

Madness of the Mind: Growing the Self in the Mind of the Other, and in the Psychotherapeutic Relationship

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Abstract

The art of psychotherapy has been defined as the capacity of the psychotherapist's mind to receive the psyche of the patient, particularly its unconscious contents. This deceptively simple definition implies the enormously complex art of receiving the most disturbed, dissociated, maddening, often young and primitive, frightening, and fragmented aspects of the patient's multiple ages and selves, in the hope perhaps that we might make available to our own mind, to the patient's mind, and within the therapeutic relationship, whatever it is that we discover together, perhaps with the possibility that this may allow that these dissociated, fragmented, lost, and potentially transformative aspects of self might become more accessible to both therapist and patient. The complexity of this process is further intensified when cultural difference is an important aspect of therapeutic engagement. This paper will explore this rich and complex art. It will include exploration of psychoanalytic, relational, and transpersonal psychotherapeutic perspectives as they inform the potentials and mysteries of this deeply receptive process. The paper will consider the potential this receiving of the other might have for the growth of both the therapist and patient within the life span of clinical engagement and will include consideration of implications for cross cultural clinical work. Clinical vignettes illustrating and informing the ideas explored in this paper will be woven throughout the paper.

Whakarāpopotonga

Kua tautuhia te toi whakaora hinengaro ko te kaha o te hinengaro o te kaiwhakaora hinengaro ki te pupuri i te hinengaro o te tūrora, mātuatua nei ko ngā matū maurimoe. E tohu ana te tautuhinga ngāwari nei i te kaha uaua o te mahi pupuri i ngā maramara tirohanga, ngā tau, ngā whaiaro tini o ngā tūrora arā noa atu te wairangi, te noho wehe, te kārangirangi, he taiohi, he māori, whakawehiwehi, i runga i te wawata tērā pea ka tuwhera ki ō tātau ake hinengaro, ko

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tō te tūroro ki waenga hoki i te whakapiringa haumanu. E kene pea mā te mea ka kitea, e tuku ēnei tirohanga pūreirei, kongakonga, ngaro, ā, ngā tirohanga hurihanga whaiaro e whakamāmā ake ki te kaiwhakaora me te tūroro. Ka kaha ake te auatanga o tēnei hātepe i te mea ko te rerekētanga o te ahurea te wāhanga nui o te mahi haumanu. Ka wheraina e tēnei tuhinga te tirohanga toitaurea mōmona nei. Ka whakaurua te wherawherahanga o te wetewetenga hinengaro, te tātanga, me ngā tirohanga whakaoranga hinengaro wairua i te mea ko ēnei ngā kaiwhakamōhio i ngā pirikoko o tēnei hātepe toropupū tino hōhonu. Ka whakaarohia e te pepa nei te ēkene pea o te whakaurunga mai o tētahi kē atu mō te whakatipuranga o te kaihaumanu me te tūroro i roto i te wā huitahi ai. Ka whakaarohia ake anō hoki ngā hikaro mō te mahi haumanu ahurea whakawhiti. Ka rarangahia ngā kōrero haumanu e whakaahua e whakaatu ana i ngā whakaaro tūhuraina i roto i tēnei tuhinga.

Keywords: analytic attitude; aggression; cross-cultural; negative capability; reparation; restoration; hate

Introduction

O wad some Power the giftie gie us To see oursels as ithers see us! — Robbie Burns

In *Subjects of Analysis* (1994) Thomas Ogden quoted Michael Ondaatje (1987), “The first sentence of every novel should be: ‘Trust me, this will take time but there is order here, very faint, very human.’ Meander if you want to get to town” (cited in Ogden, p. 1). I make the same invitation to you now as I attempt to reveal some of the contents of my own mind, its madness and its creativity, to the degree that I can muster this, as I meet the mind of another.

It was early morning. Tana had been having a difficult time, and I wondered how he would be today, as I walked to my waiting room to greet him. As I opened the door, I discovered Tana lying curled and motionless on my waiting room floor, refusing to move, gently crying, the first time he had cried in the six years we had worked together. For the next thirty minutes he lay immobile, silent, except for the sound of muffled tears streaming endlessly down his face.

This moment, like so many in my clinical work, took me utterly by surprise, and in doing so undid the coherence of my mind. I felt bewildered, with little or no idea initially of what was going on. Some such moments I have handled “better” than others. Each of these moments and the therapies that proceeded them provided me with profound learning about the mysteries of the psyche, and of the psychotherapeutic endeavour. Whilst meta-psychological theories about the nature of mind, and interpersonal capacities to reach my patients in such difficult moments, played their parts in helping me and my patients to reach each other, it was not theory of the meta-psychological kind that initially guided my beingness with each of my patients in the heat of these clinical moments.

Uncertainties, Mysteries, Doubts, and the Analytic Attitude

Robert Snell (2013) in his recent book *Uncertainties, Mysteries, Doubts: Romanticism and the Analytic Attitude*, noted that it was the poet Samuel Taylor Coleridge, in 1805, who first

“coined the word ‘psycho-analytical’, predating Freud by ninety-one years” (p.1). He linked the origins of the deeply receptive stance of the analytic attitude as intertwined with the development of Romanticism, a stance he described as an “undirected but somehow actively receptive state of mind”, one which provides “a commitment, founded in respect, to maintaining a radically open-minded stance: a suspended state somewhere between passivity and readiness for emotional and verbal activity” (p.1). As Keats famously observed (and to whom Bion (1970) referred in advocating the value of reverie), “I mean Negative Capability, that is, when a man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason” (1817, cited in Ou, 2011, p.1).

