“The unconscious is a shy beast: don’t pounce!” The making of psychotherapy (and a psychotherapist) in Aotearoa New Zealand

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Abstract

Psychoanalysis, psychotherapy, and Jungian analytical psychology, it could be argued, have as their centrepiece the encounter with the other, both within and without, and the attempt to bring an understanding mind to these others. In this we grapple, encounter, and receive the often-disturbing forces of the unconscious mind, including the implicit early relational experiences which in combination with our biological, and arguably spiritual, template, form the mind into the subjectivity that we experience as the self. But what if the very systems of thought which we utilise to inform our understanding of, and attempt to guide our encounter with, the unconscious, are themselves manifestations of a cultural unconscious, discourses which actually fabricate our very subjectivity as therapist and

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patient, thus constituting the very subjectivity which, by contrast, psychoanalysis and Jungian psychology, suggest is innate and a priori of discourse? This paper explores these complex tensions and how they may inform the construction of psychotherapy in Aotearoa New Zealand. The paper concludes with an exploration of the possible clinical implications of these ideas, including consideration of some clinical vignettes.

Whakarāpopotonga

Me kī rā ka taea te tautohe, ko te aronga nui a te wetewetenga hinengaro, te whakaora hinengaro me te wetewetenga hinengaro Hūniana, ko te tūtakinga ki tērā atu ōku, ā-roto, ā-waho me te whakatau kia mau mai he hinengaro mātau ki ēnei tāngata atu nei. I tēnei ka whātōtō, ka tutuki, ka tangoa mai ngā awenga whakararurarunga o te hinengaro maurimoe, ngā mātaunga wheako whaiora o mua anā ki te honotahi ki ō tātau āhua koiora, tae atu pea ki te hua wairua, ka ahua te hinengaro ki te aronga mōhiohia nei e tātau ko kiritau. Engari, ka pēhea ki te tūpono ko ngā pūnaha o whakaaro whakamahia e tātau hai whai mātauranga, ka whakamātau ai ki te taki i ā tātau tukihanga i te hinengaro maurimoe, ngā whakaaranga ake a te ahurei maurimoe, ēnei kōreroreronga whakaara tirohanga ā-kaihaumanu ā-tūroro, anā he whakaahunga ake i te ngākaukino arā ko te ahurei wetewetenga hinengaro me te hinengaro Hūniana, e kī ana he āhua nō mua noa atu o te whakawhitinga kōrero. E wherawhera ana tēnei pepa i ēnei whakararunga uaua, ā, tērā pea ka whakahouhia te āhua o te whakaora hinengaro i Aotearoa Niu Tīreni.

Keywords: Foucault; psychotherapy; Aotearoa New Zealand; psychoanalysis; Jung; discourse; truth.

McNay (1994) noted French philosopher and historian Michel Foucault's proposition that "The central problem of contemporary thought is its inability to think the other" (McNay, 1994, p. 80):

> … we are afraid to conceive of the other in the time of our own thought … The history of the order imposed on things would be the history of the same (Foucault, 1966, p. xxiv, cited in McNay, 1994, p. 80).

Psychoanalysis, psychotherapy, and Jungian analytical psychology, it could be argued, have as their centrepiece, the encounter with the other, both within and without, and the attempt to bring an understanding mind to these others. In this we grapple, encounter, and receive the often-disturbing forces of the unconscious mind, including the implicit early relational experiences which in combination with our biological, and arguably spiritual, template form the mind into the subjectivity that we experience as the self.

But what if the very systems of thought which we utilise to inform our understanding of, and attempt to guide our encounter with the unconscious, are themselves manifestations of a cultural unconscious, discourses which actually fabricate our subjectivity as therapist and patient, thus constituting the very subjectivity which, by contrast, psychoanalysis and Jungian psychology, suggest is innate and *a priori* of discourse?

Janet Frame

In 1945, prior to publication of her first book, renowned Aotearoa New Zealand author Janet Frame was first admitted to Seacliff Mental Hospital. There her subjectivity was arguably constructed by medical psychiatric discourse leading to an inaccurate diagnosis of schizophrenia and numerous ECT treatments. Michael King (2000) described how close she came to a leucotomy, before the publication of her first book garnered positive attention. In 1951 in Avondale Hospital, King further described,

> Because of what her hospital notes described as a 'strong resentment' of ECT, medical staff attempted to reduce the severity of the symptoms by the prolonged use of insulin shock therapy. This treatment produced comas and convulsions, accompanied by writhings and moanings, believed to have beneficial effects for schizophrenics. It had no discernible beneficial effect on Frame, other than to leave her drowsy and 'mentally numb' in the immediate aftermath. (p. 105)

Arguably, the subjectivities of the clinicians of the time in these hospitals were also fabricated by psychiatric discourse that medicalised emotional distress. Subsequently, when in England in 1957, Frame was admitted to the Maudsley Clinic where Dr. Alan Miller advised, as Frame herself put it,

> I had never suffered from schizophrenia, … I should never have been admitted to a mental hospital. Any problems I now experienced were mostly a direct result of my stay in hospital. I smiled. "Thank you", I said shyly, formally, as if I had won a prize. (Frame, 1989, p. 375, cited in King, 2000, p. 186)

The unconscious, like Frame, is indeed a shy beast. We are wise not to pounce.

Discourse

Foucault (in Simon, 1971) proposed that during each historical era there is a "distinctive epistemological structure — an 'episteme' — that governed how thinkers would think" (Garland, 2014, p. 369). Foucault suggested,

> … what I am trying to do is grasp the implicit systems which determine our most familiar behaviour without knowing it … (Foucault in Simon, 1971, p. 201, cited in Garland, 2014, p. 369)

> My problem is essentially the definition of the implicit systems in which we find ourselves prisoners: what I would like to grasp is the system of limits and exclusions which we practise without knowing it; I would like to make the cultural unconscious apparent. (Foucault in Simon, 1971, p. 198, cited in Garland, 2014, p. 369)

Ruptures in the possibilities for what it is possible to think or do are often indicated by heated passions, as taken for granted truths are interrogated and new possibilities for thinking and doing arise. As Rose (1996) noted,

> What today appears marginal, eccentric, or disreputable, was frequently, at the time it was written, central, normal, and respectable (p. 43).

This paper explores these possible "implicit systems" in which we find ourselves prisoners, the "cultural unconscious" that fabricates the possibility of psychotherapy in Aotearoa New Zealand. I[1] articulate four systems of thought in relation to the nature of the self, which I suggest make possible the practice of psychotherapy as a doable and thinkable thing in this country. The paper concludes with reflections on clinical moments and how these discourses might construct my and our subjectivities as psychotherapists, as well as considering the possibilities for transcending such discursive construction.

Discourse 1: The saviour and the one to be saved; Christian missionary discourse and the formation of "New Zealand"

Sociologist Nikolas Rose has written extensively about the discourses that have made possible the now relentless prevalence of what he described as the "PSY" disciplines, including psychotherapy, in all aspects of our lives, from the psychiatric report in criminal trials, to the self-help books in our book shops, to the so-called "relationship experts" that pop up on our television screens as we addictively consume uncomfortable episodes of *Married at First Sight*.

He suggested that the discourses of the PSY disciplines have "entered into the true" in contemporary society, and have claimed as their exclusive territory the lens through which we come to understand and know the "truth" of the workings of human subjectivity; the very fabric of ourselves. Further, he described the violence of the contests that lead to the emergence of such truths, commenting:

> … truth is not only the outcome of construction but of contestation. There are battles over truth, … [to] force something into the true … Truth that is to say, is always thrown by acts of violence. (1996, p. 55)

In relation to the conditions of possibility that made possible psychotherapy in Aotearoa New Zealand, this violence of the contest of the true preceded colonisation.

