscious talk about normality is not the only level at which the matter needs to be considered. In her view, 'underneath it all there is always a normal in the unconscious or conscious mind of the couples we work with and that determines how they are with each other'. Thus, an appreciation of clients' normative positions is not to be understood as simply related to the conscious and manifest positions they express but needs to consider determinants that are, as yet, out of awareness.

The adoption of a client-centric normality is at times the result of limitations practitioners experience in relation to their knowledge of the socio-cultural imperatives impinging on clients' lives. In Focus Group 2, participants discussed whether client's curiosity is to be considered normal and its apparent absence less so using a theoretical lens tampered by socio-cultural sensitivity:

> Catherine: Well I think your point about cultural difference and how, maybe we are not taking enough into account how culture, you were saying how curiosity might not be something…
> Riya: could be considered disrespectful…
> Catherine: …and there are all sorts of things like that, where presumably one, yes one would feel at a loss, you wouldn't, you'd have to find out about the cultural norms… yes, but if you were trying to achieve a particular thing that was totally at odds with the cultural sort of, you'd be struggling.
> Riya: …and it might affect us differently. As we were saying earlier, we all adjust to what we are working with in the room and we'll explore it and find out more about the meaning to the couple.

When clients present with ego-syntonic behaviours that therapists find worrying for some theoretical or ethical reason, they are faced with a dilemma:

> So, you are really talking about the couple, about an ab-normative aspect of normality, aren't you? And it does go a bit against what we do as therapists because we are interested in what is normal for the couple, what works for them - in a sense. Except…, perhaps with certain areas where we would have a view. It is not, is not normal to sleep with your child, or have sex with your child, I mean something that is very clear but there is a whole other sort of area…
>
> (Sandra, Focus group 1)

Participants also noted that clients do at times use their definition of normality in rather problematic ways. The idea that normality can at times be weaponised, was met with much approval:

> Sometimes I find it is very much used as a weapon, so we know what partner is trying to get you to agree that something is normal, or something is not normal, in a kind of attack on the other…and that is quite difficult. And Trisha said people's reactions, some people seem to be comforted by some type of

> sense that what they are going through is normal and yet some people find that extremely unhelpful.
>
> (Trisha, Focus Group 3)

Similarly, in Focus Group 4, Lydia spoke of how 'There is a belief in most couples, what I want is normal and my partner is rubbish because they do not agree with my normal.' Additionally, Victoria in Focus Group 2 tells us of how in couple therapy, 'one would be saying: my partner does X, Y and Z, and, Lydia, that's not normal!' This may be followed by an attempt 'of trying to impose something that is described as normal on the other.' The complexity of considering normality in the clinical situation is clearly even more challenging if it becomes the battleground around which partners pitch their battles or partners defend themselves for taking responsibility for problems they might have contributed to.

Finally, Victoria pointed out that clients' normative beliefs may lead them to pass judgement on their therapists if these fail to define normality in a manner that meets the couple's defensive needs:

> I did have somebody some years ago and he was a barrister and his wife a dentist. A very beautiful woman and she had had another relationship. It wasn't clear the nature of the relationship. She said she hadn't been sexual and he had very clear concrete ideas about what was right and was wrong. And initially, trying to think about what was happening within the relationship, this, that their distress could be manifested in this way, as they were leaving one night, he was 6 foot 5 and we all stood up and he sort of towered over me and he said: "you have no moral compass at all. That's not normal." And in the moment, I felt, maybe I haven't any more! Maybe I haven't. I didn't have anything to say really, I thought we'd need to think

about it more next week. In that moment I felt…because I wasn't judging, I was not judging…

(Victoria, Focus group 2)

Code 1.3.2: Complexity of normality sought by patient

Psychotherapists agree that 'couples worry about normality. Are they different from everybody else? What are other people coming for? Is it normal to have those questions and difficulties?' (Marie, Focus group 2). Couple-patients often present as seeking some form of normality. In Focus Group 4, Lydia tells us that 'the patient has got an idea of what is normal…and I, as the therapist, am meant to make it better somehow. So, I can fail by not.' Returning clients' relationships to the state of so-called normality, however that may come to be defined, can become the evaluative criterion of the therapist's effort.

However, what couples aim to achieve through therapy is not always clear even if 'they come with an experience that something is not OK' (Rachel, Focus Group 1). In Focus Group 2, the participants contemplated whether a particular couple they were discussing wished to move towards a healthier manner of relating or simply return to the familiar and stable but somewhat dysfunctional patterns:

Marie: Well, they are being destructive, and they do not want to be destructive any more, they want a different kind of projective system that will enable them not to be…

Ian: Or they might want to return to what they had before this upset that might not have been very healthy in the first place but somehow it was destabilised.

(Focus Group 2)

Later in this same focus group the dilemma as to whether clients really seek normality or the familiar was elaborated on further:

> Catherine; But also, the understanding of why because you say, we are talking this morning, as to why a woman would choose a partner just like a tyrannical father because it feels like home. When you say something feels like home, that feels like quite a comfortable place, but it isn't. It is a familiar place, but you choose it because you know it but it's not really what you need or want.
>
> Victoria: There is a difference between familiar and normal, isn't it? The familiar which goes to make up one's identity and then you tend to move to an unfamiliar place, then the kind of moving, accepting a different identity, seeing to a different way, can be very challenging indeed.
>
> (Focus Group 2)

Clearly, clinical experience seems to have taught these psychotherapists that clients' desired normality is often a desire to return to the familiar and a defence for what might be possible, new and desirable. Here, a client-centric definition of normality is challenged even if this does not invalidate the need to appreciate and understand the client's desired normality.

In contrast, ideas about the importance of supporting and validating clients' normality as the valued goal of treatment were also aired. For example, when Focus Group 3 was discussing one participant's experience in seeing an Afro-Caribbean male patient, a desire to support this patient's normality was clearly expressed:

> Grace: Perhaps his experience of the world around him he experiences is not one of normality he can relate to. It then makes me think, well if you think of their normality, how can they be empowered or flourish? I do actively want to use the word flourish, rather than just survive or exist, or you know that,

how can you move towards that within their normality which might not be ours?

(Grace, Focus Group 3)

The client's sense of desire for normality may change as therapy progresses. A couple may approach therapy seeking to move away from a particular source of distress and end up modifying aspects of their relating which were previously thought of as normal:

Sandra: … the couple might start off with feeling themselves to be normal, they might change their view of that through the course of the therapy. Not because the therapist is saying you can't behave like that, this isn't normal kind of thing, but actually something that was actually a shared defence that felt completely ego-syntonic and normal. As the couple get help, they start to get a view on it and start to actually feel, we're wondering why we are doing that? It no longer actually feels normal anymore.
Rachel: Or the other way around…

(Focus Group 1)

Later, participants in this group discussed a couple in which one partner might normalise a particular behaviour and perhaps even seek approval from the couple therapist:

Sandra: for example …the example of the child in the bed, might the couple are saying this is completely normal for us this isn't a problem, I suppose, one might feel that you've got to stay with that and that during the course of the therapy they'll get to a point where they don't actually think it is not normal anymore… .You've got to be, to understand why they feel it's normal and what it all means, what its meaning for them I suppose.
Hannah: I mean it is an interesting one. Yes! But then, I suppose there is a question about how long you do something, or work something, work before, when it starts to then border into something that is much more collusive. You're not helping them with it. I mean I suppose if we think about violence, in terms of working with violence, the criticism, the external

> criticism at least of, of working with couples who are violent is by working with couples one could be communicating that that is normal.
>
> (Focus Group 1)

Some psychotherapists are cautious about normality being predominantly patient-defined. Participants in Focus Group 3 discussed how a couple normalised their sexless romantic relationship. While the behaviour itself seems to escape judgement, a curiosity persisted as to whether this relates to something problematic:

> Eva: what you describe could easily be with a lot of couples who might say we haven't had sex, we don't have any sexual contact, we might, you know put out arms around each other occasionally and kiss good night or whatever, but we do not have any sexual contact and that is normal for us and it is not problematic. So are we going to problematise something that for them feels normal? At this stage of whatever is going on for them?
> Isabel: But we would still, speaking personally, I would still make some type of judgement maybe around defensive fit, you know, is this a defensive fit? This couple are quite happy, well, are you saying about colluding, someone else said right at the beginning, by colluding this couple are happy not to have sex, we are happy with that, it's fine for us!
>
> (Focus Group 3)

A similar sentiment was expressed in Focus Group 1 when Linda discussed a couple's normalisation of psychological pain as being part and parcel of relating.

> I suppose it would be interesting to know the extent to which that pain was, quote, unquote "normalised" in that couple. If that couldn't be talked, about, couldn't be addressed and it could have been in part symptomatic of other forms of relating. So, mmm, yeah, in terms of different developmental stages, in terms of different changes, mmm, and what can be known about at the level of consciousness, how much does it register if you speak to a

couple where they are at? Can they actually hear you? Can they take something in?

(Linda, Focus Group 1)

Psychotherapists expressed these, at times, contrasting positions, as they sought to articulate how they come to strike a balance between their sense of clinical responsibility and a sense of respect for patients' beliefs around normality. The two often seem to co-exist in the therapist's minds, creating a dynamic tension leading to much pondering as to how best position interventions.

Sub-theme 1.4: Socio-cultural

Theme 1 centres around who is to define normality, with the most salient sub-theme centring around how psychotherapists manage their responsibility in thinking about normality. However, it is also clear that socio-cultural imperatives feature strongly in their considerations of how to manage the responsibility to not harm their patients. Being culturally insensitive to their individuality and inappropriately characterising behaviours and beliefs as normal or otherwise is felt to have the potential to inflict damage. Importantly, this sensitivity to the variability of norms was not simply limited to those dictated by the dominant culture:

Charlotte: Except that even in one culture there might be practices that other people in that culture wouldn't do…
Sandra: Sure, and different socio-economic groups
Hannah: religion, if we look up different religions you know…

(Focus Group 1)

Code 1.4.1: The Polymorphic nature of normality

The possibility of a multiplicity of normalities emerged as a main concern in group discussions, with Leah in Focus Group 4, rather emphatically stating: 'Oh my gosh, normal! Potentially there is as many definitions of normal as there are people on this planet.' The irony of this statement instigated hearty laughter from the rest of the group. Many participants shared how they struggled with their own frustration as to how challenging it is to find a clean-cut definition of relational normality:

> It is messy, relationships are messy, they really are, at times not so but often they are…that's normal. I think messy is normal. One size does not fit all in how we work.
>
> (Victoria, Focus Group 2)

The multiplicity of normalities is not simply socio-culturally dependent on the macrosystem level but also at the individual and microsystem levels. Furthermore, some argued that normality is not simply idiosyncratic but can even prove to be situational:

> It wouldn't be normal to have a child run over and not feel, not go into one of those nodes, so that phrase came to mind immediately. … so what happens with couples that are perhaps good enough but want to flourish? You can start looking at that side of the spectrum so that made me question what actually is normal, what is that mid-point?
>
> (Grace, Focus Group 3)

In Focus Group 3 the polymorphic nature of normality was further highlighted in terms of the impact of socio-cultural realities over time. This exchange followed a discussion about normative developmental psychoanalytic theory which was opened up to expose practitioners' concerns that the theory did not fully capture the complexities they held in mind:

Isabel: Is it a cultural norm, societal norms in different times?
Amelia: I think that's what provoked my wish to be here. It was much more domestic in that I work mainly in private practice from home and I am aware that I can be trapped in my own ideas of what's normal and that comes from a very narrow-minded life and a narrow approach to things. And, I am aware that as I grow older my clients produce a new, a new, what is for them, a new normality which comes across, often comes in conflict with my own moral code, mmm, it's very challenging. So, I am trying to be a bit more open to societal changes, what is normal as opposed to what is common – such as the use of drugs, for instance.
Eva: I thought about the GP, you know apocryphally. Anecdotally GPs have codes they put on notes and NFN, normal for Norfolk [laughter] - this is what came to my mind, which people say how contextual normality is, isn't it, and with a couple…
Isabel: There was also a TV program, Normal for Norfolk, which wasn't related to medicine but was a rather eccentric family in a stately home and all about the life within that home. But it was called Normal for Norfolk because of the sort of, particular prejudices and associations with that…

(Focus Group 3)

The degree to which normality is considered changeable is perhaps best exemplified by the rather provocative exchange that took place in Focus Group 4. The group were contemplating how normality changes over time as the psychotherapist matures professionally and personally. In response, others suggested that patients themselves go through similar developmental changes in their normality. Harry spoke of different trends he had discerned in areas of his work. Specifically, he referred to the increased incidence of self-harm which has become an all too common manifestation of psychological distress amongst younger patients. The exchange provoked strong emotional responses:

> Harry: you know self-harm, cutting which used to be quite a rarity, I think, is now almost a rite of passage for many adolescents… They turn up in their droves in the clinics, you know, with all the scares and stuff on them. This is really scary…
> Lydia: Normality changes, right?
> [group makes approving sounds: Yeah, yeah…]
>
> (Focus Group 4)

Furthermore, participants also reflected that their view of normality may be age- related. Identifying self as belonging to the 'sort of older part of the population', Amelia in Focus Group 3 suggested that psychotherapists, by virtue of their older age, might be more risk-averse 'than a 20-year-old is as part of his brain normality'. Eva then concluded that 'what is normal at one stage is not normal in another stage in life'.

Finally, participants in Focus Group 3 noted that normality may not simply relate to the cultural imperatives of a certain societal culture or the body of knowledge influencing psychotherapists' thinking, but may also relate to norms inherent to particular training institutions:

> I don't know, I think there is institutional bias there, I felt during the training, a little bit, mmm. I think there would be times we read about Jung and I'd bring in those concepts later and there can be 'this is how we think' and in a way we create our norm and so I found I am interested in these other tools and ways of thinking so that in a way I could create a norm from all of that, so I think essentially that is why I got into positive psychology as well as the Jungian side of things and, you know, transactional and spiritual, existential… I am kind of interested in the whole picture. I think there was an element of, I felt make sure you only write in this frame of reference. So, I think it's

> interesting, we have created a norm here and to remain curious about these other schools of thought.
>
> (Grace, Focus Group 3)

Code 1.4.2: Holding context in mind

Considering normality to be multifaceted or situational, has implications for practicing psychotherapists. Contextual determinants of reality or at least, the normality as perceived by patients, needs to be held in mind as the implications for treatment may be very significant. Harry's views, expressed in Focus Group 4, show sensitivity to the reality of manifest symptomology, as well as contextual factors:

> …if you look at the research on bisexuality and, probably more so, trans but we haven't got that data so much developed… the consequence of not fitting in, of carrying a non-hetero normative identity, if you like, has a psychological cost because you are carrying, you don't fit anywhere. You don't fit in the gay community, you don't fit in the heterosexual community, you're homeless, you're an itinerant and that can be freeing and exciting, but it's also got a cost to it. The idea of having open relationships, which if we are talking about negotiated non-monogamy is a strain for the people who are negotiating it however, because they do not fit in into the bell curve, that central bit. There are, they're in the margins, being in the margins has cost.

Similarly, in Focus Group 2, Victoria made reference to Kleinian and post-Kleinian theory when referring to mourning processes. The challenge presented while working with a Chinese patient where such a framework felt less applicable was discussed:

> …I think quite a lot is the idea of Steiner's psychic retreat and how unavailable will that leave one partner, and in that case, what might have attracted the other, in terms of unconscious phantasy. So that is how, tends to be how I think about or try to understand the couple in front of me. And when I have to take a step back perhaps, it's that I am

> thinking about an Asian couple that I saw, …she in particular talks about the tension between her culture, the eastern culture, and his western culture and the difficulties she finds in trying to work out what's, and she does use 'what is normal for her?'. And that has really challenged my thinking in terms of what is normal and what am I trying to help to make sense of. If that is the backdrop of my thinking, which actually, it doesn't work like that in my culture. It has actually been very creative between us and I've learnt a lot and so has she. But there is something of that…led me to question that idea of this culture and normality and how to really hold that in mind.
>
> (Victoria, Focus Group 2)

While the psychotherapist is clearly not abandoning models that inform their thinking, the context (multicultural couple and European psychotherapist seeing an Asian patient) leads to the taking of 'a step back'. Psychotherapists are not provided with a formula as to how they resolve this dilemma, but the theory and contextual factors seem to be held as carefully counterweighted factors.

This balancing act, occurring when theoretical, diagnostic and contextual factors are all seen to merit respectful consideration was illustrated here:

> I was just going to talk about the labelling. And this was a long, long time ago, very early on in my career as a couple therapist. Anthony Batsman came to talk to us about mental health issues and I remember him saying that we should treat people who'd been labelled, who had a diagnosis of schizophrenia or bipolar, with great respect. That we should actually take the label seriously and treat them with respect because there is a fragility there that people, people could be overwhelmed by emotional content and we should be respectful of their particular normality for them. It's not saying labels don't matter … he is saying treat, treat the illnesses with respect and

> awareness. And maybe that's a bit like different cultures, in a way, one should treat it with respect and not just same, same as us you know… .We should treat some differences, accept them and treat them with respect.
>
> (Abigail, Focus Group 4)

The internal conversation weighing contextual factors and norms pertaining to psychological theory is lively and dynamic. Eva in Focus Group 3 noted how 'psychoanalytic theory may not really fit so well' which necessitates psychotherapists to 'have to get very aware of not knowing'. At other times, the balance seems rather different. For example, Rachel in Focus Group 1 expressed a clear position that monogamy is a norm rooted in human experience:

> There is the notion of couple based on the idea that we share, that there should be exclusiveness, exclusivity, mmm, culturally, actually that's resistance to culture and to everything, in human experience. The couple is based on the sense that we would like to create a sense of exclusivity between us, that I am here for you and you are here for me and actually that's normality, if you like, and now it's been provoked and in a very basic way.

In response to whether the normality is adherence to the cultural norm, Rachel concluded:

> Not culture. I would say human experience, resistance to history and cultural norm, that couples exist because people feel entitled to some sort of exclusivity within the relationship.
>
> (Rachel, Focus Group 1)

Natalia, drawing on theory then added that: 'Attachment, I suppose comes in here. I think it is true that our concepts are, originated in the 19th century and century, but I

think we have to hold on to something and I don't think they are only cultural. They are also universal descriptions…'.

Similarly, while participants contemplated the fluidity of normality with regards to certain behaviours, others seemed to be less permissively considered. For example, in Focus Group 1, Hannah noted that 'if we think about breastfeeding a child when 5 or 6, I mean something comes into our minds whether we think that's normal or not'. But then suggested that 'I mean there are some things…' seemingly implying that there exists a category of behaviours whose abnormality is less unclear. In response Sandra suggested 'breastfeeding your husband' as a possible exemplifier of such a behaviour which was then met with approval and laughter from a number of group participants.

Finally, the importance of socio-cultural contextual reality is not simply to be afforded towards patients' realities but equally towards one's own lived experience. In a remarkably frank disclosure of Oliver's internal process the group was told of how:

> I was raised as a Catholic and although politically am for feminist analysis, I can see arguments around managing conception. If I have clients thinking, should we have this child or not, I still, there is still part of my mind that is thinking: oh! This little baby, you are going to murder them. It's a crazy part of my mind, I think, but it's still there. It's the culture I was formed in from a very early stage, it is something that is challenging. And maybe it is counter-transferential, I picked something, yes though I am alert to that, I sometimes find it disturbing quite how reactionary markers are still in my character. I take that to analysis, supervision as appropriate, so...
>
> (Oliver, Focus Group 3)

True to psychoanalytic technique, therapists recognise a need to differentiate between 'reactionary markers' and counter-transference feelings, with the latter being clearly considered of greater value than the former. The context, it seems, is considered with a breath that is very considerable. This context includes the training institutions and the personal histories from which the psychotherapist draws their knowledge. The above exemplifies the need to consider individual and micro level contextual realities, both for the therapist and the patient.

