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The New Zealand Association of Psychotherapists (Inc.)

Te Roopuu Whakaora Hinengaro

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Cover motif *Hands* by Liam Davidson, Auckland

Editorial

As psychotherapists we are very familiar with the close, private, transference oriented settings in which we carry out most of our work with individuals, couples and groups. We provide a place where painful experience, long held secrets and inadequate relationships can be uncovered, unravelled and redeemed. It is a privileged place that must be guarded from intrusion and violation.

It is not surprising, therefore, that as psychotherapists we are not prominent in the wider cultural, social and political arena. For many, the prospect of this sort of visibility is personally daunting. Quite apart from issues of professional boundaries and the sanctity of the therapeutic dyad, many would feel temperamentally disinclined to have a more recognisable social profile. There may also be issues of professional identity and confidence. What is the rightful place of psychotherapy in the fabric of our culture? We are notably more inward looking than outward looking in our professional demeanour, with some obvious and prominent exceptions.

Therefore, to have Andrew Samuels as keynote speaker at our 1997 Christchurch Conference was a refreshing reminder that psychotherapy has the potential for a very political edge. It was also a challenge to us that as a profession we go largely unconscious to the expression of this edge. It was a reminder as well that the Conference topic of *Difference and Integration* applied as much to our professional relationship with the cultural and political milieu of which we are a part, as to how we as an Association manage difference and integration among ourselves. I hope that the impetus given this is not lost.

I consider it very important that as we celebrate this 50th year of NZAP as an organisation, we be reminded of the social and crusading spirit that seemed so much a part of the founding of the organisation. For these reasons it is most appropriate that Andrew's keynote address be the first article in this edition of the NZAP *Forum*. As psychotherapists we consider ourselves one of the barometers of pain and distress in the culture. We are also I would suggest, one of the witnesses to the indomitability of the human spirit. We have a number of psychotherapeutic lenses and methodologies from which we can

make meaning of our cultural and political milieu and of the actions of individuals and groups within it. We should not be shy in offering our interpretations, our caveats and our suggestions publicly.

In this 50th year also Ruth and Brian Manchester produced for us *Notes towards a History* of the Association. We appreciate the effort and intensity that this required. We need to know where we have come from, and what has inspired us on the way. Equally, we need to recognise that we are making our history right now. How do we want that to look to future historians of the Association? It is in our hands.

Peter Hubbard
Editor

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This is a lightly edited version of the transcript of the keynote address given at the annual conference of the New Zealand Association of Psychotherapists held in Christchurch in February 1997.

Introduction

The paper divides into five sections. The first section is called 'We've had 100 Years of Psychotherapy Wanting to Improve the World, but It's Stayed Pretty Much the Same.' Many therapists know of Hillman and Ventura's book *We've had 100 years of psychotherapy but the world is getting worse.* However, therapists displaying concern about politics is not a new phenomenon.

The second section is called 'Grounds for a Cautiously Optimistic Prognosis'. The third is on 'The Economic Psyche' and the fourth is on 'The Political Self'. Finally, there is a section called 'Citizens as Therapists'. The first two sections are the more academic parts of the paper but set the scene for the fun and games of the last three sections. One earns the right to experiment!

We've Had 100 Years of Psychotherapy, Wanting to Improve ....

Many psychotherapists, particularly in New Zealand it seems, want psychotherapy at last to realise the social and political potential which was there from the beginning, and which the pioneers knew about and cared about. Many want this to happen, but have we actually got beyond the slogans about it? Have we, as the Americans say, reached the beef? Where is the detail? Where are attempts to go beyond the slogan?

Winning a debate in any area of knowledge or practice, like therapy, isn't enough. We need to push on from the victory in a debate about psychotherapists

playing a role in social and political processes to conceive of them actually playing that role and achieving results. But we also need to acknowledge that anybody seeking to improve anything in this world is up against massive and impersonal forces that do not want things to change: the economic system, the workings and institutions of global capitalism, patriarchy and its ways. I also have in mind the following paradoxical problem: the human unconscious and the human soul are the sources of imagination, creativity, hope, smiles - but they are also sources of our problems. The unconscious in its cruel and negative aspects resists improvement and change and definitely contributes to the difficulties human beings face. This statement could be seen as a psychotherapist's philosophy of life: the very thing that gives us hope that solutions might be found is also the source of the problems that scream out for solutions.

At the beginning of the enterprise called psychotherapy, the founders felt themselves to be social critics just as much as personal therapists. In 1913, in a paper entitled *The Claims of Psycho-Analysis to the Interest of the Sciences*, Freud said that psychoanalysis had the capacity 'to throw light on the origins of our cultural institutions, on religion, morality, justice and philosophy. Our knowledge of the neurotic illness of individuals has been of much assistance to our understanding of the great social institutions.' And Jung, in 1946, in a collection of essays on Nazi Germany, said 'We are living in times of great disruption. Political passions are aflame, internal upheavals have brought nations to the brink of chaos. This critical state of things has such a tremendous influence on the psychic life of the individual that the analyst feels the violence of its impact even in the quiet of his [or her] consulting room. The psychologist cannot avoid coming to grips with contemporary history, even if his [or her] very soul shrinks from the political uproar, the lying propaganda and the jarring speeches of the demagogues. We need not mention his [or her] duties as a citizen which confront him [or her] with a similar task.'

The great founders of humanistic psychology such as Maslow, Rogers and Perls recognised the same thing - that they had in their hands a tool of social criticism and a possible agent of social change for the better, just as much as something that would help individuals in emotional difficulties.

Then there's the Frankfurt School, the group of thinkers who tried to marry up Freud and Marx, producing books and papers in profusion, even now. Probably psychotherapy trainees do not study the Frankfurt School but, in my view, they should. Or Wilhelm Reich and his work in the area between

communism and psycho-analysis. All manner of radical therapists have existed for many, many years. One thinks of R. D. Laing. What about more modern thinkers, post-Jungians like Hillman, Bosnak or myself? Increasingly, psychoanalysts are thinking about society. If we listen to the titles of their books, we will hear their message. Neil Altman on *The Analyst in the Inner City,* Philip Cushman on *The Making of the Self, The Making of America*. Or Arnold Mindell, John Rowan, Joanna Macey. Or feminist psychotherapists like Susie Orbach and others. **This is not a new project.** It is so old that we might even consider it a failed one.

Similarly, psychotherapists work in and their ideas are used in all kinds of social and communal institutions, and have been for 100 years, sometimes making a little headway, but often doing well. It simply is not new. Grim, psychodynamic insights have been brought to clinical engagements with people living in poverty. I repeat: we need to face that the project is not only not new, it may not work. Why?

Let's be therapists of this political project that we as therapists have. Let's analyse the possible reasons why it hasn't worked and use that analysis as a basis for a way forward. To paraphrase Freud, it is not only impossible to bring psychotherapy to the world, it is also very difficult.

The first reason why we failed is our incurable psychotherapy reductionism and triumphalism. We write articles for newspapers about the phallic symbolism of cruise missiles going down ventilator shafts in Baghdad. We talk about Mrs Thatcher as a restorative container for British infantile greed. The Jungians are just as bad, or even worse with their archetypal reductionism - the military industrial complex as the work of the Greek God Hephaestus, feminism as the legacy of Artemis. What is the point of this? If we are inviting the world into therapy, then the world has been right not to come to its first session. What motivates such psychotherapeutic reductionism is a quite understandable desire to be right. Many times when talking to therapists about politics, I have felt our energy as dedicated to the successful application of an idea to a social problem, rather than having much to do with the resolution of that social problem.

Another reason why we failed is that we split off our social analysis and social criticism from our clinical knowledge. There has been a big divide between the therapist as a sort of social critic and the therapist as a professional working with an individual, family, marriage, or small group. I think this has been a terrible mistake because, if we don't bring in our clinical knowledge, then what

possible grounds are there for anybody listening to what we say about politics? Clinical expertise is all we have. Hence it is very important to me to continue to be a clinician, even though I have had opportunities not to. Our therapy work constitutes what marketing people call our USP - unique selling point - when it comes to social criticism. It is more than a question of using what we hear from clients in an evidential way. It is also about seeing how the inner world - emotion, affect, fantasy - builds up in a ceaseless feedback loop with the outer world. It is understanding that outer world problems contain emotional and fantasy elements as well, seeing how the political and the psychological mutually irradiate. That is what I mean by not splitting politics off from clinical work.

The third reason why we have failed has to do with the professional mentality of many therapists, stemming from psychoanalysis even if the therapist is not a psychoanalyst. There is a residual worry in the culture of the profession about abandoning 'neutrality'. This worry affects even those people, like me, who have abandoned a good deal of the professional neutrality they were trained to privilege. I feel guilty and anxious because the critics of the abandonment of professional neutrality have got a point - they do need to be listened to. This is not the time and place in a keynote address to go into the detail of why the critics of those who have abandoned professional neutrality and abstinence are wrong. Suffice it to say that it is possible to have a debate about this, to dispute what constitutes good practice. My colleague, the psychoanalyst Earl Hopper, working in similar areas to mine, says, quite honestly, that we are going to have to start advocating what is at present 'bad practice' in order to achieve a new definition of what might constitute good practice.

The fourth reason why I think we've failed is that we do not have access to politicians, powerful people and opinion formers. On the one hand, I think this is a real problem and I wish we did have such access - and I do not just mean having politicians as clients. There are very good reasons why any serious student of political process might not want to have us on board. Our record is appalling, One does not have to be Jeffrey Masson and write a book against therapy, or James Hillman and give up practising therapy, or the novelist Fay Weldon launching yet another attack on what she calls 'therapism', to conclude that many attempts by therapists to work in the social domain have been disasters. Consider First World War attempts by therapists to deal with shell shock and battle neurosis, or the affective part of psychological testing (TAT), or co-operation by therapists with oppressive regimes all over the world and at all stages of the history of therapy, including Jung and his ambivalent

relationship with Nazi ideology. Nikolas Rose, a Professor of Sociology at the University of London, refers to our profession's goal as being to 'govern' the soul and, actually, if one looks at the grim record, one can see what he's getting at. Then there's the whole question of our weddedness to normative standards in relation to gender, or parenting, or sexuality. There has been an appalling failure by the psychotherapeutic professions to come to the aid of lone parents and their families as they are made the scapegoats for economic failure by almost every Western-type society.

Then there is the whole question of sexual orientation and the fact that, even in the mid 1990s, it was necessary for me and others to launch a campaign in London to end the discrimination against lesbian and gay candidates for training at the Institute of Psycho-Analysis. Never mind the fact that most psychoanalytic theories about homosexuality are prejudice dressed up as theory.