Snell (2013) went on to provide a poetic evocation of the notion of the analytic attitude, reviewing a wide range of analytic authors’ writings about this elusive and poignant way of being. He began with Freud’s description of the foundational psychoanalytic pairing of the patient’s free association and the therapist’s evenly suspended attention, a pairing which Bollas (2007) suggested articulates the beginnings of relational intersubjectivity in psychoanalytic thought. Snell admired Bion’s (1967/1988) reverie without memory or desire, and Klein’s (1946) concept of projective identification as psychic states swirl between and within patient and therapist. He movingly affirmed Symington’s (2008) emphasis on spiritual generosity within psychotherapy in which the therapist’s presence provides “the mind of the patient with what, if it were a matter of physical experience, one could say was good food” (Bion, 1990, cited in Snell, 2013, p. 52). Snell appreciated Winnicott’s (1965) primary maternal preoccupation and his evocation of this experience as capturing the therapist’s attempt to provide the patient with a mind “as an open space available for the patient to move into, come and inhabit, and crucially shape as his own” (Snell, p. 52). By contrast to Klein and Bion, Donell Stern (2009) critiqued the idea of projective identification as too unidirectional, instead postulating the concept of both the therapist’s and the patient’s dissociated material arising in the form of mutually generated unformulated experience. This becomes known via enactment, including mutual enactments, in which both the patient’s and the therapist’s unconscious intertwine, and dissociation is inter-personalised.

Perhaps most prescient of early analytic writers in relation to the deeply disturbing and intersubjective nature of analytic work is Carl Jung, who passionately advocated what we now refer to as a relational approach many decades before the relational turn was alleged to have commenced. In 1928 Jung wrote:

How can the patient learn to abandon his neurotic subterfuges when he sees the doctor playing hide and seek with his own personality, as though unable, for fear of being thought inferior, to drop the professional mask of authority, competence, superior knowledge, et cetera? The touchstone of every analysis that has not stopped short at partial success, or come to a standstill with no successor at all, is always this person-to-person relationship, a psychological situation in which the patient confronts the doctor on equal terms, and with the same ruthless criticism that he must inevitably learn from the doctor in the course of this treatment.... The patient must have the right to the freest criticism, and a true sense of human equality ... (Jung, 1993, pp. 137-138, cited in Snell, 2013, pp. 56-57)

In Ogden (2004) we discover an eloquent contemporary advocate of the possibilities of this most complex of interactions. In his concept of the analytic third as it emerges via the intermingling of the patient and analyst's body-mind-psyche, we discover the possibility of something new emerging, from the intermingling of the two, the possibility of a new object of analysis arising within the matrix of the patient's and analyst's minds. As Ogden noted:

The individuals engaging in this form of relatedness unconsciously subjugate themselves to a mutually generated intersubjective third for the purpose of freeing themselves from the limits of whom they had been to that point.... The act of having oneself "given back" by the other is not a returning of oneself to an original state; rather, it is a creation of oneself as a (transformed, more fully human, self-reflective) subject for the first time. (Ogden, 2004, p. 189)

Ogden (1999) also commented that poetry can convey "what I can only talk about" (p. 491), and offered this poem (R. Ammons, "Poetics", 1986, cited in Ogden, 1999, p. 491):

Not so much looking for the shape
As being available
To any shape that may be
Summoning itself
Through me
From the self not mine but ours.

All of these writers were exploring the potent challenges and creative possibilities of receiving the mind of the other within our own minds. And all gesture towards the capacity that Keats suggested in his conceptualisation of negative capability. The capacity to eschew understanding, to bear uncertainty, allowing new truths and self-states to arise, not by grasping after them, but by deep intrapsychic and interpersonal exploration.

I have always felt drawn to the evocative beauty of such writing. The invitation to be present to mystery, to receive that which is ineffable, unknown. To deeply surrender in therapeutic work and in life itself, to the very human, and in my view transcendent, nature of our experience, as we are present to the universe in a single moment of therapeutic encounter, knowing that for all our grasping to know, so much remains a mystery. And more than this, that being present and indeed receptive to this mystery might provide a home for unformulated aspects of self, present within ourselves and with our patients.

Challenges of Clinical Encounter

But in the reality of the clinical encounter what does such a stance really mean? What is such a stance asking of us as therapists? For when the poetic beauty of such evocative invitations towards negative capability meet the reality of a patient wracked by vicious self-hatred and potentially lethal impulses, what am I to do, how am I to be? Is a receptive mind enough? And how do I respond to these destructive, dangerous, cruel, and hateful aspects which I might receive into my own mind? And beyond receptivity, how and what do I make

available to my patient, of the material I have received and perhaps processed, contained, and digested.

Clinical Moment — James

James, an occasional artist, had been coming to see me twice a week for four years, since he was 30. In the earlier stages of our work our breaks in therapy had been horrendous. James was tortured by vicious self-harm and self-hatred that seemed almost completely overwhelming of all aspects of his psyche. In the previous four years before he met me, he had been in and out of mental health services and had engaged with up to 20 therapists, key workers, psychiatrists, doctors, and psychologists. None had had continuous contact with him for more than six months. He anticipated I would be just another in a long line of body-minds in whom he was not able to find a home for his most disturbed aspects of self. Thus, when our first holiday break arose three months into our work, and I was soon to be away for two weeks, James sat motionless, utterly unable or unwilling to speak. For three sessions I think we both felt utterly persecuted by his silent withdrawal. My anxiety was overwhelming as I attempted to reach him, thoughts of his suicide flooded my mind over the break. Upon my return from the break this scenario repeated itself with three further sessions of silent, hostile withdrawal. All I felt I could do was to survive his apparent hatred of both my presence, and my absence.

Gradually I discovered that this enactment closely paralleled his early maternal attachment history. James was born to a single mother whose own early life had been relentlessly neglectful. Six weeks after James's birth, his mother placed him in day care, the beginning of an endless stream of early caregivers. His mother's unreliability was exacerbated by her emotional reactivity. She would regularly and unpredictably leave the family home, often for days at a time, leaving him in the hands of a caring but overwhelmed neighbour. In response, upon his mother's return, James would respond by lying motionless, unable or unwilling to respond to his mother's attempts to re-engage. A year into our work James drew a picture which he entitled "The Break", to capture his experience of the breaks that occurred in our therapeutic contact.

The Break

The image depicted two scenes: on the right-hand side he depicted a screaming infant, utterly disintegrated by the experience of maternal loss, a breakdown that felt all encompassing, unable to formulate the unsoothable terror he experienced. On the left-hand side he drew his experience of us in therapy when he felt most connected with me, capturing an experience of passion that enlivened him, me holding him up to the sky, as an infant, young, playful, hopeful. In between and separating these two images, James drew a jagged line, like a violent lightning bolt, symbolising breaks in our therapy. The loss of contact. And the terror that this evokes. James said of this picture:

You're the person on the left. Wearing your red jumper. Literally holding a little part of me, the infant part of me. I outlined the two of you with warm yellows and oranges, as that warmth and safety is kinda what I associate with you "holding" me.