Summary of Theme One

Participants voiced how seriously they take the political implications inherent to applying normative categories. There is an awareness of the need to hear the patient's voice and respect their culture and worldview. Psychotherapists showed a reflexivity as to how they might be biased or restricted in considering patients' realities because of theoretical positions they subscribe to, their own socio-cultural background as well as the particular leanings and limitations of the institution they trained in. The importance of personal psychotherapy, academic training and the supervisory processes in developing a capacity to consider all factors attracted wide consensus. It is clear that while some psychotherapists express an essentialist epistemological position with regards to normality, this theme reflects a strong social constructivist or context-focused (Protter, 1985) view of psychoanalytic reality.

Theme Two: Indigenous to the Analytic Frame

Theme overview

Theme 2 captures the manner in which participating psychotherapists think about relational normality within the framework of psychoanalytic theory. Four main subthemes emerged capturing their thinking around quality of dynamic processes, sub-optimal as normal, capacity and genesis (developmental trajectories).

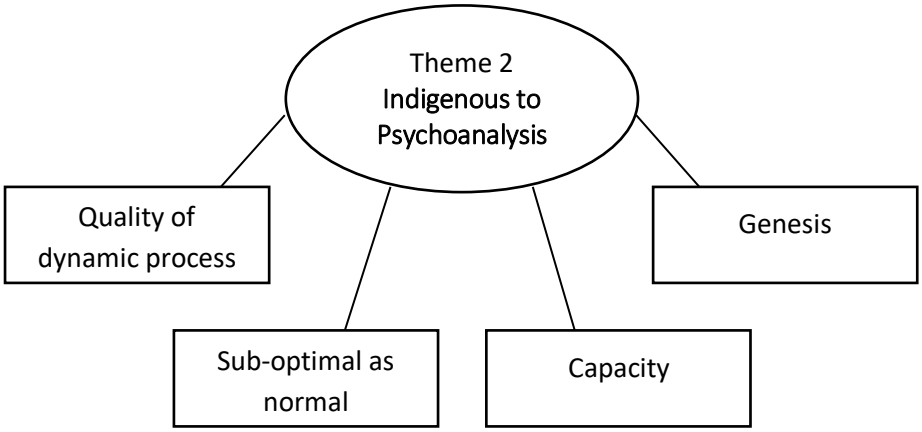

Figure 4.3. Thematic map for Theme 2

Subtheme 2.1: Quality of Dynamic Processes

In keeping with the psychoanalytic tradition, psychotherapists made rich references to dynamic communicative and transformational processes happening, between which, in this theme are labelled as intra-couple. Additionally, couple psychotherapists noted the quality of exchanges happening between the patient-couple and their therapist, which are here labelled as intra-clinical. Summing up the universality of the ever-changing dynamic processes in couple psychotherapy, Evelyn (in Focus Group 4) spoke of how

'We're all in it together, aren't you?' linking patient's experience of these dynamic processes with that experienced by the practitioner seeing them. She concludes that inevitably this evolution has 'got to go both ways'.

Code 2.1.1: Intra-couple

Participants repeatedly noted the dynamic nature of unconscious exchanges by making reference to projective processes, often linking these with more complex ideas that have emerged in the field of couple psychoanalytic treatment. Reflecting about developmental theory, Marie in Focus Group 2, speaks of the couple's need to find a way of managing these processes in a satisfactory manner:

> the stages of development, you know, what might be the equivalent when we are looking at a couple from an initial falling in love stage, sort of merging, to a disillusionment /separation, and finding a satisfying projective system – maybe the establishment of a working projective system could be what's experienced as normal for that particular couple.

Participants seemed keenly aware that, while projective processes were of significance in thinking about normality, 'it is really difficult to think about what is normal and what is subnormal level of projection' (Dawn, Focus Group 1). Moreover, Lydia in Focus Group 4 sheds some light on the types of ideas that are applied in thinking about projection:

> …underneath it all, there is always a normal in the unconscious or conscious mind of the couples we work with and that determines how they are with each other….It's unconscious phantasy, it's unconscious belief, it's the projective system, it's all of it, isn't it?

These Kleinian and post-Kleinian concepts are used alongside those coming from different theoretical trajectories. In the extract below, Jungian psychology is referred to

in a rather permissive pluralistic manner. At a later point in this focus group discussion, one participant points out that:

> Something about the psychic equilibrium of the couple, that is, you know, stuck in one position. Actually, in the Jungian sense, you know, someone staring out of the window, that it becomes what Jacob is saying, a kind of place where no one can move or think and it's something like that that I think is, at least part of trying to get to, I don't use the term normality, again get to a place that is open enough and there is enough space to think feelingly. That's another jargon Fisher-type, but I like that term, to think feelingly…
>
> (Evelyn, Focus Group 4)

The focus groups afforded insight into how psychotherapists track couple dynamics, attending to both emotional and behaviour cues:

> Maybe it was also a feeling of defeat that somehow, we weren't going to get very far with it. There was a sort of feeling of not being able to…, I mean this person was suicidal as well, kept making suicide attempts, my feeling was, it's just a horrible proximity to something so, …so anti-life, so destructive… I was experiencing a countertransference of the level of distress, it was terrible.
>
> (Catherine, Focus Group 2)

It is clear that attending to the emotional experience within the couple dyad identified through the experience of being empathically attuned with a patient-couple, happens alongside observation of the more overt dynamics:

> when you have a couple in front of you, sometimes they can relate to each other in a way which is quite free-flowing, without edge and sometimes they resort to this very rigid, very familiar defensive relating so I guess you are sort of trying to gauge how much there is of that and how much there is of something healthier. I guess I would be, sort of working trying to help them trying to understand what triggers the more psychotic-type relating.

(Catherine, Focus Group 2)

At times, psychotherapists seemed to refer to couple dynamics in rather unsophisticated, colloquial ways. For example, Dawn in Focus Group 1, described a supervisee referring to a particular couple as being 'so rigid'. Similarly, within the same focus group, Linda spoke of how 'robust' a couple's relationship was. Description of relational dynamics seemed so familiar to practicing psychotherapists and were used with such fluency and ease, that one might rather easily miss out on their significance. Seemingly unsophisticated description is clearly linked to complex theoretical notions as in the following example:

> But then there is a kind of line, I think there is a baseline whether people can move in and out as opposed to staying stuck, like a projective gridlock which might think of as not, not normal couple relating.
>
> (Evelyn, Focus Group 4)

Psychotherapists do not consider the evaluation of personal states of mind as being as central as an appreciation of how these come together in a couple. In the following poignant account from focus group 4, in which one partner is depicted as being wheelchair bound and therefore not be in an ordinary 'state of affairs', it is the dynamic between them that determines whether the relationship works or not:

> Abigail: A bit like if someone is in, you know, in a wheelchair, you could say that someone is in a normal state. If you are married to someone who is in a wheelchair and you keep saying "I really want to go for a walk", you know "let's run, let's go for a run", then you could say "well you know…" [group laughter]. It's tolerating the difference even if it's not average or whatever…

> Harry: I mean, you have introduced a new word, I think it's the first time I have heard it this morning, which is 'functional'. Which is another, another, slicing of it or something.
> Traci: Yeah, exactly and I wonder whether we are edging towards a, something that we value, that we want to call normal, which is a compilation of these things, which is around this functioning in a good-enough way…
>
> (Focus Group 4)

It seems that analysis of dynamic processes is aimed at providing couples with the possibility of changing something of the relational dance, or couple fit, they enact between them, whether this be behavioural, emotional, conscious or unconscious. The position that emerged in Focus Group 2 garnered the approval from other group members:

> Riya: …it is assumed that we are always working towards a resolution, a depressive position, something that we are working to, …mourning a loss. All these sorts of statements and processes are what we would regard as…
> Ian: …healthy.

It seems clear that participants believed that achievement of desired therapeutic outcome is greatly facilitated by identifying and intervening at the level of the intra-couple dynamics:

> Riya: We give them a choice and an experience of having the opportunity to process something that does feel different which might be closer to the healthy normal end, but also we, although we might be wholly in our mind an objective sense of what normal looks like, this does not necessarily mean, as we all know that, that is where we will necessarily get to with each of our couples.
>
> (Riya, Focus Group 2)

Code 2.1.2: Intra-clinical

Participating psychotherapists made reference to the consideration they give to particular feelings and thoughts they experience in the presence of patient-couples, normally referred to as transference processes. Intra-clinical dynamics include these types of discernment-aiding phenomena alongside other, perhaps, more concrete happenings in the clinical situation. Couple therapists maintain a close watch, trying to discern whether any shift in their own behaviour is in any way a reflection of the patient's or patient-couple's state of mind. Personal processes are believed to have the potential of being linked with that of the couple in meaningful ways and psychotherapists strive to remain aware of this possibility:

> Trisha: …am I acting in a way that's normal for me in my role as therapist? Or am I suddenly doing weird and wonderful things that are not normal for me, in which case, what is that about?
> Oliver: I am thinking as a …[prolonged pause], I have a sort of ideal of always making a little check to see where I am before a client so I can sort of help distinguish that but sometimes I don't. Especially if I had a very difficult one (session) just before and have been stirred up. It can take some time to sort of settle down and find that facility in oneself so actually I might behave in a way that I might realise quite a bit after the event that, oh gosh, that was really, I was enacting something from the previous session or the session before that.
>
> (Focus Group 3)

Later the group heard of 'an interesting experience' that Eva had with an individual patient the previous evening when an external event intruded into the clinical setting:

> Eva: Suddenly, towards the end of the session there was a smell of burning and this is at home and I am sitting and thinking: is my house burning down? Suddenly, am I going to have to figure out how to get this client out of here …

> or has it some part of what's going on in the room? You know, is the client noticing this as well, has he gone into this slightly dreamy state, you know, what's going on? …Trying to work out actually, is there a counter-transference aspect to this or is there something where I need to take some radical action *pronto* here? It was so unusual.
> Oliver: Outside the norm.
> Trisha: I am still sitting here struggling with this idea of what is normal for the clients being something we pathologise…
>
> (Focus Group 3)

Maintaining a keen interest in the symbolic is central to psychoanalytic thinking but clearly, the process of discerning the source of symbolic content in the intra-clinical space can prove challenging.

Generally, participants dwelt only briefly on overt intra-clinical processes, but a number of very poignant examples were provided. One participant spoke of how a couple presenting in a very insular manner could not allow their therapist to know what they needed. Commenting about the infertile, futile quality of the transactions, the therapist likens this to masturbation:

> But at least with ambivalence is thinking space, isn't there? You know that's the thing you know, because they are really clumping, really clumping down, that couple of Natalia's today so to actually, she couldn't really get in there and do any work, except to be with them to masturbate…
>
> (Charlotte, Focus Group 1)

At other times it might not be a matter of poor communication but an outright objection to disclose and discuss experience deemed of relevance. Interestingly, psychotherapy is often dependent on conversation and these clients might be seen to challenge the

normality of the therapeutic context as participants in Focus Group 4 seem to be concluding:

> Lydia: yeah, yeah… and I think I would treat a couple where one partner really doesn't want to talk or can't talk. I can see myself in the room trying to persuade them because that is my normality. If you can't communicate with your partner how can you…
> Traci: But that's what you're here for…
> Abigail: Well that reminds me, once I had a client who was recommended, she came to see me and mmm, she didn't want to talk at all about anything except the fact that her life was lousy. When I wanted to find some roots for that, her relationship with her mother, her parents' relationship, "OH GOD! I knew you'd be like, these psychotherapists just interested in the mother, I'm not talking about the mother". Relationship with siblings "No!" She wouldn't talk about the past at all, it was really, really difficult. I remember at one point I said "well, that's what you do, you know? If you go to a homeopath, they'll probably give you a little white pill. And you could say 'I didn't come here to get a little white pill' but that's what you do in homeopathy and here we talk about the past". And she said "Oh, you are always trying to make comparisons" and it was… because that is our normality, to talk about the past, that is just like at a homeopath, it's normal to give a white pill.
>
> (Focus Group 4)

More problematic processes seemed to both draw and focus the participants' minds. There seemed to be a preoccupation to discern what might be problematic in the patient's internal world by attending to more than the mere narrative presented. In Focus Group 4, Abigail gave the example of a man frequenting orgies causing his wife much upset:

> Do you think normal, I am just wondering that could be something, a capacity for some idea of the other? … I remember seeing someone who had come

> because his wife had found out that he was having orgies and various things and was threatening to leave him. And he wanted to come to therapy, just so the wife would know that he was coming and then she'd be quiet.

The therapist does not seem to come to any particular judgement about the patient's involvement in these activities but is rather more interested in the manner in which the partner keeps, or fails to keep, his wife's feelings in mind. She proceeds with trying to understand what drives this behaviour:

> And I asked him to explain why he was going to these, what's going on? And he said: well, I used to date women but I found that if you meet someone online, you spend quite a lot of money on meals and then you spend money on a hotel and you can't always guarantee sex, but I found that if you go to an orgy and pay money you can guarantee sex. He had no sense of a relationship with me, or a relationship with any of these women. Everything seemed to be a part object and, mmm, I decided I could not work with that level of disturbance. My level of expertise wasn't deep enough, so I said he should go to [named specialist clinic] the Portland for that level. So sometimes we do see clients where actually I do think, actually I can't work with somebody who's got no sense of a relationship at all with me, as a therapist, or with anyone else. It makes you, it gives you a sense of chill.
>
> (Abigail, Focus Group 4)

The discernment of severe pathology or a degree of abnormality is, at least in part, dependent on appreciation of the quality of interpersonal space between patient and psychotherapist. This reflects elements of the partners' difficulty with relating within their couple relationships.

Couple therapists seem to have a high tolerance threshold when it comes to hearing and working with somewhat less main stream experiences. Sometimes their capacities are severely tested. One participant talks of a couple in which one partner was undergoing a sex change and the couple's vulnerabilities meant the whole process was extremely fraught:

> I was thinking about a couple I saw. One of them was transgender and transitioning to becoming a man and the other one was a man, an older man. And she had had a double mastectomy in order to prepare to become a man but then she got pregnant and there was something about that, that was so shocking to me, that you could choose to, she already had a child and then she had this double mastectomy in order to have this gay relationship with this young man and then got pregnant. Fortunately, it was a consultation. I did not have to work with them but in terms, for me, that felt very difficult to process and to understand and just the attack and well, on the body - the confusion to, to not make sure that ….and she was going to have this, this baby having had this double mastectomy and then where was…
>
> (Catherine, Focus Group 2)

The psychotherapist was open about the confusion experienced as well as their shock at learning of the unplanned happenings. The couple were in acute distress, but the peculiarities of their situation is not considered as particularly abnormal. The practitioner is clearly more drawn towards understanding the couple and, as Riya then suggested, appreciating that this was 'probably reflecting some type of disturbance…'. In response, Ian verbalises the question that repeatedly emerged in discussions: 'How much is that, is, mmm, your shock because of what it touches in you and how is that countertransference?' A lot of thought seems to be given to discernment between reactivity and transference processes.

Intra-clinical are not simply static phenomena providing diagnostic insight into of a couple's state. The couple psychotherapist considers the various aspects of the dynamic process witnessed in the room. The manner in which the couple makes use of interventions offered to them, changes in their psychological states (in the example below illustrated as regression, expressed by Linda), as well as the shifts in their capacities beyond that seen at the start of the therapeutic process. Upon reflection, Dawn then suggests that ultimately, the crucial goal beyond diagnostic categorisation is gaining an understanding of how the couple's psyches interact and fit together in the making up of their particular coupling:

> Linda: … in terms of different developmental stages, in terms of different changes, mmm, and how can be known about at the level of consciousness, how much does it register if you speak to a couple, where they are at? Can they actually hear you? Can they take something in? I was then thinking about the process. Is it opening up, can they take in more? And then the therapeutic reaction, the regression and I just wonder whether those are the type of things one can think about, how far away from the usual relating of a borderline or a detached, attached narcissistic couple relating, how far from what one might have expected? You know the assessment type, what is going on? How far from that do they stray and are there areas that can't be known, that they are avoiding, that they invade and pervert, maybe other ways of relating?
>
> Dawn: I wonder whether when you made that assessment then whether, what isn't in the assessment is that you are assessing the degree of pathology in the couple and then we have ways and means of categorising the pathology with our concepts and our ideas, like unconscious couple fit…
>
> (Focus Group 1)

The achievement of the desired therapeutic outcome is also facilitated by the quality of the intra-clinical experience they share with one another and their therapist:

> We give them a choice and an experience of having the opportunity to process something that does feel different which might be closer to the healthy normal end, but also we, although we might be wholly in our mind an objective sense of what normal looks like, this does not necessarily mean, as we all know that, that is where we will necessarily get to with each of our couples.
>
> (Riya, Focus Group2)

It is clear that participants believed that the skilful management of the intra-clinical process contributed to positive therapeutic outcome. Normative thinking around the manifest content is relegated to the background as the desire to gain meaningful understanding of the intra-clinical process gains primacy.

Subtheme 2.2: Sub-optimal States as Normal

The whole debate about relational normality indicated that participating couple psychotherapists often held a realistic, non-idealised view of psychic and relational life. In Focus Group 1, Dawn poignantly pointed out that 'this is really important. What you are saying is the inherent nature of conflict in living with the other, what the other represents. As a couple therapist you are confronted with it, in a different way from seeing someone individually.' Affirming a link between the normality of inter-personal difficulties and individual psychological states, Linda affirms this non-utopian view where 'identity like normalcy is never fully achieved but it may be something people strive for or try to avoid'.

Code 2.2.1: Dystopian relationality

Within the couple, the dynamic processes inherent to its existence as a dyadic relationship do not necessarily unfold in an ideal manner. Reflecting on some clinical material shared in Focus Group 3, Eva suggested that what was being looked at amounted to 'the normal tension between defensive and developmental forces within relationship'. This then led Amelia to refer to the Winnicottian notion of 'good enough' as being 'a bit of theory but it's also a bit of everyday life', underlining a sense that perfection in this field is elusive. Utopian relational normality is elusive. Camila (in Focus Group 4) even suggested that 'psychoanalysis invented "good enough" to get rid of normal'.

This permissive view of normality does not seem to speak of a capricious tolerance on the part of liberal therapists:

> Theory normalises in that sense, because you read out all sort of things that people would actually, you know, not consider normal or be surprised that people have these types of fantasies. But the theory normalises it and we are very use to that - so we hear a lot of things and we think it quite normally actually to have these fantasies and wishes…
>
> (Marie, Focus Group 2)

Interestingly, perhaps expressing yet another facet of the psychotherapists' complex relationship with notions of normality, the participants spoke of how various undesired states are in fact normal, in the sense that they are an expected reaction of particular life events. Some participants spoke of a need to normalise such experiences:

> Pathology and normality, I was thinking, we very often, in our environment are using the term normalise…what would that mean then there's a lack of trust after an affair which for me would suggest: is it something about taking

> judgement off? The worry or the presenting problem so whatever diagnosis, pathology,… exploring the judgement, the meaning behind that…
>
> (Camila, Focus Group 4)

The idea that a utopian normality is evasive and that destructive forces operate in the psyche does not mean that couple psychotherapists normalise or de-pathologise all behaviours and experiences. The following exchange highlights a number of interesting considerations made in evaluating processes in the everyday life of a particular couple:

> Trisha: I am thinking of a couple who basically do not touch each other, I mean to the extent that they will walk around each other in a big thing in the kitchen to make sure they don't accidentally brush… . Now I am, am not saying it isn't a problem because it is for one partner although it isn't for the other partner, but I am thinking about the children and they are growing in this environment thinking more what is that, what impact is that having on their children? So, I am thinking that this is not normal, in a way, it is not normal to grow up with parents that do everything that they possibly can to avoid any physical contact. So even if that wasn't a problem for the couple, if they said we've got some other issues and they were quite happy that they don't touch each other, actually I think I would still be worried that it was a problem, that it wasn't normal in some way…
>
> Amelia: But are, I mean, might be, I listen to you say that, it might be sort normal but it's not optimal for the children because they should have physical contact. So inevitably there is a sort of judgement I am making…
>
> (Focus Group 3)

The action of the couple is not seen as intrinsically abnormal but the psychotherapist is drawn to consider the impact specific behaviours have on both partners and their children. Asked as to how these impacts are judged, Amelia suggests that practitioners

draw on 'various theory, developmental theory' while Eva referred to the belief that 'we have embodied physical beings who need and desire some type of physical contact with each other'. The term embodiment seems to indicate the latter statement is informed by related theory.