Finally, and appropriately here in New Zealand, with talk of biculturalism and multiculturalism in the air, the claim of psychotherapeutic thinking to universality is damaging. Yet it is so difficult to get beyond it, to come to terms with the Oedipus complex as characteristic only of *fin-de-siècle* Vienna, or with Jung's idea that women should not wear trousers. Moreover, at the heart of Western psychological theorising is a notion of the self that may actually be quite destructive even in the West, and irrelevant everywhere else. Such a self rests on fantasies of autonomy, self sufficiency and disconnectedness. There is empty space between us, according to psychoanalysis, space that is overcome by projection and introjection. Such thinking is not neutral in that it is very convenient for the powerful to function (and to sell the idea to the less powerful) as if there is only empty space between us. So the problematic claim of psychotherapy thinking to universality is much more than simply an imposition of 'white' psychology on 'non-white' psychology.

Grounds for a Cautiously Optimistic Prognosis

I think I have got the credentials to talk about a cautiously optimistic prognosis. With others, I have founded a number of small organisations in Britain working at the interface of psychotherapy and politics. Since *The Political Psyche* came out in 1993 I reminded myself that the major work of politics is stuffing envelopes and I decided to get into political organising once again. In my youth I was very politically committed and I learned that you have to add organising to all the other political virtues. It is in fact the quality that guarantees all the others, to paraphrase what Churchill said about courage.

One organisation is called Psychotherapists and Counsellors for Social Responsibility. We thought we would get 50 or 60 members. We had nearly 800 at the last count and it is still rising. We are, in fact, the largest psychotherapy body in the UK if you leave out the umbrella organisations. It does not mean that all the 800 members see PCSR as their primary affiliation. Probably none of them do, including me. Nevertheless it is a sign of the times that something like this has come into being. I wanted to call it 'Psychotherapists Sans Frontières' until somebody pointed out that this could be translated as 'Therapists Without Boundaries'!

I started a second organisation together with Susie Orbach. It is called Antidote, and is a psychotherapy-based think tank. Whereas in PCSR the idea was to recruit as many therapists as possible, in order to create a movement for therapists, in Antidote we want very few therapists because the idea is to get into multidisciplinary work with other professionals in other disciplines: academics, politicians, media people. We seek to do collaborative work in areas as diverse as emotional education and emotional literacy on the one hand and economic policy and attitudes to money on the other hand.

The third organisation is called the St James' Alliance. This is an attempt to bring together the disparate elements in what I call transformative politics. Basically this refers to those political groups that have some kind of commitment to spiritual and/or psychological values. Mostly, but not exclusively, these stem from environmentalism, the new economics movement (following Schumacher) and certain kinds of feminism. The problem with all these social movements, as they're called, is that (in Britain at least) they are single-issue-based groups who are unbelievably unsympathetic and hostile and enviously destructive towards the aims and goals of other single-issue groups. So a person working on poverty in the inner city simply has no interest in animal rights and animal liberation, and vice versa. What we are trying to do with the St James' Alliance is to get these people to sit down and see what it is they do have in common and whether some kind of loosely-woven alliance of the elements of transformative politics could happen.

Another forum where I and others are working is the British Labour Party. We take to the Labour Party Conference a fringe meeting called The Political Psyche Network. We had some trouble with the most recent conference prior to the 1997 General Election because I put in, as a proposed title for the meeting, 'Preparing for Failure'. What I meant was that we are not going to be able to achieve what the membership of the party wants. The party officials

heard this as suggesting that we might not win the election. We got a letter from party headquarters saying you cannot call it that, so we called it 'Preparing for Disappointment' instead, which was all right apparently.

Other work that I have done personally has been with the remarkable United States Senator Bill Bradley; there has been a series of conferences on myth and politics. I have done some conflict resolution work and, as you know, I try to do things in books as well. Anyway, these are some credentials for talking about the optimistic side of this.

There is a change in the definition of politics going on. Feminism started it off with 'the personal is political' and all the work on the hidden politics of family process. I would like to build on and go beyond what feminism achieved in redefining politics. This involves understanding how much of human aspiration, how much of that reaching upwards, onwards, outwards, that we know of in the arts, or in spirituality, may actually also be achieved in and by social and political action. What happens generally is that there is a kind of breakdown or dysfunction in language that has to be overcome. The language of the heart (inner world language) and the language of politics (outer world language) have got so separated that bringing them together sounds somewhat flakey. This breakdown in language is, of course, a problem but it is also an opportunity to create a hybrid language. It has become somewhat easier to do it in a postmodern, pluralistic, multicultural world. The hybrid language reflects psyche in some ways and polis in others. Moreover, what was an academic, feminist insight is poised to break into mainstream conceptions of politics.

Another very interesting development is that people are beginning to see that there is a difference between what we could loosely call political **power** and what we could loosely call political **energy**. Political power is what everyone knows it is and the people that have it are the people we know have it - whites, men, financial institutions, the military, governments and the like. Political energy is more to do with an imagination-based approach to politics, a focused approach that uses imagination as much as realism or empiricism or facts. Almost by definition political energy doesn't get things done, therefore it doesn't show up according to the kinds of measurements that are conventionally used. Yet so many people seem to know that it exists and that it is the polar opposite, at present, of political power. Recognising that there is something called political energy is in and of itself empowering. It enables you to stop judging a political situation, a political act, a political statement by the kinds

of criteria that the media and the so-called real world use. Those criteria have much to commend them, but the criteria for political energy also have much to commend them. I think this discrimination between political power and political energy is a new and exciting development.

Another reason why I think we can be cautiously optimistic is that the politics of difference with which many Western type societies are presently engaged have started to spawn a psychology of difference based on experience and not on definition. The experience of being a Maori, the experience of being a child, or a woman, or a lesbian or gay man, or a Jew. Not what a Jew*is*, or is supposed to be; not what a woman *is*, or is supposed to be; not what a Maori *is*, or is supposed to be. Rather, fashioning a psychology based on the experiences, testimonies and stories of these relatively marginal groups (which are anyway not as homogeneous as they seem. Women are not exactly a marginal group except when it comes to politics and there, in many senses, they still are, which is why I included them under the heading of a marginal group.)

Another reason to be somewhat optimistic and hopeful is that everybody wants to do multidisciplinary work now. This is what might save us from the reductionism and the triumphalism which I put at the top of the list of reasons why our project has failed. In the air at the moment, there are attempts in many disciplines to reach out and find people who are doing different work with which they can achieve a linkage: for example, between religious studies and sociology or between psychology and physics. These diverse disciplines are linked up now in ways which the conventional Western academy could not have imagined even 25 years ago. Moreover the nature of knowledge is changing. Tacit, intuitive, feeling-based or fantasy-derived, heuristic knowledge is finding a new welcome, even in bastions of rationalistic Enlightenment thought like universities.

A further reason for optimism is the psychotherapy professions themselves are beginning to pay more attention to their political problems such as the historic discrimination against homosexuals. The question of the hierarchy within the profession also needs to be addressed: psychoanalysts who belong to the International Psycho-Analytic Association at the top, some Jungian analysts at second, psychoanalytic psychotherapists third, other Jungian analysts fourth, Lacanians fifth, psychodynamic therapists about sixth, humanistic therapists coming in seventh and last. This hierarchy may not be completely relevant for New Zealand, but I have had enough conversations in the few days I've been here to know there is a hierarchy and reading the entrance criteria for

membership of this Association further convinces me that this is the case.

There is also the beginning of a challenge, not only to the hierarchy, but also to what in academic jargon is called the 'social and economic location' of psychotherapy, which, roughly speaking, means 'do we consider ourselves as on the social level of teachers, community workers and priests, or do we more accurately resemble gynaecologists or lawyers?' It is, of course, very much a question of money.

Further, hope lies in what I call the frontier areas. All kinds of innovative work is being done outside of the traditional psychotherapy centres in Europe and north America. For example, my colleague, Craig San Roque in Alice Springs, addressing the question of aboriginal alcoholism, speaks roughly along the following lines: these people never had alcohol, so they never had the kinds of containing myths and rituals which surround alcohol. The containing myths and rituals of much of Western civilisation around alcohol are best expressed in Euripides' play *The Bacchae*. Can we take the essence of *The Bacchae*, says Craig, and make it into something that speaks to the problems of alcoholism in aboriginal people? Yes, he says, as he writes his jointly authored epic, *Sugar Man*. It could only happen in the unsophisticated, naive, brash, inexperienced, but oh-so-alive frontier.

Let me give another example which cuts right across the hierarchy and right across the schools of psychotherapy as can happen if you're in a frontier area. I remember meeting a young woman in Moscow. 'What do you like to do?' I said to her, 'What interests you?' 'Oh,' she said, 'I like Winnicott and Neurolinguistic Programming'. You cannot imagine anyone in London...

The Economic Psyche

Why am I suddenly announcing some talk about economics? The first reason has to do with credibility. If you want to be involved in this exciting interface between psychology and politics, you'd better start talking about economics quickly, because it is, as they say, the bottom line issue and if we psychotherapists can't hack it in debate and discussion when it comes to economics then we won't get listened to, and perhaps shouldn't be listened to, when it comes to softer and easier areas. Soft areas for psychotherapists include things like child sexual abuse, family matters, education, even the environment. Money? Economics? They're much more difficult, which is why I've chosen them.

There is also a question of authority here, because economic policy, as stated

in the documents and statements and as visible in its effects, rests on notions of human nature. There is going on at the moment what I call the 'human nature debate'. It is a struggle over a relatively scarce resource called human nature. Now this is a metaphor - I don't mean human nature is a resource literally. What I mean is that those people who advocate free market economics, and you've had your taste of them here in New Zealand, buttress what they do by implicit and sometimes explicit appeals to human nature defined in terms roughly along the following lines: it is human nature to be greedy, acquisitive, competitive, to look after yourself and your family's interests and to only look after the interests of others to the extent that you need some sort of structure, even if you don't call it society, within which to function. Unfortunately, that side of the human nature debate has thoroughly won the argument and social democratic tinkering with economics does not alter that fact. The other side, the side that speaks about co-operation, collaboration, altruism and an already existing sense of connectedness in the economics sphere, lost and has often been castigated as idealistic or over-idealistic, unpractical and adolescent.

I want us as professionals in this area, expert analysts of this resource called human nature, to enter the human nature debate, not only on the positive side, but rather as attesting to the **ambivalent** quality of human nature. Yes, we are greedy and cruel, and yes, we can co-operate and be altruistic as well.

Economics also brings in ethical issues. People are dying because of economics and even if they're not actually dying there is something called the 'feminization of poverty' to consider. This is the phenomenon, not just in the majority world, but in the Western minority world as well, whereby it is women and therefore children who suffer most from economic problems, economic privation and economic change. As a country gets richer, women and children get richer more slowly than the men do. This is the feminization of poverty.

Another ethical reason for focusing on economics as therapists is that our bit of the wealth/health connection needs to be understood. I'm not just talking about psychological problems of the rich, about which we know quite a bit - Howard Hughes and so forth - or the psychological problems of the poor which a lot of psychiatric social work literature has managed to address. I am actually talking about the psychological problems of the people in the middle - of middle income, middle-class clients. What I've discovered in my practice is that a great deal of emotional misery and neurosis in middle-class clients does stem from economic sources, *but the sources have to do with merely their living in*

an unjust, unfair and crazy economic system. Just being in that system makes you psychologically ill. You don't have to be suffering from it in a poverty sense, or mad-makingly overwhelmed with its goodies if you are rich. You just have to be middle-class and it drives you crazy. Economic inequality drives everybody nuts - that is what psychotherapists need to be aware of in their clinical work.