On the right I drew the little part of me when you go on a break. All by himself, no clear features, just a black outline that I want to attack. The blues and the reds are me attacking myself.

The image is evocative of Bion's (1962) description of the infant's experience of absence, the experience of:

—a person, a breast that is needed in order to satiate the internal experience of absence, and the terrifying distress, indeed “nameless dread” the infant experiences as a result ... This needed object is a bad object. All objects that are needed are bad objects because they tantalise. They are needed because they are not possessed: in fact, if they were possessed there would be no lack. (pp. 83-84)

This resonates with my patient's attempts to communicate into me these disintegrating and consequently aggressive infantile states of terror that breaks in our therapy evoked. I as the needed object, who is suddenly not there, who tantalises by my absence, and evokes the nameless dread of the infant abandoned to his inner terror. As my patient began to find words for these experiences, after 18 months of therapy breaks characterised by suicidal threats and silent hostile withdrawal, James managed to reveal:

I wanna be stubborn. I want you to feel inadequate and incapable. I want you to feel like you failed ... because that's how I feel. Failed. I might be resentful towards you. You say you'll do things and then you don't. I can't trust you — rely on you. Ever since I told you it makes me anxious when you lean forward, not a single session has gone by without you doing that. You don't take me seriously — you want to intentionally hurt me. That's OK, I'll hurt you back.... How do I show you? By creating as much distance between us as possible. I still get anxious though. I really am scared that you're gonna leave — hand me over — lock me up — die soon. I can explain the fear, rationalise it but it doesn't make the fear any less intense. So I'll leave you before you leave me.

James drew other images during our therapy, representing his impulses to turn this hatred destructively upon himself. These included an image of a foetus under violent attack, and a dark, lifeless coffin surrounded by symbols of his torturous inner struggle between life and death. In relation to a particularly long break he revealed:

You're on holiday for six weeks. I ... know exactly what to do.... I will refuse to have any contact with you at all. I will make sure that I end the last session before your break prematurely. I will be silent for the first half of the session, which will be followed by a full-scale tantrum, after which I will walk out. This should have you worried about my mental stability while you are sipping cocktails on some tropical beach. During your break I will indulge in any form of self-destruction I please. When you come back I will give you a detailed report on how much, how often, and how badly I hurt myself. By this time you should feel inadequate, incompetent and defeated. All the while I will be enjoying you try and try again and fail miserably every time.

My Own Inner World

Ogden (2004) suggested that the task of the therapist is in large part to receive such states of mind, to allow them to enter the psyche and soma of the therapist. He described the process of reverie, of dreaming, in order to make possible the unthought known as a thinkable thing. But of course such disturbed states land in my mind and body not with me as an empty, unsoiled container (to use Bion's metaphor), but as a psyche with my own intrapsychic inner world pre-existing my contact with my patient. This is a point well made by Donnel Stern (2009) but articulated many years earlier by others such as Jung (1966) who noted:

Even the most experienced psychotherapist will discover again and again that he is caught up in a bond, a combination resting on mutual unconsciousness. And though he may believe himself to be in possession of all the necessary knowledge concerning the constellated archetypes, he will in the end come to realise that there are very many things indeed of which his academic knowledge never dreamed. (Jung, 1966, p. 178)

Indeed, I believe I have been interacting with the material in the images in my patient's pictures my whole life. For my own experience as an infant included being with a maternal other overwhelmed by her own distress. Thus, in response to the kinds of communications my patient offered, I must negotiate the labyrinth of my own mind including the affective experience of powerlessness and fear that gripped my body each time my patient withdrew into apparent suicidal retreat. These affective disturbances met an inner world within me already populated by maternal distress, and an infantile demand within me that I fix, heal, and save the distressed other. These primitive aspects continually persecuted me into therapeutic action, omnipotently seeking to save the distressed other.

Accident

Then, some years ago I went for a run, demanding that my body perform, and persecuted into action yet again. I ran a red light, knowing my body would take me to safety. But this time psyche demanded I pay attention. I did not see the car that hit me. I remember thinking, "someone's had an accident" as I heard the crash. Only when I landed did I realise the "accident" had happened to me.

Where once the defences of omnipotence and omniscience had allowed me to keep at bay the depth of my vulnerability, now these defences collapsed. In the holding environment of my friends' love and my therapist's and supervisor's analytic sensitivity, I slowly began to make sense of the terror that assaulted me. In it I rediscovered the infant that I was, whose vulnerabilities I so desperately sought to disavow.

My experience of the accident and the consequent physical and psychic collapse, disintegration, and ongoing transformation I have experienced has enabled me to encounter not only the violent aspects of my early maternal and familial history, but also the disavowed vulnerability of the infant and boy that I was in this frightening early environment. Whilst terrifying, as Winnicott (1974) has written, the breakdown had already occurred, and this time in my dream life and in my dilapidated states, as I regathered these tender and

frightened aspects of myself, I slowly came to discover the vulnerability that my manic omnipotence had kept at bay: the creative illness that was my accident and its consequences invited me to discover the humanity of my divinity and the divinity of my humanity. Jung wrote of the possibility of creative illness; an experience in which we are brought to our knees by our own humanity. Indeed, Jung himself famously experienced his own terrifying encounter with the unconscious, an experience of many years that brought him to his own emotional knees, as madness threatened to overwhelm his psyche, his own early history erupting in disturbances in his own mind.

Inner Freedom

Neville Symington (1986, 2003, 2007), in exploring the conditions that allow for transformation in psychotherapeutic work, noted that the therapist is faced with a deep emotional struggle if they are to negotiate the powerful injunctions of the most primitive aspects of their own superego. It is a task of speaking the truth no matter how painful or difficult, always being receptive to the idea that one's truth as a therapist can be radically transformed in the encounter with the other, constantly open to the fluidity of what such truth speaking reveals. Saying as clearly and honestly as he or she can what emerges in relation to the patient. Symington suggested that often therapists retreat and seek to avoid the emotional strains of such a demanding therapeutic task, either failing to get beyond the dictates of superego demands to be "a good therapist", or the opposite, to enact persecutory and reactive attacks on the patient, fuelled by unconscious complimentary counter-transference. Alternatively, we can be captured by a compulsion to provide perceived compassionate empathic understanding whilst failing to forcefully assist the patient to face their own self-destructive attacks. In so doing we often avoid the patient's persecutory self-hatred and thus avoid the kind of therapeutic engagement which might be required if true transformation is to occur.