Perhaps more controversial is the ideal that since non-optimal mental states are normal, then one can consider presentations carrying a clear diagnostic label associated with psychological pathology as normal. While this was not a widely expressed view, its assertion by senor psychotherapists merits noting:

> Natalia: yes, being a borderline couple is difficult, it is difficult to manage your life that way, but it is what it is. It is not abnormal – it is just a way of relating. It's painful I think…
> Dawn: That's normal…
> Natalia: yeah, that's normal. Yeah, I think we can agree that pain is normal, loss and pain is universal and loss…
>
> (Focus Group 1)

At the other end of the spectrum, from the normalisation of psychic pain is the consideration of happiness, as discussed in Focus Group 3. Happiness is seen as part of some utopian desired state. Referencing Freud, the normality that is to be achieved as a result of treatment is seen to be a form of common unhappiness. One can certainly not accuse couple psychotherapists to be holding on to a romantic world view:

> Grace: … the whole concept of happiness is an interesting one because you read so much about it as well now. Do you have a right to be happy? What does happiness look like? Is it a personal responsibility, is it a couple responsibility, is it both? Mmm…
> Eva: Is it normal to be happy?

Greta: Happy only in retrospect…

Oliver: Is it a governmental responsibility, Cameron and all of that…?

Researcher: And is it normal not to be happy?

Grace: And is unhappy in some ways quite different to, it's almost like, you've got to be content, positive, happy, joy, there's a sort of content people get confused about. Like yeah, you know, I am content, I am not joyful, excessive joy. And then there is the unhappy, I feel like it's almost like, is it just symbols, unhappy or happy?

Oliver: But even those concepts they position people in ways that might not be helpful to them, might actually undermine their contentedness. And ordinary unhappiness? I mean, I don't see my role to make people happy. To get them to think about what is going on for them and that might help, or it might not to actually make them happy. I would run a mile from that.

Grace: And Freud said psychoanalysis can only offer the opportunity of transferring neurotic misery into common unhappiness.

(Focus Group 3)

This non-utopian view of internal and relational life led to Grace to disclose that she had been drawn into 'doing some yoga teacher training alongside some positive psychology… as a sort of question mark after … traditional psychotherapy'. She offered the group a challenge to consider:

> OK, so what happens with couples that are perhaps good enough but want to flourish? You can start looking at that side of the spectrum so that made me question what actually is normal, what is that mid-point?
>
> (Grace, Focus Group 3)

Code 2.2.2: The conflicted psyche

Participants noted that opposing forces seem to be operating simultaneously within the psyche, resulting in both life-enriching and life-limiting exchanges within coupledom:

> I think that part of being human is being destructive as well, you know, creative. We have got hatred as well as anxiety, as well as love and creativity and so on. And to me, in my mind, that's kind of normal
>
> (Sandra, Focus Group 1)

Later, in the same focus group, Natalia spoke of how when meeting a couple or individual, what she considers is how they manage their 'destructiveness and hate'. She stated emphatically that these, 'I certainly consider normal'. On the other hand, what denotes abnormality, in this practitioner's view is 'denial, areas that are taken out, the areas that cannot be thought about, …areas of prohibition'. Affirming this position while endorsing a vision of a psyche split between competing forces, another participant draws on theory, adding:

> …well, someone formulated this rather well, called Bion, [group laughter] about the importance of, about the links between L, H and K and what's dangerous is minus L, minus H and minus K, not knowing, not knowing about your hate and not knowing, denying your love , you know, if you took Bion, he would say that health or normality; well I don't know, this is a question but, is a good relationship between those 3, L, H and K and not the denial minus L, H and K.
>
> (Sandra, Focus Group 1)

Knowing about internal conflictual processes and feelings seemed to be appreciated as an important element of well-being or normality. The stark absence of any awareness of

such feelings alerts the couple therapist to areas that require attention. Indeed, this type of presentation was seen as a form of pseudo-normality demanding of the therapist's attention:

> Sandra: But I guess we'd have to sort of think somewhere, it is normal to want to have children or at least to have ambivalent feelings [Yeah, Yeah – Charlotte]. Whether that is right or wrong, who knows? But what was striking with this couple was that there was no ambivalence…
> Charlotte: Or admitted ambivalence
> Sandra: Or admitted yeah…that came into the therapy.
> Natalia: Could we agree that ambivalence about things is normal? [Laughter and approval, yeah, yeah, from group]. Well I think this is important because that's where we start to wonder that perhaps there is some difficulty - when ambivalence is denied.
>
> (Focus Group 1)

Psychic processes are clearly not always pain free or economical. In Focus Group 3, participants discussed how a female partner in a young couple experienced internal conflict related to being in a relationship which triggered off much anxiety in her. On one hand, she longed for her partner's responsiveness, but fearing her partner non-responsiveness might stir up unbearable feelings, she opted to protectively avoid monitoring their communications over social media. While defensive of anxiety, the psychotherapist believed that strategy helped her manage conflict between parts of her psyche and her needs, and the relational reality she experienced:

> Eva: …a couple I am seeing at the moment. They are quite young, and they are much more tech savvy and one of them was talking about how distressed she used to get when her partner didn't respond to her WhatsApp very quickly. So, her way of managing was to put WhatsApp away so that she would not be seeing that he'd read it and not responded. It was her way of

> managing her anxiety and she doesn't need to do that anymore which is great process but, actually that was an, an adaptive defensive strategy which worked. You could say that's problematic in itself but actually worked for her for a period of time until it becomes no longer necessary.
> Oliver: But that's true of defences generally, they were useful at a certain stage and maybe they were not so helpful now.
>
> (Focus Group 3)

Subtheme 2.3: Capacity

Participants spoke of how couples, and individuals within these couples, managed their internal and interpersonal relational experiences. This assessment of capacity is particularly important at the very start of the therapeutic process, not least because therapists need to know whether the couple can deal with the stressful novelty of the therapeutic setup:

> I assess the couple's capacity to manage the frame. The demand of the therapy, mmm, that feels much more indicative in my mind sort of in a non-scientific way can they arrive on time, can they wait, can they bear, can they be directable, can they take what it takes to manage the process of an assessment. I suppose that's where I am thinking about degrees or perhaps psychological ill-health.
>
> (Natalia, Focus Group1)

Clearly, both processes, that are internal to individuals as well as the couple's inter-personal capacity to manage a particular reality (in this case the therapeutic setting is used as the experiential sample) are considered in assessing normality in terms of capacity.

Code 2.3.1: Management of personal process

Individuals participating in a relationship bring to bear their individual abilities. In Focus Group 3, Isabel reflects on the manner individuals present in therapy and what this says about their capacities. Having a degree of defensiveness or psychological skin is considered important here:

> I think about it in terms of what is a normal level of defensiveness and what's the extreme. So, you know, the couple who come in and can't say a thing at all and the ones who, one or both; it tends to happen more with individuals I think, but I have had experiences of somebody coming into the room and immediately bursts into tears and sort of poured everything out. And you think this person has no skin, mmm, and I think a lot of people come somewhere in between and that tends to feel more normal.
>
> (Isabel, Focus Group 3)

These individual-level capacities contribute to the manner in which partners relate to one another. In Focus Group 2, participants contemplated the link between the individual's capacity for distance regulation and the shared capacity for closeness:

> Marie: Ok, alright. I was just wondering if it might have to do with the elasticity of the distance between the two partners. If partners can deal with individuation and togetherness and come in and out of that and have an elasticity in that, to me that would possibly be when you get to a certain degree of normality.
>
> Riya: and that's on a continuum as well, isn't it?
>
> (Marie, Focus Group 2)

The individuals' experience in the couple itself and what this might say about their capacities is closely attended to as practitioners form their view of a particular couple.

One participant shared the challenges she faced when assessing a couple's situation as the presented narrative raised concerns in her mind:

> Open relationships is a good example of that because, and I am trying to think in terms of normativity as to capacity and distress. Like, how much distress does it cause to people that are in that relationship. Maybe none, maybe a tremendous amount and what is their capacity to manage what life throws at them. And then I come across the normative ideas. If both partners are claiming that having multiple partners, open relationships, is actually not distressing for them, and they have the capacity to bear the fallout of that, do I put that in the normal range because it is not normative or do I hold on to my theory?…as in… I think these two things don't seem to fit easily in my mind because when a couple claims that they do not experience distress and they have the capacity to manage these, not very normative ways of being a couple, I am wondering if they are cut off…
>
> (Natalia, Focus Group 1)

It is interesting to note that psychotherapists do not take what they are presented with at face value. A lack of distress might indicate a capacity to bear stress or an incapacity to know about it. For instance, a clinical account was provided about a same sex couple struggling with their differing positions around monogamy. The problem was understood to relate to the fact they both lack a template for the type of relationship they wanted, and acquiring this meant their relationship improved:

> What caught my interest as well was a case I saw, a gay couple recently and they sort of lacked a blueprint for long term gay relationships because they had a lot of heterosexual friends and they just work out, yeah because what was normal for one was not normal for the other. When I met them, they were at the brink of splitting up, they lived separately for 6 months, then they came back together. But in that year, they managed to reorganise what is normal for them as a couple

> and that was really interesting - it had a lot to do with both their attitudes towards monogamy. They somehow managed to re-organise that for themselves.
>
> (Greta, Focus Group 3)

In another instance, participants homed in on something they thought to be crucial in the management of the differences inherent to a dyadic relationship in which two persons must come to some workable way of sharing life. Curiosity, or the maintenance of an inquisitive state of mind was said to be key:

> Victoria: There is a difference between familiar and normal, isn't it? The familiar which goes to make up one's identity and then you tend to move to an unfamiliar place, then the kind of moving, accepting a different identity, seeing to a different way, can be very challenging indeed.
> Catherine: But we are looking for curiosity. Aren't we? We are looking why people are saying, we, I, I don't particularly like it when they say: "he's the problem". It all is there, and they come not knowing what is really going on with him. I do not, I think it might have something to do with me because I keep on…in a way is that a norm? You keep wanting, you are relieved when you feel, you find someone who is curious. But it doesn't mean…
> Victoria: But that's desire…
> Catherine: You are not interested in someone…
>
> (Focus Group 2)

Additionally, individuals' capacities are not static. Individual development or the lack of it impacts the couple's trajectory directly, as illustrated here:

> When you talk about psychic development as a couple, you could, you know, you could say that this couple have only got this far in becoming an adult intimate couple. Maybe they are like two siblings or like, they can't, the sort of couple that come because they are terrified of making a commitment…
>
> (Dawn, Focus Group 1)

Code 2.3.2: Interpersonal maintenance

The capacity to function as part of a couple requires a capacity to engage with the other. A limited or lack of such abilities can greatly hamper relational processes. One participant suggests that rather than 'external circumstances being focused on' exclusively as being 'normal or not', thoughtful reflective attention to the couple-patient's presentation leads to:

> thinking about how, the tools they have to cope. So, what I mean by that, the tools they have to cope with situations. So, what I mean by that is, their ability to tolerate different opposing opinions within a couple or to be able to think and feel, the mentalising – holding on to that, the depressive position that gets talked about. In a way, being able to do, find a way to access that, as being a normal stage, as being something, I am aiming to create. That sort of normality, that then they can think about what they want and their issues, rather than get tied up in an external normality. I try to create an internal normality.
>
> (Grace, Focus Group 3)

Certain personal capacities, which are here articulated in terms of psychoanalytic, are thought of as essential in relationship maintenance. These have great value beyond that of mere psychic management or survival. The capacity is not conceptualised as simply internal but as dyadic (tolerance of opposing opinions) and synergistic.

On one level, some participants thought that relational ability is innate but clearly its manifestation in adult romantic relationships might be compromised. Partners come together because, in Charlotte's (in Focus Group 1) view, 'we are wired to connect' but the quality of the linking process is a focus of the couple psychotherapist's curiosity and investigation. She adds:

> I don't know. I think it's quite hard not to think about, when you think about a couple, not to think about what they do together and what they do together is create something together. That doesn't have to be a child, but you know there is a reason they are in a dyad rather than on their own I suppose, and there is that type of potential for creativity that seems quite important when there are one another's minds involved. In a way, aren't we wired to connect, to have that, type of, you know, interaction, to stimulate one another in some way?
>
> (Charlotte, Focus Group 1)

The interpersonal communicative function is crucially important if a relationship is to flourish. A senior psychotherapist recounted how a male client refused to talk to his partner and then turning up for couple therapy, refused to talk to the therapist. The desire to part-take in the therapy and in his relationship was undermined by his silences, a real challenge to the psychotherapist's normality and psychoanalytic understanding of normal reparative processes in dyadic relationships:

> And I was thinking, somebody shouted at me last week. The couple had had a fight, he didn't want to talk about it, he'd been silent for a few weeks and I obviously encouraged the man to talk about what happened and he starts shouting at me at some point saying "a problem shared is a problem doubled, a problem shared is not a problem halved" and there was my normality, right! In order to get to the bottom of what happened between you, you have to talk. And he said "I bloody well don't want to talk" which is obviously part of our normality, that's what we impose, isn't it? You need to be able to talk about it.
>
> (Lydia, Focus Group 4)

Another participant in this focus group suggested that the vital capacity to have 'some idea of the other' was in fact absent in a patient requesting treatment. When the

patient presented in a manner that indicated that he related to persons as 'part object', the severity of the limitations he faced in being in a relationship could be more fully appreciated and appropriate referral to specialist services could be made. Resonating with Abigail's view, Evelyn spoke of how a capacity for relationships is one way of discerning normality:

> I am just thinking about normality and normal, maybe there is a given that we all think that there has to be enough of a relationship or that's part of the measurement, I don't know… self-other…
>
> (Evelyn, Focus Group 4)

Additionally, possessing a degree of psychological flexibility, some capacity to change and adapt to one's relational environment is essential. Evelyn used a tidal metaphor to depict this capacity while making explicit links with psychoanalytic theory:

> I don't know where I am going with this but when they are in a kind of paranoid schizoid state, mmm, moving to a depressive state, and that ebbs and flows so you can't have, it's not static, is it? But then there is a kind of line, I think there is a baseline whether people can move in and out as opposed to staying stuck like a projective gridlock which might think of as not, not normal couple relating.
>
> (Evelyn, Focus Group 4)

She also made use of technical terminology to denote particular types of stasis in the relational process but other participants also described these capacities in more ordinary terms, as indicated here:

> Creative, people can move in and out of needing each other, people respond in caring ways, mmm, what else? They can talk about their thoughts as feelings with each other, feel that they get a response, there's a whole list of

> things that I do think of as a healthy relationship, or people threating each other well.
>
> (Ian, Focus Group 2)

The capacity to move in and out of diverse psychological states, knowing of their existence and avoiding a fixed mental gestalt, is linked to a capacity for ambivalence. Charlotte (in Focus Group 1) spoke of a patient's lack of openness to relational experience and the hope that 'at least, with ambivalence there is thinking space'. However, psychotherapists do not only try to understand internal processes, but they are also interested in anything that allows a grasp of their patient's capacities or limits thereof. Observations are carefully examined in this search for insight about interpersonal processes:

> In some way, because I have been doing some reading on that space recently, the mentalisation space where you are looking at speed of reaction, ability to think and feel, in a way, looking at the extremes of borderline, in a way you find yourself coming back to a, the opposite of that, is a more neutral space. Not exactly the opposite. That could be an extreme in its own right but, so is the ability to hold on to curiosity…
>
> (Grace, Focus Group 3)

Ultimately, the aim of treatment is to ensure that the couple in their synergistic efforts come to a place where they can manage that which they experience effectively. Influenced by object relations theory, one participant speaks of the couple coming to function as a container at the end of successful treatment. The container they create between them consists of 'something' internalised from the therapeutic experience that they can jointly continue to apply:

> Internalising enough of a container, or something, to not need to come, to feel that they can do it themselves. They can either create that space, that they have with you or they can hold on to that they've internalised something.
>
> (Catherine, Focus Group 2)

Subtheme 2.4: Genesis

In reflecting about relational normality, participants spoke of developmental pathways, both personal to the individual members of the couple dyad and to the couple itself. While history was not necessarily characterised as lacking normality, there was an implied understanding that personal and couple histories, including those witnessed by patients throughout their lives, impacted the quality of relationships manifest in patient-couples.

Code 2.4.1: Personal developmental journeys

Participants paid attention to their patients' life stories. Reflecting psychoanalytic thinking around developmental and maturational processes, couple psychotherapists seemed to pay attention to both the historical trajectories of the individuals pertaining to the patient-couples they worked with, and of the couples themselves.

In Focus Group 4, one participant spoke of the infant's development which may be normal or less so. One aspect of this journey is the experience of interacting with carers which is believed to shape relational capacities which in turn may serve as an index of relational normality. Interestingly, another participant added that the maturational process in later life may lead to a restriction of functionality and have an impact on the

couple relationship. Psychotherapy becomes a way to provide a positive relational experience which facilitates development:

> Abigail: I was just thinking that maybe normal development is just a baby in relationship with another and learning from the other. You know, the baby smiles, the mother smiles, the baby smiles. You know, that, there is this development about learning from another which you might hope in a relationship and in the therapy, to have that as the basis and when that feels really impossible, I'm not saying it's abnormal because this takes a long time, but that's what we would, I suppose, hope continues, that basic thing that we're not, we are people who learn from others and interact with others and that's something we seem to maintain throughout life.
>
> Harry: But it's interesting because functionality over time in couple relationships becomes quite restricted and that's, that's, they come into a very tight corridor, and that notion of evolution is maybe, and development is maybe what therapy offers. The possibility of something, some change, something development some function…
>
> Lydia: But I think that's were Warren Coleman is so helpful in marriage as a container, you know, the therapy is there to breathe some air into the container, broaden it out, make it a bit more flexible, develop capacity to explore what this relationship container is.
>
> (Focus Group 4)

In another focus group, one participant made an explicit link between developmental stage theories (such as Freud's psychosexual development model) and the maturational process in couple relationships which is here conceptualised to occur in progressive stages or phases:

> … the stages of development, you know, what might be the equivalent when we are looking at a couple from an initial falling in love stage, sort of merging, to a disillusionment /separation, and finding a satisfying projective system –

> maybe the establishment of a working projective system could be what's experienced as normal for that particular couple.
>
> (Marie, Focus Group 2)

Clinically, the attentive appreciation of a couple's history over time, the experiences that led them to present for therapy, and how past relational experiences may be interlinked with presented difficulties is given great importance. Clinical accounts shared by participants showed the meticulous attention with which such events are examined:

> Well, that, that he had a reaction to a relationship that ended, it's because the former partner wanted a child, he collapsed, had, you know, a breakdown, whatever that meant. That must have, can't be a coincidence, I mean, it could be a coincidence about the end of the relationship but the fact that the other partner wanted a child was the stated reason why the relationship finished. So, I have to, I have to, hold the two in my mind and together linked really.
>
> (Charlotte, Focus Group 1)

This psychotherapist illustrates how attention is paid to understanding personal histories and how this may be linked to manifest difficulties in the couple. This inquiry is not simply about relational histories within families of origin, past and current relationships. Attending to 'all sorts of trauma' which Dawn, in Focus Group 1, suggested 'means that the developmental process has got, you know, affected'. Supporting the inevitable link between personal experience and couple functioning, Sandra affirmed:

> when you talk about psychic development as a couple, you could, you know, you could say that this couple have only got this far in becoming an adult intimate couple, maybe they are like two siblings or like, they can't, the sort of couple that come because they are terrified of making a commitment…they would have been identifying that they got something that isn't normal.
>
> (Sandra, Focus Group 1)

Code 2.4.2: Transgenerational legacies

The type of legacies handed down through subsequent generations and even those further apart was clearly considered important. Psychotherapists seemed to think of normality as not simply pertaining to the individual. Many seemed to hold a wider, multigenerational perspective.