Aotearoa New Zealand pre-colonial and colonial context

On 19 March 2019, a few days after the Christchurch mosque attacks, anthropologist, sociologist and historian Anne Salmond wrote an article in the *New Zealand Herald* in response to Prime Minister Jacinda Ardern's statement that "They are us"; that those who have been hurt are us, and Ardern's assertion that "he", the violent perpetrator, is "not us". This is an idea that quickly took hold in the collective, that the violence that was perpetrated was not us, that the violence was in the other. In response, Salmond commented that, in

1 Throughout this paper, use of the first person 'I' refers to the first author, John O'Connor.

fact, the doctrine of white supremacy was foundational to the forming of New Zealand. She wrote,

> White supremacy is a part of us, a dark power in the land. In its soft version, it looks bland and reasonable. Eminent New Zealanders assure their fellows that Māori were lucky to be colonised by Europeans, that Te Reo Māori is worthless, that tikanga Māori has nothing to teach us. … And in its hard version, it's violent and hateful, spewing out curses, incarcerating young Māori in large numbers, denying them a decent education, homes, and jobs, telling them they have no future and are better off dead.

When I first read this, I felt the part of me that wanted to disavow it, that wanted to say, "that's not me, I don't perpetrate that kind of violence." However, I suggest, murderous racial violence is embedded in the discourse of this country, in me, and inevitably, in the practice of psychotherapy in Aotearoa New Zealand.

Pre-European contact with the Indigenous New Zealand "other"

The construction of the "indigenous other", prior to European contact, was profoundly influenced by Christian missionary discourse, in which the self is constructed as a soul to be saved, intertwined with Christianity's "Great Chain of Being" hierarchy, later supplemented by evolutionary Darwinian discourse, with God at the apex, white British men just below, and natives much further down. (For discussion of how racialised hierarchies became mapped on to the Great Chain of Being see Robert Young's (2004) *White Mythologies*). It is this Christian discourse, and the missionary zeal it informed, which enabled the construction of the "other" in the eyes of the British colonists, as a heathen native, inferior and in need of, indeed worthy of, saving.

Captain James Cook's 1769 voyage to Aotearoa New Zealand was sponsored by the Admiralty and the Royal Society of London (Salmond, 1991). The President of the Royal Society, the Earl of Morton, provided Cook with a set of "hints", intended to guide Cook and his men in how they should interact, should they encounter "natives" during their Pacific voyages. Morton, in 1768, in part, advocated,

> To have it still in view that shedding the blood of these people is a crime of the highest nature:— They [Natives] are human creatures, the work of the same omnipotent Author [God], equally under his care with the most polished European. …
>
> Therefore, should they in a hostile manner oppose a landing, and kill some men in the attempt, even this would hardly justify firing among them, 'till every other gentle method had been tried.
>
> There are many ways to convince them of the Superiority of Europeans, without slaying any of those poor people — for Example. — (sic) By shooting some of the Birds or other animals that are near them … (cited in Salmond, 1991, pp. 112–113)

Morton attempts to have it both ways: on the one hand recognising the essential equality of all humans as equal in the eyes of God, whilst nevertheless asserting the superiority of "polished" Europeans. The discourse of the humanitarian Christian is implicit, assuming as it does the universal truth of one Christian God. Such texts set the scene for later missionary zeal in relation to Indigenous New Zealanders, for the civilising of the heathen native via this "omnipotent author".

The tensions of humanitarian impulses and assumptions of European superiority also informed British instructions by Lord Normanby, Secretary of State for the Colonies, in 1839, to William Hobson, prior to Hobson's journey to New Zealand to seek agreement with Māori for the signing of Te Tiriti o Waitangi, the Treaty of Waitangi. These instructions include the following text:

> Believing, however, that their own [Māori] welfare would, under the circumstances I have mentioned, be best promoted by the surrender to her Majesty …, and persuaded that the benefits of British protection and laws administered by British judges … (in Buick, 2020, p. 71)

> There are yet other duties owing to the aborigines of New Zealand which may be all comprised in the comprehensive expression of promoting their civilisation, understanding by that term … [the] advancement of mankind. For their religious instruction liberal provision has already been made by the zeal of the missionaries, and the Missionary Societies in this kingdom, and it will be at once the most important and the most grateful of your duties to this ignorant race of men to afford them the most encouragement, protection and support to their Christian teachers. … until they can be brought within the pale of civilised life, … (in Buick, 2020, p. 74)

Perhaps most revealing of the discourses underpinning this "missionary zeal" are these comments by Reverend Samuel Marsden in 1815,

> The natives of New Zealand are far advanced in civilisation, and apparently prepared for receiving the knowledge of Christianity more than any savage nation I have seen. Their Habits of Industry are very strong: … they only want the means … the more I see of these people the more I am pleased with, and astonished at, their moral ideas and Characters. … (cited in Orange, 2013, p. 10)

> Their [the Māori] *minds appear like a rich soil that has never been cultivated, and only want the proper means of improvement to render them fit to rank with civilised nations.* [Emphasis added] … there was only one remedy which could effectually free them from their cruel spiritual bondage and misery, and that was the Gospel of a Crucified Saviour (cited in Salmond, 2017, p. 61).

Christian discourse constructs Māori as promising prima materia, but in need of alchemical Christian transformation: the transformative substance is Christianity itself. As Salmond (2017) noted,

> The upper [European] end of the Great Chain of Being (with God at its apex, followed by the ranks of "civilised people") was lit with the light of knowledge and understanding; the lower ranks … was sunk in primeval darkness. The missionary enterprise was understood as taking the Gospel of God to savages lost in epistemic murk, and raising them up to enlightenment. (p. 60)

At the centre of this Christian discourse is the conceptualisation of a self and a soul beyond discourse, a self and soul that is God's creation and in need of God's salvation. This same notion is implicit in subsequent psychotherapeutic discourse: a self *a priori* of discourse in need of liberation from inner imprisonment. Such systems of thought underpin Mika and Stewart's (2016) observation of the

> very primal need of the West to control how and when Māori will manifest as this or that, including as a wanting entity … the West has … canonically guessed Māori in advance as either needing or wanting something in particular, or generally being needing and wanting … Māori need and want and are henceforth productive; they ontologically match the expectations of the coloniser. (p. 305)

Thus, the fabrication of New Zealand was profoundly informed by the formation of a binary pair, the superior British saviour, and the indigenous other in need of being saved. And the scene is set for the psychotherapeutic white saviour of the heathen native patient's soul.

Discourse 2: Soma, sickness, and insanity — the self as a sick soma in need of healing

Subsequently the hegemony of Christian discourse in which the self is constructed as a soul in need of salvation was by the nineteenth century considerably under threat, as the influence of Enlightenment science, and the medical model informed by this science, increasingly challenged Christianity's monopoly on the discourses which fabricated the idea of the self. As Salmond (2017) noted,

> … the *Endeavour* expedition was a travelling sideshow of the Enlightenment, lavishly provided with scientific equipment to scan the heavens, collect and examine plants and animals, and explore the remote corners of the planet. … a mechanistic, quantitative vision of reality was going viral. Many aspects of life were transformed … As the mind's eye replaced the Eye of God, people were separated from Nature, and eventually from each other. … This "Order of Things", as Michel Foucault has called it, lay at the heart of Enlightenment science. (p. 34)
>
> … the *Endeavour* voyage epitomised this way of understanding the world. (p. 36)

Nietzsche (1887) argued that in the generations pre-dating Luther, the authority of the Church as the holder of the truth of the human soul was beyond question (see also Bluhm, 1956). Previously priests, and the written Bible, readable only by the minority literate population, to which priests and monks were a central part, were the holders of all knowledge, and indisputable truths arose from the word of God. Now in the "contest of the true", the nature of the "essential" "truth" of the "self" profoundly shifted. With the emergence of industrialisation, and the Enlightenment's emphasis on science, emerged a perspective in which the world could be known and the universe measured, a perspective which, for example, gave rise to the subjectivity of the botanist Joseph Banks and his scientific endeavours to measure the botany of the South Pacific in his voyages with Captain James Cook (Salmond, 2017).