For much of my time as a therapist I have been unconsciously persecuted into therapeutic action, whilst avoiding the unbearable task of staying with the unbearable states of others as they are communicated (in)to me. Yet it is this task, I think, that is truly healing. For it is this which enables us to empathically reach and be with the unformulated states of our patients, states that have never been reached. States which feel deeply disturbing for the therapist. To do so I must be willing to feel this disturbance, to allow it to enter me, to feel states of terror, hatred, love, sexual desire, primitive anxiety, and desperate persecution, all as they intermingle with the internal states of my own mind, populated by the states of hatred, love, sexual desire, and persecutory terror as they have emerged in my own life. Jung (1966) noted that the first and foundational therapeutic task of the psychotherapist is to be willing to be influenced by the patient's psyche, whilst Clark (2006) noted that it is our own woundedness that provides the portal through which we receive our patient's intrapsychic disturbance, and which enables the patient's own damaged inner world to impact upon and influence us. It is this intermingling, and the willingness to stay present to such states in myself and in my patient, a capacity which so many of our patients experienced as being unavailable to them in their own relational childhood experience, providing company for that which has never previously been accompanied, that offers the hope for empathic resonance, gradual symbolisation and formulation of that which has been unformulated. To do so, I believe, enactments — often

mutual enactments — are inevitable, and I have to bear in myself that which feels unbearable, including my own impulses of homicide and suicide, hatred and love.

Manic Reparation

Of course, the capacity to be influenced is not on its own sufficient. We also need the capacity to find our own mind, to undertake what Symington (1986) described as the psychotherapist's "act of inner freedom", in order to discover our own mind in relation to the patient's experience and to speak that as truthfully as we can. Henri Rey (1994) noted that by contrast, we can be compelled towards manic restorative action in order to restore the interpersonal homeostasis of disturbed interpersonal therapeutic relations, a process he referred to as manic reparation (p. 219), in which the self is persecuted by internal anxiety in an attempt to repair the perceived damage done to the other. Rey further noted that the psyche in states of manic reparation seeks to defend against the internal attack of the punishing superego, by seeking to enlarge the ego via defences of omnipotence and omniscience, enabling the self to thus "feel superior to the menacing and punishing [inner] object ... by being bigger than the object; by making the [inner attacking] object smaller" (1994, p. 209). The more difficult challenge is not of speedy restoration of interpersonal disruption, a quick restoration which avoids any real transformation of the internal world, but rather of a deep and disturbing grappling with our own destructive aggression and our guilt about this aggression, in order to seek a deeper reparation within which the vulnerability of our and our patient's internal terror is received and surrendered to, the inner persecuted object is repaired, matured, and softened, and compassion for our own vulnerability generated, as reality is faced, in order that a more honest meeting with the interpersonal other may also be possible. I suggest that Rey's repaired inner object within the therapist, capable of both love and aggression, forgiveness and being forgiven, is crucial to the psyche's capacity for recognition of the other within the clinical dyad.

Similarly, Snell (2013) in his exploration of an analytic attitude encouraged therapeutic stillness, contemplative thought, reverie and digestion in the face of such external and internal attack. It is this capacity which enables the possibility of dreaming, and gradually of making such deeply disturbing emotional material available within the therapeutic relationship as an analytic third to be thought about, contained, metabolised, and eventually understood.

Socio-Political Challenge

It is not only the violence of the intrapsychic which mitigates against the therapeutic stance which embodies and embraces uncertainty, mystery and doubt; it is also a socio-political one. As Snell (2013) noted, "Such listening is always at risk, in crisis; it is undertaken in an emotional and cultural forcefield which is always threatening fatally to compromise it" (p. 33). Indeed, the challenge has been there since the beginning. Snell noted Freud on the one hand emphasised the unconscious to unconscious communication of the psychoanalytic twins of free association and evenly hovering attention, whilst struggling with the enlightenment need for rationality, and the importance of science and positivism,

manifested in his articulation of a metapsychology imposed as universal, structural, and Oedipally inevitable. He cited Bollas, (2007), who suggested that Freud was thus “in perpetual conflict and contradiction with himself” (Bollas, p. 30, cited in Snell, p. 34), and also quoted Toril Moi (1989) who noted, “born in the encounter between the hysterical woman and the positive man of science [psychoanalysis] is shot through with paradoxes and difficulties” (Moi, p. 196, cited in Snell, p. 32).

Thus, the force field of my own mind with its compulsion to save, encounters the compulsion of our cultural and socio-political context, in which efficiency, doing, and change are urgently demanded. Yet what if the urgency of this very demand mitigates against the creativity of new possibilities if we are to truly take on the invitation not to know, which does not mean impotence, but rather the profound gift of presence, in the unformulated, disassociated, terrifyingly unknown aspects of our own and others’ psyches.

Perhaps this tension is in us all. The impulse to know, the impulse to impose the truth of our view of the psyche, to use our maps and morals to know what the patient cannot know, and yet the disturbing inevitability that all is confusing, that, as Jung suggested, each therapeutic journey is a unique, unknown, and thus terrifying engagement with our own and the other’s unconscious; confrontation with the unconscious every time. How can I possibly bear such an “impossible” profession?

Some critique the deeply receptive nature of the analytic attitude as being passive, even submissive. However, I suggest that it in fact involves a deep and active engagement in one’s own and the patient’s inner world and the co-creation which the meeting of these worlds enables. Indeed, far from passive or submissive, such an engagement, in which we take up Symington’s invitation to strive for an act of therapeutic and emotional freedom involves utilising the depth of our intrapsychic and intersubjective exploration to speak the truth as potently, poignantly, and honestly as we are able, in the hope that imprisoned aspects of the psyche may find an emotional freedom.