In Focus Group 3, psychotherapists discussed a couple engaged in a sadomasochistic manner and how this seems to be linked to the relational templates provided by their own parental couples. One participant suggested that this can be thought of as a particular form of socialisation happening within the family which in turn leads to particular behaviours and feelings being felt to be normal. In this case the clinician seemed to think otherwise, demonstrated in this debate:

> Trisha: I am thinking about a particular couple, who have a very sadomasochistic fit, mmm and have been running with that for 30 years, and it is disturbing to be with. And we think of it in supervision as being pathological and unhealthy and not good for them and something they need to get out of. Mmm, but to them it is normal because it is based on a template of relationship they saw their parents having the relationship they have with one of their parents. It is how relationships are, it's how they

operate. They operate along sadomasochistic lines and that is what a relationship is and does.

Eva: So, their personal culture suggests that that is normal.

Trisha: For them it is normal…

Amelia: At least they feel a home.

(Focus Group 3)

The legacy inherited by individuals and potentially becoming manifest in the couple relationships are not simply thought about in terms of transmitted experience but also in terms of structure. One participant spoke of how:

> … things like generational boundaries, but it's easier again to assess for things that seem off, rather than the normalcy, but I suppose you could think there is a bit of healthy couple functioning here, this is why they came. Generational boundaries, the extent to which perhaps there aren't so many ghosts in the nursery in terms of the kinds of things that get projected around within the couple…
>
> (Linda, Focus Group 1)

The presence of adequate boundaries between generations means that what is transferred across the generational divide is less likely to be haunting, or abnormal.

The way parents relate to one another and their children contributes to the template individuals internalise as to how relationships ought to be lived out. The impact of this legacy relates to the quality of these internalised representations:

> Trisha: But then I am thinking about the internalised parental couple…. [Yeah, mmm -approving utterances from various] …and what is that going to do in terms of a template for the children? So that becomes their future relationship.
>
> (Trisha, Focus Group 3)

Possessing a good template, a shared and relationship-supporting model of persons-in-relationship, is seen to enhance the capacity to be in relationship by way of providing a functional model to emulate.

Summary of Theme Two

The second theme highlights the sophisticated, thoughtful and non-mechanistic manner in which psychoanalytic theory is applied by participant couple psychotherapists. The themes reflect the reviewed psychoanalytic theory particularly that which is applied in the practice of couple psychotherapy. The strongest subtheme, reflecting the relational focus of participant psychotherapists, focuses on the quality of dynamic processes emerging and witnessed in the clinical setting. The two final subthemes capture other aspects of personal and relational life, namely the historical. The third subtheme qualifies psychoanalytic normality enriching understanding of the other themes. It is clear that, while couple psychotherapists may reference utopian and idealistic models of normality, they do not necessarily consider deviation from such templates as abnormal.

Theme Three: Non-native Paradigms

Theme Overview

Ways of thinking about normality that are not necessarily psychoanalytic in nature have found their way into the practitioner's lexicon and practice. These ideas are freely applied although one could sense the participants' unease as to how such ideas sit alongside their psychoanalytic frame of reference.

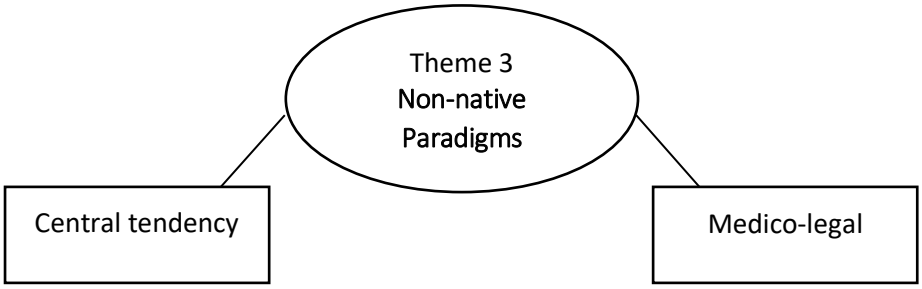

Figure 4.4. Thematic map for Theme 3

Subtheme 3.1: Central Tendency

Statistical models of normality were both explicitly and implicitly evident in the conversations taking place within all focus groups. For instance, the manner in which statistical notions insidiously find their way into clinical conversation was challenged and questioned:

> Hannah: But there is a difference, I mean I am just following on from Natalia, there is a difference between what might be usual, something might be usual, but you might not use the word normal, I mean, there is a question about how you even use the word, I mean people use it differently, because you might not say 'well it's normal to say like that', I mean you might. Or you say, "that's quite a usual feeling", you are not applying model of normality in

that context, are you? You just might be saying there are lots of people who experience that as a sort of reassuring technique.

Linda: Sorry, is that a statistical concept you have or is that a measure of?

(Focus Group 1)

Code 3.1.1: Provision of a cut-off point

The quest for some way of identifying what might constitute clinically relevant cut off points is something that influences thinking even when the discourse is not overtly statistical in nature:

Sandra: Well, one of the things that came to my mind is that when we think about something like narcissism, I think about ordinary narcissism, in the sense that we all have difficulties relating to another person or managing someone having another point of view or not being same as us. The sort of ordinary problems that you might say are normal, whereas there are other couples that absolutely can't bear it, you know, and go to quite extreme lengths that try to convince the other person that they got the same mind or tell them that they do not think that because they need them to think something else. So you can think of it, think of it, a kind of an issue like that, or how we relate, narcissism, issues about relating and you can think about issues like that as a spectrum from something that's quite ordinary and normal on the one end, to something that becomes more and more extreme, almost psychotic, if you like, at the other end. So that was one thought I had.

Group Members: Umm

Charlotte: It is a continuum but then what do we decide is acceptable, it is a continuum, where's the dot in space, yes?

Sandra: …or when does it stop being normal?

Charlotte: Yes… or normal enough?

(Focus Group 1)

Understandably, should something promise to simplify the matter by providing a clear-cut differentiation between the normal and the abnormal, its appeal would be considerable as is clearly indicated in the exchange that took place here:

> Evelyn: Yeah, I had something like this, is this normal or average or healthy? What does normal mean?
> Traci: I had that thought too. I had trouble with the word normal because I think it's mmm, loaded or we might say overdetermined. I can really only, when applying it to something like work I think I am most comfortable giving a definition as within a bell curve – in other words, a scientific definition. Not an emotional definition.
>
> (Focus Group 4)

However, the conversation very soon becomes more complicated through the consideration of pathological states of mind and how these might sit on the bell curve distribution. Clearly, the statistical model resides in psychotherapists' minds, but it is not seen as the ultimate arbitrator of what accurate clinical judgment entails:

> Evelyn: So, when you say scientific you mean, if a couple could be referred to as a borderline couple, you might say, yeah, I might say they are not on the normal curve, they are in…
> Traci: No. I was thinking in reference to the Researcher's invitation and that was attempting to have a definition of what is relational normality. So, I wasn't going into individual psychopathology.
> Evelyn: I was thinking about, is it internal or external? How do you measure normality? You were talking about the couple psyche, thinking about something that is more internal than apparent and I became quite confused how you would go about measuring something like that, so don't know that…
> Traci: That's why I fall back on the model, I think, you know…
> Evelyn: So social science in a way.

> Traci: If, if we need to define it, maybe one doesn't need to define it but if we're talking about something we have to agree what it means. How do you define what it means? What's to say what's normal and what's not normal or something else? So, what's how I came to think where you have, if you have a classic bell curve, and that's populated, you can say, the ones that are represented…
>
> (Focus Group 4)

Discussions in another focus group reflected similar dilemmas as an appreciation for what a statistical model might say about normality was juxtaposed against the non-utopian model of normality noted previously. One participant notes this:

> I was very pleased that you brought this topic up, because I find it comes up a lot particularly in the early few sessions with couples, that sense of what is normal and also, what comes to mind for me a lot is a comment I had read somewhere, and I can't tell you where I read it, that everyone is only normal on the average. It's that idea of that curve, and that we spend maybe 80% in the normal.
>
> (Grace, Focus Group 3)

Doubts psychotherapists held about statistical models centres around the measures or psychological tests they are familiar with. Measurement of relational function or capacity is difficult to operationalise in a meaningful manner. Psychotherapists, as we have seen, use their counter-transference to get hold of some hard-to-define aspects of relational process, as illustrated in this exchange:

> Evelyn: So, are you saying that's abnormal then? No, I mean, I am just thinking about normality and normal, maybe there is a given that we all think that there has to be enough of a relationship or that's part of the measurement, I don't know… self-other…

> Abigail: Some sort of psychopathology, yeah… I suppose that felt pathological, I didn't feel as if I could have a relationship with this person…
>
> (Focus Group 4)

The increased use of psychological measures as a way of providing evidence of therapeutic efficacy led to some appreciation of the information these procedures provide. One participant admits that she avoided giving any consideration to the psychological tests used at the service where she practices:

> I used not to look at them [laughter] but now I do and discover to my, to my shock that one of the couples I see, his disillusionment in the relationship has markedly deteriorated. He was very happy to start with and now he is not sure whether he would choose another partner. I looked at this form and thought to myself, oh my God! I hadn't realised how disaffected he is with the relationship.
>
> (Catherine, Focus Group 2)

In contrast, the use of measures and the tendency to attribute value to psychological tests was seen rather negatively by some participants as evidence of a defensive, risk-averse culture within therapeutic services. Asked about how the use of measures influence participants' thinking led to the following exchange:

> Eva: Depends whether we are concerned about defensive practice or not… half of the reason for the risk thing is to alert us to people who might statistically be at risk, so we can cover our backs if something untoward happens. Organisationally, you know, we have responsibility to show we have done something if we alerted that someone might jump off London bridge.
> Oliver: So, it's an institutional acting out, possibly?

Eva: I mean that's one aspect of it. Defensive practice that effects not just s but the profession and the medical profession and everybody…
Amelia: That's the new normal isn't it?
Eva: Yeah…

(Focus Group 3)

Code 3.1.2: Psychic normality outside the norm

Participants were in agreement that at times, what might be statistically normal is in fact psychologically problematic and vice versa. They spoke of how a standardised measure of psychological well-being might indicate a suicidal ideation, but this cannot be accepted as necessarily indicative of abnormality. The normalisation of suicidal feelings in the following exchange exemplifies a view that was widely accepted amongst participants:

Eva: so, you might say, it might be pretty normal to have suicidal thoughts…
Greta: I have had several discussions like that with clients, you know, when I felt I had to raise risk that came up in the questionnaires, in the CORE form, they said it's absolutely normal, isn't it to think that life ends and to be involved in that but they were not stirred up and the other was not stirred up by it either.
Eva: But you might find out talking to colleagues, let alone clients, you know, if they are honest about it, that it is quite normal to have suicidal feelings every now and then.

(Focus Group 4)

Clinicians also seemed to share a sense that, at times, statistical models fail to capture what clinicians value. Often, the disturbances they discern is not reflected in the measures of individual or relational function. This insensitivity to clinically-relevant

phenomena means that when the measures indicate that the presentation is not problematic, this is also not given much credit:

> Ian: Catherine has heard me say this many times because we worked at the [hospital named deleted] in the NHS where they use these scores. They do not work for couples because you can have a situation where, let's say, the husband is projecting enormously into the wife …. It doesn't really measure couple functioning these things…
> Catherine: It doesn't measure disturbance like the one we saw today where they had ticked 'not at all' for absolutely everything…
> Catherine: It doesn't measure disturbance like the one we saw today where they had ticked 'not at all' for absolutely everything.
> Riya: It's important for risk I think, for that, if we start looking at recovery post assessment we have the same pattern, don't we, in IAPT (Improving Access to Psychological Therapies).
>
> (Focus Group 2)

Interestingly, clinicians seem to find creative ways to make use of self-reported measures, even when sceptical about their use. In examining discrepancy in the couple satisfaction scores between partners, something about the couple's interpersonal dynamics can be discerned. Here again, even if scores remain within the statistical norm for respective partners, the relational dynamic the responses might indicate may nonetheless be considered problematic:

> Just going back to the forms. I am quite surprised how little clients ask about them actually, because I was thinking about the satisfaction index. For example, we could be arousing a lot of worry with things like, there's one about whether you ever have second thoughts about the relationship and whether you ever wonder whether there is somebody else out there for me? Mmm, how do people know what is normal in that regard and if you have just had the worse row ever with your partner, might it be quite normal to be

> thinking: I wish I never had got into this relationship, and things like that. I am fascinated with how little people raise that. I think they are usually more interested in what their partner might have said. As a clinician, I find that interesting with the satisfaction index it is comparing the two within the couple. Especially if they are a way apart because I think, how does that work?
>
> (Trisha, Focus Group 3)

Additionally, some participants expressed concern that providing factual statistical data to patients was not necessarily helpful. In the following exchange, the manner in which the couple were using their child was seen as problematic and representative of dysfunctional aspects of the couple dynamic. Whether such a behaviour was statistically normal or not was not deemed of much value:

> Victoria: It is the way the child will be made use of not necessarily in consciousness… what came into my mind is a couple I am working with in the moment, he really has not been seeing his children and they are mid-teens and the way that it's been characterised, they've been apart for 5 years, is that actually he left and had an affair and when the time is right, she will encourage the children to see him. And I asked who decided when the time was right and how would that be able to be conceptualised? And I think, being able to ask in such a simple way, has started to open up the conversation – tentative because it is not whether it is right, and I think also, it was linked to a session I had with them individually, and she said 'he left, I am a single parent' and I said that perhaps it is so difficult to keep in mind that everyone is mourning and everyone has suffered a loss. And she hadn't thought about him might have suffered a loss as well.
>
> Ian: But you did not tell her that 80% of people in your situation allow contact after 6 months… [subdued laughter by group member]
>
> (Focus Group 2)

The relationship between couple psychotherapists and psychological measures is complex, with many showing a degree of appreciation while noting more problematic aspects related to their use. It is important to note that this sub-theme is not simply about formal psychological modelling of normality operationalised in psychometric measures. Less sophisticated references to 'usual', 'familiar' and 'continuum' permeated many focus group conversations. Implicit in such references is the idea that the frequency with which psychotherapists encounter a particular presentation may come to have some bearing on their assessment of normality.

Subtheme 3.2: Medico-legal

The final subtheme relates to the medical and legal frameworks which between them traditionally define what is healthy and legal. Psychotherapists made few direct references to these frameworks, but the strength of positions expressed merits consideration. Inferred reference to the medical model, punctuated much of the discourse in all focus groups. Numerous references to health, illness and symptoms permeate many of the extracts presented throughout this chapter.

Code 3.2.1: Health

The lexicon associated with health, the medical model and psychiatry are clearly closely knit with psychoanalytic discourse evident in all focus groups. Such reference was uppermost in participants' minds when thinking about normality, as illustrated by Ian (in Focus Group 2): 'I agree completely with the use of the word healthy because that's the first thought I had.'

In Focus Group 4 participants drew direct parallels between a couple seeking psychotherapy and a visit to the GP. However, participants noted that the dyadic nature of couple relationship introduced the possibility that one partner might seek to defensively present the other as abnormal. The therapist might hold a different view. The following exchange highlights one of the key limitations of the medical paradigm in that it often reflects a linear cause-effect worldview while relationships are necessarily systemic in nature:

> Harry: But if you think that I am going to a GP, you go to your GP because something is wrong, something isn't right, something's not normal. So, in a sense couples who come for help are in some sense saying: this isn't normal.
> Evelyn: But they might be saying that he is not normal or she's not normal…
> Harry: That's what she's saying, yeah, isn't she?
>
> (Focus Group 4)

The issue of normality also drew parallels with one of the bastions of the medical model, namely the diagnostic tradition. Direct reference was made to diagnostic manuals as conferring an enviable simplicity to psychiatric practice, in response to earlier discussion of how relational and psychoanalytic normality is less easy to define and more fluid:

> I felt the same actually, it felt oh, DSM gives us… lucky them, they've got psychiatrists, us? They've got DSM, they've got DSM to say this is normal and this is not…
>
> (Rachel, Focus Group 1)

In response, a critical view of the mental health diagnostics was made, with specific reference being made to a perceived lack of objectivity seen in the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association. It seems

that even the fleeting hope that a straightforward path to differentiating normality for something else was rather short-lived:

> …it is subjective, when you were saying about the DSM and that's luckily, isn't it, but it isn't because it's like a dictionary they keep changing and they decide what is normal and what is not normal and that sort of changes with time but there is nothing that's sort of, objective about it…
>
> (Hannah, Focus Group 1)

Additionally, some were critical that the medical model and mental health in particular (alongside the legal system) ascertained their expertise in order to avoid contemplating difficult experiences in any depth. Medical (and legal) definitions were felt to be essentially defensive in nature:

> Do you think that sometimes that's used as a defence against thinking though? In a way that the legal and medical definitions are a foreclosure against further exploration. In a way, to talk about what is normal and what's not, it's like that's unacceptable and that's it, we are not going to talk about, about that because you are awful…
>
> (Charlotte, Focus Group 1)

Interestingly, these reservations did not inhibit participants from making use of psychiatric labels commonly found in diagnostic manuals such as borderline, depression, and psychotic. For example, in focus group 3, when discussing the assessment of relational capacity, Catherine suggested that psychotherapists are 'trying to gauge how much there is of that and how much there is of something healthier. I guess I would be, sort of working trying to help them trying to understand what triggers the more psychotic type relating'. In another focus group, psychological pain was discussed in

contrast with psychical pain which then led to the realisation of how the medical model at times infuses psychotherapeutic discourse:

> Natalia: Yeah, I think the some of the basic concepts of psychoanalysis do describe the universal human situation, experience where things are not so then it causes psychic pain.
> Dawn: But do we describe this as normal just because they are universal? Sure, the denial of it will cause pain and that is normal?
> Rachel: Or usual?
> Linda: But it is very difficult because we talk about mental health and illness, don't we? We don't talk about normality and abnormality anymore.
> Rachel: That is the psychiatric model.
>
> (Focus Group 1)

The use of the health paradigm in thinking about problematic states of minds and relational difficulties seemed more palatable than talk of normality. However, it is clear that this did not do away with the issue of judgement that rendered the whole discourse around normality so uncomfortable for many participants:

> …the problem with value judgement is the distinction between health and unhealth and … you are at the receiving end of someone's value judgement, because you are being told that you are not healthy…
>
> (Harry, Focus Group 4)

Code 3.2.2: Legal

Participants debated at length the elusiveness of coming to an agreed definition of normality. However, when one participant in Focus Group 4 described being banned from working on a mental health ward because he challenged the lead clinician, there was a rather provocative suggestion by Traci that 'you were not subscribing to norms in our society… then perhaps we have a definition!' Clearly, if societal norms, often

formalised through the legal framework, could be accepted as defining normality, then participants could be rid of their predicament.