The last ethical point concerns ethnic minorities. I have no idea what the statistics are but I am absolutely sure that the per capita income of Maori and their families in this country is less than the per capita income of other ethnic groups. I'll return to that in a kind of depressing coda at the end of the talk.

Economics at the moment is not only a dismal science as Carlyle said, it is a dismal **male** science. It is impossible in Britain and America to get young women to study economics in spite of the fact that changes are going on in this area - there's even a journal called *Feminist Economics*, which is very good indeed. As you may know, a lot of women's work in Western type societies is simply not showing up in the GNP and other statistics. Not only women's work, but children's work as well, and I don't just mean child slave labour that might be going on in the Indian subcontinent about which you read, but just the work and labour of children in ordinary families doesn't show up on GNP either. We have to challenge the whole myth of contemporary economics.

The clients are very interesting here. I did a survey of 2000 psychotherapists in seven countries. Fourteen different institutions participated in the survey (see Samuels, 1993). I asked people if their clients talked about politics and social issues and which ones they talked about. Worldwide, gender issues for women was top by a long way, but, also by a comfortable margin, number two was economics. I gave some specifics: inflation, poverty and distribution of wealth. I was amazed to find that, to the extent that clients are talking about politics, and to the extent that there are therapists receptive to them talking about politics, and to the extent that those therapists would own up to it in a survey, economics is the number two issue which I think is very interesting.

Personal Economics

Let's get personal about economics. I divide this into (1) economics past, (2) economics present, (3) economics benevolent, and (4) economics shameful. My method here is to try to be psychological about the kind of thing we are not trained to be psychological about. It is, in the best sense of the term, a consciousness raising exercise.

Economics past. What was your first 'economic memory' - about money, or the economy, about your parents' jobs? What was your first economic memory? What was the first time you became aware that there was an economic system in existence, with polarities of wealth and poverty, with unfairness - the first memory of that kind? How was money dealt with in your family of origin? Who controlled it? What kind of source of difficulty, or indeed ease, was it? What class was your family, and what did your family feel about it?

Economics present. Have you done better than your parents? And if so, how do you feel about it? Have you done worse? And if so, how do you feel about that? Are you much the same economically speaking, and how do you feel? How open about money are you, really? How do you handle money in your personal relationships now?

Economics benevolent. How much more tax would you be prepared to pay if you knew where it was going and could control where it was going? What economic and material goodies could you do without?

Now this is a difficult one -**Economics shameful.** I used to call this 'economics sadistic' but it put people off. I want you to fantasize about the most shameful, sadistic, controlling, horrible thing you could or would do if you had a very large sum of money - hundreds of millions of dollars for example. Just to give you an illustration of the kind of thing I have in mind - because I don't mean that you would take all the capitalists and poison them which you may not really think of as a shameful fantasy. There was a college professor of philosophy at one of my workshops in America and he said 'Well, if I had unlimited funds, I'd buy or obtain a very large amount of skiing land at Aspen and I'd fence it off so nobody could use it.' I didn't think this was very sadistic, to say the least. Then he added: 'And I'd hire the US Marine Corps and machine gun anyone who came near.' Then he burst into tears and told us about his tycoon father and the relationship he'd had with him and so on and so forth. So it is not just a question of a self congratulatory sadistic or shameful fantasy I am after. This is about really owning our own bit of the system we can all too glibly detach ourselves from.

The Political Self

Have you noticed that the 'economic psyche' and the 'political self' are hybrid tags? Economics and politics are not words you associate with the psyche or the self.

Earlier, I mentioned political energy. Never mind about defining it precisely. Just associate whatever you want to the idea of political energy. Now - score yourself for political energy, on a scale where zero is a kind of political moribund state, a political catatonia, and 10 is political hypermania. Score yourself on a scale of 0-10, just as you are now. The next time you have a committee meeting, score yourself. What you'll find is that quite a lot of what look like wrangles and disputes are because people are at very different political energy levels. Now let's get more sophisticated and refined with this. When you're with people of the same sex, does your political energy level go up or down? When you're dealing with a political conflict at home, as opposed to the office, which are you more likely to be - very high or low on the political energy scale? You can't answer just yes or no - just think about it. The context is terribly, terribly important for this political energy business. There are some people whose energy level for professional politics seems to be at the 8, 9, 10 end of this and there are others who simply cannot understand that, but have a very high political energy level for real world politics. Now I think those two groups of people ought to talk more, because what they have in common is the high level of political energy. This is supposed to be a value neutral scale, but of course it isn't, obviously. If someone is, in every context, around 0, 1, 2, I regard that as neurotic, just as much a problem as in the case of someone who, in every context, is around 8, 9, 10.

Where do your politics come from? What have been the influences that have made you the political self you are today? What role, for example, did your mother play, or your father? Are you in reaction to their politics, to his or her politics, or are you in identification with his or her politics, or what? And what about your parents, if you had two, as a duo? What I mean is, the image we have of our parents' relationship is a highly political one. You know the story of Lilith, I'm sure, which is the real primal scene of Western culture. Not Adam and Eve, Adam and Lilith. God made Lilith from the same dust as he made Adam, and at the same time, none of this Adam's rib business. The first night in the garden, Adam gets on top of Lilith to make love to her and she protests, saying 'Why are you assuming the superior position, when we are created at the same time from the same stuff?' Adam goes on and rapes her. It is the first marital rape. Lilith calls out the name of God, whizzes up into the stratosphere and has a subsequent career as a she-demon, responsible for stillbirths, which means she attacks what's fundamental to women in Western culture, and responsible for wet dreams, which attacks what's fundamental to men in Western culture, namely the control of their own sexuality. The relationship

between a person's parents is the most political inner world relationship imaginable.

Other significant figures might well have played a part in creating your politics. Teachers, priests, people you meet on a train. It's quite extraordinary how many people will attribute a rise in their political consciousness at such and such a moment in their lives to a strange, chance encounter. Your sex plays a part in your politics, and your sexual orientation as well. I imagine both those points are self evident. Class clearly also is central. Ethnic, religious and national factors play a part as well. National psychology and the impact that has on people's politics is a field that is only beginning to be researched just now. One needs to be awfully careful if you come from a European background about what you say about the relation of the earth to psychology, because there is a shocking history attached to some people who have made that connection (i.e. the Nazis). But there's something in the idea. There is something in the way the earth plays a part in nation building. Jung's phrase was 'the foreign land assimilates its conqueror.' That's happening here, I think, and it's certainly happening in Australia, as well. There is something about the space you inhabit and the earth you are on that plays a part in your politics. (But be careful to keep this observation in the area of metaphor - not to literalize, because that way lies fascism.)

For some people, a specific event is the key thing in their politicality, in the development of political self. For me, the Suez crisis played a huge role in making me aware that there was something called politics.

There are 'political types' to consider - people do their politics in different ways. Let me just give a list of political types that I've drawn up: warrior, terrorist, martyr, exhibitionist, leader, activist, parent, follower, child, victim, healer, analyst, negotiator, bridge-builder, diplomat, philosopher, mystic, ostrich. You don't have to choose just one of these as fitting you. You can say 'I'm often a terrorist with a bit of bridge-builder thrown in', or 'I'm a mystic with a child part' in terms of politics. There are some people who are very well developed in one particular type. They are good at doing their politics in the style or type of a martyr, say, but they really need to work more on their diplomat side. One can use this political typology with discrimination.

I have found that a lot of political conflict comes about because people are actually doing politics in such totally different styles that this is in fact stopping anyone from seeing what the real differences of opinion are and what the real struggle is about. People are simply approaching politics in totally different

ways. For those of you who know the Jungian typology, it is a bit like when an intuitive meets a thinker. There is often complete miscomprehension and misrecognition. I think this happens in political typology as well.

This has been a very compressed introduction to the political self. I asked you to see how political energy flowed through your political veins, asked you where did you get your politics from, and I wanted you to start thinking about what political type you are. You don't have to use my tags. Just start thinking of politics as something people do in different ways, just like we do sex or aggression or spirituality in very different ways. Somebody pointed out to me when I last talked about this that I am trying to do for politicality what, by now, we do quite automatically for sexuality. Nobody does sex in the same way all their life and it would be awful if everybody did sex in the same way. So, too, for politics.

Citizens-As-Therapists

As therapists, you are now trained to use your subjectivity in the service of the client, to regard what comes up in you on a less than rational or other than rational level, as pertaining not only to you but also to the client. You have permission to regard your subjectivity as a not-me possession. It's called sometimes the countertransference revolution. It has stopped therapy from being an on-high, mechanical, experience-distant activity. It has put the receptivity of the therapist at the centre of the work. You know all that stuff, of course.

Most citizens today have private reactions to politics which they have been trained to disregard as extraneous, as of low grade, and as being slightly embarrassing. They don't know the facts, they don't know the history, they don't know the lingo and they're scared of saying the wrong thing in the wrong place, or they're going to go over the top and get involved in a nasty political argument, or maybe they get only involved in nasty political arguments. But tacit private politics is **not** privileged in citizenship the way that private countertransference reactions are privileged in psychotherapy. Now, I'm not saying that psychotherapists should offer this precious gift of countertransference to the world. What I am saying, though, is that, if a group of relatively responsible and reasonably well trained and quite thoughtful professionals are valuing subjectivity in this way, then it is not inconceivable that much larger groupings of people that we call 'the people' or 'the citizens' might also begin to value their political subjectivity in a parallel way.

I run events called political clinics in which citizens sit around as if they were therapists considering in their minds a political problem which I have asked them to think of as their client. I have explained to them how therapists approach a client, in a state of countertransference readiness - open to receive the unconscious-to-unconscious, or body-to-body communications. People who are not therapists pick it up pretty quickly. It's quite amazing what comes up when people start reporting their crazy-seeming, body-based, image-based, and fantastical responses to issues such as medical care, Northern Ireland, nuclear proliferation, homelessness, just to name a few topics that have come up. People express what seem like totally mad things and then we try and decode it. When we've decoded it as well as we can, the group has a normal sort of political discussion on the same theme. It is quite amazing what there is locked up in the radical imagination that is excluded from conventional politics. If citizens were more like therapists in their valuing of private responses to public phenomena, then I think we'd have a quite interesting further stage in the development of the notion of the citizen. I think we spend far too much time putting psychology to work in analyzing the leaders. But it's the citizens that can be reframed as therapists.

In the tradition I come from, which is broadly speaking psychoanalytical, the citizen is very rarely in the adult role. Therefore the citizen cannot be a therapist, if a therapist is an adult. The citizen is usually theorized as a baby having a transference to the parental state. The citizen is dependent, having a transference to the caring and/or hurtful medical system. The citizen is passive, functioning as a bystander in relation to forces sensed to be more powerful. The citizen as baby, client, passive, is a formulation that keeps the citizen in his or her place. Citizen as adult, **citizen as therapist**, moves the citizen (just slightly) to a different place.