Clinical Moment — Jennifer

Jennifer was struggling with suicidal impulses, the strength of which frightened us both. She said:

My mind is constantly going “to cut or not to cut, to cut or not to cut” ... And I just keep thinking that I don’t want this as much as you do. I don’t want to live as much as you want me to live. I don’t want to make a life as much as you’d like me to have a life. And I’m not as strong as you think I am. I just can’t do it. I just feel too exhausted. Too tired. To constantly fight this urge to self-destruct. I just want to let go. I want to not-kill myself coz others would get hurt and don’t want me to die. But I don’t want to keep fighting just for me. I wish everyone would just get off my back and let me die. Why is other people’s hurt about my death more important than the hurt I’m experiencing right now? I just want everything to stop.

Neutrality, abstinence, distance, passivity, I suggest are insufficient in the face of such aggressive and dangerous hatred. Foundational, as Winnicott (1949) potently articulated, is

the necessity that the therapist survive, and more than this that the therapist's capacity to think survives the relentlessness of the attack. But to do so I think it is necessary for the therapist to mobilise their own creative aggression in the service of aligning with the distressed infant trapped by the hatred which is turned on the self, whilst vigorously engaging with the violence of the self-destructive aspects attacking the self. It is a delicate but also forceful engagement.

I find Donald Kalsched's (1996, 2013) formulation of such psychic agony helpful in holding my own mind in the face of such disturbing impulses. Kalsched described the attachment research evidencing the establishment of early dissociative defences in the traumatised child and noted:

With this traumatic splitting, aggression that should be available to the child to protect itself against its persecutors is diverted back into the inner world to attack the very vulnerability that threatens the 'old order' of control. As Fairbairn (1981, pp.114-15) writes, the child, unable to express either its neediness or its rage, "uses a maximum of its aggression to subdue a maximum of its libidinal need". (Kalsched, 2013, pp. 83-84)

Kalsched further noted:

The child so worthy of preservation as a representative of the human soul and its aliveness, can be permanently exiled by defensive processes and the antilife forces that get established in the psyche after early childhood trauma. When this happens, the soul goes into hiding and its "urge to release itself" may be all but extinguished. (p. 85)

I suggest such hatred, which can manifest in so many clinical presentations, whether it be active suicidality and self-harm, dangerous substance abuse, hate-filled anorexia, or relentless self-sacrifice to others' needs at the expense of one's own being, requires me on the one hand to surrender to the uncertainty, to the mystery such hatred reflects, and at the same time I am called upon to speak the truth, as best I know at any time, neither obedient to the demands of my own superego lest my aggression do harm, nor the injunctions of my patient, but rather to speak truthfully and often forcefully of their destructiveness. Thus, in the face of such destructiveness I often attempt to convey, "The hatred of the vulnerability you experience is enormously understandable. Your early history was filled with such hatred — understandably, you turn on this vulnerability — to kill it lest it kill you — but this destructiveness is not the only possibility for life. Terrifying though it is, vulnerability, need, and tenderness can be embraced and cared for, and that is your challenge, a challenge I can help you with — but you will need to let me".

Loving Hate

Such an intervention usually evokes hatred from the patient towards me. They hate me for challenging the psychic retreat of self-attack which has both preserved and imprisoned them for so long. This hate towards me, I suggest, is a life-giving impulse on the part of the

terrified patient. For their life has been dominated by a paranoid-schizoid belief that aggression/hatred/hate is dangerous and will lead to destruction/abandonment/retaliation and that any aggression that goes towards the other, in this case me, is enormously dangerous. As Bollas (1989) wrote, the therapist:

—who cannot be got rid of ... [the therapist's] ability to survive, his presence and aliveness resuscitate in the patient archaic experiences of the intimate area of experiencing... The route to this person's object relating will then emerge from aggression and encounter, through a form of loving hate, ... that permits [her] to come into the here and now of object relating. (p. 194)

I suggest the hatred evoked by my firm challenge to the destructive intrapsychic other relates to what Balint (1952) suggested is “hate [that] is the last remnant, a denial of, and a defence against the primitive object love (or the dependent archaic love)” (p. 358).

Reparation

In my experience such interventions, over time, invite the terrified infantile states of my patients to emerge, tentatively at first, from their psychic retreat. Milton (2015) emphasised the importance of the therapist retaining their own mind and facing into the inevitable disruptions between the patient's demand that the therapist change their response, rather than that the patient transform their inner world. As Milton commented, such a stance communicates, “we can be in aggressive states with each other without destruction of the relationship” (p. 6). Similarly, in my own work I seek to retain the contents of my own mind, to speak truthfully to this, facing the inevitable disturbances this brings to the patient who will often attack my mind with the message that forcefully communicates, “my misery is your command” (Benjamin, 1996, p. 115). In response I often firmly communicate in one form or another, “I'm here to enhance your well-being, not to passively observe as you self-destruct”. Such a stance requires that guilt about my own aggression, or love, does not overwhelm me. It is a stance enabled by an inner object within the therapist that does not fear aggression or love, and is, I suggest, a stance which over time enables the patient's reparative inner transformation. It is a stance in which both patient and therapist are allowed their own mind, and one in which faith in the possibilities of inner transformation is inherent. As Rey (1994) noted:

—only when the superego becomes less cruel, less demanding of perfection, is the ego capable of accepting an internal object that is not perfectly repaired, can accept compromise, forgive and be forgiven, and experience hope and gratitude. Perhaps it is then that love has won the day ... (p. 227)

Spiritual Lens

Kalsched (2013) went further, bringing a spiritual lens to work with traumatised patients, suggesting that the self-care system that leads patients to isolate and attack the vulnerability

of their infancy, is also a creative and protective response intended to enable these traumatised self-states a place of dissociated isolation from which they may be protected from further harm whilst awaiting the possibility of release and freedom, terrifying and excruciating though this may be. Kalsched's formulation is ultimately enormously hopeful even in the face of such destructiveness. He suggested, "An inner child regresses into an inner sanctuary in order to preserve a sacred core of personality from further violation or to keep it out of unbearable suffering.... But something is being saved for future growth" (p.192). Kalsched quoted Margaret Arden (1998) who noted:

The miracle of psychoanalysis — and it is a miracle — is that when a person comes to understand the core of his or her childhood experience, all the anger, all the rejection of life, turns out to have been for one purpose — to preserve, at whatever cost, the child who is capable of love. (Arden, 1998, pp. 4-5, cited in Kalsched, p. 240)

“I'm Furious”

I have previously written about a patient who after six years of work was beginning to discover her most tender and vulnerable self (O'Connor, 2017). Jane had recently argued with her mother and was close to tears as we explored her grief of never having the maternal responsiveness for which she had longed. Unexpectedly I heard a knock on my front door. (My office was then in the front of a house I owned). I went to the front door. A woman loudly announced, “I'm the midwife”. She had arrived to see my friend and her infant who were staying with me; they were at the back of the house. I asked the midwife to use the side entrance. As I returned to Jane I felt guilty for not having protected the therapeutic space sufficiently. Jane glared. She appeared to inhabit a completely different self-state. She provocatively spoke of her fantasy of sexually seducing me. I felt ill. My mind whirred.