Against this backdrop of scepticism, the importance of the legal framework was affirmed as of crucial importance. In the focus groups, there seemed to be a sense that the legal framework needs to be accepted in order to be able to operate a psychotherapy practice. At no moment was dissent voiced – surprising perhaps when one considers the political debate around the pathologising and criminalisation of homosexuality discussed in several of the focus groups, as illustrated here:

> I think fundamentally, the first thing is to know what is legal and what is not,… well actually, you know, you referred to the incest taboo for example, that is also prohibited by law so that is definitely outside what we can define as normal. If we are looking for, sort of, for the most basic definition, mmm, then we are looking for the legal framework…
>
> (Natalia, Focus Group 1)

Related to the matter of legality is the issue of risk. Participants were keenly aware of the risks, including the potential for violence inherent to working with distressed couples:

> I mean it is an interesting one. Yes! But then, I suppose there is a question about how long you do something, or work something work before, when it starts to then border into something that is much more collusive. You're not helping them with it. I mean I suppose if we think about violence, in terms of working with violence, the criticism, the external criticism at least of, of working with couples who are violent is by working with couples, one could be communicating that that is normal. One could be colluding with the idea.
>
> (Hannah, Focus Group 1)

Additionally, other behaviours that might have legal safeguarding implications were not far from participants' minds:

> I was following on from what Natalia was saying, because you were asking about projection, and you know, and how that relates to normality, I was thinking it is really difficult to think about what is normal and what is subnormal level of projection. But of course, if you are on the spectrum where you project into your child as a sexual object, you end up in the area of pervasion – I mean that how we would think of it psychoanalytically rather than legality…
>
> (Dawn, Focus group 1)

Thinking about aspects of couple relating which might be illegal, or on the verge of being so, was clearly something that troubled practitioners. However, any tendency to define normality through the medico-legal framework was also criticised as being a form of 'foreclosure against further exploration. In a way to talk about what is normal and what's not, it's like that's unacceptable and that isn't' (Charlotte, Focus Group 1). In this sense, this subtheme was clearly held with a degree of cynical reserve by a number of participants.

Summary of Theme Three

The final theme draws together the manner in which mathematical/psychological models of normality and the frames of reference offered by two traditional and prestigious professions of medicine and law impacts couple psychotherapists thinking. Participants refer to these frameworks with reserve, conscious that the conceptualisations of normality they propose do not do justice to clinical complexity but are nonetheless useful from time to time.

Chapter Summary and Conclusion

The data gathered from the four focus groups is rich and multi-layered. The researcher's aim of gaining insight into couple psychotherapists' use of explicit and implicit notions of normality revealed the complexity of their considerations. The application of theory, reflexive awareness of how bias might impact assessment, together with a marked sense of clinical responsibility alongside a desire to respect their patients' worldviews are all held in mind. Participants applied a number of lenses through which an attempt is made to understand the individual patient's or the couple-patient's experience in a comprehensive and clinically relevant manner. The following chapter discusses these findings in detail, relating them to the reviewed literature, and exploring the manner in which the identified themes and subthemes are held together in think about normality in couple psychoanalytically-informed couple psychotherapy.

Towards a Couple Psychoanalytic Model of Normality

Chapter 5

Chapter Overview

This chapter will discuss the research findings in relation to the research questions and the reviewed literature. A conceptual model bringing together the political, the psychoanalytic and the non-psychoanalytic themes identified in this study will be proposed. This will be followed by a response to each of the four research questions. The strengths and limitations of the applied methodology will be deliberated followed by reflections about the role of the researcher.

Summary of Research Outcomes

A review of the literature highlighted an absence of publications exploring the conceptualisation of normality as applied in psychoanalytically-informed couple psychotherapy. The lacuna in theoretical and clinical reflection on normality means that practitioners have little guidance on how to manage concepts of normality, and as a consequence, the manner in which they are applied is not thoroughly understood.

This research set out to address apparent gaps in knowledge, with the central aim of contributing to an enriched understanding of the manner in which normality is conceptualised in couple psychotherapy. Exploring the interplay between the implicit and explicit, theory-derived concepts of relational normality, it aimed to understand how couple psychotherapists draw on these different ideas in their clinical work.

The thorough analysis of the literature led to the formulation of the four research questions guiding this study, namely:

1. How do couple psychotherapists conceptualise relational normality when working with their couple-patients within the psychoanalytic model?
2. What other frameworks and ideas are applied in considering normality?
3. How do cultural influences and personal biases impact therapists' conceptualisation of relational normality?
4. How does training support development of thinking around relational normality?

Twenty-seven experienced psychoanalytically-trained couple psychotherapists participated in the study. Focus groups were used for data collection because of their ability to harness the group process to stimulate discussion and elicit rich data (Morgan and Krueger, 1993). Thematic Analysis (Braun and Clarke, 2006, 2013) was applied to the transcribed focus group data which lead to the identification of three main themes and their related subthemes.

The choice of focus groups as the means of data gathering method permits a degree of generalisation (Sim, 1998; Vicsek, 2010). The manner in which conceptualisation of relational normality has been identified to take place allows for a cautious application of the findings beyond the confines of this research.

Themes in the Conceptualisation of Relational Normality

Thematic Analysis of the rich collected data led to the identification of three main themes which featured strongly in discussions about relational normality amongst participants. Each theme is summarised below.

Theme 1: Consideration of the Political

> …we live in an age of identity politics and… it's so much about me, having to find ways of expressing, express oneself in terms of sexuality, cultural expression and so on, and I think again, it sort of widens the whole spectrum of what, what might, we might think of as normal.
>
> (Dawn, Focus Group 1)

The discernment of where the power to define normality is to reside, is paramount in psychotherapists' minds. This authority can reside in the psychotherapists by virtue of their professional role, in their patients since treatment impacts their lives or in the cultural milieu which informs and forms psychotherapists and patients alike. Throughout the focus groups, the evolution of the discussions implied that couple psychotherapists believe that power does not necessarily need to reside in one and exclude all others. Additionally, psychotherapists express a degree of ambivalence or struggle around the conceptualisation of normality. This uncertainty facilitates their openness to consider the implications of their patients' points of view and socio-cultural factors.

Practitioners understand that their professional responsibility requires them to, from time to time, define normality in terms of psychopathology or even legality. There was consensus that the preferred stance when approaching the question of normality is to maintain a curious, permissive, fluid and client-centred explorative attitude, informed by the penetrating lens of psychoanalytic theory. Theory is valued for its ability to facilitate understanding of the clinical picture, however the limitations in the psychotherapists' mastery of theory or of psychoanalytic theory itself, are kept in mind. Theory is not seen as an ever evolving and developing body of knowledge.

Moreover, the consideration of clients' perspectives on normality is highly valued and sensitivity to socio-cultural norms is believed to be essential. Indeed, failure to weigh in these considerations is felt to undermine therapeutic efficacy and the relevance of psychotherapeutic endeavour. A distinct sense of consensus was evident around the dangers involved in labelling gross abnormality where the individual or couple is seen to be defective. Paradoxically, the inevitability of normative thinking and judgement was also something many admitted to.

The fact that the strongest theme centres upon political considerations shows how far these psychotherapists have moved away from what Protter (1985) termed the correspondence-essentialism stance. Psychotherapists do not see themselves as highly tuned instruments who, having undergone sufficient training, are now able to capture irrefutable reality. While professional training involves much emphasis on theoretical input, much of which involves immersion in psychoanalytic theory, many consider this to be chiefly in support of 'understand the meaning of something rather than come(ing) to judgement' (Catherine, Focus Group 2). Indeed, some participants believed that it is necessary to consider the political dimensions of the training couple psychotherapists receive. Training institutions themselves are not immune of their political allegiances potentially influencing what come to be perceived as normal in patients, trainees and qualified graduates.

Epistemologically, couple psychotherapists, in the large part express leaning towards a view of psychoanalytic theory emphasising contextual understanding (Protter, 1985), in line with Stern's (1985) pragmatic view of analytic practice. Reality is discerned with

ever greater reliability in the process of clinical exploration, but the discovery is subjective and not necessarily universal. This is in line with Hewison's (2008) account of the discernment of 'clinical fact' in couple psychotherapy discussed in Chapter 2.

Theme 2: Consideration of the Indigenous

> …we all have a normal in mind. We don't call it normal, we call it: are they in the paranoid schizoid? Are they in the depressive position? Can they love between? How rigid is the projective system? How much of a phantasy-determined couple are they?
>
> (Lydia, Focus Group 4)

Psychoanalytic theory, and specifically couple psychoanalytic theory, is focal in couple psychotherapists' minds when considering normality even if they often avoid direct reference to the term normal. Unsurprisingly, the aspects of theory they are mostly drawn to relates to the quality of dynamic processes in their work with couples. Scharff and Scharff (2014) point out that it was the interest in the analyst-analysand relationship, characteristic of Object relations school, which facilitated the emergence of couple psychotherapy in the United Kingdom. Such an interest is clearly still alive and well, finding fruitful application in the analysis of the processes emerging in the couple psychotherapy setting. It is precisely the quality of conscious and unconscious processes between partners and between the couple and their therapist that is believed to reliably inform the assessment of couple functioning and normality. Implicit in much of the research data is a sense that couple psychotherapists are less conflicted about discerning process or dynamic-type abnormality then labelling persons and couples as lacking normality.

Psychoanalytic theory provides a lens through which the personal and relational histories, as well as personal and relational capacities, are examined. Various psychoanalytic concepts are applied, as well as more specialist couple theory. Freud's belief that the psyche cannot be easily rid of 'the human instinct of aggression and self-destruction' (Freud, 1930, p. 340) is endorsed by couple psychotherapists. They do not have unrealistic expectations of what their patient-couples are able to master. Indeed, they tend to normalise sub-optimal states of psychic and relational functioning.

It is perfectly feasible, according to this perspective, to be sub-optimal in certain areas but be generally well-functioning, healthy or normal. Indeed, there is some support for this view in the literature with Cachia and Scharff (2014) arguing that couple psychotherapists need to avoid aiming for too high a goal in terms of couple functioning as this may harm the therapy outcome. While this might seem rather confusing, parallels can be found in various areas of life. For example, a student may fail to perform optimally but prove strong enough to succeed in passing examinations. Too much enthusiasm on the part of parents and teachers may prove to be counter-productive.

<u>Theme 3: Consideration of Non-native Paradigms</u>

> …when does it stop being normal?
> Charlotte: Yes… or normal enough?
>
> (Sandra, Focus Group 1)

> …you go to your GP because something is wrong, something isn't right, something's not normal. So, in a sense couples who come for help are in some sense saying: this isn't normal.
>
> (Harry, Focus Group 4)

> I think fundamentally, the first thing is to know what is legal… the incest taboo for example, that is also prohibited by law so that is definitely outside what we can define as normal.
>
> (Natalia, Focus group 1)

It is clear that couple psychotherapists make reference to non-psychoanalytic models of normality, exemplified by the above quotes, even if these are held with a degree of scepticism. There was a clear sense of consensus across focus groups that equating statistical normality with psychic or relational normality was simplistic, unidimensional and not supportive of the therapist's grasp of clinical reality. These reservations centre upon the use of psychometric measures of couple functioning and individual well-being, which couple psychotherapists make use of in clinical settings.

Couple psychotherapists find the utility of psychological measures to be variable with test results often failing to identify the personal or relational distress that later emerges during treatment. Measures are occasionally useful in alerting practitioners to hidden distress but, all too often, they miss identifying the types of problems couple psychotherapists tend to be concerned about.

A few participants believe that the use of measures represents defensive practice where the treatment provider feels intimidated by the legal implication of psychotherapy practice. Reider (1950) warned that the assessment of normality can be experienced as a treat as when 'abnormality is the danger, it is equated to instinctual wishes felt as dangerous… The psychoanalyst and the psychiatrist stand *in loco parentis* with an accusatory, 'You are not normal!' (p.48). However, failure to discern abnormality is

equally dangerous to the parentified psychotherapist or psychotherapy institution as the quality of their care may be called into question.

Medical and legal paradigms also play a part in the couple psychotherapist's conceptualisation of normality. Couple psychotherapists necessarily converse with these professions in executing responsibilities intrinsic to their clinical duties (such as safeguarding vulnerable individuals). The importance of the guiding texts of these professions, represented by the diagnostic manuals in psychiatry or the law in legal practice, are not considered to provide adequate definitions of normality. Couple psychotherapists find themselves being both envious of the clarity these provide, while simultaneously being critical of how reductionist and simplistic these are.

The conflicted nature of this relationship is nowhere clearer then when couple psychotherapists are confronted with their patients being at risk or are thought to be placing others at risk. Here a reference to these authoritative frames of reference is advocated even if there remains an acknowledgement that psychoanalytically, the picture may be far from straightforward.

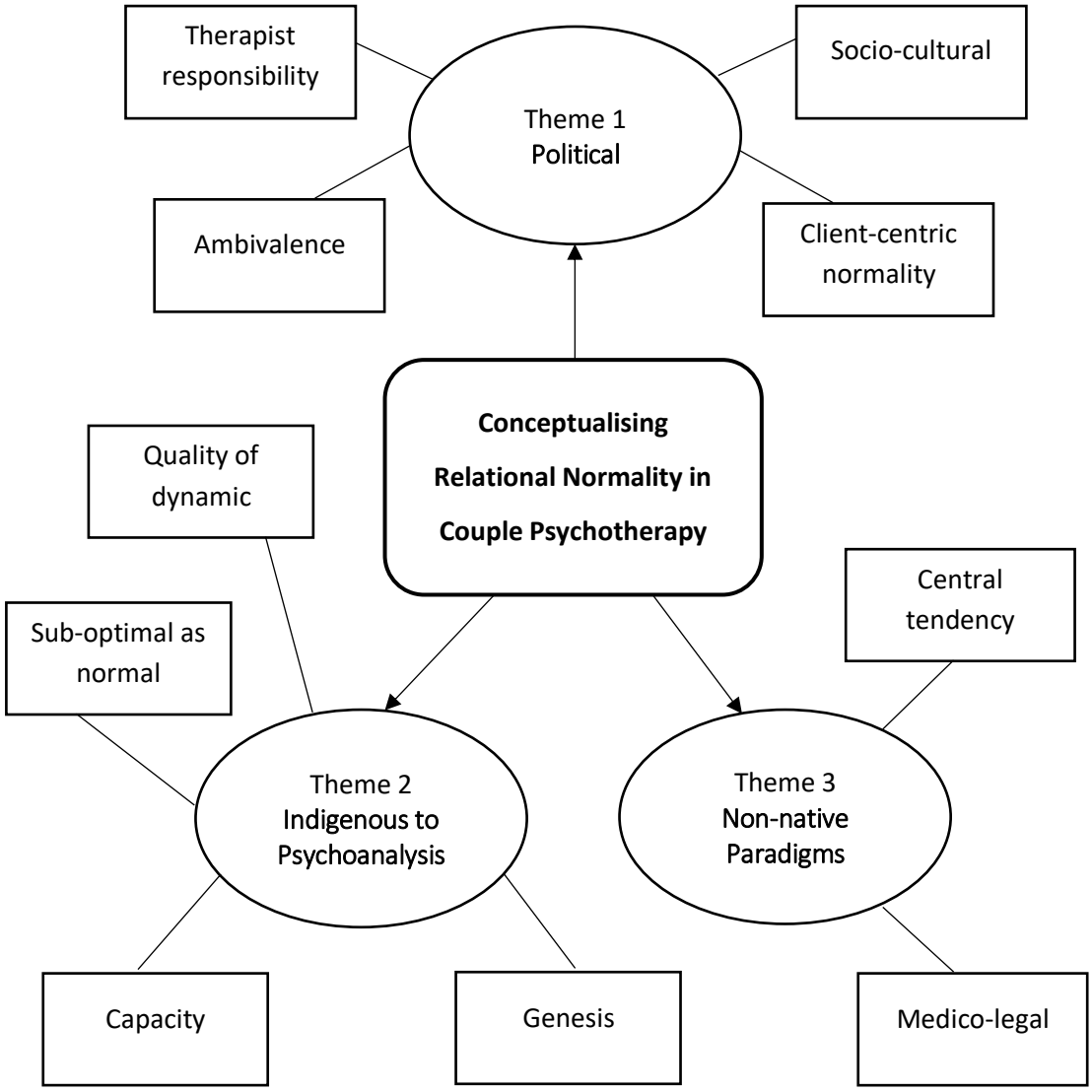

Figure 5.1. Thematic map showing the three main themes and their component subthemes. Namely the *Political,* referring to considerations as to who defines relational normality; *Indigenous*, referring to the use of psychoanalytic models in considering normality; and *Non-native paradigms,* referring to ideas sourced from outside the psychoanalytic tradition.

Conceptualising Relational Normality as a Dynamic Equilibrium

Couple psychotherapists balance the three themes identified in this study as they seek to consider a range of constituent elements. In line with Moser's (1992) understanding, conceptualisation of relational normality by couple psychotherapists involves the initial creation of personal mini-theories. However, therapists must then move beyond these ideas by weighing up the multiple aspects of the realities they are faced with. One cannot claim this happens in assessing every clinical presentation but, when involved in a reflective process, experienced couple psychotherapists conceptualise normality in a complex and dynamic manner.

The conceptualisation of normality involves the couple psychotherapists engaging in a three-way balancing act leading to a state of *dynamic equilibrium* between consideration of power, psychoanalytic and non-psychoanalytic considerations. The process is akin to using a three-panned weighing balance, as illustrated in Figure 5.2 below. This is a sensitive instrument which, unlike its two-armed counterpart, does not need equal weights in each pan to achieve equilibrium. The contents of two pans might very much compensate for the weight of the third. Each pan is weighed down by one of the three themes or perspectives on normality identified in this research. The political, the psychoanalytic and the non-psychoanalytic all feature in couple psychotherapists' thinking processes, and although there is no indication that these are given equal weighting, no aspect is completely disregarded.

Figure 5.2. Discerning normality: A 3-way balancing of political, psychoanalytical and non-psychoanalytical considerations. The resting position of choice may vary from one couple psychoanalytical psychotherapist to another.

It is clear that couple psychotherapists consider it limiting to discern normality in a static unidimensional manner. It would be unwise to rigidly favour psychoanalytic theory (placed in one pan) and not consider power (placed in the second pan) or ignore the statistical / psychological, medical and legal perspectives (placed in the third pan) when assessing a couple's presentation.

The three considerations do not always carry an equal weighting in the process of discerning normality. Indeed, it is clear that different couple psychotherapists held somewhat divergent positions with regards to their relative importance. It is equally true that relative importance is situational and dependent on the couple's presentation. For example, when safeguarding surfaced in the focus group discussions, the legal factors took on great importance and the relative weighting of the other themes diminished. Likewise, when exploring a couple's distress, consideration of the

psychoanalytic became central alongside consideration of the political dimension (in particular what the couple thinking about normality is and the socio-political dimension).

This weighing in of the three themes is a continuous process in treatment. This is true whether the psychotherapist is formulating an interpretation, assessing risk, or discerning the seriousness of psychopathology. Ultimately, the aim is not to achieve a perfect equilibrium between the three pans but to ensure that what is located in one pan (or theme) is allowed to shift or have an impact on, the contents of the two other pans. The three-panned balance comes to a resting position when a state of *Dynamic Reflexive Equilibrium* is achieved but may again shift as new material or facts emerge.

The conceptualisation of normality in this three-way manner suggests that many couple psychotherapists are firmly located within a social constructivist epistemological framework. The Correspondence-Essentialism (Protter, 1985, 1996) 'facts' characteristic of psychiatric diagnosis and developmental theory are not necessarily considered as capturing immutable facts. In many ways, these practitioners consider knowledge emerging from the social constructivist clinical context and clinical text as having primary value, or at least equal value to that derived from essentialist theory. They reconcile the two positions by looking at truths conceived within the essentialist framework in the same way as those derived through the more tentative social-constructivist mode of inquiry. Theoretical truths provide useful information and approximate reality, but no fact is untainted by the context that surrounds it.

Addressing the Research Questions

The research questions guided the development of the Focus Group Schedule (Appendix B). The included questions allowed for the emergence of the three themes providing insight into the manner in which couple psychoanalytic psychotherapists conceptualise relational normality. A response to these research questions can now be attempted. Each of the four research questions will be addressed in turn.

The Psychoanalytic Conceptualising of Relational Normality

The first research question sought to understand how couple psychotherapists conceptualised normality in their work with couples. Participants in this research experienced surprise, as well as a degree of anxiety and uncertainty, when invited to consider the first research question. The most salient features of couple psychotherapists' response to the first research question is their concurrent sense of responsibility (subtheme 1.1, *Therapist Responsibility*) and the associated discomfort this causes (as illustrated in subtheme 1.2, *Ambivalence)*. Participant couple psychotherapists were preoccupied with the impact the power differential between patient and professional on the process of designating who is normal and who is not.

