Psychoanalytic Reflections on Wairua and Trauma: Spiritual Holding at a Māori Mental Health Service in New Zealand

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Abstract

Psychoanalytic work within a cultural framework of a Māori mental health service raises central questions of the socio-political dimensions of intergenerational trauma as part of the impacts of colonisation. Importantly, the sacred aspect of this trauma is addressed, often dismissed in Western political thought as secondary, yet so central in most indigenous experiences. In this article, some thought is given to the complexities of this work in regards to "spiritual holding", a means of addressing and healing the politico-sacred wounds of a person.

Waitara

Mai i ngā mahi tātarihanga hinengaro i raro i te ahurea ratonga hauora hinengaro ka ara ake ngā pātai mō ngā taha hāpori-tōrangapū whakapā atu ki ngā whetuki tirohia ā-rēanga, arokorehia ai mai i ngā whakaaro tōrangapū Hauāuru, ahakoa te noho pū ki te maha o ngā wheako tāngata whenua. I tēnei tuhinga, ka whāia ētahi whakaaro ki te uauatanga o tēnei mahi arā, te 'pūnga wairua', he huarahi aronga whakaora hoki i ngā mamae rangapū-tapu o te tangata.

Keywords: psychoanalysis; culture; colonisation; sacred; spirituality; wairua

The Pillar of Wairua

Manawanui is a state-funded Māori mental health service of the Auckland District Health Board. Although important, it is beyond the scope of this paper to address the *whakapapa* or genealogy of the tragic trajectory of mental health services for Māori (Kingi, 2007). Manawanui has adopted the indigenous Māori mental health model of *te whare tapa wha* (the house of well-being) as a holistic model of Māori health or well-being. This model

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formulates four major pillars or aspects of well-being, the corners of the house of well-being, namely *whanau* or the family health, *hinengaro* or mental health, *tinana* or physical health, and *wairua* or spiritual health (Durie, 2001). These four pillars hold the protective space of health and well-being for Māori and in fact, it could be argued, for most people.

Distress is the result of an imbalance of these four aspects, and healing would require ideally the involvement of all four cornerstones. In this manner, Māori mental health is more clinically sophisticated than the common Western psychiatric medical model. For example, schizophrenia or psychosis within a Māori mental health model is not merely addressed as a brain disease with medication, or is only considered to be an intra-psychic process (*hinengaro*) engaging talking therapies, but rather requires the addition of understanding the *whanau* (extended family), the whole body (*tinana*), as well as the spiritual (*wairua*), which leads to an integrated intervention of healing the whole person. For me as a consultant clinical psychologist, this clinical-cultural interface avoids reductionism and enhances clinical depth and range (Lambrecht, 2017a). So emotion regulation groups (Linehan, 1993) together with psychodrama called *Pae Manawa* can be run applying the wisdom of the *atua* or the gods, or a mentalization based treatment *Whakaaro Roopu Hui* (Bateman & Fonagy, 2004) group which has been run for over three years within a cultural framework.

In New Zealand, the *tohunga* (Māori shaman) considers mental health difficulties to be the result of intergenerational afflictions between the living and the *tupuna* or ancestors (Hiroa, 1910). This is not so different from genetic, psychoanalytic or attachment theories of mental health. The *whare tapa wha* model gives me as a therapist the opportunity to access thinking that Western psychoanalysis and psychology struggles with, such as body-mind issues, political-systemic processes, as well as working with "anomalous" or exceptional experiences that belong to the *wairua* or spirit aspect of the model (Randal, Geekie, Lambrecht & Taitimu, 2008). The *wairua* part can incorporate the findings of para-psychological research and spiritual practices (Radin, 2006). Clients together with Māori mental health professionals are often grateful that their worldview and "anomalous"experiences are not dismissed or considered to be "crazy", where hearing voices need not be psychosis but may, after a discerning assessment, be the calling of their *tupuna* or ancestors (Lambrecht, 2009). In this space "the paranormal is normal".

The term *wairua* is made up of two parts, first *wai*, which means unique, special, unprecedented. The second part of the word *rua* refers to both an abyss and a container. *Wai-rua* then is that which is unique, special, which is contained within. Importantly, *wairua* is not to be understood in a religious, ritualistic, or intellectual manner (Bidois, 2012). It is not *tikanga* or cultural even, it is utterly unique. In other words, it needs to be experienced to be present. To move cross-culturally for a moment, w*airua* as a unique container and abyss within us resonates with the complex mystical definitions of Advaita Vedanta (Deutsch, 1969), notions of Zen (Watts, 1957), with the Jewish mystical concept of the *Ayin Soph Or* in Kabbalah (Scholem, 1960), as well as the negative path of the Christian mystic Meister Eckhart (Fox, 2014).