Concluding Reflections

This talk has been about a two-way street between the world of the psyche and its therapists and the world of politics and its therapists. I want us to walk this low and difficult road in clinical practice as well. When therapists do talk about politics, usually they report it in the context of a ten-minute chat as the session is winding down. According to me, that chat may well be the heart of the session. I don't want addressing politics in therapy to be a special interest. I want it to be ordinary mainstream therapy practice.

Now comes a difficult bit. In secure conference chambers peopled by liberals, the vulnerable win the conference: Maoris, women, lesbians and gays, poor

people, psychiatric patients, and the like. Virtually every conference I go to is driven within that secure liberal space by what looks like such a victory, and don't we all feel good about it, on behalf of those marginal and dispossessed people? But it isn't a real victory. You can't make a revolution in a three-day conference and it's horrific when people feel that that's what has happened.

I will simply end with a quote from my personal, cultural tradition, from Hillel, the first-century Jewish sage: 'If I'm not for myself, who will be for me? If I'm only for myself, what am I? And if not now, when?'

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Impediments to the Experience of Being Loved in Psychotherapy

Ian McDougall

Introduction

There appears to be increasing acceptance amongst therapists that psychotherapy involves 'a cure through love', as first expressed ninety years ago by Sigmund Freud. Ferenzci, Suttie, Halmos, Laing, Yalom, Greben, Hobson, Lomas and Vaillant are among those who have expressed this view.[1] Closer to home, Dr Eng-Kong Tan, analytic psychotherapist of Sydney, alluded to it with sensitivity and wisdom in his keynote address to the 1991 Annual Conference of NZAP.[2] 1 think it is likely that Dr Maurice Bevan-Brown, whom we particularly honour in connection with the fiftieth anniversary of NZAP, would have concurred. It is certainly, in my reading, consistent with *The Sources of Love and Fear,* the little book he produced for a lay audience and first published in 1950. In a brief section on pyschotherapy, good psychotherapy is based on providing the patient with 'a new and more adequate parent', and

1 Freud, S. *The Freud/Jung Letters.* The Hogarth Press and Routledge and Kegan Paul, London, 1974, p 12 - 13.
Ferenczi, S. The principles of relaxation and neo-carthasis. *International Journal of Psychoanalysis* v 11, 1930, p 428 - 443.
Suttie, I. *The Origins of Love and Hate.* Kegan Paul, Trench, Trubner & Co Ltd, London, 1935, p 212 - 213.
Halmos, P. *The Faith of the Counsellors.* Constable, London, 1965, Chapter Three.
Laing, R. *The Divided Self* Penguin Books, 1965, p 165.
Yalom, I. *Existential Psychotherapy.* Basic Books, 1980, p 407 - 408.
Greben, S. *Love's Labour: The Experience and Practice of Psychotherapy.* Plume Books, New American Library, New York, 1984.
Hobson, R. *Forms of Feeling: The Heart of Psychotherapy.* Tavistock Publications, London, 1985, p 211 - 212.
Lomas, P. *The Limits of Interpretation: What's Wrong with Psychoanalysis.* Penguin Books, 1987, p 147 - 148.
Vaillant, G. *The Wisdom of the Ego.* Harvard University Press, 1993, p 4.

2 Tan, E. *Love and Intimacy: Reflections of an Analytic Psychotherapist.* Keynote Address, Christchurch, NZ at the Annual Conference of the NZ Association of Psychotherapists, 15th February 1991. (Published, Newsletter of the Association, March, 1991)

for Bevan-Brown a loving attitude is the essence of good parenting. [3] Philosopher and psychoanalyst Jonathan Lear in similar vein, though more precisely, asserts in a recent book that love is the force in nature that promotes individuation. [4]

Nevertheless there has been no systematic attempt to delineate why it is often so difficult for clients in therapy to experience that they are loved, when circumstances often show that they are. I refer to those clients, more difficult to treat or help who are ordinarily described as severely psychoneurotic or character disordered, where effective change seems to take two to five or more years of committed involvement by therapist and client.

In this time of rationed resources and preoccupation with briefer methods, it behoves us as dynamic psychotherapists to discover what impediments or obstacles there may be to clients experiencing what appears to make the difference and supports whatever other interventions promote remediation, growth, change and symptomatic recovery.

What is meant here by 'a cure through love'? These were Freud's words and in my observation he meant something different from the later authors. He was referring to transference love in the conditions in which it developed in psychoanalysis after he replaced hypnosis with free association, that is with the evolution in the treatment of an established transference neurosis. The assertion appears to have been most clearly expressed by him according to Bergmann in the *Gradiva:*

> The process of cure is accomplished in a relapse into love, if we combine all the many components of the sexual instinct under the term 'love'; and such a relapse is indispensable, for the symptoms on account of which the treatment has been undertaken are nothing other than precipitates of the earlier struggles connected with repression or the return of the repressed, and can only be resolved and washed away by a fresh tide of the same passion. [5]

Ferenczi by contrast clearly identified that it was love in the other direction, from therapist to client, that was curative. 'It is the physician's love which cures

3 Bevan-Brown, M. *The Sources of Love and Fear*. The Raven Press, Christchurch, 1960, p 4.

4 Lear, J. *Love and its Place in Nature: A Philosophical Interpretation of Freudian Psychoanalysis*. Faber and Faber, 1990.

5 Bergmann, M. On the Fate of the Intrapsychic Image of the Psychoanalyst after Termination of the Analysis. *Psychoanalytic Study of the Child* v 43, 1988, p 138.

the patient'.[6] Suttie further clarified the matter when quoting Ferenczi ... "the nature of the love being understood as *a feeling interest responsiveness – not a goal-inhibited sexuality.*'[7] It is in this latter sense that I use the word love in this paper, but in doing so I am conscious of the need to explain a statement I made recently in a paper reviewing my thirty years as a psychotherapist. In asserting that love is the vital ingredient, I said, 'It is mainly agape, though it may include philias and be inspired by eros.'[8] Eros here denotes transference love in a broader relational sense than Freud intended and assuredly does not mean that a therapist's sexual passion is likely to be helpful, even if not overtly expressed. As Sheldon Kardener pointed out in discussing the incest taboo as it applies in the physician-patient relationship, because the physician or therapist is experienced as a parent, the patient or client "becomes an orphan"if the relationship becomes sexualised by the 'parent'.[9] And of course the incest victim who comes to therapy is grossly re-traumatised. Ferenzci eloquently warned of the damage in his famous paper, 'Confusion of Tongues Between Adults and the Child: The Language of Tenderness and Passion.' [10] Whelan recently wrote a devastating account of the child's predicament.[11] Confusing also is that there is a higher form of eros referred to by philosophers. Rhodes states that 'agape does have an objective, namely that everyone shall realise his/their full potential'. And it does not differ from eros, 'for even the most cursory reading of Plato makes it clear that this is what eros wants for its human object'.[12] The directional difference, Freud's "relapse into love" from patient to analyst, versus the opposite, 'the physician's love' which 'cures', can I think be understood as reflecting the different patient populations being worked with. The first is with predominantly oedipal problems, the latter, pre-oedipal.

I have been interested in impediments to the experience of being loved for some years. The most telling or crystallising event for me occurred quite recently when a client said to me, 'How can I know that you care for me when you are

6 Ferenczi, S. op. cit.

7 Suttie, I. op. cit. p 212.

8 McDougall, I. *Psychotherapy and Me: A Personal Account.* Unpublished paper presented to Wellington Branch NZAP, April 1995.

9 Kardener, S. Sex and the Physician-Patient Relationship. *American Journal of Psychiatry* v 131 no 10, 1974, p 1134 - 1136.

10 Ferenzci, S. Confusion of Tongues Between Adults and the Child: The Language of Tenderness and of Passion. In Balint, M (ed) *Final Contributions to the Problems and Methods of Psychoanalysis.* 1933. London, Kamac Books, 1980, p 156 - 157.

11 Whelan, M. The Loss of Sense of Reality in Incest and Child Sexual Abuse: A Psychoanalytic Perspective. *Australian and New Zealand Journal of Psychiatry* v 29 no 3, 1995, p 416 - 417.

12 Rhodes, C. *The Necessity for Love: The History of Interpersonal Relations.* Constable, London, 1972, p 88.

part of me.' This happened during a phase of therapy when she was more often experiencing me as separate from her and feeling panicky about it. I certainly had not been asking her about the matter directly and it seemed to me that she needed to have noticed the distinction before she could comment. She could not cognitively recognise the quality of her relationship with me when she was still largely imbedded in needed self-object experiences of me.

For the purposes of raising the inquiry I shall consider the Client, the Therapist and the Context.

The Client

In my earlier thinking, informed by Transactional Analysis theory, I had mainly seen impediments in the client as based on a refusal or reluctance to recognise what was incongruent with hard won survival decisions, often elaborated cognitively somewhere between three and eight years of age.[13] Work at that developmental level leading to redecisions and changed beliefs about self, other, the world and the future, was undertaken in phantasy or chair work with projected internal self and object representations, or in the transference. It often enabled quite rapid progress to be made. In TA terms, second degree impasses could be resolved, but third degree preverbal ones, related to a sense of always having felt a particular way, for example evil, were much harder to resolve and often required a much longer time in therapy.[14]

I now consider that the much longer time in therapy is related to a need to reattach to the therapist, to be involved in healthy dependency, rather than dysfunctional symbiotic systems dictated by the other, and have related self-object experiences leading to self cohesion and object distinction.[15] Developmental and/or remedial experiences appear to be necessary before redecisions can be made.[16] Whether in childhood or adult life, renewed development and change has to be initiated in the face of closedness and

13 Goulding, R. New Directions in Transactional Analysis: Creating an Environment for Redecision and Change. In Sager, Clifford and Helen Singer Kaplan (eds). *Progress in Group and Family Therapy.* Brunner/Mazel, New York, 1972, p 105 - 134.

14 Mellor, K. Impasses: A Developmental and Structural Understanding. *Transactional Analysis Journal* v 10 no 3, 1980, p 213 - 220.

15 Holmes, J. Attachment Theory: A Biological Basis for Psychotherapy? *British Journal of Psychiatry* v 163, 1993, p 430 - 438.
Phillips, R. *Structural Symbiotic Systems: Correlations with Ego-States, Behaviour and Physiology.* 1975. Monograph obtainable from the author, 100 Eastdowne Drive, Chapel Hill, North Carolina, 27514.
Wolf, E. *Treating the Self. Elements of Clinical Self Psychology.* The Guilford Press, 1988, p 54 - 55.

16 Joines, V. Using Redecision Therapy with Different Personality Adaptations. *Transactional Analysis Journal* v 16 no 3, 1986, p 152 - 160.

circularity.[17] What is being protected is segregated, developmentally early states of mind such as those referred to by Winnicott as 'primitive agonies' in his last paper, 'Fear of Breakdown', with compensating beliefs in magical transformation or rescue.[18]

I have schematically listed difficulties arising in the client as follows and will clarify some clinical aspects of the operation of the impediments listed. It is not possible to give in depth development within the compass of this paper but my hope is that the items will be sufficiently recognisable to evoke your own clinical experience.