The answer to the questions as to how couple psychotherapists approach conceptualising normality must be that they do so with much caution. There is little, if any literature relating to how couple psychotherapists manage thinking about normality in practice, but the cautious reserve expressed across all focus groups resonates with that expressed by McCann (2017) when he advocates the need for couple

psychotherapists 'to question their own pre-existing assumptions and to build a more accepting therapeutic container' (p. 57).

This sense of caution is not unrelated to the pervasive sense of ambiguity around the concept of normality and the fact that reflection about this notion is not frequently practiced. These realities are reminiscent of the literature both in the apparent lack of investment in developing thinking in this area and the abundant conceptual ambiguity described in the literature (Abrams, 1979, 1989; Horton, 1971). In agreement with Abrams (1979, 1989), this study highlights the need for investment in theoretical investigation of the concept of normality. Various participants expressed their sense that theory supported their capacity to address their patient-couple's difficulties. However, if theory is ambiguous or found to be somewhat archaic, it is unlikely to provide much containment for the couple psychotherapist and ultimately it is treatment that will suffer.

One area where this deficit becomes manifest is in the relative ease with which specific couple processes are labelled as abnormal. This is sometimes done while seemingly maintaining the assumption that labelling does not have any bearing on the normality status of the individual or couple simply because no inference is made about gross normality. In describing the *ambiguity of the concept* (Code 1.2.1), a number of examples illustrated how some psychotherapists seem to believe that that description of psychic processes is intrinsically norm free. Indeed, a few, somewhat dissident voices even suggested that normative thinking is foreign to analytic theory.

The literature is clear that there is a degree of normativity inherent to psychoanalytic thought (Jones, 1942; Freud, 1966; Kaplan, 1967; Sabshin, 1967; Horton, 1971; Offer and Sabshin, 1974). Moreover, Cohler (2000) considers the assumption that avoiding the labelling of gross abnormality offers immunity from normative thinking as benevolent but naive. The strategy is not without risk as it is difficult to avoid a restrictive normativity, if one misses out in applying rigorous critique to all levels of theoretical consideration. The focus group data provided evidence that at least some psychotherapists face this possible pitfall.

Experienced couple psychotherapists are not prone to using normality in a defensive manner. They are aware of the complexity of the phenomenon and the anxiety that such thinking evokes in them. Whenever possible, they are eager to avoid thinking in terms of a dichotomous gross normality / abnormality and some even claim that they never think in these terms. Such thinking is felt to limit the in-depth appreciation of the patient-couple's experience. Rather than discerning who is normal and who is not, focus is drawn towards the intricacies of the couple's intrapsychic and interpersonal life very much in the manner described by various authors in the field of couple psychotherapy (Balfour, Clulow and Dearnley, 1986; Lanman, Grier and Evans, 2003; Cachia and Scharff, 2014). These may be deemed problematic, unhealthy, even abnormal and therefore meriting therapeutic intervention.

Unsurprisingly, the main frame of reference employed by couple psychotherapists in conceptualising normality is psychoanalytic theory. This is captured in Theme 2, which is

the second strongest theme with four specific subthemes, which relate to particular aspects of psychoanalytic theory. These will be discussed in turn.

Quality of the dynamic processes within the couple or between the couple and their therapist are considered in assessing normality. The nature of these processes is discerned through the observation of manifest behaviour (including the emotional climate within the couple) as well as unconscious exchanges discerned by the psychotherapist. Couple psychotherapists gave mention to a number of theory-derived criteria indicative of normality:

1. *Quality of the couple fit* (Dicks, 1957; Cleavely, 1983) provides insight into the nature of the life-enhancing or destructive linking processes. For the couple psychotherapist, the discernment of normality is primarily related to the nature of interpersonal dynamics rather than intrapersonal processes. It is not simply the individual's state of mind that matters but the, at times, unconscious fit between the partners' psyches.
2. *Projective processes (*Klein, 1946; Jaffe, 1968; Scharff and Scharff, 1987; Hinshelwood 1991) involved in the setting up of *shared unconscious phantasy* (Tarsh and Bollinghaus, 1999) and *unconscious belief* (Morgan, 2010, 2019) - Impoverished or destructive manifestation of these processes is linked to arrest in psychic development but what exactly constitutes subnormal levels of projection seems difficult to ascertain. Reference to Kleinian, Bionian and post-Kleinian theory was made across the four focus groups.
3. *Processes related to containment* (Segal, 1962; Coleman, 1993; Morgan and Ruszczynski, 1998) with specific reference to Kleinian and Jungian theory. The

quality of the container created within the couple relationship is considered in evaluating relational normality.

4. *Transference* (Colman, 1993; Siegel, 1997; Scharff And Scharff, 2014) feelings experienced in working with couples are considered key in assessing the quality of the couple relationship. Moreover, these feelings are instrumental in identifying elusive pathological states of mind or relational dynamics.

While couple psychotherapists tend to move away from using the term normality, they are keenly aware that in assessing dynamic processes, their own experience risks contaminating their judgement by serving as a template of what is good and functional. In line with the view expressed by Siegel (1997), they are cautious about serving as the sole evaluator of what is normal. In assessing these processes, the type of models and thinking applied is in line with Freud's (1937) 'ideal fiction' representing the first trend in psychoanalytic thinking, as described by Offer and Sabshin (1974). An ideal dynamic is not what couple psychotherapists look for but the ideal serves as a valuable marker against which to evaluate process. This is akin to the use of a maritime tidal datum serving as a reference point for sailors. It serves an important function, allowing prediction of how the tide will behave but is not in itself indicative of an optimal sea level. Such a thing simply does not exist.

The normality of sub-optimal states emerged as a strongly held belief about psychic life and relationality in general. Couple psychotherapists of a psychoanalytic persuasion do not devote themselves to romantic fantasies. The psyche is a place of conflict with creative and destructive forces in operation so that the associated couple processes are

not necessarily benign or painless. Rather than hoping for an ideal state of being, couple therapists seek to support maturational processes and the development of the capacities that allow couples to manage their internal and external realities.

This subtheme indicates the strength of the 'ideal fiction' or utopian view of normality in couple psychoanalytic psychotherapy. However, psychotherapists seem to be extending their argument further leading to the normalisation of the sub-optimal. This does not sit comfortably with the application of psychiatric models of mental health (identified in the *Medico-legal* subtheme 2.3) and the importance Lanman (2003) places on assessing the couple's mental health status.

One could argue that most couple psychotherapists do not suffer from what Bartlett (2011) considers to be 'the pathology of normality' (p.70). Like Reider's (1950) rejection of rigid pseudonormality and Bollas's (1987) description of normopathy, couple psychotherapists are diffident of couples and individuals who seemingly lack any ambivalence or conflict about the relationships they are involved in.

However, unlike Bartlett (2011), couple psychotherapists do not seem to have a well-articulated and coherent account as to how they manage their allegiance to both the normalisation of abnormality and the mental health paradigm so often mentioned in the focus groups. In terms of Protter's (1985, 1996) model of development of psychoanalytic theory, it seems that couple psychotherapists find themselves caught up between the Correspondence-Essentialism of psychiatric diagnosis and a more post-modern position where the clinical context and clinical text are of primary value.

Capacity describes psychic resources employed to manage experience. It is assessed in a multidimensional manner departing from examining the couple's reactions to the psychoanalytic frame and the manner in which intrapersonal and interpersonal environments are managed. Couple psychotherapists mention several dimensions. More specifically, individuals in relationships benefit from processing:

i. A robust enough psychological 'skin' or defence;
ii. A capacity for closeness allowing sufficient distance regulation;
iii. A capacity to know of personal distress and to bear it;
iv. A capacity for curiosity about self and other; and,
v. A capacity to contemplate ambivalence towards love objects and relationships.

On the other hand, in order to manage being part of a couple, interpersonal capacities are vital relationship-maintaining tools and their quality impacts normality. These include:

i. A capacity to tolerate difference
ii. An openness to relational experience
iii. A capacity to communicate feelings and ideas
iv. Psychological flexibility allowing evolution of the couple fit

Psychoanalysis has long recognised that relational capacities can serve as evaluative criteria of normality (Glover, 1932). In her seminal paper titled *On Mental Health*, Klein (1960) describes normality in terms of specific capacities or elements, namely, 'emotional maturity, strength of character, capacity to deal with conflicting emotions, a balance between internal life and adaptation to reality, and successful welding into a

whole of the different parts of the personality' (p. 237). Perhaps reflecting the influence Klein has had on couple psychotherapy theory (Ruszczynski, 1993; Hewison, 2004; Morgan, 2019), her views echoed through the focus group discussions. In particular, the awareness that normality requires an ability to adapt to both internal and external realities seems congruent with the idea that the normal individual or couple need to allow for the development of their relationships. They need to adapt to these changes, while being able to manage the emotional challenges this often entails. The couple psychoanalytic literature makes specific reference to capacity, particularly when considering assessment processes where we find reference to normality as an 'ideal fiction' (Cachia and Scharff, 2014), denoting that what is desired is not necessarily optimal, but needs to be sufficient.

The Genesis or developmental trajectory of patient-couples (Code 2.4.2) and individuals (Code 2.4.1) is an evaluative criterion used to consider normality. Psychoanalytic development, stages of development in infancy, as well as development across the adult lifespan are referenced. Additionally, relational histories, family of origin, past and present relational experience, are considered in thinking about the couple's psychic development.

Significant emphasis is placed on transgenerational legacies. Partners' experience of their own parental couples is considered alongside wider multigenerational perspectives. Couple psychotherapists are, to some degree, engaged in an investigative process, seeking to identify factors that might contribute to their understanding of the couples' relational difficulties. When history provides individuals in a couple with a good

template of what a relationship-supporting model of persons-in-relationship looks like, then the capacity to be in a relationship is enhanced.

It is interesting to note that while in the literature developmental theory and concepts of normality are linked, at times in ways considered problematic, such concerns were largely absent amongst participants. Developmental theory has often reflected societal norms, incorporating them with little critical evaluation by the psychoanalytic community (Jones, 1942; Cheuvront, 2010). This process was instrumental in the pathologising and subsequent criminalisation of homosexuality (Schwartz, 1999; Cohler, 2000). The research participants were clearly conscious of this history but the pathologising of homosexuality is seemingly thought of as an error of diagnostic processes somewhat distinct from developmental theory. Couple psychotherapists applying normative developmental models are not necessarily engaging in what Schwartz (1999) terms as 'developmentalism'. At the same time, their stance towards normative developmental theory is clearly less critical than that of Schwartz.

The Application of Non-psychoanalytic Frameworks in Couple Psychotherapy

This second research question is answered by the third and final theme discussed earlier. This brings together the manner in which paradigms originating beyond psychoanalysis are considered. The main referenced paradigms here are those of statistical *central tendency* (subtheme 3.1), and the *medico-legal* (subtheme 3.2) capturing the influence of the medical model and law.

Central tendency (subtheme 3.1) refers to the belief that statistics or the bell curve that allows for an appraisal of normality, is held with some scepticism by a limited number of couple psychotherapists. This subtheme captured numerous conversations exploring statistics with reference to psychometric measures developed through the discipline of psychology. It is therefore possible to consider the theme of central tendency to largely reflect psychological models of normality sitting alongside the medical and legal. However, this is not entirely true as some of the more implicit references to central tendencies had a rather unsophisticated quality about them. Participants mentioned terms such as 'the usual' and 'familiar' which seem to reference personal experience rather to psychological constructs.

Experienced couple psychotherapists are not easily seduced by the allure of a statistical normality which might mitigate against the uncertainty that thinking about normality stirs up. The literature has acknowledged that psychoanalytic thought and statistical notions of normality do not sit comfortably together (Offer and Sabshin, 1974; Verhaeghe, 2004). Statistical measures tend to depend on the reductionist operationalisation of complex psychic and relational phenomena while psychoanalysis is engaged in attending to the minutiae of psychic and relational processes. In line with Verhaeghe's (2004) observations, psychotherapists make assessment of normality based on an initiative, experience-based sense of average. This is particularly true when faced with phenomena that do not easily lend themselves to psychometric assessment or where such assessment would be cumbersome.

The medical model in the *Medico-legal* subtheme (3.2) involved explicit and implicit references to mental and physical health, where disease is often defined through symptomology and diagnosis. Approaching couple psychotherapy was likened to visiting a general practitioner when troubled by ill health. However, while there was an appreciation that patients seek help from both psychotherapists and general practitioners, psychotherapists believe there are differences between these practitioners' positions. Firstly, when seeing a couple, couple psychotherapists understand that they might not be the only person judging a member of the couple. Thus, the assessment process is not simply a process of diagnosis but can represent significant process issues (such as collusion with one party and a loss of the couple state of mind (Morgan 2001, 2019). Additionally, diagnostic processes within the medical model are considered to be simplistic, particularly with regards to the use of diagnostic manuals in mental health.

A somewhat surprising finding, implicit in the data, is the relatively uncritical equating of normality with health, even if psychiatric classification does not sit comfortably alongside psychoanalysis. Ian in Focus Group 2, for example, said that he would 'agree completely with the use of the word healthy because that's the first thought' he had when asked what he thought relational normality entailed. While some questioned whether disease or symptom-based models of normality can be applied to the psyche, this critique was not prevalent. The more common implicit view seemed to be congruent with that expressed by Romano (1950), who equated normality with being mostly free of pain, discomfort and disability, even if this is somewhat contradictory of the normalisation of the sub-optimal (Subtheme 2.2: Sub-optimal as normal). It is clear that while couple

psychotherapists have moved away from the Correspondence-Essentialism paradigm (Protter, 1985) of normality, their critique of the medical model and particularly the mental health literature lacks the decisiveness evident in authors such as Bartlett (2011) and Leader (2011).

When it comes to legal considerations (subtheme 3.2, *Medico-legal*), participants did not subscribe to Menninger's (1945) views that normality is defined as the accommodation of social norms, nor their formalisation enshrined in the legal system. However, while legal definitions of normality were considered crude, there seems to be a distinct reverence to the dictates of law. If the law considered something as abnormal, participants seemed willing to accept that this was a boundary they had to operate within.

In contrast, implicit in the argument that the use of psychological measures represents defensive practice (see subtheme 3.1) is the belief that fear of legal repercussions might impinge on the creativity and freedom of the therapeutic endeavour. The reserve that couple psychotherapists display seems to echo Reider's (1950) concern that normality can come to serve defensive purposes on societal and institutional levels.

The numerous references in the focus group data to the role psychoanalysis played in justifying the criminalisation of homosexuality makes it clear that experienced couple psychotherapists know that the relationship between the practice of couple psychotherapy and the law is not a marriage made in heaven. This remains true in spite

of the expressed respect for the rule of law which, like psychoanalysis, cannot be assumed to prescribe normality.

The Impact of Cultural and Personal Influences on the Conceptualisation of Normality

The third research question examines the degree of awareness and sensitivity practitioners have to the possibility impact of personal beliefs might have on their concepts of normality. It is clear that couple psychotherapists are acutely aware of the stigma and bias inherent to the clinical setup itself, where the psychotherapist is the designated expert and the patient may feel defective. The strength of the first theme (*The Political, 1.0*) strongly suggests that couple psychotherapists are cognisant of the need to be aware of their biased beliefs which is evidenced in the significant anxiety around assessing normality (see Code 1.2.2, *Fear of damaging patients)*. Perhaps their exposure to, and the at times violent, power struggles in couple relationships, encourages such sensitivity.

Data analysis identified *socio-cultural factors* (captured in Subtheme 1.4) as being of crucial importance in assigning normality. The need to keep context in mind (detailed in Code 1.4.2) is essential in minimising the bias inherent to the psychotherapist's personal life experience. First of all, normality is considered to be somewhat polymorphic, that is, having a capacity to morph or evolve into a multiplicity of normalities depending on cultural context. Thus, experienced couple psychotherapists are keenly aware that their own cultural, religious and personal and professional training backgrounds predispose them to particular views of what is normal, healthy and acceptable, and what is not.

Couple psychotherapists may, in the course of working with a couple, identify problematic behaviours or processes, but even then, context remains relevant or becomes even more so. The difficulty being examined may carry specific meaning within a particular context, and perhaps even lead to a realisation that the normative theoretical template employed by the psychotherapist has real limitations (such as in taking a cross-cultural perspective on mourning).

However, couple psychotherapists do not necessarily believe that what is culturally acceptable is normal. A discussion around open relationships highlighted the challenge these present for couple psychotherapists familiar with modelling relationships in terms of a dyadic process. A few psychotherapists seemed to express rather rigid views although others expressed a recognition that the psychoanalytic theory they reference may be somewhat archaic and in need of updated (such as in accounting for the relational choices of sexual minorities). This is not necessarily an issue with psychoanalytic theory itself but can very well be an issue around training and professional development.

In discussing the complexity of clinical judgement (Code 1.1.1), it is clear that experienced couple psychotherapists endeavour to move away from the more emotive, simplistic, reactive or instinctive appraisal of a clinical situation to a more sophisticated reflexive position. Such a stance allows for the application of a disciplined discernment and the utilisation of relevant theory. In achieving *dynamic equilibrium* between various considerations (graphically represented as a three-pan weighing balance), psychoanalytically informed couple psychotherapists avoid rushing the process. They

seem to engage in a serious of hypothesis forming and testing until their assessment feels as coherent as possible with their multiple frames of reference.

The importance of keeping track of what one feels and thinks, in the presence of couples narrating their life story or enacting behaviours in vivo within the consulting room, is universally acknowledged. Psychotherapists describe a need to move away from being instinctive or haphazard and actively challenge their feeling and thinking (see Code 1.1.1). The importance of formal supervision plays in evaluating responses will be explored when discussing the final research question. However, it is clear from the above that an internal reflexive-supervisory process takes place within these practitioners' minds. It seems that experienced couple psychotherapists engage in an internal discourse about their reactions to the material they are presented with, even before this is perhaps explored in formal supervisory meetings.

Amelia, in Focus Group 3, for example, spoke of being aware of how she can get caught up in her own ideas of normality which she attributes to 'a very narrow-minded life and a narrow approach to things'. She is nonetheless able to keep in mind that the point of seeing couples in treatment is not 'what they are doing or what I think'. She is drawn to consider underlying psychological processes seeking a deeper understanding of the couple's narrative. Her reactivity leads her to, tentatively, perhaps even temporarily, label as not normal and meriting attention a specific behaviour, but the position is repeatedly re-examined. Amelia then speaks of how psychoanalytic thinking provides a lens through which she is able to examine matters in a more useful manner.

It is clear that couple psychotherapists are drawn to what feels to them to be lacking normality, whether this be because the behaviour stands out (described as 'less usual') or elicits concern (often spoken in terms of being 'not healthy'). Indeed, participants spoke of how interpretation, often considered the golden arrow of the analytic arsenal may find its inception in some less normal feature of the couple's presentation. One might wrongly assume that when a behaviour is interpreted, this means that abnormality has been securely discerned. However, Hinshelwood (1991) reminds us that the interpretative process involves hypothesis testing. An interpretation focus as a non-usual feature of the couple's presentation might lead to a reaction that helps the professional understand that feature further and perhaps even come to think of it as non-problematic and in some way normal. In this manner, couple psychotherapists seem to have adopted the epistemological position that Protter (1995) termed 'clinical context', where psychoanalytic truth is found in the appreciation of the personal narrative emerging in the therapeutic encounter.

The Role of Training in Supporting Thinking around Relational Normality?

The final research question relates to a code within the first subtheme of the main theme which explores *maintaining the therapeutic position* (1.1.2). Couple psychotherapists are unequivocal that rigorous training, including the requirement of personal therapy and supervision, are crucial in being able to think about normality in a sophisticated manner.