Such scientific rationalism made the world, and the "souls'" who inhabited it, knowable in a way that the priesthood never could. Not only was the gaze of Enlightenment science turned upon the natural world and the hierarchy of human "races", but moreover this gaze, through the lens of medical science, came to penetrate the inner world of "man".

Insanity and asylums

An effect of this contest of the true was the emergence of Western mental health treatment in Aotearoa New Zealand, via the transportation of imperial medical scientific knowledge and the consequent manifestation of "insanity" in the Aotearoa New Zealand context, and thus the fabrication of lunatic asylums, in the mid-nineteenth century, eventually built throughout Aotearoa New Zealand, reflecting a Western medical lens that gazed piercingly into the mind and body of the human soma, and constructed madness, like the Indigenous of early colonial contact, as a thing to be disciplined, contained, surveyed, controlled, and perhaps even saved and cured.

Emergence of asylums

With the transnational transportation of imperial medical scientific knowledge into the Aotearoa New Zealand context, the self was no longer only a soul to be saved, but now also a sick, insane, soma to be treated, confined, disciplined, and perhaps healed. The power knowledge nexus of British imperial medical science gave rise to the most bizarre of imperial constructions, the asylum. As a correspondent to the Nelson Examiner wrote in 1864 in a letter to the Editor, entitled "The Lunatic Asylum":

> I see the lunatic asylum subject is again revived. What, then, is lunacy? …We know the common idea of lunacy is, that a person deprived of reason is mad, or does not know what he is doing, … But what does lunacy mean? Is it to believe that to be true which is false? …Very well; let us see how this rule will work in practice. One set in religion believes that to be true which another believes to be false and absurd. Are, then, those who were thus "labouring under delusion," as they say, to be put into a Lunatic Asylum, or, rather, Lunatic Prison? … according to the principles of the firm of Lunatic Asylum and Co., it ought to be done. I am, &c., The Ghost of Samuel. (sic) (3 March, 1864, p. 3)

Foucault (1967) observed in his lengthy *History of madness* that, "The language of psychiatry … is a monologue of reason about madness" (Foucault, 1967 cited in Rose 2019, p. 150). If psychotherapy is another manifestation of this "monologue of reason about madness", then the vast Gothic inspired fabrications of the asylum, and with it the dominance of so-called "moral treatment", are the physical discursive effects of this "reason monologue". For example, in 1884 Seacliff emerged in Aotearoa New Zealand, complete with panoptic tower, housing the insane, who were constructed as mentally unwell.

Michael King, in his biography of Janet Frame (2000), described the Seacliff of 1945 thus:

> In keeping with Otago's predominant culture of origin, the hospital's architectural style was known as "Scottish baronial". To non-residents, who feared both its patients and its staff, the turrets and mock battlements gave the building the appearance of a castle out of a Gothic novel or a horror movie.
>
> Seacliff was, in fact, a Victorian lunatic asylum, with all the qualities that designation implies. It was vast — the largest public building in the country for 50 years from the time it opened in 1884. ... the institution functioned in effect as a prison for most of the more than 1200 patients deemed to require custodial care. Treatment was limited to traditional work therapy [moral treatment], which for women patients meant sewing or cleaning duties, to electro-convulsive or insulin shock therapy, or to the operation known as prefrontal leucotomy, which severed many of the fibres connecting the front part of the cerebral cortex to the remainder of the brain and reduced some patients to a vegetative, albeit less anxious, condition. (p. 72)

By the mid-nineteenth century in England the medical monopoly over madness was firmly in place. As Knewstubb (2011) noted,

> These were the years of high imperialism in which the medical profession played an important part. Britain trained doctors for colonial settlements and imperial administrations ... Medical networks operated across national boundaries and the role of doctor as an agent of Empire is a story still unfolding. (Crowther & Dupree, 2007, p. 5, cited in Knewstubb, 2011, p. 27)
>
> Lunatic asylums were no exception to the operation of these medical "webs of empire". Doctors for colonial asylums brought British medicine as part of the expansion of "civilisation" to the new world (Knewstubb, 2011, p. 27).

Between the 1850s and the 1960s New Zealand constructed numerous vast asylums, later called mental hospitals. In less than a hundred years from Cook's first arrival, a union of transnational knowledge and power, in the form of the European medical model of the nature of self, had emerged, via the nexus of imperial dominance and Enlightenment science, enabling the construction of lunatics as people that needed to be housed in hospitals, and madness as needing to be treated, not "just" prayed over.

Asylums: moral treatment

The emphasis of therapeutic treatment in asylums in the nineteenth century was termed "moral treatment", and was captured by medical discourse, though, as described below, there was nothing very "medical" about it. It ostensibly focused on regular routines and occupational activities, outdoors for men and indoors for women. Cameron Duder (2007) noted in his history of Ashburn Hall,

> Moral treatment … worked from the assumption that insanity was curable. Practitioners thought that with an orderly return, everyday work tasks and a comfortable environment, patients would recover their self-control and master their illness. … *The individual's own desire to restrain him or herself was to be encouraged through social reinforcement, expectations, and rewards.* [Emphasis added] (p. 24)

As a description of a disciplinary technology, the idea that "moral treatment" might lead the individual to discover their "own desire to restrain him or herself" is evocative. As McNay (1994) noted,

> Far from being liberated, the mad are reduced, in the asylum, to a state of silence and shame and trapped under a perpetual, objectifying gaze that does not listen to madness in its own being, but obscures that beneath a condemnatory morality. (p 24)

Thus, Thomas Clouston, who had taught Dr Truby King, commented in relation to moral treatment,

> It is a law of our being that we must be orderly to some extent in our lives, while for the mentally unsound, order is an especially healing process. It is one of the chief symptoms of our patients that they have lost the sense of normal time and order which characterises sane and civilised men and women, and we must by our hospital arrangements endeavour to restore it to them. (Cited in Duder, 2007, p. 26)

The reference to "civilised" men and women reflects a handing of the baton from missionary discourse which informed the original colonial project to Aotearoa New Zealand in which the mind of the indigenous other, "psyche-nullius", was "discovered" as "fertile soil" to be transformed by the civilising substance which was Christianity; now civilisation was to be ensured by a medical discourse that permitted a moral regime to enable the transformation of the mad mind of the other to turn upon itself, to gaze into its own madness, and to transform itself into a civilised being.

However, the morality of this treatment was infused by the violence of the contest of the true, reflected, for example, in a newspaper article, appearing in the *New Zealand Tablet* in 1881, entitled "Infamy". It outlined concern for the humanitarian wellbeing of "inmates" in the Wellington Asylum.

> The report of the Royal Commission appointed to inquire into the condition of things in connection with the lunatic asylum in Wellington has been published, and the feelings with which it is read throughout New Zealand should be those of shame and burning indignation. The colony has suffered a deep disgrace, and human nature, in its most helpless and pitiable state, has been brutally used.

> Under the guise of a pleasing exterior, such as might well deceive the public eye, — a paraphernalia of billiard tables and pictures, periodicals, and entertainments, among which the patients were now and then exhibited, poor wretches who had incurred the displeasure of their keepers were exposed to the most atrocious treatment. *M'Cintosh*, a comparatively sane man, was taken from his bed at night, in the depth of winter, and subjected to a prolonged shower bath of ice cold water, from which he staggered out half fainting; *Feardon* was struck in the face with violence enough to bring blood from his ear; *Hall*, an inoffensive lunatic, was confined in that horrible instrument of torture, the straight-jacket, for several months until at last his release was enforced by a fall in which he broke his collar-bone. "A hasty word or act might call forth the fist of the superintendent, and a lunatic was punished for his lunacy." … All this is disgraceful to a civilised community, and reflects grossly on their Government. If madness were a crime it could not have been more harshly visited, or obtained less sympathy even on the part of those whose duty was its alleviation.
>
> The credit of the colony, then, so far as it is retrievable in this matter, depends on the fundamental alteration and amelioration of everything connected with the Asylum in question; It also depends to a considerable degree on the exemplary punishment of all found guilty of a part in the matter, according to these several measures. (April 22, 1881, p.13)

Indigenous "insane"