The Politico-Sacred Whakapapa of Trauma

This paper seeks to articulate some of the personal-political-sacred complexities of colonisation, how the sacred and the political intersect with intergenerational trauma, as

already addressed elsewhere (Lambrecht, 2014a). However, it is often not obvious how to apply this cultural-clinical integration on the ground (Lambrecht & Taitimu, 2012). What is helpful is that the *whare tapa wha* model of well-being has far more space for innovation and experimentation. For instance, the therapeutic importance of "good-enough holding" (Winnicott, 2005), related primarily to the *whanau* theme, can now be related along personal, systemic, political, cultural, and spiritual dimensions when working at a Māori mental health service. Importantly, Winnicott always had a social approach to trauma without having to sacrifice the inner world (Alford, 2013). Working with trauma and Winnicott's notion of "holding" allows therefore systemic thinking that considers the community as contributing to healing the ruptures and taboos of the mind, emotions, and spirit. Importantly, as O'Loughlin pointed out so rightly: "This is not to suggest that memory work is easy. Families are fractious. Tribal groups are fractious. Nation states are fractious" (2013, p. 259).

At a Māori mental health service, these dimensions are openly acknowledged. Also, there is more scope to work with long-term psychotherapy within the clinical-cultural interface, because the *hinengaro* or the mind is respected. This is so different from working within a more medical model of a general mental health system. As O'Loughlin noted, "Here I would like to conclude by focusing on the capacity for psychoanalytically informed therapists to not only work directly with persons who have suffered trauma, but to extend their influence in the social arena to address the severance of social links, the denial of memory, the erasure of generational and ancestral wisdom, and the rupture of genealogical continuity" (2013, p. 262).

Trauma has threads leading to the historical past, often ignored or denied. Colonisation has had very painful long-term trauma effects on many indigenous cultures across the world through violence, dominance, subversion, and marginalisation of people. Historical trauma becomes transmitted down the generations, and this is understood as inter-generational trauma, which is significant in addressing direct traumatic effects on a person (Davoine & Gaudillière, 2004). For Garon (2004), trauma across generations leads to dissociations or splitting in the intergenerational transmission across generations. The first generation may begin with negation, which then the second generation proceeds to deny. By the third generation, the secrets may have become foreclosed. In the therapeutic space, this is manifested in a progression from the unspeakable to the unnamable to the unthinkable. In Aotearoa or New Zealand, for many of my clients, the brutal or devious land loss through colonisation has led to intergenerational poverty (Walker, 2004), substance abuse, and sexual abuse in their family history. The trauma across generations leads to truncated personal and political power and stories in the present tense, with gaps and splits in the coherence of their inner and cultural worlds. So the unthinkable hovers beyond the horizon of insight and is often morphed into psychosis, in which the unnamable is never quite grasped in the symbolic, and the unspeakable is disavowed in the real (Lambrecht, 2014a).

In providing a psychoanalytic and clinical reading of land loss and resultant poverty for Māori in the New Zealand past, I am very clear that this is only one of many possible readings, and that many aspects are involved. It is beyond the scope of this paper to address the high mental health rates amongst Māori that are related to colonisation (Tapsell & Mellsop, 2007). In my clinical work with some *tangata whai i te ora* (persons seeking well-being), it has at times emerged that their *tupuna* (ancestors), who have experienced land loss due to colonisation, sat with powerless rage against colonisation; a rage and loss repressed

and medicated with alcohol; a common lubricant of destruction of families and *whanau* of indigenous people across the world. In this generation the children become victims of deferred rage, domestic violence and abuse becomes a consequence that begins to fray the connections of attachment three generations into the present. By the fourth generation the intergenerational trauma spills over in the form of psychosis, mood disorders, as well as personality disorders through poor affect regulation, given the loss of secure *whanau* and community "holding". *Tangata whai i te ora* or clients then carry the burden of the land loss not only in the real sense, but also relationally in terms of disturbed attachment patterns across generations, creating intergenerational trauma that scars the internal world. The land loss of generations ago can affect the inner world of the person sitting in front of me today.