(1) The **inability:** – to perceive love when therapist/other is part of self.

There are clients who note that they are loved by friends, family members and perhaps their therapist but do not **feel** that they are. They don't have the experience and when the fact is clarified with them they are likely in the first instance to say, 'yes of course' they know that they are. But related affect is absent and they reply briefly and defensively. They don't go on to talk warmly about the gift of being loved. It is in my experience threatening to have the matter noted and any of the need related causes detailed in this account may be operating. If therapist and/or client do not discover the discrepancy they may labour long and fruitlessly. On the other hand, as earlier mentioned, there are clients who do not recognise the fact in a cognitive sense at all, as their experience of being cared for is too embedded in primitive self object experience of the therapist. They cannot challenge their negative cognitive beliefs about love until they move to at least the beginnings of whole object relating with the therapist, and become effectively aware of the therapist's separate existence. That is a crucial and often very frightening step. I discovered from the client mentioned previously, that she had to test my acceptance and support for her individuality before she was able to do so. More than that, she had to cognitively recognise me as providing a 'bridge' for her.

Love of the necessary kind, can be defined in systems terms as inputs of an informational character, verbal and non-verbal cues, words, facial expressions, touch, which elicit the meanings within systems associated with normal dependency, that one's existence is important to the other, needs will be freely

17 Erskine, R and J Moursand. *Integrative Psychotherapy in Action.* Sage Publications, London, 1988, p 29 - 40 & p 51.
Ryle, A. Object relations theory and activity theory: A proposed link by way of the procedural sequence model. *British Journal of Medical Psychology* v 64 1991, p 307 - 316.

18 Winnicott, D. Fear of Breakdown. *International Review of Psychoanalysis* no 1, 1974, p 104.

met and dangers avoided.[19] The earliest of such experiences within the first few hours, days, weeks and months of life include merger, graphically alluded to by Michael Balint as resulting in a 'harmonious interpenetrating mix-up'.[20]

Recent psychobiological research in affect, attachment and memory is worth noting in connection with the inability to perceive. Implicit, non declarative memory is involved in extracting prototypical information from the character and quality of early attachment experiences, and is not accessible to consciousness. The authors, Amini et al, of the synthesising report from the Langley Porter Psychiatric Institute, state:

> In such a view, when patients come to psychotherapy and engage the therapist in their transferential life, they are exhibiting the outward manifestation of the implicit memory inside them of the early attachment relationship. This is not a discrete record of an event, **and it can never be accessed directly by consciousness** (my emphasis). What these patients do in their lives and in the office, while it seems at times baffling to the outside observer, follows naturally from this implicit knowledge. At the same time, when patients participate in psychotherapy, they not only activate this implicit memory, but also engage the mechanism whereby such stored material can be modified. To the extent that the therapist becomes an important figure of attachment, the patients begin to extract the rules that govern the nature of the relationship between patient and therapist, and the modification of stored prototypes has begun. In a gradual, iterative process, the attachment-related generalisations of the patients are revised closer to those which approximate healthy interactive functioning in the larger social environment.[21]

(2) The **need:** – to avoid catastrophe, death/suicide, madness, abandonment, loss of self (fragmentation);

to be found unlovable (confirmation of beliefs), I am, 'dirty', 'evil', 'bad', 'defective';

to avoid the pain of not being appreciated, cared for, protected, shame, rage, sadness, despair/hopelessness, longing, emptiness;

to avoid knowing what actually happened, deprivation, physical abuse, sexual abuse.

19 McDougall, I. Psychic Energy, Physical Energy and the Body Psychotherapies. *Australasian Journal of Transactional Analysis* v 3 no 1, 1982, p 27.

20 Balint, M. *Thrills and Regressions.* The Hogarth Press, London, 1959, p 62 - 69.

21 Amini, F, T Lewis, R Lannon, A Louie, G Baumbacher, T McGuiness and Z Schiff. Affect, Attachment, Memory: Contributions Toward Psychobiologic Integration. *Psychiatry* v 59, 1996, p 213 - 239.

Where the impediment to feeling loved in later life is the avoidance of catastrophe, that is death/suicide, psychosis, life threatening psychosomatic disorders, abandonment terrors and fragmentation fears, there has been competition for survival between parent and child,[22] and such a traumatic level of impingement that one might speak of a 'discordant interpenetrating mixup'. Alternatively there have been gross deficits in life supporting contact, or both. Such experiences include Winnicott's 'primitive agonies', for example, 'falling forever' and 'failure of indwelling', for which he says anxiety is not a strong enough word.[23]

For the client to be open to experiencing the feeling of being loved in archaic states of self, connected in somatic and primitive affective memory with contemporary states related to attaching anew, is from the position of the 'infant inside' to risk catastrophe, He or she cannot 'know' without regressing to that level again, that primitive introjected elements of the historical parent will not overwhelm or attempt to destroy elements of his/her emergent self as happened many years previously.

The outcome for some who survive such horrors in their growing up experience is to protectively identify in the depressive position with the traumatising and rejecting other's view of them; or conjure similar beliefs from their own creativeness, that they are 'bad', 'dirty', 'evil' or 'defective', With such beliefs, and the specifics are many, they cling through life to the hope of perfectability and retain the illusion that they may yet be found loveable, that the caretakers can be induced to have a change of mind. Those more developmentally fixated in the schizoid-paranoid position, the time of 'toxic mixup' can be left with virtually no hope, with the feeling or conviction, which if it could be articulated would say something like 'I have always been this way and am utterly beyond redemption.' Hence in therapy when such people regress to the archaic states potentially connected with attaching anew, they are likely to feel, crazy, profoundly defeated and lacking in viability.

It is however regularly discoverable that life-related affects persist, though they are strongly warded off, dissociated from or disavowed. In the absence of loving containment they are too disturbing to be experienced and sustained by the fragile, barely hatched self. The somatic aspect should not be forgotten in this connection, with extreme tensions, gross physiological dysregulation and terror, which may signal not just psychic fragmentation, but threat to physical

22 Phillips, R. op. cit.

23 Winnicott, D. op. cit.

existence and bodily integrity. Shame, rage, sadness, longing, emptiness and despair/hopelessness occur. Even the last, associated with what Engel described as a biological state of depression-withdrawal, a kind of mini-hibernation, waits I believe for the environment to become beneficent again.[24]

Richard Erskine, in an excellent, comprehensive and clinically seasoned paper on the psychotherapy of dissociation, defines what he means by 'contact', and identifies the dilemma for many clients posed by juxtaposition:

> The juxtaposition of the therapist's attunement with the memory of the lack of attunement in previous significant relationships produces intense emotional memories of needs not being met. Rather than experience those feelings, the client may react defensively to the contact offered by the therapist with fear, anger, or even further dissociation. The contrast between the contact available with the therapist and the lack of contact in the original trauma(s) is often more than clients can bear; so they defend against the current contact to avoid the emotional memories.[25]

Buie and Adler in their paper on the definitive treatment of the borderline personality identify the rageful and primitive guilty ('I am evil') obstacles which are effects of aloneness, to developing needed holding introjects, for patients suffering from severe psychopathology. They state that:

> This process would simply require a period of time for its occurrence were it not for the psychodynamic obstacles that block it in therapy just as they block it in life. They are consequences or corollaries, of aloneness. The inevitability of rage is one such corollary that interferes with the process of forming holding introjects.

They go on to say that there are three sources of this rage which are summarised here as, 1) holding is never enough, 2) experience of the object is distorted by means of projection of hostile introjects and 3) the object is so endowed with holding sustenance as to be deeply envied.[26]

Michael Lewis points out that the development of shame requires maturation and that socialisation is the eliciting force. He also notes a distinction between the sexes:

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24 Engel, G. *Psychological Development in Health and Disease.* W B Saunders Company, 1962, p 55 & p 127.

25 Erskine, R. Inquiry, Attunement, and Involvement in the Psychotherapy of Dissociation. *Transactional Analysis Journal* v 23 no 4, 1993, p 185 -186 & p 187.

26 Buie, D and G Adler. Definitive Treatment of the Borderline Personality. *International Journal of Psychoanalytic Psychotherapy* v 9, 1982-83, p 65 - 67.

> Parents who practice love withdrawal or who express contempt or disgust affect their children's sense of pride and shame. The available data indicates that girls and women are more likely than boys and men to make global self-attributions 'I am bad,' not 'My performance was bad' - when they fail. Thus, girls and women may experience more shame than boys and men. [27]

To be open to the experience of being loved in the present is to be open, at least for part of the time, to the full range of human feelings and their undefended connection in memory to the past. It is I believe not possible to feel loved in the states of self connected with attaching anew, of being open to merger and the 'harmonious interpenetrating mix-up', without also encountering the 'discordant' equivalent. It is not possible to simply be open to isolated 'safe' fragments of experience without risking further fragmentation. What is encountered, what the therapist and the client expect to be encountered is often almost unimaginably terrible. And this is so even when the client has always 'known' at some level 'the way it was', or has been able to recall some related sensations, affects, images, even words, and talk about them. It is another thing again to experience what happened within the boundary of the self with full intensity, and the immediacy of a reliving, feeling vulnerable and dependent as very young child. A child moreover whose only psychological need or 'Wish', at the times of maximal deprivation and or trauma may have been to be 'held, touched and taken care of'.[28]

To 'know' that one's existence, one's once and forever particularity was of so little account to the people who should have been there to provide tenderness, constancy and encouragement, at the start of the growing up and becoming a valued part of the world enterprise, but were not, is cruel beyond measure. I'm talking here of the meaning caught by the child who experiences him or herself as neglected, not the observation of a sophisticated observer, or an older part of the client who for example can understand, that it wasn't for example mother's fault that she was so clinically depressed in the first few weeks and months, that she could not respond. And associated with that meaning, however dimly understood in the physical cum primitive affective experience of the earliest emergent self, is the terror of threatened non-existence as previously noted. Add to neglect the threat of grossly inconstant or chaotic care, impulsive or concerted violence, and the child may have had to ward off the conclusion, correct or not, that their death was actively sought. Change

27 Lewis, M. *Shame: The Exposed Self.* New York, The Free Press, 1992, p 10.

28 Levin, P. *Cycles of Power: A Users Guide to the Seven Seasons of Life.* Deerfield Beach, Florida, Health Communications Inc, 1988.

from that position can consequently be experienced as risking annihilation and being murdered.

(3) The **demand:** – to be loved by people from the past;
to be rescued/saved by particular (phantasy) figures;
to receive justice;
to be revenged.