The links between humanitarian discourse, and medical discourse, in relation to the insane, is most profoundly revealed in the treatment of the "indigenous insane". As Swartz (2010) noted,

> Although [it was] not yet clearly apparent in the 1860s, colonial asylum doctors were soon to be faced with the problem of managing an insane population diverse not only in terms of class, but also of race, culture, and illness presentation. This opened a Pandora's Box of speculation on the psyche and insanity of indigenous populations, their intelligence and personality structure, emotions, and habits. Scholarly work inscribing the insanity in colonized populations as intrinsically different from that found in European countries became a thriving industry lasting well into the twentieth century. (p. 171)

Similarly, Burke's (2006) thesis examining the archive of the Auckland Asylum, in relation to the treatment of Māori patients, 1860 to 1900, reveals the "civilising" and "ordering" discourses infusing this treatment. She noted,

> In the colonial period, asylum authorities and physicians were preoccupied with the "civilising mission" for both Māori and non-Māori patients. The visibility of this language was particularly noticeable in descriptions such as "industrious in her habits", or "quiet and industrious, but stupid". Moreover, patients were categorised as "clean and orderly", as having "dirty habits", or as "prevailed on to stop his filthy

> habits". For Māori, like non-Māori, civilisation included cleanliness, orderliness and Christianity. However, for Māori, unlike non-Māori, it also meant the acceptance of Eurocentric notions of the "self" based on whiteness. For example, Hemi Te K's acceptance of this was expressed in his case records when he revealed that "he thinks he will have to lose his dark skin and become white". (p. 55)

Asylum summary

For 100 years, between 1852 and the late 1950s, asylums, later renamed mental hospitals, came to dominate the physical landscape, and the psychological territory, of the suffering human mind in Aotearoa New Zealand. They were places to survey, control, and ostensibly treat the suffering other. In the 1980s, liberal economic theory increasingly captured political discourse in Aotearoa New Zealand and informed the deinstitutionalisation of mental health patients and the move to "community-based" treatment. But this transition was preceded by yet another rupture in the systems of thought which informed the construction of the nature of self in Aotearoa New Zealand.

Discourse 3: Self and psyche: psychoanalysis and the mind

By the early twentieth century, the hegemony of medical science, and its dominance in claiming the mad body and self as its own, began to be challenged by a psychoanalytic discourse in which self now became constructed as a psyche in conflict, and in need of interpretation rather than medical intervention. The interface of these discourses and the tensions between them are revealed in newspaper articles of the time, as the medical man and the psychotherapist began to be fabricated by discourses of science, medicine, and psychoanalysis. For example, in an article in the Lyttelton Times in 1914, entitled "Science up-to-date: Psychotherapy", James Collier wrote:

> Our … universities in New Zealand … are still without this indispensable complement of efficient psychological teaching … What, then, does psychotherapy undertake? It undertakes, in the interests of health, to influence psycho-physical states — namely states of the mind-brain system, or occurring in other parts of the body that are somehow under the influence of the mind. It may be directed towards removing the sources of a disturbance, placing the patient under different conditions, curing the disease if possible, and acting "directly on the psychophysical state, inhibiting the pain, suppressing the emotion, substituting pleasant ideas, distracting the whole mind, filling it with agreeable feelings, until the normal equilibrium is restored". (January 17, 1914, p. 6)

In a follow up article Collier (1914, February 23) further commented:

> Professor Muensterberg is the ideal psychotherapist. … Following Freud, he invariably sets himself to find the origin of the particular obsession or disturbance, and its starting point. It is not always easy to find. Some strong emotional experience in early life had become the generating point of a persistent obsession; or it may have been a past episode, or an organic sensation, or only a chance experience … The antecedent

> cause may be indignation or fear, or surprise, or an accident. Having found it, his aim is to remove the freak idea, the unreasonable dread, the absurd consequence. He side-tracks it and switches it off by linking it with appropriate associations. All ways are to be used for this end. Sympathy and encouragement, reasoning (into which an element of suggestion often enters), persuasion (which is only a kind of suggestion), formal assurance are all to be tried. (p. 8)

In the *Ohinemuri Gazette*, 1920, an article entitled "Original sin girl: Mind healing cure" provides a description of a treatment by Dr Dodd,

> [a] specialist in the new treatment of psychotherapy or mind healing. … he first set about exploring the child's mind in an effort to discover some happening or emotion in the child's earlier life that had been "stowed away in the subconscious self" but was still upsetting the mental balance in another direction. … "This is a striking example of the wonders that have been worked by psychotherapy, or mind cure, which has been so extensively employed for the cure of soldiers suffering from war shock." (September 24, 1920, p. 3)

And in a letter to the Editor of the *Auckland Sun* in 1927, a correspondent entitled "Humanist" wrote of the need for psychotherapy rather than imprisonment of criminals:

> My opinion is that none of these unfortunate human derelicts should be dragged into court punishment at all, which is as inhuman as it is ridiculous. Their cases should be handled only by a trained psychiatrist who is the only one fully qualified to take charge of them. It is only psychotherapy which can get at the root causes of abnormality, and effect a cure, if possible, in the individual case … And in the meantime, the least one can ask is that any judge or magistrate called upon to deal with such cases should be first at any rate in the elements of psychotherapy. ("Sub-Normal Youths", August 12, 1927, p. 8)

Again, emerging from the transnational transportation of European knowledge, this time a psychoanalytic discourse, psychoanalysis transforms the sick body into a conflicted psyche, in need of the input from the expert of the psyche, still a medical man but now psychoanalytically informed. The confluence of psychoanalytic and medical discourse in the construction of subjectivity is further revealed in Dr Stuart Moore's article entitled "Psychotherapy", published in the *New Zealand Medical Journal* in 1913. In it he advocates for the benefits of Freudian informed analysis and hypnotism whilst describing the dangers of the non-medical quack:

> The subject [of psychotherapy] was far too long left in the hands of the unscientific. Unfortunately, by them it was submerged in a malodorous swamp of superstition, humbug and confusion of thought (p. 514) … this knowledge, which should permeate and influence our whole work in medicine, surgery, and midwifery, stands woefully neglected and quackery triumphant, spews forth its unscientific statement and

> superstitions on a credulous public. The overthrow of quackery must be brought about by the systematic attaining and dissemination of knowledge in the medical profession. … Despite all the nonsense with which this subject is popularly surrounded, I hope by giving a brief account of its modern scientific foundation to show that the line which divides true science from its counterfeit is here as everywhere, distinct. … Religion, morality, mysticism, have nothing to do with our subject. (p. 515)

And so emerged another battle for the soul and psyche of the citizens of Aotearoa New Zealand.

Founding of NZAP

These medical and psychoanalytic contests of the true are apparent in the words of Charles Bevan-Brown, the leading figure in the establishment of the New Zealand Association of Psychotherapists (NZAP) in Aotearoa New Zealand in 1947. Manchester and Manchester (1996) noted Bevan-Brown found New Zealand in 1940 to be a "psychiatric wilderness" and that "Medical students received little psychiatric training and almost no appreciation of the new neuroses and psychosomatic medicine" (p. 11). Further, they commented,

> [Bevan-Brown] expressed great concern that [medical] conditions of psychological origin or with a psychological component are too often treated by medication or even surgery. Those of us who looked back to the 1940s can remember surgical procedures regularly performed and talked about, that seem to be of only minor consequence and incidence today. [Bevan-Brown] is alleged to have said "God help the masochistic woman who meets up with the sadistic surgeon — she will almost certainly lose some of her organs." (p. 11)

His warning brings to mind Janet Frame's close call with psychosurgery. Bevan-Brown further perceived that the inhabitants of Aotearoa New Zealand appeared blind to the reality that central to emotional health is the care of the infant. Manchester and Manchester (1996) further commented,

> In putting forward new and radical ideas on "natural" childbirth, home confinements, mother-infant bonding, early child care practices, relaxation of the rigidities of the Plunket system, restraint on physical punishment of children and advocacy of abolition of corporal punishment in the school system, and radical reduction of the use of electroconvulsive therapy in the treatment of mental illness, Dr Bevan-Brown became surrounded by a somewhat "frosty" professional climate and to be regarded by some as an "impractical crackpot". (p. 15)

In the contest of what is able to "enter the true", there arises a new truth regarding the nature of self, a "psychoanalytic infant true self" and a governmental technology in the form of psychotherapy, that might facilitate this truth into existence. In more recent times, the apparently hostile companions of psychoanalysis, cognitive behavioural therapy, and the humanistic traditions, have gained more traction within psychotherapy in Aotearoa New

Zealand. Yet, whilst we erect fences of disagreement between them, these approaches all share a belief that the truth about, and freedom for, the self, rests in the power of the individual to liberate themself from inner constraint.