The “ill” feeling was familiar, the feeling of wanting to evacuate the most primitive parts of myself. As we were coming to the end of the session I firmly suggested, “Before the knock at the door, you seemed very tender. I think your shift to talking of wanting to sexually seduce me is an attempt to rid yourself of the most tender and youngest parts of yourself, as if perhaps you fear that there may be another baby here, whose attention is taking me from you, and your wanting to seduce me, is a preemptive attempt to rid yourself of your most vulnerable self, for fear that I may reject her”. Jane appeared furious.

At some point in this exchange Jane commented, “You seem angry”. I felt caught. She was right. I was angry. If I fudged her enquiry, I would repeat the trauma of her history, relational environments in which her own emotional experience was disavowed. If on the other hand I was honest, the internal persecutor in my own psyche might attack me with the shame that my aggression might be destructive. And might my anger drive her emotional tenderness and honest hate back further into psychic retreat? I replied, “I'm furious. I feel furious on behalf of your tenderness which seems to have been obliterated as if her need for contact was too dangerous”. To which my patient replied, “Well, I'm angry too”. And we parted that day in hostile silence.

Was I enacting a complementary identification with an attacking object within my patient or was there something freeing in the potency of my aggressive care for her tender selves, in

contrast to the aggressive attack she tended to enact upon herself? Did this help her to come out from the psychic retreat of sexualised self-hatred? In the next session Jane was tender. She spoke of her wish that she be my only patient, that I not have a life outside of this therapeutic hour, that she did not want to share me. Slowly we explored her archaic attachment longings; her feeling that her mother could never pay attention to her earliest affectively laden body-mind experience. Her profound grief that this would never be possible.

I suggest my expression of anger invites the nascent affect that has been obliterated by shame to reveal itself again. For my fury also communicates my passionate interest in the tenderness that lurks behind the sexualisation. Of course, in utilising our aggressive capacities in service of the tender selves within our patients, we constantly run the risk that our firmness in support of the tender selves, and in response to the self-destructive aspects of the patient's psyche, can be experienced as persecutory; that my firmness on behalf of the tender selves can be experienced by a patient as an attack on that self.

Shame

John Steiner (1993) wrote of psychic retreats as capturing the way patients sequester from themselves and from others psychic states experienced as disavowed in the earliest relational experiences. He suggested that when the patient has the courage to begin to emerge from such retreats and reveal to the exposure of the therapist's gaze the affectively charged aspects of self for so long sequestered away, shame is an inevitable initial concomitant of such courage.

—emerging from the psychic retreat leads to the feeling of being observed [by the therapist], this leads to shame and humiliation, ... the anxieties that arise in relation to the [therapist] observing object does not lessen my view of the importance of anxieties associated with the [parental] primary object. However, it is often the case that shame and humiliation are the initial experiences that confront the patient as he is faced with a new reality. These have to be endured if progress is to be made ... (Steiner, 1993, p. 18)

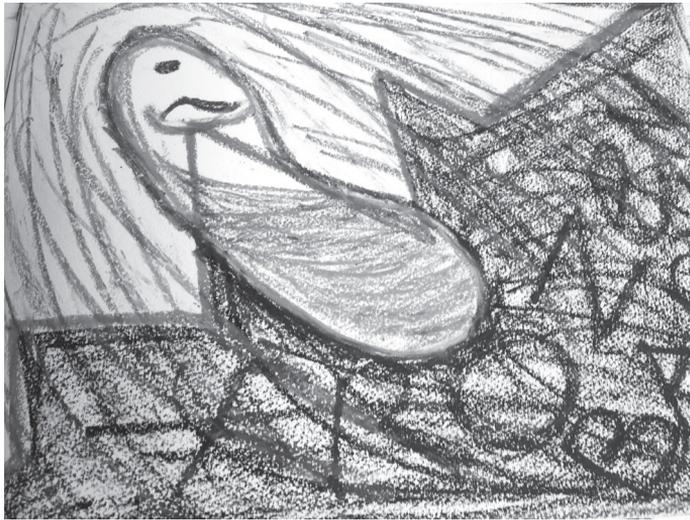
Indeed, the patient's unconscious fear is that these primitive and tender aspects will be attacked once again. There is always the risk that as the tenderness is revealed the patient becomes frightened, as my patient in the midwife moment above did, and shame once again obliterates this tenderness. The initial emergence is fragile and calls for enormous compassion on the part of the therapist for these tender states, alongside often forceful challenge of self-destructive impulses.

Elizabeth Carr (1999), in her collection of articles exploring whether shame is the central affect of disorders of the self, minutely explored this territory. A central theme of these articles was the idea that in therapy there is a risk that our attention on the shame our patient experiences takes us and the patient from the primary affective material which the shame camouflages. Mollon (2005) wrote that the birth of shame arises when there is an early failure of empathic relational response to an affectively infused emotional experience. When shame arises in this delicate work, I often seek to tenderly offer to the patient that, "it

is a shame that the shame has arisen", as it seems, at the very least, to have taken us away from, and at worst aggressively obliterated, the tender vulnerability, the grief, the fear, the anger, the sadness, of more primary affective selfstates. In so doing I seek to invite those tender selfstates to re-emerge from the shame that has reappeared and cloaked them.

Dissociation Inter-Personalised — Frozen Baby

Stern (2009) suggested a mutual enactment is dissociation inter-personalised, as both therapist and patient's unformulated self-states entwined. I once undertook a course exploring the use of art in therapeutic and supervisory work. We were invited to hold in mind a patient who we had worked with and to be guided by our reverie to draw an image that arose in relation to this patient. The following image arose, and I drew it in relation to Jane.