Given such a *whakapapa* or genealogy of trauma for some *tangata whai i te ora*, I am more "curious as a therapist to listen to where a person comes from, how identities and relationships are formed, what patterns occur in specific stories. These are always in some way intertwined with political and traumatic histories of the land. By listening to the gaps, the unknown, ruptures, impasses, underlying dilemmas, the political, cultural, and personal, as well as the pain, it becomes possible to figure out what may be helpful" (Lambrecht, 2017b, p. 131). I wish to explore the subjective space, and seek to focus on the alliances between us, and listen to the relational eddies and knots, constantly negotiating and mirroring as a good-enough therapist. The aim is to address both personal and political histories that move beyond empty articulations (Charles, 2012). Such stories quickly lead to rich cultural, political and economic entanglements intertwined with the political and the traumatic histories of the land that construct an identity in therapy of both the therapist, the *tangata whai i te ora*, as well as the space between us.

For example, working with one *tangata whai i te ora*, diagnosed with bipolar disorder, paranoid schizophrenia, whilst steeped in a strong belief in witchcraft or *makutu* (Smith, 1921), his story revealed how his grandfather turned to severe alcohol abuse after a boundary conflict with the state. This led to land loss and severe financial hardship. One part of the therapy focused on the intergenerational trauma, the "return of the repressed" (Freud, 1939/1985, p. 372), through the work with the symbol of boundaries: returning between the cultural boundary between Māori and Pākehā (Caucasian), the familial and oedipal boundary between father and son, through the personal boundary of hurt and rage, as well as the existential boundary between the real and the unreal when intense paranoid feelings emerged in the name of witchcraft (*makutu*).

He worked through his boundary issues by addressing his deep woundedness and destructive rage that compensated for the loss of *mana* (respect and inner power) of his *whanau* (family) and himself. He began to appreciate the brittleness of his false self that functioned as a defense against being overwhelmed. He began to approach his inner world with more openness. He worked through his introjects, and we experienced the projective identifications in the therapy room, both in terms of person and race. His work accessed the defended unaccepted feelings about his abuse and neglect. Boundaries of his father's land that were violated by the state had created intergenerational aftershocks that led to destructive rage and rigid defenses or boundaries within his inner and relational spaces. With a more powerful, flexible, playful, and vulnerable self, the real self in a Winnicottian

sense, culture and spirituality became a potential and transitional space between himself and the world (Lambrecht, 2017b). Then and only then, could he access the space of *wairua* or spirituality in a safe and discerning manner. He could towards the end of therapy then discerningly read the signs of *wairua* or "synchronicities" (Jung, 1952/1972) without the terror of paranoia and resulting in a subtle richness of meaning.

Spiritual Holding

It is not always easy to distinguish between madness and the sacred. Lukoff (2011) suggested that there are overlaps with extreme painful states such as psychosis of mania and mystical states. These overlaps could be considered to be "spiritual emergencies" or the "dark night of the soul" in the Christian tradition, similar to initiation illnesses in indigenous shamanic traditions. I have worked with some who have had intense *kundalini* emergencies, Chinese *qigong* psychosis, *matakite*, a Māori term for hearing voices and seeing visions, as well as in my training as a *sangoma* (South African shaman), the *ukuthwasa* (shamanic initiation illness), and *amafufunyana* (possession and psychotic states) (Lambrecht, 2014b). These distinctions are not always clear or easily made. Such devastating experiences in a cultural context can relate to the overstepping of taboos or *tapu* (Māori). The breaking of *tapu* or taboo, the sacred versus the mundane (*noa*), means that spiritual holding of the ancestors is lost and requires healing. One example that may be helpful here is what was shared with me by Wiremu NiaNia, a *tohunga* or shaman. He worked with a young adolescent who became psychotic and terrified (personal communication, 2011) because his home was located on land that had been the site of a brutal battlefield. The land needed cleansing before personal healing could continue. The *tapu* of bloodshed needed to be lifted and healed before other mental health healing methods could be applied. The sacred body needed to be resettled, remoulded, and remembered in its relation to the land.

Importantly, my notion of "spiritual holding," based on Winnicott's (2005) concept of "holding," requires acknowledgement not merely in terms of thoughts and religious rules about the spirit. Rather, it focuses on lived experience, namely sacred, "anomalous" or exceptional experiences. Real acceptance and knowledge is required to traverse this complex sacred place that is often a liminal space, filled with dread or *Unbehagen* (Lambrecht, 2015). In Western psychoanalytic discourse exceptions concerning the sacred exist, this type of holding has some precedence, such as in Jung's (1916/1957) "transcendent function", or in Grotstein's (1996) "transcendent position".