Discourse 4: Wairua and the indigenous challenge

Moreover, the hegemony of Western therapies in relation to the construction of psychotherapy and the nature of self in Aotearoa New Zealand have, in the past 40 years, ruptured again with the Indigenous challenge.

In 1986 a paper at the NZAP conference was entitled "Understanding the Maori", a title disturbingly resonant with Mika and Stewart's (2016) Māori other, a "needing and wanting entity". Since 1986, Māori authors and clinicians have vehemently asserted an Indigenous challenge to this positioning of Māori as the sick one in need of the white therapist's healing powers. In so doing we come full circle, as Indigenous Māori refuse the discourse that preceded and informed the colonial project in New Zealand, that of the superior white saviour and the heathen Māori other to be saved, instead articulating an Indigenous psychotherapy in which the need to free the "colonised self" is central. Paraire Huata, in his provocatively entitled paper "Māori psychotherapy — A cultural oxymoron" (2010), commented,

> Before you cross my border, let me give you some glimpses of what you will encounter.
>
> You will hear a different language. You will see a group, a community. You will smell a different aroma, you will taste food for the mind and spirit. You will touch beyond the constraints of the physical realm. In fact, you will be bombarded with a cacophony of sounds and images that may tell you that you are in a foreign land. Perhaps you are. (pp. 4-5)
>
> The term Māori psychotherapy is an oxymoron. As we know an oxymoron is a figure of speech that combines two normally contradicted terms. …
>
> Psychotherapy in many ways represents the clinical expressions for a Eurocentric modality best understood as being of the predominant culture. Is psychotherapy a noun or an adjective, I'm unsure.
>
> Under the notion of biculturalism then we are often forced into an oxymoron. (p. 5)
>
> I trust then that the journey you have as an association embracing all of your differences and struggling to not talk past each other will bear fruit that your grandchildren will gladly consume together. (p. 6)

Even in his assertion of the oxymoron of Māori psychotherapy, he gestures to the freeing of the Indigenous self, as Māori bombard non-Māori psychotherapists "with a cacophony … [from] … A foreign land". Subsequently, Māori clinicians such as Morice & Woodard (2011) have argued that,

> the need for a Māori psychotherapy is relatively obvious to anyone who is Māori. The purpose of a Māori psychotherapy is no different from the purpose of a Pākeha psychotherapy for Pākeha [non-Māori of European descent] or tau iwi [non-Māori]. However, as long as psychotherapy remains mono-cultural, it will remain unable to meet the needs and aspirations of Māori practitioners and Māori clients. (p. 15, cited in Hall, 2015, p. 80)

Therefore, Reidy (2014) for example, proposes a conceptualisation of a mana enhancing psychotherapy, whilst Fleming (2016) proposed that attachment to matauranga Māori, to whanau, and to the nonhuman world, is essential. Similarly, Hall (2015) argued that "for Māori, these attachments are fostered through a dynamic whakapapa system of Tūhonotanga" (p. 132).

Woodard (2008; 2019), also wrote of the Indigenous self, a self inextricably intertwined with whenua; that tangata whenua literally means "people — land", there is no "of" conjunction. Connell (2008) more broadly explored the production of knowledge within social sciences and articulated what she described as a Northern bias in the production of this knowledge. She argued for theories arising from and specific to a Southern perspective that might "present and represent experiences from the periphery and, therefore, that reclaim erased wisdom, knowledge and experience" (Tudor, 2018, p.132). Woodard (2014) also argued that the Tohunga Suppression Act (1907) is a painful example of an attempt to maintain the dominance of Western approaches to psyche and to disable Indigenous knowledge, whilst Morice et al., (2017) proposed that,

> through the lens of te Tiriti, Māori psychotherapy would be actively encouraged to develop itself, both as a modern, westernised approach to care for the psyche or soul, and as a contemporary indigenous social healthcare practice rooted in traditional Māori values, worldview, and healing practices. (p. 126)

Māori and the therapy of the psyche, prior to European contact

Of course, Māori therapy of psyche had been practiced for many centuries before European contact. Indeed, Tudor (2018) noted that the phrase "indigenous psychotherapy" has probably been utilised only relatively recently, citing Torrey (1970) as a possible beginning point, whilst suggesting that the practice itself may well have a much longer history (p. 66, and p. 76, footnote 116). For example, Salmond (2017) described the death of the Māori Rangatira Ruatara, in 1815, in which,

> Convinced that Ruatara's hau was being assailed by Atua (powerful ancestors), perhaps those of the Europeans, the tohunga (priest) isolated the young chief from all but his closest relatives, and tried to prevent the missionaries from visiting the tapu enclosure. … The scene was set for an ontological collision, with Ruatara's life in the balance. Competing cosmologies swirled around his sickbed. Ideas of ora and life, mate and death, tapu and the Christian God, atua and Satan, hau and the immortal soul battled it out over his wracked, tormented body. (p. 58)

It is the dominant construction of psychotherapy, rather than the fact of its Indigenous practice, that is now rupturing, as a further contest over what can "enter the true" is well under way.

Pastoral power and the violence of kindness

Each of these ruptures in the discourses constructing the nature of self were, and are, ostensibly informed by apparently benign attempts to tend to the wellbeing of humankind. Christianity, attempting to save the Indigenous other in service of our own souls; medical science, attempting to heal the sick soma; psychoanalysis, attempting to free the psyche from its conflicted torment; and Indigenous knowledge seeking to free a colonised self. Each in its own way appears to seek to participate in the emancipatory project of being a self, freely and truthfully, the utopian possibility of a self free of oppression and subjugation. As Nikolas Rose (1999) noted,

> Even when professional help is needed, one of its first tasks is to help individuals "come to a belief in their own ability to make changes in themselves and their lives". Therapy is no attempt to enforce conformity but apparently part of a profoundly emancipatory project of learning to be a self. (p. 242)

Of course, freedom and truth have been such central pillars of psychotherapeutic work. Winnicott's true self (1965), the spontaneous gesture of the infant held in maternal preoccupation; Brandchaft's (Brandchaft et al., 2010) imprisoned spirit, emerging from its intrapsychic cell; Jung's (1966) individuation from the collective; Bion's (1962; 1970) transformations in "O"; and Woodard's (2008; 2019) indigenous self of whenua and tangata, all speak to the idea that there is an inner self, whether intrapsychic, interpersonal, sociocultural, or transpersonal, seeking expression and freedom and truth.