Those clients who as children were resilient enough and creative enough, who were fortunate in having some support from others, an older sibling, a caring grandparent or teacher, may, out of hurt or spite, continue to hold to an early formulated preconscious demand.[29] That is, they will not allow themselves to be fully touched by love and 'insist' that only their parents will do, and that when they are, everything will be as it should 'by rights' have been. Also the setting will be that earlier time and they will still be little as they were then.[30] Any risk of being open to people in the present is avoided because it doesn't fit the demand and would spoil what 'should have been'. The client may alternatively require that their therapist behave precisely as a phantasised rescuer would, and not permit themselves to fully accept the meaning of being loved in the here and now. Another client for some time could only accept what she felt conditionally, that is for as long as she could believe that it would go on 'forever'. She also insisted that unless I was thinking about her continuously, during every moment of the day then I couldn't really care for her, as she had always thought that was the way it would be.

Others hold out for justice and believe that their lives cannot properly go ahead unless justice is substantively achieved. A client worked extremely well in a group where he was very much liked. He appeared to be moving to where he could embrace a very different and non masochistic future. But when he recognised that his deceased abusive father could not be brought to trial he left the group and didn't come back.

Related is the wish for revenge. The daughter of a holocaust survivor was grossly controlled by her traumatised and extremely domineering mother. She had a phantasy of confronting her and saw her visibly wilt like a dying flower, but then became blocked by guilt and concluded that if she could not have her revenge she wanted no part of life.

29 McNeel, J. The Parent Interview. *Transactional Analysis Journal* v 6 no 1, 1976, p 65.

30 Berne, E. *What Do You Say After You Say Hello: The Psychology of Human Destiny.* Grove Press Inc., New York, 1972, p 50 - 51.

(4) The **numbing** and **disconnection:** – of Post Traumatic Stress Disorder, biological/neurological impairments, functional psychoses and dissociative defences.

The flashbacks, hyper arousal, irritability and especially perhaps the emotional numbing caused by the neurological dysfunctions underlying Post Traumatic Stress Disorder, may all seriously interfere with the accurate processing of affective inputs in traumatised people.[31] Care may be perceived as threat, or not perceived at all. Further, the biological impairments often compound many of the psychological impediments already discussed as well of course as the often radical distancing of dissociative defences. Residual impairments from Schizophrenic Disorders, prolonged treatment resistant Bipolar Disorders, Autism, Attention Deficit Disorder and organic brain disorders of varying severity, may also cause much difficulty. One client developed normally until around eighteen months when she developed viral encephalitis. She was extremely irritable and could not be held or touched. Her subsequent development was greatly skewed with underlying schizoid dissociation, foreground borderline characteristics and unbridgeable difficulties in the relationship with her parents who were clearly caring and wanted the best for her.

(5) The **fear:** – of decathecting familiar introjects.

Common to all the impediments I have discussed is the profound difficulty experienced by clients in decathecting their familiar introjects, related symbiotic engagements with people in their lives and psychological defence mechanisms, especially the more primitive ones.[32] To do so involves renouncing the specifics of what they have always hoped for, but even more, internally facing fears of abandonment and other expected catastrophes. In the parts of self in which the risk must be taken the client does not know, though 'older' parts may see differently, that what is dreaded will not occur. The dilemma is that if they were able to freely acknowledge the new and more secure love in the here and now, it would be easier to take the risk; but to acknowledge that in any global and continued way, linking archaic mind to current states of being, is to enter what family therapist Virginia Satir has called 'the chaos'.[33] And as therapists

31 Rauch, S, B van der Kolk, et al. A Symptom Provocation Study of Post Traumatic Stress Disorder Using Positron Emission Tomography and Script-Driven Imagery. *Archives of General Psychiatry* v 53, 1996, p 380 - 387.

32 McDougall, I. *How People Change in Psychotherapy: A Transactional Analytic, Psychodynamic, and Systems View.* Paper presented at the NZAP Annual Conference, February 1989.

33 Satir, V. The Tools of the Therapist. In Lankton, S and J Zweig (eds). *Developing Ericksonian Therapy: State of the Art.* Brunner/Mazel, New York, 1988, p 513 - 523.

know, for many clients there are both internal loyalties, and external relationship and systemic family pressures very much supporting the 'no change' position as well.[34]

In my observation it is extremely difficult for some incest victims to decathect the ambivalently loved and needed abusive father, as he may have been all they had when mother was effectively unavailable. To risk being loved in the present is to lose him, breach loyalty and experience the horror of the abuse.

The Therapist's Contribution

The literature originating from therapists indicates that this is an awkward and embarrassing topic to write about. Lomas is clear about the importance of the therapist's love but is keenly aware that anyone talking about it is likely to be viewed askance and thought to be narcissistically indulgent, or to be covering up less commendable motives.[35] Yalom, who is also very much in support, nevertheless quite early in a brief account states that it is a matter that readily makes one 'squirm'.[36] He goes on to say that that is not surprising considering the strange skewed sort of relationship the therapeutic one is. Both authors mention the neglect of a small number of key books on the subject, those already referred to by Suttie and Halmos, and that by Carlos Sequin, *Love in Psychotherapy*.[37] In reflecting on my own experience, I clearly recall reading Ian Suttie's, *The Origins of Love and Hate,* and especially the well known chapter, "The 'Taboo' on Tenderness", almost forty years ago and being much impressed by it.[38] But subsequently I relegated my old copy to a kind of mental Siberia on the basis that its language was archaic and didn't sound scientific enough! When finally many years later I revived my interest again, I found him even more admirable and prescient.

Heinz Kohut, who it is suggested might be a theorist capable of getting the question re-examined by the 'back door', acknowledges that love might have been responsible for some of the 'cures' effected by charismatic therapists such as CG Jung, but scathingly attributes the results to transferences induced by

34 Boromenyi-Nagy, I and D Ulrich. Contextual Family Therapy. In Gurman, A and D Kniskern. *Handbook of Family Therapy.* Brunner/Mazel, 1981, p 162 - 163 & p 166.
Watzlawick, P, P Weakland and R Fisch. *Change: Principles of Problem Formation and Problem Resolution.* Norton, New York, 1974.

35 Lomas, P, op. cit. p. 146.

36 Yalom, I. op. cit. p. 407.

37 Sequin, C. *Love in Psychotherapy.* Libra, New York, 1965.

38 Suttie, I. op. cit. Chapter 6.

their narcissistic characters. He appeared to seek a much cooler 'scientific' and dispassionate solution.[39]

Therapists are more comfortable talking about care, unconditional positive regard, sustained empathic immersion, and metaphoric 'holding', but one wonders at what cost?

Ann France, in her excellent book, *Consuming Psychotherapy,* carefully argues for the need for love in psychotherapy, and in doing so questions the pronouncements of a number of analytic authorities. She concludes that 'The "love" required in the therapeutic context is a warm, sustained concern which inspires security and is not afraid, at times, to express itself by human gestures, if appropriate to the relationship.'[40] What France is saying is akin to the supposition arrived at by Canadian psychiatrist and psychotherapist Stanley Greben, which is that psychotherapy is and essentially needs to be, 'A simple human process'.[41] Neither contend that technique and the use of the therapeutic frame is not important.[42] Fanita English stated the need for both most cogently:

> To be a loving human being is a prerequisite for a therapist. However, without solid technique and a certain artistic flair, a therapist can be engulfed by the problems of her patients, and she can end up crucified or devoured by their cannibalistic needs when they seek ways to fill a certain emptiness within themselves.[43]

There is, as arrived at long ago by Carl Rogers, a need for emotional congruence and clarity in this matter, as it is difficult enough for the client to encounter the inevitable confusion of transference projections, and therapist countertransference.[44]

The matter has also I think been bedevilled by a too pessimistic, even cynical view of love that has come down from Freud's account of 'Transference Love'.[45] Diane Ackerman, in her wonderful "A Natural History of Love", reports a brief conversation with a friend thinking of going into therapy. She reflects

39 Lomas, P. op. cit. p 147.
Kohut, H. *The Analysis of the Self.* International Universities Press, New York, 1971, p 222, footnote.

40 France, A. *Consuming Psychotherapy.* Free Association Books, London, 1988, Chapter 11.

41 Greben, S. op. cit. Chapter 12.

42 Fletcher, L. The Psychotherapeutic Frame and its Relation to Patient Abuse. *Australian Journal of Psychotherapy* v 8 no 1 & 2, 1989.

43 English, F. What is a Good Therapist? *Transactional Analysis Journal* v 7 no 2, 1977, p 49.

44 Rogers, C and J Wood. Client-Centred Theory: Carl R. Rogers. In Burton A (ed). *Operational Theories of Personality.* Brunner/Mazel, New York, 1974, p 226 - 227.

45 Freud, S. *Observations on Transference Love.* Standard Edition 12, 1915, p 160. Or in Gay, Peter (ed). *The Freud Reader.* Vintage Books, 1995, p 378 - 387.

something of the old position but lightens it up.[46] A review of the recent book edited by Ethel Spector Persons and others, *On Freud's "Observations on Transference Love"*, by Paul C. Horton is more directly critical. He states that:

> The authors do little to challenge Freud's philosophically and politically tinged equation of normal love with the narrowly sexual. Surely, on the basis of their vast clinical experience, they must know that there are mature, reality based forms of love, expressions that transcend the self and serve as powerful mediators of emotional and intellectual growth, and that these forms sometimes arise, even passionately in the treatment setting. Yet, the reader is left to wonder if orthodox psychoanalysts think there is anything realistic or healthy about any form of love.[47]

The Context

In 1957, Eric Fromm wrote about, 'Love and its Disintegration in Contemporary Western Society', and firmly placed the blame with the nature of capitalism. He stated that:

> Both useful things and useful human energy and skill are transformed into commodities which are exchanged without the use of force and without fraud under the conditions of the market. Shoes, useful and needed as they may be, have no economic value if there is no demand for them on the market. Human energy and skill are without exchange value if there is no demand for them under existing market conditions.

He further said that 'Capital commands labour; amassed things, that which is dead, are of superior value to labour, to human powers, to that which is alive.'[48] A full analysis of the relationship is not possible here, but I doubt if there are many among you who have not experienced the related effects of the current new right ideology in health and mental health care, where people are confused with commodities in the interest of efficiency and money saving. The valuation of professionals as deliverers of care to the living needy is grossly discounted and the down stream or parallel process effect on patients or clients can be truly anti-libidinal and deadening. A very experienced, creative and innovative mental health worker, an advocate for 'A Better Life' for her patients long

46 Ackerman, D. *A Natural History of Love.* Vintage Books, New York, 1994, p 322 - 326.

47 Person, E, A Hagelin and P Fonagy (eds). *On Freud's "Observations of Transference Love".* Yale University Press, 1993.
Horton, P. Book Forum. *American Journal of Psychiatry* v 152 no 4, 1995 p 642 - 644.

48 Fromm, E. *The Art of Loving.* George Allen & Unwin, 1957. Or Thorosons, an imprint of Harper Collins Publishers, 1995, p 65 - 66.

before that became a catch cry, quietly and tearfully complained to me that 'sometimes we don't get enough for ourselves.'[49]

The outlook for our vulnerable clients is likely to worsen further if the health reforms include a further push for privatisation in mental health care. The culture of competitiveness furnishing more and better care for those who can afford it will be to the detriment of those who cannot. It will resonate with and unconsciously confirm their early experience and physiological/affective frames of reference which signify that their existence is not important, needs will not be freely met and protection from dangers will not be available.