The management of difficult feelings evoked when working with complex couple presentations requires capacities nurtured by personal therapy. Additionally,

supervision facilitates the development of therapeutic capacity, particularly in learning how to differentiate between transference reactions and emotional responses pertaining to self. Couple psychotherapists admit that even intense preparation does not render them immune to confusing their own subjective experience with that of the patient, allowing for subjectivity and bias.

While couple psychotherapy training is seen to enhance the capacity to think about normality because of the encouragement to think deeply about all matters pertaining to practice, a number of shortfalls were identified. Firstly, some psychotherapists believe that training courses are overly economical when it comes to diversity training. Secondly, training institutions themselves tend towards normative ways of being by developing a degree of theoretical and practice orthodoxy. The latter was considered somewhat inevitable and possibly counterbalanced by instilling an open-minded questioning curiosity in graduates.

Strengths and Limitations of the Applied Methodology

This study represents a unique attempt at gaining an understanding of how couple psychoanalytic psychotherapists conceptualise normality and apply it. It addresses what has, as yet, been a largely unexplored aspect of theory and practice.

The Research Participants

The research's main strength lies in the fact that it managed to recruit a sizable number of highly experienced couple psychoanalytic psychotherapists. Two-thirds had practiced

for over 9 years and some for much longer. In fact, only 15% of participants had practiced for 4 years or less.

A limitation of this study is the gender imbalance with only 15% of participants being male, although this reflects the gender representation in the profession itself. Indeed, a review of couple psychotherapists listed on the BPC website shows only 12 male members listed on the 'find a therapist' facility as opposed to 52 females (British Psychoanalytic Council, 2019). Another limitation to the study is the fact that twenty-three of the twenty-seven participants were white with less than 15% coming from mixed or Asian backgrounds. This suggests that the results may not represent the concepts of normality held by psychotherapists from ethnic minority groups.

One of the inherent limitations of this study is that it took place in the United Kingdom and therefore does not necessarily address the research question to a wider audience. While, as has already been discussed, a degree of theoretical generalisability is possible (Sim, 1998; Vicsek, 2010), replication of the study in other countries (such as the United States and Italy) would enrich understanding and allow for insight about differences between groups of practitioners.

Data Collection and Analysis

The use of focus groups to gather data proved very effective as evidenced by the richness of the opinions, the expression of contrasting views and unfolding of lively debates across all focus groups. The research interview guide proved sufficiently

adaptable to allow the flow of discussion in the group to be guided, without causing disruption with themes emerging in an organic manner.

Focus groups have a particular appeal to couple psychotherapists, and possibly, to psychotherapists more generally. Clinical discussion groups are a well-established part of both training and post-qualification clinical practice, so the setting is both familiar and appreciated. Indeed, many participants felt the focus group experience was sufficiently enriching for them to consider it part of their Continued Professional Development (CPD) process. It is likely that this contributed to the successful recruitment of experienced participants.

Successful recruitment of participants allowed for the creation of four focus groups. These provided rich data which was subjected to Thematic Analysis and allowed for sufficient data saturation to be achieved (Braun and Clarke, 2013). This chosen method of data collection and analysis identified clinically relevant themes and subthemes with some potential for generalisability to the population as already discussed (Sim, 1998; Vicsek, 2010). Reliability and validity were supported by the application of checks as specified in the methodology, including the review by a qualitative researcher working in a field unrelated to couple psychotherapy.

The addition of a quantitative component to this research, as already noted, would have further enriched the findings of this study (Jick, 1979) but the chosen design was deemed sufficient for a Professional Doctorate (Smith, 2015). In the final chapter,

specific recommendations for survey research drawing on the findings of this study are proposed.

The Researcher's Speaking Position

In facilitating the focus groups, the researcher used the group process to explore emergent themes (Morgan and Krueger, 1993; Zeller, 1993), while allowing participants enough free reign for the discussion to evolve organically. The researcher's collegial relationship with many of the participants did not seem to hamper the process. More challenging for the facilitator was staying in role and refraining from joining in the lively exchanges that took place. Participants were energised by the focus group questions and whenever clarification was sought by the facilitator, they engaged enthusiastically. It was clear that these senior practitioners are very familiar with the skills needed to engage in lively debate about clinical matters within group settings.

In the data analysis stage, the researcher transcribed and then coded the data, ensuring maximum immersion in the data itself. The researcher's background in couple psychoanalytic psychotherapy supported the data analysis process, allowing for an appreciation of the complex theoretical and clinical discussions that ensued amongst the focus group members. However, proximity to the subject matter risked challenging the researcher's objectivity potentially weakening the validity of the research findings. The research methodology specified a number of safeguards which were adhered to. However, as the data analysis progressed, the repeated exposure to the multitude of positions expressed supported the researcher capacity to distance oneself sufficiently as to secure a more reflexive third position.

Chapter Conclusion

The application of concepts of normality in psychoanalytically-informed couple psychotherapy is complex and multi-faceted. The results indicate that the conceptualisation of normality in the practice of psychoanalytically-informed couple psychotherapy is best thought of a process of achieving a *dynamic equilibrium* where political, psychoanalytical and non-psychoanalytical considerations are all weighed in. This model of the concept merits further investigation and validation. The next chapter will present the implications of the study to the research, theory and practice of psychoanalytically-informed couple psychotherapy.

Conclusion

Chapter 6

The clarification of conceptual ambiguity benefits both the theoretical coherence of psychoanalytic thought as well as psychoanalytically-informed psychotherapy (Jones, 1942; Abrams, 1989). This research highlights the need to clarify the conceptualisation of relational and psychic normality in the practice of couple psychotherapy and how intrinsically linked these normalities are. Couple psychotherapists generally value a permissive and open-minded approach in thinking about normality and are eager to avoid applying a dichotomous categorisation of what they observe. Normality is easier to consider at micro or process level assessment but becomes a cause of anxiety when involving the evaluation of gross normality of individual patients or patent-couples.

A model for the conceptualisation of relational normality as involving the attainment of *dynamic equilibrium* between the three themes identified in this research was proposed. The political, the psychoanalytic and the non-psychoanalytic all feature in couple psychotherapists' evaluation and conceptualisation of normality. While there is no indication that these are given equal weighting, no aspect is completely discarded.

Implications for the Psychoanalytic Couple Theory

The literature supporting couple psychoanalytic therapy has relied heavy on the main corpus of analytic literature, to draw out concepts subsequently applied in work with couples. Epistemological critique of theory is largely absent in couple psychoanalytic literature. The results of this study indicate that practitioners have adopted the more recent epistemological positions Protter (1985) terms 'clinical context' and 'clinical text'. It is especially true that *clinical context* is a valued position as clinicians deliberate on how to come to terms with their *therapist responsibility* (Subtheme 1.1) and the value

they ascribe to a *client-centric normality* (Subtheme 1.3). This suggests that the profession has moved towards what Protter termed as 'a person-centered antireductionistic direction… reflected in the post-Freudian upsurgence of self-in-relation psychologies as a counterpart to biological drive views' (Protter, 1996, p. 538). Couple psychoanalytic psychotherapy is yet to fully articulate how the tension between epistemological positions is to be addressed.

Investment in theoretical investigation into normality from a couple psychoanalytic perspective would be of value, addressing a distinct absence in the literature. This research indicates that there is a need to articulate the relationship between psychoanalytic normality, other conceptualisations of normality within practitioners' field of vision, and the political dimension in greater depth. The idea that normality in psychoanalytically-informed couple psychotherapy can be conceptualised as a dynamic equilibrium between various considerations has been proposed and discussed. The research methodology employed for this study suggests that the proposed conceptual model may have application beyond the confines of this study (Sim, 1998; Vicsek, 2010). A deepening of theoretical understanding and potential elaboration or challenging of this model would certainly prove clinically relevant, providing a theoretical framework with which relational normality can be more systematically considered.

Implications for the Practice of Psychoanalytic Couple Psychotherapy

Couple psychotherapists think about normality even if simply to avoid being caught in the trap of the dichotomous normal versus abnormal thinking. It seems sensible for

training institutions, supervisors and practitioners to consider the impact of normative thinking and related struggles described in this study.

The importance of personal therapy and the supervisory process are affirmed by the research findings. Additionally, the value of a curriculum that encourages curiosity and fosters an ability to think permissively has also been reported to support sophisticated ways of thinking about relational normality that is avoidant of prejudice and bias. On the other hand, research participants expressed a belief that training around diversity was somewhat limited. A few participants felt that restrictive orthodoxy within training institutions inhibited trainees' openness to exploring diverse theoretical pathways. Training programmes need to consider the identified deficiencies noted in some training programmes as well as the strengths so as to create the type of learning climate focus group members valued.

A number of generalisations about what practitioners think can be made in line with Vicsek's (2010) suggestion that findings drawn from focus group research can inform us about the population, albeit in cautious and non-probabilistic manner. First of all, it is likely that the themes that emerged from the conversations amongst the participants are shared by other similarly trained practitioners. However, the degree by which the permissive, post-modern stance evident in these research findings will emerge amongst other groups of practitioners, cannot be assured.

The study shows that there are a variety of positions that practitioners assume with regards to normality in couple psychotherapy. Some of these views may have been

expressed by a very limited number of participants but their existence is nevertheless significant by virtue of its occurrence. One can establish with some confidence that:

i. Couple psychotherapists express a wide range of beliefs about the importance of considering normativity in their practice. While most think this matter merits thoughtful consideration, a few felt that it was largely irrelevant to psychoanalytic practice. It seems that some psychotherapists believe that not thinking about normality amounts to being immune from the normative implications of psychoanalytic theory and practice.

ii. A number of couple psychotherapists believe that by using alternatives to the term normality (such as healthy, creative, happy, well-adjusted, good or helpful), normative thinking can be warded off. This type of thinking seems to have accompanied the practice of psychotherapy since its early years, with Ernest Jones voicing similar concerns as far back as 1942.

iii. The degree of rigidity with which psychoanalytic theory and personal belief is held is a matter of concern for many couple psychotherapists. This is implied in the repeated affirmation practitioners made about their need to examine their position. Some participants described themselves as somewhat narrow minded or blinded by their own beliefs. It is clear that extensive training and years of experience do not necessarily provide immunity from restrictive ways of thinking.

iv. The attainment of a dynamic equilibrium between the three themes identified in this study is facilitated by the belief that theoretical rigidity is detrimental to the therapeutic process. This allows psychotherapists to use psychoanalytic models and concepts that emerged in the Correspondence-Essentialism stage of theoretical development (Protter, 1985, 1996) in the same way as those emerging

in the more social constructivist or context-driven stage. Theory is seen to provide useful approximations of the truth which remains sensitive to the influences of the contextual elements in which the therapeutic institution, psychotherapist and patient are immersed in.

v. Couple psychotherapists engage in a very active discernment of normality involving an active scrutiny of thoughts and feelings that emerge in the clinical situation. Client presentations that are unusual, lacking a well-known form or stirring up of nervousness or alarm immediately become the focus of psychotherapeutic investigation. The professional registers the experience and then filters it through layers of psychoanalytic and non-psychoanalytic knowledge. The presentation is compared to previous clinical experience and possibly discussed in supervision. Initial reactions to clinical material are valued as starting points for further inquiry.

Implications for Research

This study has demonstrated the value of research into the conceptualisation of normality in couple psychotherapy. It has also highlighted the absence of a meta-theory as to how couple psychotherapists integrate psychoanalytic theory with other theoretical and empirical data.

The research findings supporting the proposed conceptualisation of normality as *dynamic equilibrium* in the three-way balancing of the identified themes merit replication and further investigation. Replication of the study with other cohorts of couple psychotherapists, including those not trained in the psychoanalytic tradition, would allow an assessment of the robustness of the concept. It would be interesting and

valuable to gain an understanding of how couple therapists working within different schools of thought (such as the systemic or emotionally-focused) conceptualise normality and to what degree this overlaps with the results of this study.

Quantitative research into the relative importance of each of the three themes identified in this study would shed important light into how different couple psychotherapists conceptualise normality. It is possible to operationalise each of the three themes, as well as their subthemes and creating a research questionnaire assessing the relative weighting couple psychotherapists give to each theme. The self-reporting questionnaire using Likert scale questions can be devised so as to appraise the relative importance research participants give to the identified themes when evaluating relational normality across a number of selected clinical vignettes.

Data analysis should allow the cross tabulation of findings against a variety of factors such as the participating clinicians' theoretical orientations, years of clinical experience, years of personal therapy and therapist gender. The findings of this research will allow triangulation of the qualitative findings of this study, with survey data furthering knowledge.

The impact of diversity on the conceptualisation of normality could also be explored if the above methodology was modified so as to assess the impact of the practitioner bias. The research can look at how differences between the psychotherapist's gender, race and sexual orientation and that of the patient-couple in the provided vignettes, impacts the relative weighting given to each of the three themes.

Participant psychotherapists were keenly aware that concepts of normality evolve as the practitioner matures. Comparative cross-sectional and longitudinal studies would provide insight into how clinical experience impacts thinking with regards to normality. The research design would allow for comparison of data gathered from pre-clinical trainees, more advanced trainees seeing patients, newly qualified and experienced couple psychoanalytical psychotherapists.

Additionally, a comparative study looking at how therapists trained to different degree of rigor conceptualise relational normality would provide valuable insight. The results would be useful in shedding light at how the duration and composition of training programmes impacts conceptualisation. For example, couple psychotherapists registered with the British Psychoanalytic Council have undergone intense personal psychoanalysis and will have also attended an infant observation workshop. Most other couple practitioners would have attended weekly psychotherapy but would have not done an infant observation. It would be useful to understand whether this has any bearing on normative thinking.

Final Thoughts

This research has shown that the conceptualisation of relational normality is a multifaceted and complex process. Experienced couple psychotherapist often weighed in and evaluated the diverse consideration which, in this study have been labelled as the political, indigenous and non-native themes.

The study also highlighted that the conceptualisation of normality does not simply apply to individual patients and couples. Couple psychotherapy itself, the training institutions that support its development and the society in which these are embedded cannot escape the fact that normative ways of thinking is an insidious part of everyday life. This study is one first step in starting to address the need to understand how couple psychotherapists conceptualise normality in their specific field.

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Appendix A

Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Title of Research Project:

Exploring notions of relational normality as conceived by psychoanalytically informed couple psychotherapists

Research Institutions

University of East London (UEL)
CASS School of Education and Communities
Stratford Campus
Water Lane
London E15 4LZ

Tavistock Relationships (TR)
70 Warren Street
London W1T 5PB

UEL Research Ethics Committee

If you have any queries regarding the conduct of the programme in which you are being asked to participate, please contact:

Catherine Fieulleteau
Ethics Integrity Manager
Graduate School, EB 1.43
University of East London
Docklands Campus
London E16 2RD

Telephone: 020 8223 6683
Email: researchethics@uel.ac.uk

The Principal Researcher Details

Pierre Cachia CPsyhcol
70 Warren Street
London W1T 5PB

Telephone: 07891292083
Email: pcachia@tavistockrelationships.org

Research Study Information Sheet

Thank you for considering to participate in this research which will help our understanding of the thinking that goes on in the therapists' minds when working with distressed couples. The project has gained ethical approval by the ethics committee of both Tavistock Relationships and the University of East London. The purpose of this document is to provide you with the information that you need to consider in deciding whether to participate in this study.

Project Title

Exploring notions of relational normality as conceived by psychoanalytically informed couple psychotherapists

Project Description

Psychic normality has been given considerable thought in psychoanalytic theory. The importance of this was recognised early on with Jones (1942) asserting that "What constitutes the 'normal' mind, and whether such a thing can actually exist, are questions of considerable theoretical, and sometimes of practical, interest" (p.1). When considering that a central tenant of psychoanalytic couple psychotherapy is the maxim that "the couple is the patient" (Ruszczynski 1993), it is surprising that the notion of normality is given little mention in the couple psychotherapy literature. The need for a systematic investigation of the implicit and explicit notions of normality utilised in working with patient-couples is therefore clear.

This study will utilise a focus group methodology with four groups of up to 8 participant couple therapists discussing their ideas around the subject matter. Each group will last up to 90 minutes.

This study is partially funded by a study grant from Tavistock Relationships which has also granted the use of its facilities for focus group meetings. The lead researcher has provided all other resources.

Confidentiality of the Data

All data related to the study will be held securely. All electronic records are held in encrypted form. In analysing data all identifying details will be deleted or anonymised. Verbatim quotations from interviews with the researcher may form part of the final report and may be required for publication purposes however such extracts will be carefully anonymised so as to ensure confidentiality. Findings from this study will be disseminated within the professional community and more widely through journal publications and other digital or print media.

The researcher will be supervised in completing the project by Dr Avi Shmueli (Consultant Couple Psychotherapist) and Dr David Hewison (Research Lead at Tavistock Relationships, London).

Once the research is completed all records will be destroyed securely (raw data will be erased within 24 months of recording).

Post-Focus Group Support

While participating in this research is not envisaged to be a stressful experience, in the eventuality that you find yourself wanting to discuss your experience I will be available to talk things through. Additionally an independent practitioner specialised in Counselling Psychology will be available providing independent support:

Details: Dr Haneyeh Belyani
Chartered Counselling Psychologist
Counselling Psychology Group
www.drbelyani.com

Location

All research related meetings will take place on Tavistock Relationships premises in London..

Disclaimer

You are not obliged to take part in this study, and are free to withdraw at any time and without notice. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to explain why you made this choice

UNIVERSITY OF EAST LONDON

Consent to Participate in an Experimental Programme Involving the Use of Human Participants.

Exploring notions of relational normality as conceived by psychoanalytically informed couple psychotherapists

I have the read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen once the experimental programme has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications.

Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Investigator's Name (BLOCK CAPITALS)

.....

Investigator's Signature

.....

Date: .....

Appendix B

Focus Group Schedule and Guidance

Questions to read out are in **bold**. Prompts are also provided, to be read out if and when needed (for example, if people do not understand a question, or to help encourage further discussion).

Guidance for Focus Group Facilitators

It is important that these guidelines are adhered to. Make sure you are familiar with them and that a copy is available throughout the focus group sessions.

- ☐ The two facilitators have different roles. The lead researcher will serve as the main facilitator and the other will take notes and make sure the recording equipment is running properly.

- ☐ *You should try to get everyone involved in the discussion. This does not mean that everyone must have the same view, but the discussion should lead to some conclusions. You need to record both majority and minority views.*

Before the group assembles

- ☐ Test the recording equipment to make sure it is working and that the sound is recording at an acceptable level.

- ☐ Ensure you have any paperwork ready before the participants arrive, e.g. notes, name badges, Participant information sheets and Participation Consent Forms.

- ☐ Ensure that all Participation Consent Forms are signed and collected.

Preparing to start the session

- ☐ Set out the refreshments prior to the planned start time of the meeting.

- ☐ Once the participants are settled, check with the group whether they all know each other. If not, start by going round the group and getting everyone to introduce themselves. For your own convenience it helps to draw a 'map' of where everyone is sitting. You may not be able to do this if the group all know one another beforehand, but you can develop it as the session proceeds.

- ☐ Make sure that everyone is comfortable before you start and that everyone can see each other. Read out the statement on confidentiality:

Opinions expressed will be treated in confidence and all responses will remain anonymous.

- ☐ For ethical reasons participants should be asked to sign the Participation Consent Form approved by Tavistock Relationships and UREC.

- ☐ Check that there are no objections to the use of the audio recorder; then switch it on.

- ☐ Remind participants of their right to withdraw at any point in the discussion should they feel the need to.

Introduction to the session

- ☐ You need to start off by reiterating the purpose of the meeting.

Use this statement:

I'm very grateful that you have made the time to participate in this research. The purpose of this research is to develop an understanding of the explicit and implicit notions applied in thinking about normality in relational to coupledom as used in psychoanalytically/psychodynamically informed couple therapy. There are no right or wrong opinions and I would like you to feel comfortable saying what you really think and how you really feel. Illustrating your position with clinical material may prove very useful and is much appreciated.