However, paralleling the emergence of psychotherapy as a technology of self, ostensibly enabling truth and freedom, has been the development of Aotearoa New Zealand as a political entity based upon a capitalist and increasingly neoliberal economic philosophy. Neoliberal economic ideology also seeks to "free" us, but in a particular way: to be free to serve the needs of the market. As Dean (1999) noted,

> [in] The liberal economy of government … knowledge … from social economy … social statistics to criminology, educational psychology, sociology, and beyond, … become the "dialogical partners" (Weir, 1996) of liberalism's process of self-critique, self-review and self-renewal. (p. 128)

This birth of the emotionally "true" self serves the development of autonomous individuals free to choose to be the productive self required of the post-war colonial citizen. And the confessing psychotherapeutic self is the means by which we learn to become this self; a confessing self, ubiquitous in contemporary Aotearoa New Zealand, in which every aspect of our lives is psychologised, from body image, to sporting skills, and newspaper columns provide psychological love life advice to the lonely and forlorn. Indeed, it is notable that the emergence of the psychoanalytic discourse of the confessing self within the Aotearoa New Zealand context, extending beyond the parameters of the psychotherapeutic office, is not a new phenomenon. For example, in a lecture entitled "Suggestive therapeutics" reported in *Kai Tiaki: The Journal of the Nurses of New Zealand* and given to the members of the Wellington Provincial Masseurs Association in 1923, the presenter, Dr Eardley Fenwick, proposed,

> I must just hark back for a moment to the cause of psycho-asthenic states. The emotions are at the bottom of all — fear, love, hate, anxiety — ... [The patient] succeeded however in suppressing, or rather repressing this shock. ... Now if this repressed incident, incidents, unpleasant experiences, or emotional disturbances can be discovered and brought to light, the patient is half way on the road to recovery. This is, roughly, the raison d'etre of a form of psychotherapy elaborated by Freud's psychoanalysis. And the essentials of it are the discovery of the repressed emotional injuries in the subconscious mind, and the bringing of them to the surface so that their relation to the present illness may be demonstrated to the patient, and that he may deal with this by a reasoning process of his conscious mind instead of allowing it to deal with him by an unreasoning emotional process of his conscious mind. (p. 99)

In Rose's (1999) critique of the psycho-therapeutically produced self, he suggested,

> Psychotherapeutics is linked at a profound level to the socio-political obligations of the modern self. The self it seeks to liberate or restore is the entity able to steer its individual path through life by means of the act of personal decision and the assumption of personal responsibility. It is the self — freed from all moral obligation but the obligation to construct a life of its own choosing, a life in which it realises itself. Life is to be measured by the standards of personal fulfilment rather than community welfare or moral fidelity, given purpose through the accumulation of choices and experiences, the accretion of personal pleasures, the triumphs and tragedies of love, sex, and happiness. (p. 258)

Winnicott's (1965) true self, Jung's (1934-39) transpersonal Self, and Freud's (Breuer and Freud, 1957) transformation from misery to ordinary human unhappiness, with the capacity to love and to work, all speak to this possibility of "freedom" to be a self, autonomous, independent, and productive. Tragically, psychotherapy is littered with the horrendous consequences facilitated by the minds of "free men" inhabiting the role of holder of truth and healer of the psyche, whilst hurting those we seek to heal.

Homosexuality and the dark other

Perhaps one of the most graphically painful manifestations of psychotherapy as a dangerous material effect of discourse is reflected in the history of the psychotherapeutic treatment of homosexuality, including here in Aotearoa New Zealand. Basil James, a former President of NZAP, was one of many whose minds were captured by a medical and psychotherapeutic discourse that pathologised homosexuality. Whilst in Britain in 1962, he wrote a paper entitled "Case of homosexuality treated by aversion therapy". He described a disturbing behavioural treatment in which nude photographs of men were paired with an emetic dose of apomorphine by injection, inducing nausea, whilst

> The aversive effect of this pattern [of same sex sexual attraction] on [the patient] and its consequent social repercussions was then described in slow and graphic terms ending with words such as "sickening", "nauseating", etc., followed by the noise of one vomiting. (p. 769)

In 1967 in the *New Zealand Medical Journal*, James wrote an overview of behavioural therapeutic principles informing the 'treatment' of homosexuality, noting,

> Behaviour therapists view homosexuality as a symptom, a biologically and socially maladaptive response, … [and thus, aversive] techniques are roughly of two kinds — those using chemical and emetic agents and those using electric shock … apormorphine technique seems to have been largely replaced by the use of unpleasant electric shock delivered from finger electrodes as the aversive stimulus. (1967, p. 252)

Tragically, medical and psychiatric discourses in relation to race, gender and same sex attraction combined in even more disturbing ways, as outlined in Laurie Guy's article "'Straightening the queers': Medical perspectives on homosexuality in mid-twentieth century New Zealand". Guy (2000) described the psychiatrist Laurie Gluckman, who, in 1966, gave a diagnostic summary of 100 lesbians he had treated, labelling 68 with terms such as psychotic, prepsychotic, and psychopathic (p. 113). In relation to Māori, Guy noted, that Gluckman,

> once labelled certain Māori lesbians as suffering from "heterochromophobia", that is, from "a sexual neurosis in which sexual expression is stimulated by a racially different skin colour to that of the patient". (Guy, 2000, p. 113)

Similarly, the dark shadow of race theories appropriation of Darwinism and the Christian "Great chain of Being" (Young, 2004) is reflected in racialising discourses uncomfortably revealed by Johnstone and Reid (2000), in which the researchers interviewed 247 psychiatrists regarding their training and its effectiveness for helping work with Māori clients. They noted, "11.3% all male, all New Zealand born, and with 10 or more years' clinical experience, believed that Māori were biologically or genetically more predisposed than others to mental illness" (p. 135). Numerous racist qualitative comments included the following,

> This questionnaire is worthless! I mean the Maoris (sic) are always going on about the importance of land etc, etc, so why did they bloody well give it away. They went

> on about the importance of forestries and lakes and then that bloody idiot cut down the tree on One Tree Hill. I feel that they are getting the appropriate services they need, just not using them, medication is the answer — but they just don't take their pills — if cannabis was prescribed, I'd bet they'd bloody take that. (p. 142)

Me on the couch

As someone who has lain on the couch of psychoanalysis for decades, seeking to enhance my authenticity, authority, and autonomy, to quote Chris Milton (2013), it is frightening to consider how the discourses I have just described might course through the fabric of my being, and constitute my very subjectivity.

The Christian discourse of missionary zeal encouraged me to choose the confirmation name of Francis, as the shy 12-year-old that I was sought to inhabit the priest like identity of my Catholic faith, guided by the prayer of St Francis (2022):

> Lord, make me an instrument of your peace.
> Where there is hatred let me sow love;
> Where there is injury, pardon;
> Where there is doubt, faith;
> Where there is despair, hope;
> Where there is darkness, light;
> Where there is sadness, joy.
> O Divine Master, grant that I may not so much seek
> To be consoled as to console;
> To be understood as to understand;
> To be loved as to love.
> For it is in giving that we receive;
> It is in pardoning that we are pardoned;
> And it is in dying that we are born to eternal life.

The asylums, subsequently relabelled mental hospitals, infused my childhood; my aunt with whom I lived, worked as a social worker at Kingseat Hospital for decades. In the 1970s I would go to Kingseat open days, fairs, and picnics, mingling with the patients, doctors, and nurses, bewildered and enchanted by the strange and fascinating conversations that emerged. St Francis was right at home. These encounters shaped my choice of profession, as I discussed with my aunt the possibility of becoming a social worker, then discovered such a thing as a psychotherapist which seemed to inhabit similar terrain. I still immensely value residential therapeutic communities, having been part of initiating one with Segar House 23 years ago.

Psychoanalysis introduced me to an inner self, the shock of discovering an inner world perpetually bubbling beneath the surface, informing my every move; this now felt the answer to freedom and truth. Before Indigenous discourse shocked me out of my slumber, inviting me to wairua, to Māori, to hongi, mauri, and the breath of life. Perhaps the indigenous ally, rather than saviour, was my true psychotherapeutic home.

The true self

Foucault had little time for the concept of a "true self", an inner truth to which we might listen, and which might be enabled by the confessional act of psychotherapy. He critiqued faith in such a possibility as a misguided belief and enactment of Christian pastoral power and a regrettable belief in the idea that freedom might reside in the confession of one's inner truths. Such inner revelation, Foucault suggested, merely reflecting the emergence of a self fabricated by the discursive systems of thought of the time. Jung's dialogue between ego and the trans-personal and transcendent self is reduced, through a Foucauldian lens, to a self-deception, in which we mistake the phenomenological experience of freedom, inner truth and numinous connection, as evidence of relationship with a transpersonal Self, rather than, as Foucault would argue, yet another manifestation of discourse and its material effects.