To provide a vignette in this regard, in my therapeutic work with a Māori woman at a personality disorder specialist unit in Auckland, similar issues arose. She struggled with severe dissociative features due to significant childhood and institutional abuse and neglect. One day, after several months of therapy, she hesitantly and with trepidation told me that she regularly "sees" people in the street walking through bus stations.

She was concerned that I would send her to an inpatient unit due to such so-called visual hallucinations. This was not an unreasonable concern, as from a psychiatric perspective, such visual hallucinations would raise concerns of her mothering, and maybe her child should be removed. However, I saw no concern in regards to her mothering capacity. Through collaborative exploration, it emerged that for her, and true to her cultural

background, these were people, who had passed away. Applying skills of normalisation and distress tolerance, mentalizing, as well as validation, she was able to down regulate her emotions, avoid dissociation or "splitting," to use a psychoanalytical object relation term. She was able to accept the departed for who they are. It needed neither denial of her exceptional experiences, nor paranoid terror of the dead, the paranoid-schizoid position (Klein, 1975). It was more helpful to support my client to engage with the *tupuna* respectfully, as well as setting limits of how the dead may speak to her. In this regard, as I address elsewhere more fully, it is worth asking in which manner psychoanalysis can be of value to those who have exceptional spiritual, paranormal or psychic experiences (Lambrecht, 2016b, in press).

Spiritual Holding as a Transitional Spiritual Space

Beyond mere content, spiritual holding as a function and process could be said to allow for altered states of consciousness or trance states to occur in transitional spaces, as within the spaces of therapy, art or play. Levi-Strauss, the anthropologist, claimed that the shaman was the first psychoanalyst (1963). For shamans as for therapists, mind (*hinengaro*) and relationships are closely related to a transitional space. For this article I will hold the somewhat contentious position that common to most shamanic traditions across the world is the shifting of the mind in some sense, even if the specific rituals are different (Winkelman, 2010). Different from religious rituals, in which the form of the ritual is the meaning, in shamanic rituals the form not only holds meaning, but also creates a transitional space to alter consciousness. The repetition of the ritual is in fact more like stepping into a field of resonance, the repetition becomes the ground upon which the mind takes flight, and new forms appear.

This is true for music, art, psychoanalysis, and trance states (Lambrecht, 2016b, in press). The ritual provides a specific spiritual holding that allows the trance state to be safe and effective, and in fact is a part of the technology that alters the mind. In therapy, the ritual of the therapy process, the same time, place, and resonances of voice, care, and pain, become the ritualised space of transition (Sinclair & Lambrecht, 2016). Thus should a therapy session begin with a *karakia,* often translated as a prayer, the *karakia* is in fact an act of incantation, a much more lively space of spiritual enactment (Naida Glavish, *tikanga* advisor of ADHB, personal communication. 2016).

These identities are never fixed, they remain productive and transitional. Similarly, when I sit in my psychotherapeutic practice, I become aware of my body, the same posture, the sudden silence of my mind. Bion (1984) is right: the dark threshold of not knowing, not remembering or desiring, is a transitional space for the therapist in allowing in this very repetition, new forms of life and knowledge to emerge. My body and mind shift through repetition of the ritual of therapy, the same room, the same time, the same person, into a space where healing may occur. I speak, much like a shaman, an oracle, sometimes things come out of my mouth that I was not aware of, a flow of words seems to make sense beyond my own comprehension. It is only possible if I allow this to occur with a more subtle mental space that shamans know in their ritual of divination where the mind is altered in a quieter, gentler, but nonetheless profound manner. Again the shamanic consultation around divination is very often ritualised, and different to religion, it does not merely repeat

meaning, but rather actively produces new knowledge, relevant and personal to the client. Similar to a shaman, I am at times not sure in the session, who is speaking, and I am also not sure if it matters, as long as the knowledge is effective and helpful.

Conclusion

Spiritual holding within a sacred-political space in the clinical work at a Māori mental health service is an attempt to consider one amongst many possibilities about how to consider the cultural-clinical interface in psychotherapy. I realise that I have stretched psychoanalytic or psychodynamic psychotherapy into curious places, such as into the resonating nets of historical trauma and spiritual spaces that psychoanalytic theory can tolerate if it is considered to be an effective lens or method, rather than a reductionistic truth. Psychoanalysis has much to gain by listening to indigenous cultures and their practices of consciousness, which neuroscience is beginning to evidence through the research on different types of states of consciousness or meditation. Other cultures have also something to gain from psychoanalysis in its knowledge of internal processes. There need be no loss, only gain through discerning wisdom.

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