In the linking of societal to individual influences, I have long been impressed by the synthesising views of anthropologist Ernest Becker. He argues, I think correctly, that self esteem is a principal buffer against anxiety. He refers to both fears about death and physical mutilation, and fragmentation of the self. He further argues that one crucial role of culture is to make **continued** self esteem possible. Its task is 'to provide the individual with the conviction that he is **an object of primary value in a world of meaningful action.**'[50] It should be clear that for the individual to have a convinced sense of primary value, he or she must be loved, and feel or experience that they are loved unconditionally. Achieving the other wing, of having value in a world of meaningful action, is another tragedy of our time with its scarcity of meaningful work and diminished ritual observances of cultural significance. Becker's synthesising statement is reminiscent of course of Winnicott's belief and statement that developmentally, security in the sense of being must precede doing. 'Now I want to say: "After being – doing and being done to. But first, being".'[51] The structure of the competitive money driven society with its inevitable scarcities for many with little or no work, and pressure for those in work to anxiously cling to their jobs and work excessively long hours, places great burdens on families which increasingly break down. It is extremely difficult to achieve the kind of equanimity needed to establish and maintain real support and loving contact between partners, and consequently provide the love and adequate holding needed for the healthy and undistorted growth and development of children. Children are infantilised to meet dependent needs, or parentified in dysfunctional role reversals to take care of parents and sacrifice their own

49 Central Regional Health Authority. *A Better Life: Report of the Greater Wellington Mental Health Service Review.* 1994.

50 Becker, E. The *Birth and Death of Meaning. An Interdisciplinary Perspective on the Problem of Man.* 2nd Edition. Penguin Books, 1971, p 86.

51 Winnicott, D. *Playing and Reality.* Tavistock Publications, London, 1971, p 85.

possibilities. They are frequently unconsciously driven to seek value, or love and approval indirectly in the pathologies of giving and doing, and miss the kinds of personal contact which would assure them that they are loved and of primary value. This is how later in the transference they present to their therapists who affected by similar pressures themselves have difficulty being, in Satir's words, 'present in your presence'.[52] I believe that the transformative work of therapy occurs when therapist and client are in contact. Transactional analyst Taibi Kahler, perhaps a bit tongue in cheek, pointed to the frequency of non contactful relating when he said that therapists were likely to be in their script drivers ninety percent of the time and while doing so were likely to induce their clients to cathect related (driver) Ego States.[53] Therapists are inevitably affected by the contextual factors I have mentioned and in reverse parallel process, may furnish their clients with powerful relational obstacles to the experience of being loved in therapy.

Conclusion

You will notice that I have not directly suggested solutions and yet I think this is a matter of very considerable importance for our profession, for as Diane Ackerman says:

> Nearly everyone who visits a therapist has a love disorder of one sort or another, and each has a story to tell - of love lost or denied, love twisted or betrayed, love perverted or shackled to violence. Broken attachments litter the office floors like pick-up-sticks. People appear with frayed seams and spilling pockets. Some arrive pathologically disheartened by a childhood filled with hazard, molestation, and reproach. *Mutiles de guerre,* they are invisibly handicapped, veterans of a war they didn't even know they were fighting. What battlefield could be more fierce, what enemy more dear?[54]

52 Satir, V. op. cit.

53 Kahler, T. The Annual Eric Beme Memorial Scientific Award Acceptance Speech. *Transactional Analysis Journal* v 8 no 1, 1978, p 3 - 4.

54 Ackerman, D. op. cit. p 136.

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Reworking Gender Archetypes

A Masculist Enquiry

Peter Hubbard

Abstract

In terms of difference, the analysis of gender in cultural and psychological thinking has had the benefits of a feminist input for some decades now. How might 'masculist' input into this debate be framed? One strand of the current masculist debate attaches itself to feminist analyses, another polarises around essentialist/constructivist arguments, yet another seeks to establish its own experiential ground.

This paper proposes a reworking of an established psychological hypothesis concerned with masculine and feminine archetypes. In doing so it recognises the inherent duality of gender. It attempts to do this from a masculist standpoint, and as such, to honour both essentialist and constructivist approaches.

In doing so, this paper hopes to suggest a theoretical frame that can be used in working psychotherapeutically with men and with the relationships that men form. This is not only therapeutic, but also political work.

Introduction

Intense curiosity about the nature and experience of being human draws me to the practice of psychotherapy. Such practice is underpinned by a variety of theoretical formulations. Whether acknowledged or not, these formulations depend on hypotheses about the gendered experience of being human. Such hypotheses help us focus the lens of our perception not only on intrapsychic and interpersonal processes, but also on political and cultural processes.

Differentiating the nature and experience of being human along gender lines has produced analyses that have challenged some basic constructs about gender. Essentially these analyses have arisen out of a refusal by one gender to have its identity dictated to it by the other. As a movement among some women began to examine and refute the constructs about women from the dominant patriarchal analysis, so there is a movement among some men to examine the constructs about men that come not only from this patriarchal analysis but from the feminist analyses as well. This latter has not always been well understood or received.

Differentation

In terms of deriving theoretical formulations towards a more coherent analysis for men, some interesting questions have begun to be asked about the experience of being male.

We hear the expression: The New Man. Does this mean there has been some split in the image of a man - between some older concept of what a man is, and some contemporary concept? Or perhaps this is to he understood as a shift in what has been culturally sanctioned or not sanctioned in men's attitudes and behaviour?

If there is a split, is this a classical psychological result of extreme anxiety? Or perhaps a response to some evolutionary imperative, some future calling, operating at a species level?

And there have been potential red herring questions, such as: Is there a nature versus nurture conflict here? Are we born or are we made? Can the debate be seen simply as the essentialists in the blue corner slugging it out with the constructivists in the red.

And with these questions I keep asking myself. How might all this help me understand what it may mean for me to be a 'good son of the culture'? By which I mean, what it may mean for me to be a man who experiences and expresses himself within the conventions and roles that are available, encouraged and condoned for men in this culture with all its historical roots and antecedents.

When I consider the perennial existential concerns to do with who I am and my place in the larger scheme of things, do these questions help me stay focussed on my male experience?

These are large questions. They open up possibilities concerned with further

differentiating an essential male experience from an essential female experience not just in terms of biological and evolutionary determinants, but also in terms of the archetypal and gendered determinants of masculine and feminine. It is with respect to these archetypal and gendered determinants that I would like to develop a modest proposal to do with masculine and feminine, and to attempt to do this in a late 20th century masculist sort of way. In doing so, rather than oppose the essentialist and constructivist viewpoints, I would like to keep holding both as complementary lenses.

Not unsurprisingly, when I spoke of this as a possible process or project, there were often lively discussions which sought to convince me of the logical fallacy in this premise. It was impossible, so the argument went, for me to take this particular critical standpoint because I was a man and therefore not able to free myself from the context of the dominant patriarchal paradigm. There was no standing outside it. For masculist, they asserted, read more-of-the-same.

Archetype

One such discussion highlighted my theme. I found myself enjoying a leisurely discussion with a couple, a man and a woman who were in a relationship together. We were talking about the way we saw things, and because of my curiosity, I had been asking them how they saw their relating.

In the course of considering this, the guy commented that he was "working on [his] archetypal feminine side within'. My immediate response was an involuntary nod of understanding followed by an extraordinary embarrassment as I was unable to locate if he were being serious, being smug, or being incredibly naff. Whatever, it was certainly interesting. Equally as interesting to me, however, was the response of his partner. She went quite impassive and unreadable to me.

The conversation would return to my thoughts, and I recognised a growing unease in me. I didn't know what this was about. I know we talk about masculine and feminine. And we use the word 'archetype', as in 'masculine and feminine archetype' when we want our mention of masculine and feminine to sound especially authoritative.

Yet, what is an archetype?

It is actually a little elusive to pin down, because it 'exists' in a realm of experiencing beyond that of our upper cognitive faculties, beyond our normal waking consciousness. An archetype has been called 'a thought in the mind of

God', therefore beyond our ken, as it were.

Beyond the word, beyond the form, beyond the image or the sense - this is a way of understanding the realm of archetype. As soon as we name or picture an archetype, we bring it into form. We step it down from no-form into our conceptual realm, we have an image, we call it something. These images and names are not in themselves archetypes. They represent them.

So when we talk about the archetypes of masculine and of feminine, what we language, name, see around us, imagine, are not the archetypes themselves. They are representations of the archetypes of masculine and feminine stepped down into cognition. And this is the point. As representations, they will have laid on them all the subjective responses, all the biases, all the partial understandings with which, as human beings, we are prone to colour our experiences. In this way they are constructed.

The idea of archetypes themselves is that they are sort of essentially 'neutral'. In practice I'm suggesting they never are. So I suspect the phrase 'feminine archetype' presupposes a list of qualities and traits that we call feminine and which are certainly not neutral. Conversely, and equally if differently biased, there will be a list of masculine qualities and traits.

And if like me you have been trained to be a good son or a good daughter of the culture, you and I have probably been trained to expect the women in our lives to embody and be the Feminine and to expect the men to embody and be the Masculine, and express in the world accordingly.

I can sympathise with the progressive and emancipated protestations to this statement raised from both sides of the gender fence. But I also suspect that this training will have been imprinted developmentally at a basic unconscious level. I may have a range from an instinctual to a cognitive sense of when and how I am being different from what is 'expected', yet this will always be with reference to the inculcated norm.

What are the qualities and traits of feminine, of masculine? I could suggest a reading list that would he sufficiently comprehensive, but I suspect you already know what it would contain:

- anything to do with softness, nurture, emotional intuitive thinking, receptivity, subjectiveness and the ilk is presumed feminine.
- anything to do with assertion, one-pointedness, action, logical

linear thinking, strength, objectivity etcetera is presumed masculine.

And so on. Familiar, and definitely not neutral.

My question is: This division - How come? Who says so?

When the answer comes back that somehow it is genetically, or naturally, or spiritually preordained, we must become very suspicious. It sounds like an adequate response from an essentialist viewpoint, but an answer like that tends to mask political and power agendas.

So in my search to make more meaning out of this and to try and understand my uneasy response to my friend's "I am working on my archetypal feminine side within", I turned to Carl and Emma Jung. They lay out before us a captivating concept to do with feminine and masculine - that of Anima and Animus. At its most simply expressed, Anima is the feminine within a man, Animus is the masculine within a women. It's very neat.

I am especially interested in a man's experience. So I focus on Anima, the feminine within a man. Jung calls this the Soul Image of a man, and says that for a man this Soul Image is formed:

- of aspects of the Archetypal Feminine
- of experiences of relating with females
- of aspects from his father's Anima - a sort of psychological inheritance from father to son.

Jung suggests that Anima is most often unacknowledged in a man, and is therefore prone to be part of Shadow. Which of course means that it is likely to be projected out and so can be yearned for in another person, or despised in another person. By this process of projection, the personal quickly becomes the political.