Is my subjectivity inevitably formed by discourse, unable to transcend it, as I wrestle with the difficulties of staying with uncertainty, fear, and doubt, my own and my patients, in relation for example, to contemporary transgender experience, and the discourses that traverse this terrain? Will I inevitably repeat dangerous discursively informed clinical practice, even as I seek to do my "Christian Good", a white saviour repeating the cultural unconscious of our discursively constructed times? Or is there a way for me to inhabit my self, beyond discourse? I do not know. Nevertheless, clinical moments and the work of C. G. Jung, Thomas Ogden, Wilfred Bion and others inspire possibilities in me, as does Basil James.

Helplessness and ignorance

Subsequent to his dangerous pathologising of homosexuality, James, in 1999, offered an emotional reflection in which he regretted the harm which he had perpetrated. Guy (2000) quoted James as writing in a personal communication to him, that,

> The treatment of the [homosexual] patient which I published not only, it now seems to me, sought to incorporate some of the avant garde thinking of the day (learning theory) but much more importantly, *helped me to deal with my helplessness and ignorance*. [Emphasis added] (Cited in Guy, 2000, p. 117)

Helplessness and ignorance. Perhaps the feeling psychotherapists most fear is helplessness. We will do anything but feel helpless. Perhaps it is in this moment of utter incapacity, by which I do not mean a glib lip service to Bion's without memory, desire or understanding, Keats' negative capability, mystery, uncertainty, and doubt, but rather a determined willingness to surrender to such undoing states.

To feel, particularly states of helplessness and ignorance, fear, desire, hate, love, disgust, shame, or sexual passion, without evaluation of myself as a good or bad therapist. Such evaluation inevitably requires a flight from these disturbing affective states, leading us, I suggest, to take refuge in a submission to the contemporary systems of thought of the cultural unconscious which construct the "truth" of the psyche in any given episteme. When I flee such disturbing and affective states, I cannot dream my thoughts, as Bion would encourage, I cannot bear the uncertainty of ignorance and helplessness. I am too tempted to reach impulsively for the refuge of certainty and action, of prescription drugs and electric shock treatment, with leucotomy as a last resort. I am too frightened to allow the pictogram of my dreaming mind to slowly form into a Lego block of thoughts about feelings.

By contrast, if I am courageous enough, is there the possibility of an emotional contact, an intimacy, unconscious to unconscious, that enables me to glimpse beyond these discourses? James hints at the possibility of transformation that exists in managing to bear our helplessness, of not being captured by the need to fix, heal, and cure. Do the discourses of Christianity, medicine, metapsychological psychoanalysis, perhaps even Indigenous critique, command my mind to know? Or can I bear the possibility of feeling something and knowing nothing?

Thinking and dreaming

The potency of Wilfred Bion, I think, is in his conceptualisation of the process of thinking that the mind is a pictogram, continually dreaming itself, an unconscious cinema, playing beneath the surface of our awareness. Ferro (2011) wrote,

> I believe that the "waking dream thought" (Bion, 1962) is the most significant and important of [Bion's] concepts. … our mind … constantly creates a continuous operation of "alphabetisation" of all the sensory stimuli and proto-emotions that we receive. The endpoint of this operation is the formation of alpha elements, which, when we put them into sequence, produce the waking dream thought (p. 155). … The mind that brings about this transformation does not only transform the proto-sensorial and proto-emotive chaos into affectively meaningful representation, but, through the constant repetition of this mental work, it also transmits "the method" [of thinking] employed to achieve this (a function). (p. 162)

What this means for how we might inhabit the therapeutic moment is poetically captured by Thomas Ogden (2001):

> … the analyst must be able to experience ... what it feels like being with the patient; and yet, for the most part, these experiences are unconscious. The analyst is initially, and for quite a long time, more "lived by" these predominantly unconscious feelings than he is the author of a set of thoughts, feelings, and sensations that he experiences as his own creations and can name for [her] himself. A good deal of my work as an analyst involves the effort to transform my experience of "I-ness" (myself as unselfconscious subject) into an experience of me-ness, (myself as object of analytic scrutiny). (p.19)

Central to the phenomenology of what Ogden describes is the capacity for reverie: to hold the dream thoughts of our mind, evoked in the presence of our dreaming patient, in our mind, even as these fleeting fragments slip illusively from us.

Jung (1966) described, in his psychology of the transference, the encounter, unconscious to unconscious, of the pictogram of the mind of patient and analyst. Ogden (2001) and Bion (1962) encourage my phenomenological enquiry into these fleeting dreams thoughts, slowly allowing them to cohere into representation of inevitably disturbing affective states, and Foucault (1967) warns me that to react too quickly is to risk enacting the discourses of our time. To do so, I suggest, is to avoid inhabiting my self, feeling, dreaming, and eventually thinking, recognising the immense emotional labour such a stance requires. If psychotherapy is not to be a further "monologue of reason about madness", then our only hope is to surrender to, and linger with, the irrationality of the encounter, unconscious to unconscious, therapist, and patient.

The disobedient Foucauldian

In the end, I'm not a very disciplined or obedient Foucauldian.

Jung suggested that symbols of the self that emerge in dreams are the royal road to wholeness, and that the dream symbols of the self, are "the best possible representation of a relatively unknown fact" (Jung, 1971, p 474). It is from these origins that Fordham (1993) articulated the notion of a primary Self, a priori of early relational experience and of discourse. Such a formulation is in complete contrast to the Foucauldian perspective in which self is an effect of discourse. But if identity is formed by discourse, what then is discourse formed by? I suggest the systems of thought which give rise to our subjectivity, are also preceded by a Self that gives birth to these systems of thought. As Grotstein (2007) put it:

> Not only did a mind develop to harvest the "thoughts without a thinker", but another aspect of the mind had to originate those unthought thoughts. (p. 67)

And as Jung, in his articulation of the notion of a transpersonal self, continually emphasised, such a self can only be known via experience. He noted:

> … you cannot say anything definite about it [the Self] because it is greater than you. You can only stammer as if in the presence of a greater one. And you are right if you stammer and are embarrassed, not finding suitable terms or analogies. Then you do it justice. (Jung, 1934-9, p. 432, cited in Huskinson, 2002, p. 443)

In psychoanalytic psychotherapeutic work we are invited to listen for the derivative manifestations of the unconscious as they reveal themselves like fragments of a dream, elusive to our minds, but able to be glimpsed if we linger like Ogden, patiently and attentively. And perhaps it is this experience of subjectivity, which, if we are emotionally brave enough, might allow us to glimpse beyond discourse, beyond the nexus of power and knowledge that gives rise to much that we experience as subjectivity, and to encounter the numinous beyond our conscious knowing: the symbolic that allows a representation of otherwise relatively unknown experience, and the possibility of subjectivity a priori of discourse.

Clinical vignette one[2]

Michelle, whose horrific history of early relational horror had emerged relentlessly in the tumultuous first three years of our therapeutic work, arrived withdrawn and cautious. We explored her longing for closeness and Michelle said:

> You know how you sometimes talk about me holding you in my mind in between sessions. And how I don't seem too good at doing that. … I think when we have a sucky session … it seems that you stop existing in between sessions … I don't feel … you know, how to explain it. I know you are not really gone but you stop existing. I also know I can't contact you no matter how much I might want to because you stop existing.

She appeared fragile and I felt protective and anxious. She further expressed,

> It is hard to explain the disintegration I so dread. … a feeling unlike any other. As if someone picked up an eraser and started to slowly wipe me out of existence. They started at my feet, disconnecting me from the world around me. I can feel myself floating and I know that I have to stop them from erasing me entirely, for if I am erased completely, I will never be able to come back. I will not be able to re-form, and people will never be able to connect to me again.