It captures for me not only the selfstate of the infant within my patient, but of the infant within me. Indeed, I think at the heart of our work was the mutual engagement, unconscious to unconscious, of my own infant states in relation to the patient's infant states. The drawing of the image was a form of reverie, an image that reflected not simply my history, nor my patient's, but the creation of a third emerging in the interplay of our subjectivities. As Clark (2006) suggested, "The wounded healer actually heals through his or her ... survival, management and recycling of his or her [own] wounds ..." (p. 81). It is this which enables containment and processing of the wounds of the other.

To Summarise

To summarise, when Bion (1970) encouraged us to enter therapeutic work with "suspension of memory [and] desire" (p. 44) and I meet the challenging demands of complex clinical presentations and highly destructive and/or psychotic presentations, what am I to do?

The positivistic focus of contemporary psychotherapeutic practice in which manualised treatment approaches predominate, whilst often very useful in providing an elegant solution to the difficulties of destructive and other problematic behaviours, is also — at worst — at risk of attempting to manage misplaced and destructive aggression through behavioural management, rather than to understand it in the service of inner transformation. At its worst this positivistic paradigm demands that I complete management plans, crisis management plans, take away the pills, take away the razor blades, focus on so called “safety”, and the writing of yet another treatment plan, whilst paying little attention to the patient’s inner world.

Indeed, the anxiety which I suggest underpins this attempt to control, manage, the perceived dangerousness which lurks within the psyche of the traumatised, fragmented, splintered patient, impairs and debilitates our capacity to think, to dream, to explore the meaning of such destructiveness. Whilst dangerous destructiveness at times does require firm and pragmatic intervention, such interventions also run the risk of avoiding a deeper exploration of what this destructiveness is doing, how the hate within the psyche is manifesting, and in the service of what.

I suggest there is a dialectical tension for us as therapists between knowing and not knowing, certainty and uncertainty. A truly analytic attitude asks me to deeply receive the destructiveness of the other’s psyche. To do so asks of me not only negative capability, the embracing of uncertainty and doubt, but also my utilisation of my knowing of metapsychology that serves me in this function of receptivity. In particular I bring a metapsychological perspective to aggression. I see aggression as procreative for the emerging self within the infant, and as fundamentally protective, but that when turned against the self it becomes persecutory and destructive, such circumstances arising in traumatic early relational environments.

For self-destructiveness, whatever its form, seems to me usually to be a misdirection of potentially creative aggression. Developmental studies reveal that creative aggression is essential to the infant’s survival and is almost always in the service of protection and communication of the needs of the self and its most primitive, somatic, psychic, and psychosomatic needs. The infant communicates through the body. As Broom, Booth, and Schubert (2012) noted, psyche and soma are coemergent, and it is the infant body’s aggressive psychosomatic communication of their distress that allows the infant’s maternal/paternal and early relational environment to receive their communication of need. In the best of early relational environments, the environment sufficiently attunes to this need. As Sidoli (1993) noted, “A potential to generate meaning for affect-loaded discharges is innate in the human infant ...” but that in the early stages it needs to be, “Guided and sustained by the mother [and/or relational other]. She serves as a model for symbolic functioning whenever she is able to offer a safe container for the infant’s instinctual attention” (p. 176). However, if the profoundly somatic bodily tensions are not “given a name by the mother, they have remained silent, are inarticulate, and have no access to pre-conscious or conscious thought or dreams” (p. 179). And as we know when these psycho-somatic and relational communications fail to be received, the infant is left with no choice but to turn potentially creative aggression against themselves, to make their own need bad and disavowed.

I suggest an analytic attitude requires not the management of aggression, but rather the

naming of it, the naming of its destructive manifestation as it reveals itself in my patient's presentation, with the intention that this become, in Ogden's words, an object of analysis; that the hate can be explored, that we might discover how and in what way the destructiveness functions. To do this is much more disturbing than to only behaviourally alter its course.

To do so is to discover, for example, how the patient's intrapsychic hatred is intended to punish and kill the vulnerable self, to attempt to cut it out, whilst also communicating the hatred of this vulnerability, dependency and need, and the hatred of me, the one who is needed, for the dependency I represent. To receive such disturbing communications, I must open my own psyche soma to the violence of the other. I must experience this violence in my own mind. This is deeply disturbing. Yet there is no other way if the therapist is to be midwife to the most primitive, archaic, and disturbing aspects of the other's psyche, we must receive these aspects into our own mind.

Indeed the borderline fault that runs through my psyche, and perhaps through many therapists' psyches, facilitates the reception of such disturbance, and prepares us for this most impossible and unusual profession. It is a very strange profession indeed when our job is to receive the most disturbed and destructive aspects of others' psyches into our own mind.

Parallels in Cross-Cultural Work

I also consider there are powerful parallels in relation to cross-cultural work. One of my patients, whose skin colour is so much darker than mine, brought to me a dream. She reported: "I was me but with a penis. I had dark skin, but the penis was white. It was really big, like ridiculously big. I was jerking it off, and this massive amount of sperm just coming out ... really weird. It wasn't scary, yet I woke up just as if I had woken from a scary dream". She reflected that the dream felt like her trying to get back control of something she had lost. The layers of potential meaning in this dream seemed multiple. Her attacks on me in the therapy left me feeling the subjugated other, castrating me; perhaps her dream reflected an attempt to regain potency in response to both personal, cultural, and gendered subjugation. I wondered what unknowable cultural resonances reverberated between us. What did I create in my mind in response to the darkness of her skin, of the disavowed history of countries in which dark skin is the receptacle of disavowed European self-hatred, and white skin promoted as an idealised other, and what responses are created in the racialized other in response to my fair complexion? Fanon (1982) and Dalal (2002) suggested the unconscious is colour-coded and Dalal further noted:

—the black person has to look in the white man's eyes to give himself substance, to find himself, but instead of himself he finds the white man's perception of himself, in effect he is torn asunder and becomes an object to himself. (p. 97)

Many of my patients have revealed that in their cultural difference, as they experience their perceived minority status with me, they feel a mixture of the fear that I will perpetrate an attack on their racialized selves, as has so often happened in the past, mixed with the introjected shame of crosscultural colonial and/or racialized contact, in which the dark other must see themselves in the white man's eyes. They feel the impulse on the one hand to

aggressively assert their difference and attack me for my privileged otherness, whilst testing whether I can possibly glimpse an understanding of their difference, or on the other hand the temptation to defensively idealise my whiteness, to create me as the saviour, to rescue them from their dark badness. The white superego and the black id.