I would like to kick off this conversation by inviting you to share any initial thoughts you might have had when invited to participate in this study.

Introductory question:

In working with couples, we seek to address their need for something to change. Can I ask you to reflect for a moment and then share with us what you believe you are helping couples achieve? Is it some form of so called 'normality'?

FOCUS GROUP DISCUSSION: EXPLORING NOTIONS OF NORMAILITY

- ☐ **Q1: What ideas do you associate with the notion of normality in couple relating when seeing couples in your practice?**

- ☐ **Prompt 1:** does psychoanalytic thought provide you with an adequate framework to consider normality?

- ☐ **Prompt 2:** does couple therapy help couples achieve normality and, if it does, what does that look like? What are you working towards, normality or some other end state?

☐ **Q2: Normality has been conceptualised in terms of a lack of manifest symptomology - that is, using a health/disease framework. To what extent is this true?**

☐ **Q3: Some would say that normality is not achievable. Is normality a utopian notion?**

☐ **Q4: Is normality about being average, about avoiding extremes?**

☐ **Prompt 1:** Is there any conflict between your position around normality and that related to measures of individual and relational well-being (e.g. the CORE Clinical Outcome Measure (CORE-OM) and the Couple Satisfaction Index (CSI) for those working at Tavistock Relationships). Is normality about being outside the measure's clinical range?

☐ **Prompt 2:** how do these tools influence your thinking about normality, if at all, and is this consistent with your analytic framework?

☐ **Q5: Normality can be seen as related to process with psychoanalysis, for example, suggesting that some developmental processes are normative in nature. Does this apply to thinking about couples?**

☐ **Prompt:** What particular theories do you find relevant here and do you normally refer to them in thinking about normality or a lack of it?

☐ **Q6: The couple therapist is often required to witness couples in a state of relatedness, that is, to see how couples behave in vivo. Do we think about normality as we observe the couple and ourselves in the clinical situation?**

☐ **Prompt:** can particular ways of relating be considered more or less normal?

☐ **Prompt:** Are the therapist's feelings a reliable gauge of the couple-patient's normality status?

☐ **Q7: Therapists can allow their own individual and cultural biases to impact their observations and their thinking as to how 'normal' a particular aspect of couple relating is. To what extent do you find yourself struggling with such matters in clinical practice?**

☐ **Prompt 1:** London is a very diverse city. Do couples define normality in ways that surprise you?

☐ **Q8**: **What do you think are the dangers inherent to thinking or failing to think as to how notions of normality impact couple therapists?**

Citation:

Cheuvront's (2010) paper titled Life-Long Coupled Relationships and psychoanalysis: Reconsidering Developmental Milestones and Measures of Normality in Clinical practice highlights the importance of thinking with clarity about normality in psychoanalytic practice. He asserts that psychoanalytic theory has at times, rather thoughtlessly incorporated societal norms as indicators of developmental normality, thus diminishing the value of other pathways towards normality in whichever way that might be conceptualised. Attention to impact of "cultural" normality in couple relationships is therefore very relevant to the practice of couple psychotherapy.

☐ **Q9: To what degree would you consider this statement to be true?**

☐ **Prompt 1:** What measures do you take to limit such biases and/or limitations?

☐ **Prompt 2: Considering what you have said and heard today, would you think that your training focused sufficiently on considering normality in relation to coupling?**

☐ **Q11:** I would welcome any final concluding thoughts you might wish to share.

☐ **Prompt 1:** Has participating in this forum been helpful?
☐ **Prompt 2:** Is there anything that needs clarification before we conclude this meeting?

<u>Ending the sessions</u>

Finally, summarize the discussions and thank participants for their time.

Then read the final statement:

☐ Read the following statement:

Finally, I would like to remind you that all that you have shared will be treated with the greatest level of confidentiality and will only be used for research purposes and will not be discussed in any other forum. If you have concerns about any statement you have made and perhaps wish it not to be quoted in the study, please feel free to let me know about this. I remind you that you are entitled to withdraw from this study and this includes withdrawal of your contribution to this focus group discussion.

Appendix C

Participant Demographic Information Sheet

Participant Demographic Information (to be completed prior to start of focus group) Please complete this form as accurately as you can.		
Personal details	Female	
	Male	
	Transgender	
	Other	
	Prefer not to say	

Age	18 – 25	
	26 – 35	
	36 – 45	
	46 – 55	
	56 – 65	
	66 or over	
	Prefer not to say	

Longest personal couple relationship (years)	1-5	
	6-10	
	11-15	
	16 – 20	
	21 or over	
	Prefer not to say	

Ethnic origin	White	
	Mixed	
	Asian or Asian British	
	Chinese or other ethnic group	
	Prefer not to say	

Sexual orientation	Bisexual	
	Heterosexual	
	Gay	
	Lesbian	
	Other	
	Prefer not to say	

Professional background	
Highest professional qualification in couple therapy	
Other professional qualification in psychotherapy or allied disciplines	(e.g. counselling, group therapy, psychology…)

Years of experience working with couples	2-4	
	5-6	
	7-8	
	9 +	

Professional registrations	BPC	
	BACP	
	UKCP	
	BPS	
	IGA	
	Other	

Specialisation	Couple Psychoanalytic	
	Couple Psychodynamic	
	Individual Psychoanalytic	
	Individual Psychodynamic	
	Group	
	Child	
	Other	

Appendix D

Ethical Approval from Tavistock Relationships Ethics Committee

TAVISTOCK RELATIONSHIPS

19th September 2017

ETHICS COMMITTEE CONCLUSION

"Exploring notions of relational normality as conceived by psychoanalytically informed couple psychotherapists"

Pierre Cachia
UEL Student number : 0741302

This is to confirm that Mr Cachia's Research Proposal for the Professional Doctorate in Couple Psychotherapy has been reviewed and approved for adherence to Tavistock Relationships' Code of Ethics for research.

We note the following:

1. Mr Cachia is not working with 'vulnerable' adults;
2. Mr Cachia is not doing physically intrusive or invasive procedures;
3. Mr Cachia has assessed the level of risk to himself and participants and we agree with his conclusion that it is low;
4. Mr Cachia's methods are congruent with his aims;
5. Mr Cachia's research is of value to the field of couple psychotherapy.

We support this research proposal and wish him all the best with it.

Dr David Hewison
Chair of Ethics
dhewison@tavistockrelationships.ac.uk

Appendix E

University Research Ethics Committee (UREC) Approval Letter

10th January 2018

Dear Pierre,

Project Title:	**Exploring notions of relational normality as conceived by psychoanalytically informed couple psychotherapists**
Principal Investigator:	**Dr David Hewison**
Researcher:	**Pierre Cachia**
Reference Number:	**UREC 1718 18**

I am writing to confirm the outcome of your application to the University Research Ethics Committee (UREC), which was considered by UREC on **Wednesday 15 November 2017.**

The decision made by members of the Committee is **Approved**. The Committee's response is based on the protocol described in the application form and supporting documentation. Your study has received ethical approval from the date of this letter.

Should you wish to make any changes in connection with your research project, this must be reported immediately to UREC. A Notification of Amendment form should be submitted for approval, accompanied by any additional or amended documents: http://www.uel.ac.uk/wwwmedia/schools/graduate/documents/Notification-of-Amendment-to-Approved-Ethics-App-150115.doc

Any adverse events that occur in connection with this research project must be reported immediately to UREC.

Approved Research Site

I am pleased to confirm that the approval of the proposed research applies to the following research site.

Research Site	Principal Investigator / Local Collaborator
Tavistock Relationships - London	Dr David Hewison

Approved Documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
UREC application form	2.0	4 January 2017
Participant Information sheet	2.0	4 January 2017
Consent form	2.0	4 January 2017
Interview Schedule – Focus Group Schedule and Guidance	1.0	31 October 2017
Introduction to the session	1.0	31 October 2017
Participant Demographic Information	1.0	31 October 2017
Ethical Approval from Tavistock Relationships Ethics Committee	1.0	31 October 2017
Academic Integrity Quiz Certificate	1.0	31 October 2017
Reference list	1.0	31 October 2017

Approval is given on the understanding that the UEL Code of Practice in Research is adhered to.

The University will periodically audit a random sample of applications for ethical approval, to ensure that the research study is conducted in compliance with the consent given by the ethics Committee and to the highest standards of rigour and integrity.

Please note, it is your responsibility to retain this letter for your records.

With the Committee's best wishes for the success of this project.

Yours sincerely,

Fernanda Silva
Administrative Officer for Research Governance
University Research Ethics Committee (UREC)
Email: researchethics@uel.ac.uk

Appendix F

Sample of Transcript from Focus Group 1

RESEARCHER: So, I want to start with a very simple question in the way of an obvious question. I am curious what ideas came to your head when I invited you to, for this focus group and the whole, yeah when you obviously read about that your read that it was about the notion of normality, what came to your mind?

PARTICIPANT 3: Well one of the things that came to my mind is that when we think about something like narcissism, I think about ordinary narcissism, in the sense that we all have difficulties relating to another person or managing someone having another point of view or not being same as us. The sort of ordinary problems that you might say are normal, whereas there are other couples that absolutely can't bear it, you know, and go to quite extreme lengths that try to convince the other person that they got the same mind or tell them that they do not think that because they need them to think something else. So you can think of it, think of it, a kind of an issue like that, or how we relate, narcissism, issues about relating and you can think about issues like that as a spectrum from something that's quite ordinary and normal on the one end to something that becomes more and more extreme, almost psychotic, if you like, at the other end. So that was one thought I had.

Group Members: Mmm

PARTICIPANT 6: It is a continuum but then what do we decide is acceptable, it is a continuum, where's the dot in space, yes

PARTICIPANT 3: …or when does it stop being normal

PARTICIPANT 6: Yes… or normal enough.

PARTICIPANT 2: I suppose what came to my mind is that I really never thought about, eh, what's normal. I means, that's not a concept that would immediately come to mind…eh, it made me think that perhaps, I think more in terms of, you know, well, well, what creates strength in a couple relationships, you know, what creates a degree of

happiness and how a couple can manage. I thought if, it seems so complicated to start thinking about normality. Mmm, because I think, you end up having to define something which to someone else might be perfectly reasonable or ordinary. I was thinking in terms in terms of cultural, eh, socio-economic layers of normality and, you know, how difficult it is to put one's finger on something. This is kind of, this I would define as normal. Sorry to go on but in particular, particularly, you know, we live in an age of identity politics and kind Mmm, it's so much about me, having to find ways of expressing, express oneself in terms of sexuality, cultural expression and so on and I think again it sort of widens the whole spectrum of what, what might, we might think of as normal, em, yah.

PARTICIPANT 5: I felt the same actually, it felt oh, DSM gives us, lucky them, they've got psychiatrists, US, they've got DSM, they've got DSM to say this is normal and this is not….and, and, as V said, I have not thought about normality before. When you are presented with a situation in a couple, you don't think about that, you think what is there in front of you and what is going on and start to work with what you have got as mad as it might, or not, you might have these feeling as to how this is a very disturbed state of mind, this is a very. As long as we define state of mind, as teachers here thought us… it feels like part of the human experience and normally is susceptible to culture, to history, to time, what normal only 15 years ago is not normal now when we hash tag me too…

RESEARCHER: of course

PARTICIPANT 5: …it is hard to define, even though it certainly still exists in our minds somewhere then we can search for it and think oh. Obviously, I thought about risk, or something that is really the couple's relationships is putting them both in a very unsafe situation or disturbing situation. I don't know…

PARTICIPANT 3: So, you are really talking about the couple, about an ab-normative aspect of normality, aren't you and it does go a bit against what we do as therapists because we are interested in what is normal for the couple, what works for them - in a sense. Except as you say, perhaps with certain areas where we would have a view. It is

not is not normal to sleep with your child, or have sex with your child, I mean something that is very clear but there is a whole other sort of area, aren't there which,

PARTICIPANT 5: where we we'd say, Oh!... now you…

PARTICIPANT 1: Open relationships is a good example of that because, and I am trying to think in terms of normativity as to capacity and distress. Like how much distress does it cause to people that are in that relationship. Maybe none, maybe a tremendous amount and what is their capacity to manage what life throws at them. And then I come across the normative ideas, if both partners are claiming that having multiple partners open relationships is actually not distressing for them, and they have the capacity to bear the fallout of that, do I put that in the normal range because it is not normative, or do I hold on to my theory…as in… I think these two things don't seem fit easily in my mind because when a couple claims that they do not experience distress and they have the capacity to manage these, not very normative ways of being a couple, I am wondering: if they are cut off from something? Am I being judgmental? So, I think these things, are difficult to put together, in a way.

PARTICIPANT 2: It is difficult to, I am mean, one can end up in a position of, judging in a way, what two consenting adults get up to.

PARTICIPANT 4: My first thought, it wasn't a thought, it was a sense of anxiety to do with this normal, normalcy, the normativity of it. And then my next, my thought was Mmm, interesting as if there is somewhere where we can think about things elsewhere because they are not very politically correct it is still somehow, that there is a way, way of thinking about relating adults, consenting, Mmm, to different types of behaviour, relations. Then I thought of the couples who come to see us and, and I thought well, would they come to see us, if they felt themselves, well, normal enough!

PARTICIPANT 5: Mmm, so their own experience of normality…

PARTICIPANT 4: Then I thought, well these aspects of differentiation, individuation, capacities, and I thought there is something about there, even the couples that come, because they struggle with something, the extent to which they are able to identify what it is they are struggling with because not everyone, not all the couples are, the sort of

presenting problem, and I thought, that is some, some, measure of reality check. So that's how I thought of engaging something that is quite anxious around the normativity…

RESEARCHER: Something that's a bother to the couple, that's upsetting the couple, whatever, functionality, serenity…

PARTICIPANT 4: …and their capacity to identity that in a way that, maybe connects with couple, family, generation, culture.

PARTICIPANT 6: Stress is universal though the way it is expressed and experienced is different.

PARTICIPANT 1: …but as a presentation within the couple normalcy is so often presented as, is coming up as a, as a narcissistic intolerance of difference and normalcy is claimed and the other one…, as a splitting device: this is normal whereas you are not normal. So this is often dropped…I had a couple where this was perhaps the main area of insult, you are not normal one partner said to the other and then maybe we are perhaps drafted in the service of defining what is normal, so we were completely lost in that because, of course, we had some ideas one being better than the other one but…(muted laughter)…

RESEARCHER: any yet of course, we are aware that weird (reflecting something uttered by group) …and yet of course weird is not a psychological construct, and yet we do find ourselves, partly because we are struggling, we struggle. This afternoon, this morning, while discussing C's couple we said, when is it normal, is it normal for this couple in their late 40s to be completely agreed that they would not have kids…and there was there was a bit of a question there, very quickly coming to our minds …

PARTICIPANT 6: ...yeah, I thought for me, I was following that line of thought quite hard, because the male partner had a nervous breakdown after he'd split up from the previous partner who had wanted children, I wondered what was going on in his mind about the breakdown after that, whether he was so much on board. I thought it was in the material really.

PARTICIPANT 3: But I guess we'd have to sort of think somewhere, it is normal to [Yeh! – other voice] to want to have children or at least to have ambivalent feelings [Yeh, Yeh –

PARTICIPANT 6]. Whether that is right or wrong, who knows, but what was striking with this couple was that there was no ambivalence…

PARTICIPANT 6: or admitted ambivalence

PARTICIPANT 3: or admitted yeah…that came into the therapy.

PARTICIPANT 1: Could we agree that there is ambivalence about things is normal? [Laughter and approval, yeah, yeah, from group]. Well I think this is important because that's where we start to wonder that perhaps there is some difficulty - when ambivalence is denied. Yes, maybe that's something….

RESEARCHER: which of course ties in with psychoanalytic theory in terms of conflict theory, doesn't it?

PARTICIPANT 1: I don't know about conflict theory…

RESEARCHER: Well in terms of Freud's idea of internal conflict…

PARTICIPANT 1: Ah, that one…Mmm, [laughter]

PARTICIPANT 6: But at least with ambivalence is thinking space, isn't there? You know that's the thing you know, because they really clumping, really clumping down, that couple of C's today so to actually, she couldn't really get in there and do any work, except to be with them to masturbate…the, the male partner…

RESEARCHER: PARTICIPANT 6, you said, something…. [pause] you said, 'it was in the material'

PARTICIPANT 6: Yes, I…[hesitates]

RESEARCHER: I wanted to ask you a bit, what do you see in the material and where does that idea come from? What does that mean, what were you seeing in the material?

PARTICIPANT 6: Well, that, that he had he had a reaction to a relationship that ended it's because the former partner wanted a child, he collapsed, had, you know a breakdown, whatever that meant. That must have, can't be a coincidence, I mean it could be a coincidence about the end of the relationship but the fact that the other partner wanted a child was the stated reason why the relationship finished. So, I have

to, I have to, hold the two in my mind and together linked really. That's what I meant was. That is my own stuff of course but that's what we do, I think it's hard not to think about one's own, sort of cultural in general, I know one has a personal culture, it's not just a, can be a universal one…I don't know. I think it's quite hard not to think about, when you think about a couple, not to think about what they do together and what they do together is create something together. That doesn't have to be a child, but you know there is a reason they are in a dyad rather than on their own I suppose, and there is that type of potential for creativity that seems quite important when there are one another's minds involved. In a way aren't we wired to connect, to have that, type of you know, interaction, to stimulate one another in some way.

PARTICIPANT 1: I think normalcy in my mind, in this professional, still connects a bit to psychoeducational bits of couple therapy. It's normal to worry about bad things, its normal to find it difficult when you have a baby, its normal to, I don't know, because sometimes couples just panic over the feelings that come up. Some of the normalising function already caries that word, it is actually normal…

PARTICIPANT 5: it has a curative element in its own right…

PARTICIPANT 1: Yes, and its actually normal to feel lost when you retire or when you become a parent.

RESEARCHER: But, if I ask you what analytic models speak to your understanding about normality? So, I mean, if I give an example, we think about Oedipus, don't we, and the resolution of the oedipal complex or the oedipal process, if you like, we tend to think of patients getting stuck somewhere along that continuum…

PARTICIPANT 3: well, or the depressive position…

PARTICIPANT 7: …and that's ambivalence again…

RESEARCHER: So what models are we actually employing when we see things in the material, for example, or when we are assessing a couple, what theoretical notions are actually informing us?

PARTICIPANT 4: Well I suppose, things like generational boundaries, but it's easier again to assess for things that seem off, rather than the normalcy, but I suppose you could

think there is a bit of healthy couple functioning here, this is why they came. Generational boundaries, the extent to which perhaps there aren't so many ghosts in the nursery in terms of the kinds of things that get projected around within the couple…

RESEARCHER: So, what would be normal processes of projection? How would those be discerned?

PARTICIPANT 7: Sorry, because I came a bit late, sorry, did you define it at the beginning because I'm feeling a bit lost…

Various: we discussed it in the beginning…

RESEARCHER: The question is: what notions of normality do you employ? Whether they are formal analytic or other, in looking at couple process…

PARTICIPANT 7: But there is a difference, I mean I am just following on from Participant 1, there is a difference between what might be usual, something might be usual, but you might not use the word normal, I mean, there is a question about how you even use the word, I mean people use it differently, because you might not say 'well its normal to say like that', I mean you might. Or you say, 'that's quite a usual feeling', you are not applying model of normality in that context, are you? You are just might be saying there are lots of people who experience that as a sort of reassuring technique.

PARTICIPANT 4: Sorry, is that a statistical concept you have or is that a measure of…

PARTICIPANT 7: I mean, I am just following on from…from what you are saying, I mean, it's not about normal, normal has so many sorts of connotations to the word, doesn't it?

PARTICIPANT 3: But perhaps they are linked. That when you say 'that's usual to feel like this…' that is partly a definition of normality in that many people in this situation have those feelings.

PARTICIPANT 7: Yeah, yeah…

PARTICIPANT 3: …and therefore it is a normal feeling…