In the next two sessions Michelle explored with me her impulse, when feeling as if neither she nor I existed, to make sexual contact on the internet, and her corresponding urges to seduce me, converting the feeling of powerlessness and disintegration into a feeling of contact, existence, and potency. Ogden's (2001) notion of the autistic contiguous position emerged in my mind: I wondered with her if sexual contact reflected a primitive longing to be physically held, offering the potential of a feeling of self when she felt no self existed. Michelle expressed her fear that if she was vulnerable with me this would expose "weakness" which I might exploit or abuse. I felt furious, my thinking disabled, as I remembered the cruelty of a man who had sexually assaulted Michelle in the very moment she had revealed vulnerability and longing. She had the following dream:

> I'm on a bike, there are a big group of about 20 people waiting for the light to turn green so we can all bike. Too late, I notice two police officers on the bikes, across the street. … They start chasing me on their bikes. … I fall off my bike. Two cops picked me up and want me to spend the night in jail. Then you're there, and you offer to keep an eye on me, and after you promise not to let me out of your sight, for even one second, they allow me to go with you, instead of taking me to jail … I want to move closer to you … But I'm scared you might find that inappropriate and send me to jail anyway.

The dream left me tender, and fearful: I feared that closeness could lead to danger, transgression, and imprisonment. I attempted to linger with the fear.

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2 Names and other identifying material have been altered to ensure client anonymity. As noted earlier, the use of the first person 'I' refers to the first author, John O'Connor, in relation to these clinical vignettes.

In a subsequent session I walked into my waiting room to find her barricaded with cushions between her and me, sitting on the floor hugging a soft toy. Taken aback, I said nothing. She looked sad. I glimpsed tears, not with my eyes, but with all aspects of my being, a pictogram of my mother's ferocious grief, my grandmother's soft and mournful tenderness, my brother's destructive losses. These passed my mind in an instance, like misty rain in the early morning, barely perceptible. And then my childhood cat, Tiger, curled onto my bed, comforting the seven-year-old in me from the winter cold. He snuggled with me safely, pricking my mind awake.

Looking straight ahead Michelle spoke quietly. "I don't want to see you today." The shame of my own shyness, hidden beneath my winter blanket, reassured me. Somewhere I knew this meant she wanted me to be with her, but not to look at her. I sat in a chair, in the waiting room, four or five feet from her.

> John: "That's OK … I'll just sit here."
>
> Quietly Michelle began to cry her tears. I looked out the window, avoiding intrusion. All the griefs of my life and hers were with me now.
>
> John: "You're sad today."
> Michelle: "Yes."
> John: "Do you want to tell me what you are sad about?"
> Michelle: "I'm just sad …"

Together we explored the many things she felt sad about, particularly the cruelty and reactivity of her family's rage and the empty terror this left in Michelle. Subsequently she wrote, in her journal:

> Today felt like a significant day. After more than three years with John … I cried with him for the first time. I have struggled so hard to keep myself from losing it. To keep myself from falling apart. Yet today the little girl inside me curled up in the waiting room, with her cloth rabbit clutched close to her chest, barricading herself in the corner with two chairs.
>
> And I cried. And cried. And John bore with me.
>
> He sat down on the remaining chair and respectfully allowed me my space by not looking directly at me and staying well away from my line of vision. We talked and we were quiet, and as the tears subsided I could feel myself slowly being reformed. I had dreaded this moment for months, years even, for fear of falling apart and not being put back together …That if I would start to fall apart, I would disappear, for John wouldn't be able to glue the pieces back together ... And yet today, this is exactly what seems to have happened.
>
> As the tears started falling, I could feel myself grow smaller. I … barricaded myself

> behind two chairs, where my quiet sobs would not be ridiculed, nor punished. And when John walked in to get me for my session, he just sat down and was gentle with the little girl sobbing on the floor and "held" her as much as he could, from one chair away.
>
> Today, I cried.

Existence

As my patient encounters her experience of not existing, and then in the tenderness of our therapeutic relationship discovers the possibility of being "reformed", what is this subjectivity that comes into "existence" in her own mind: is it a subjectivity formed by discourse? Or is there a self, prior to discourse, a primary Self as Fordham (1993) conceptualises, which comes into being, in the encounter between us, unconscious to unconscious? This is a question with which phenomenologists and Foucauldians have so often wrestled.

Subsequent dream

Many years later Michelle revealed the following dream:

> My parents are arguing, and I feel really tense. You walk next to me and you keep encouraging me: "You can do this now, you've come through way worse than this, it's ok, you can do this now." We walk close to each other, it isn't sexual, and it's not even fatherly. Maybe a bit fatherly, but the way a father would treat his adult daughter, not his young daughter. [A friend] treats me the same way if my parents drive me nuts. There's something really gentle about your presence. I feel myself calm down.
>
> … I felt really, really moved, comforted in a way; my dream this time was very different from any other dream I have ever had about you. It felt like we were a partnership, without that taking away from my adult self. I didn't have to be five years old to get your closeness and I didn't have to seduce you either. I felt encouraged by you that I had the strength to get through whatever I needed to get through.

Psyche had manifested what Jung had described as a symbol of the self, "the best possible representation of a relatively unknown fact" (Jung, 1971, p. 474), the "dream" union of her frightened child and the dream John within her who said "you can do this". Can we trust what psyche offers us? Can I offer a relational experience which facilitates this dream union, bearing the terror of my own helplessness and ignorance, neither fleeing to the medical discourses of clinical safety and from the dangerousness of sexual feelings within the brick mother of the clinical office, feelings, which, if I did not linger with them, I might, as Michelle once expressed, enact by "locking her up"? The word symbol comes out of the Greek syn, and ballien, meaning thrown together. Thus, a symbol is always something "thrown together" by the psyche, representing more than can be known by the conscious mind. This symbol formation capacity invites us to trust the fleeting pictogram of our mind, to feel and think, and think about feeling, allowing us to glimpse into a world beyond discourse, perhaps?

Clinical vignette two

After several years of frightening and moving work, the older Māori woman in front of me stood to depart for the last time. She walked towards me, I felt fearful: was she about to kiss me? The shy boy of my youth prepared to retreat. She slipped her hand into mine, used her other hand to pull my shoulder close. I glimpsed her intention to hongi. Unthought thoughts of the marae moments of my life filled me: All Black haka and tearful tangi, standing at the waharoa and the grief of the unmourned losses of my British ancestral history, heaved within. I lost all sense of my authority as white analyst. She pressed her nose into my nose. A hongi. We breathed the breath of life together. A uniquely Aotearoa New Zealand psychotherapeutic moment. In my relationship to St Francis, did I enact the white saviour? Or as our hands held each other's, my nose against her nose, our breath together, did this offer something new, as I surrendered to my ignorance and helplessness?

Is this what Foucault might mean by creating myself as a work of art each day? The art of feeling without submission, but with surrender, embracing my ignorance and my helplessness, and offering the possibility of feeling something with another?

Conclusion

Foucault once said,

> My point is not that everything is bad, but that everything is dangerous, which is not exactly the same as bad. If everything is dangerous, then we always have something to do. (Foucault, 1983, pp. 231-232)

I would rephrase his final word. Then we have something to feel, and to think. Bion once, perhaps apocryphally, is said to have advocated, "Don't just do something; sit there!" (Symington, 1986). This seems a counterintuitive, and indeed kind of mad, idea in a world as chaotic and as disturbed as we inhabit at the moment, that someone would encourage us to sit rather than to act. Certainly, action is important, when the madness of climate collapse, nuclear war, and pandemic terror threaten our very survival.

And yet there is in our world today such an absence of the counterintuitive impulse to think and feel, and feel and think, deeply about things, before acting reactively or prematurely. All of my many and sometimes dangerous clinical mistakes have come when I have refused to feel something of the helplessness, ignorance, and terror of my own inner world in relation to another's, and instead to enact a knowing, in so doing grasping whatever the discourses of the time demand of me, creating myself as the Christian saviour of the heathen other, avoiding, as James so honestly described, "my ignorance and helplessness". Yet there have been clinical moments of beauty. The sharing of breath, and the dreaming of feeling. As a loving supervisor once encouraged, the unconscious is indeed a shy beast, we are wise not to pounce.

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