The dynamics of Rey's (1994) manic reparation are tempting. How do we not be completely consumed, subsumed, by the shame of such histories? I suggest that to do so we must negotiate the immense emotional challenge of encountering the others in ourselves, not only intra-psychically formed, but also unconsciously colour-coded and formed within a socio-political and cultural force field of external tensions, fears, and violence. To accept this emotional challenge is to avoid the temptations of manic restoration that Rey described, in which I the guilty white person seeks absolution for the violent aggression of my ancestors, by manic restoration in the form of submission, guilt or idealisation, or the opposite, reactive denial or impotent bystander avoidance. Psychic retreats are often culturally mediated. And in my experience as the white person encounters the cross-cultural other, the possibility that we might get beyond our mutually unformulated shame, in order to reach each other, is profoundly tenuous, and yet rich with potential. I suggest that central to this task is a shared labour of relational mourning (Gerson, 2009). For when guilt and shame do not predominate, then we can misunderstand each other, be in aggressive states with each other, and stay. The task is enormously complex, and the challenges of the power differential which so often emerge in cross-cultural psychotherapeutic context can never be underestimated or overlooked. However, as the most punitive aspects of my own archaic superego have gradually repaired, and I am no longer so persecuted by an inner object that proclaims my cultural badness, I am more and more able to meet with love, aggression, and tenderness the cultural other, as they are able to do the same with me.

Psychoanalysts' Colonising Gaze

Perhaps that is where Keats' willingness to embrace mysteries, uncertainties, and doubts is profoundly helpful. Snell (2013) noted that,

—psychoanalysis requires the analyst to give up the colonising wish to bring the foreign and the other into an omniscient Enlightenment [and I would argue European] gaze ... Listening necessarily precedes knowledge and theory; yet it is [and we are] always at the risk of becoming compromised by theory, since it is always also, to a greater or lesser extent, mediated by theory that threatens to direct and dictate. When the crisis is too hot to handle, or the moment of crisis has passed and “the colonising impulse gains the upper hand”, the language of the irrational and the unconscious, is suppressed, and so too is the very possibility of psychoanalysis. (p. 33)

As I meet the cultural other in my room, there is so much I do not and cannot understand. There is so much new to be revealed potentially. If I can wait without demand, willing to speak the truth of my emotional experience as I meet the other, might this lead us to something more like transformation? It seems to me that if psychoanalysis is to embrace

negative capability in relation to crosscultural contact, this inherently means not imposing our meta-psychological theories on the other, not holding to our notions of truth about the psyche, but rather being willing to embrace notions of truth about the psyche profoundly different to our own whilst still holding on to our own minds. This is the possibility of two taboos touching, of a deep emotional engagement, of, as Symington suggested, “a meeting of souls” (2007, p. 58).

Vulnerability, Spirituality, and the Self

To conclude with a spiritual lens, the idea that psychotherapeutic work is an inherently spiritual task, has been enormously controversial within therapeutic and analytic writing. I do not propose to attempt to address this controversy, but simply to say that the transcendent for me is inherently within the mundane, and thus I am not able to conceptualise our work in terms other than spiritual.

For me the analytic attitude encompasses receptivity to the mystery of the numinous. Six months into my confrontation with the unconscious as I was recovering from my accident, I dreamt I was in a prison. An old man said, “You have to move to another prison”. It was the prison where prisoners die. I resisted but the old man insisted. At the new prison, other prisoners walked morosely. Black shapes floated ominously. I felt terrified. Suddenly the black shapes became trees, growing up and up and out through the roof. I immediately knew the trees were the path to freedom. Other prisoners started climbing. A voice came over the loud speaker system, saying, “Do not climb the trees until they’re fully grown, otherwise you will die”. I waited. The prisoners who had started to climb prematurely, suddenly fell to their deaths. I awoke feeling calm. Later I painted the image of the tree from my dream. The dream guided me for the rest of my recovery. Was this the voice of the transcendent self, advising me not to attempt to climb too quickly, a self encouraging me to resist my impulses to flee the terror of my traumatised body and mind? This dream resourced me as I surrendered to the descent demanded by my physical and psychological limitations.

For me, my dream is an invitation to surrender, not to rush back to the manic flapping of restorative action, but to bide my time, and to climb the tree out of imprisonment only when I am strong enough. Similarly, the persecuting introjects of our psyches react in the heat of affectively charged clinical and cross-cultural moments. We need time and space to calm the internal disturbance; to find our own minds. To do so we have to face and feel the fear, sometimes intrapsychic terror, of not obeying the compulsion to omnipotent action. We have to face the shaming aggressive attack of our inner world that convinces us of our badness. As we wait for deeper truths to arise. To allow for a tree of new life to slowly grow from the prison of our own and our patients’ minds. In relation to my patient Jane, I believe our therapeutic exploration has been deeply enriching. For whilst our engagement has been rigorous, aggressive, dangerous, tender, and heartfelt, it has gradually allowed the birth of selfstates previously unformulated in us both. Aspects of tenderness, infantile need, dependency, vulnerability, and love have been birthed between us.

And this birth has been literal as well as psychic. It has allowed Jane to finally in her life create new life, in the form of a young daughter to whom after much psychic preparation,

she gave birth some months ago. And in our final hour, as our work concluded, she brought her daughter in to meet me and allowed me to hold her daughter in my arms. For most of our final hour together she was utterly maternally preoccupied with her daughter. I was but an audience to the beauty of her devotion. I felt redundant, at ease, and in the presence of the universe in a mother's arms.

I am aware as I speak of the dialectical tensions between my intrapsychic worlds, that of my patients, the cultural demands of a positivistic psychotherapeutic climate, and of a violent colonial history, the competing theories that demand my obedience, and the tenderness of my own soul. Can I bear such powerful emotional forces? Can I wait? Can I wonder? In the hope, that like Hillman (Moore, 1990, p. 233), we might be midwives of the soul, allowing the birth of new life, the formulation of new self-states, and the compassion always to love both ourselves and our patients, even as we hate them, in the inevitable swirl that is the meeting of unconscious minds.

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