Yet when Jung defined Anima and Animus, I found the familiar list of Qualities and Traits about the feminine and the masculine. Where had this list come from? Who had decreed that this should be so?

Jung himself writes: "These distinctions are based on observed empirical evidence, therefore are true facts." This is thunderous prose even allowing for translation, and conveys no sense of historical context.

Yet when my friend says that he is working on his feminine, I know what he means. He is working on owning and accepting for himself, and not projecting

out on to his environment where he can indulge his potential ambivalence, the qualities and traits that are decreed to be feminine.

And there is, I believe, a trap in here for us.

The trap for me and for my friend is to do with the naming of these particular qualities and traits as specifically feminine. Why is it that in order to be, for example, nurturing, or receptive, or intuitive, or feelings subjective, we as men have to take on somehow being feminine? We are not feminine. Though we may imagine, we cannot 'know'this experience. We live defined as male - physically, emotionally, mentally, spiritually. Any quality, any trait, any behaviour we manifest will be expressed through our essential maleness.

- When I nurture I do so as a man, I am a male nurturing.
- When I am receptive I am open to receive as a man, I am a receptive male.
- When I am subjectively emotional, I experience in my male experience.

So we must avoid the trap.

Structure

In order to do this I suggest we need to explore what the models, the mythic underpinnings are that structure this division of masculine and feminine. Then we can look at how these may be recreated or retold for the 21st century so that we can avoid some of the excesses enacted in the name of masculine and feminine, as well as avoiding the experience of psychological straitjacketing represented in what I have called the trap.

In terms of exploring models for men and the boundaries of being male, I am in favour of diversity and plurality, as I am in general in this field of psychotherapy. I want to have available many ideas of how things might he whether or not they seem contradictory. The quest for some psychological unified field theory can simply be considered as a largely unacknowledged, underlying extension of heroic myth into the discipline of psychology. Yet myth and story are important. They are means by which the deep culture is retained and by which the long patterns of our cultural life bridge the generations. They are diverse. They invest and shape equally our art and our science, and are particularly apparent in the intensely metaphoric and evanescent expression we call psychotherapy. A myth or story may be particular to a culture. The deep patterns it describes may be common to many cultures.

In terms of masculine and feminine, the deep pattern with which we are very familiar, and which is reiterated in many cultural settings, is of an archetypal duality, a creative polarity of masculine and feminine:

Sky Father

Earth Mother

In this model transcendence (sky), and immanence (earth) are archetypally gendered. This underlying mythic structure is retold here in Aotearoa for example in the story of Rangi and Papa.

The power of a deep mythic structure I suggest is greatest when it is largely unconscious. It is, quite literally, the way things are. Make it conscious, and on one hand there is released the awe and wonder that can accompany the understanding of a deep knowing, and on the other there is opened up the more analytic wondering about the extent, the edges and the provenance of the myth or the model. There is the temptation to devalue or discard it now that it is known. We see only its construction and not its essence. A process of desacralisation can be entered into. It can seem that we dispel a cloud we might rudely name as superstition; we cast out a mote in the eye of logic.

Yet there remains a paradox. Even as an almost transcendent purity seems available, even claimed in such an act, even as some moral high ground is staked out, there is a deeper story. Even as the mythic structure, the comfort of the mythic container is removed and the cool, boundless thrill of engaging the existential dilemmas alone and separate remains, at some deeper turn of the spiral, the heroic myth is again being played out. The familiar characteristics of individual striving for self knowledge and self definition reassert themselves.

So I do not want to discard the mythic quality of this model of masculine and feminine that is located in Earth and Sky, and thereby risk losing its essential spiritual locus. But I want to look at how it might he framed in a way that helps me consider an enlarged and contemporary field of exploration for my enquiry about what it may mean to be a good son of the culture.

Reworking The Archetypes

I suggest we need to rework the archetypes of feminine and masculine, not in order to extrapolate some definitive new model, but as an interim expanded hypothesis to help free up our constructs systems to do with this enquiry. We need to encourage a current recounting of the ongoing myth.

My proposal is that this model, this mythic structure be expanded into a Quaternary - a Fourfold model that involves not just Sky Father and Earth Mother, but also Sky Mother and Earth Father. By doing this, the reality of gendered determinants is retained, but the location of masculine with sky only and of feminine with earth only is no longer restricted.

Sky Father	Sky Mother
Earth Father	Earth Mother

For men this involves the resurrection of the shadow archetype of Earth Father, the archetype which holds for men much of masculine expression of the qualities and traits we had hitherto given over to women. Originally these qualities and traits had been manifested in the mythic personae of the old gods of the forest and the field and of the vine. The horns and cloven feet, and the physical /sexual exuberance have been subject to considerable scrutiny and condemnation by the Sky Father religions. The old gods have been well trashed - into the devil no less, in itself an interesting political construction.

Yet the old gods belong to the old times, when not only social structures were radically different and involved far fewer people, but also when our cognitive faculties, the extent of our consciousness, may have existed at an earlier developmental stage. So also would apprehension of our essential experiences. Both Jaynes in his work on the origins of consciousness, and Wilber on the evolution of consciousness, give strong reminders that we cannot make assumptions about the past based on our current meaning-making context.

So with 'resurrection', care must be taken that old detrimental and inappropriate mythic patterns are not revived wholesale, but are repatriated into this time with discrimination. Reinvoking the mythic antagonism between fathers and sons for example, or the magical sacrifices of the fertility rites is not what I have in mind. Nor is the mythic story of the return of some messiah who will save us from the evils of this age and usher in the kingdom of god on earth. The quasi-feudal structure implied in this is not the vehicle for the depth of personal responsibilty and involvement to which we are developmentally and evolutionarily called.

Earth Father can be, as his name suggests, at least earth connected. He can be cycle-oriented and elemental-spiritual. He can be husbander of the land and guardian of the threshold. He can be subjective logos, and sensual receptive.

With the repatriation of Earth Father traits and qualities, and the reconnection

that this implies with earth and an immanent spirituality, where does this leave the notion of the inner feminine for men?

I am suggesting that there is no feminine side in a man. 'Feminine side' is merely a naming, an idea that is no longer useful, because ultimately it does not reflect the gendered reality of Who-I-Am. The historical context in which this idea was appropriate has passed. The present context demands a development of the idea - one where the hero and his celestial father god no longer define the only mythology, and one where, in a world increasingly concerned with unitive power structures as much as with fragmentation and traditional oppositional power structures, culturally condoned narcissism no longer defines the politics of survival.

In its place can he developed this much more evocative, much deeper metaphor - a metaphor that keeps calling us to values and to the exercise of discrimination. It requires us as men to include that our individual expression as male can involve that which we had traditionally been required to eschew in order to fulfil our destiny as good sons of the culture. To include it and to **make it our own.** Ultimately it calls us not to the habitual upper cognitive, mental egoic polarising of immanence and transcendence, but to finding our way when we keep including both.

If as a man I embrace as it were both Sky Father and Earth Father, if I own and express the qualities and traits represented by the example of both, and I am willing to experience the transcendent as well as the immanent yearnings for connection and meaning, then figuratively speaking I create my masculine soul-making in a way that seems "bigger" and more accepting of diversity than at present. My deep connection with the land and my environment, with my spiritual life, and with family and friends will be profoundly affected. The political and social implications here for such as homophobia on one hand, and for partnership on another are extraordinary. The economic and legal implications for such as resource management and organisational development are similarly far-reaching. This story is only just beginning to be told.

Conclusion

So why did my woman friend become instantly impassive and unreadable to me? I don't know, but I suspect it was because she also understood from her side the trap. It might be expressed like this:

> If her man values the Feminine side in himself, then, ergo, he will value that essential experience of her as a woman. This is a lot better for her

than not being valued. She may therefore have a vested interest in retaining the naming 'feminine'.

But if he develops this feminine in himself, then what becomes her role if she is no longer required to carry it in the relationship, in the spiritual connection to earth'? Is there some currently held moral high ground that would have to be relinquished?

And yet, as women are venturing down their road, they have not as far as I am aware been claiming it as an exploration of their 'masculine'. They have been claiming it as an expansion, a creative and logical extension of their 'feminine'.

A man 'getting into his feminine' may also smack somewhat of the politics of gender colonisation to her, and she may much rather he explored his 'masculine'.

However, this may make her very wary, because the experience for women of men going off to be more with themselves has historically had hard consequences for women.

This is undeniable.

It makes sense to me that she should have been unreadable to me. This is difficult territory - put this way, there does not seem to be an easy straight way through it.

I wonder if knowledge and acceptance of this fourfold model - Sky Father, Sky Mother, Earth Father, Earth Mother - because it points to the owning of projections, and to a more complex web of relating possibilities, may help allay this wariness.

The contrasexual concept of the inner feminine or masculine, Anima or Animus has had an honorable and useful short history. However, now may be the time when we can usefully discard the way those descriptions have polarised into a seemingly immutable duality. In looking at how I am expected to be as a man in order to fulfil my training as a 'good son of the culture', I want more for myself and for my sons. I want more than a training in withdrawal, in how to inhibit certain emotional experience, in culturally condoned projections. And at the same time I want to retain the uncluttered beauty of logic, the yearning for a transcendent sublime, and the glorious experience of the exercise of personal will.

Now may be the time, then, to evoke our political, historical and spiritual discrimination, to envision and to call into Being the archetypes of Masculine

and Feminine for this time in their fourfold configuration. And to engender our expression, to tell our story of the potential encoded in the seed.

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Turtle

Working with adult survivors of pre-verbal sexual abuse

Margy Pearl

Introduction

Lacan's model of child development is of particular value when one attempts to work with an adult client who was abused before language was sufficiently developed to become the primary, conscious framework for meaning-making, i.e. pre-verbally.

Simply put, Lacan's model contains: the Real (that which we cannot know, because it exists before we have a conscious awareness. It is that which is not altered by anything else, any 'other'); the Imaginary (that which exists in the earliest relationship mother/other – but it is non verbal and is non symbolised. It exists in another realm, which is kinesthetic/sensational/emotive); and the Symbolic (which is the realm that the child enters into with the acquisition of language. In our culture, this is the realm of the patriarchy – which has specific implications for victims of pre-verbal sexual abuse).

The pre-verbal child is not preconscious – it has awareness of movement, sensation and emotion, and is developing a consciousness of self. The interface between self and other is diffuse. The child lives in an Imaginary universe, into which both the Real and the Symbolic intrude. The child can be enormously impressed, but has very limited ability to express.

Narrative memory cannot exist prior to the mental and psychological development of narrative ability. Pre-verbal memory is, therefore, of neccessity non-narrative. It is kinesthetic, sensational and emotional – and, we hypothesise, it cannot always distinguish between self and other.

The desire of the self to communicate (with other), and the desire of the parent(s) (other) that the child communicate, are principal levers into the order of the Symbolic (language). Lacan calls this the mirror-phase. In terms of learning language, however, the child imitates the adult, rather than each imitating the other.

The rules about What is named, and How and When it is named, are laid down by the adults. The focus of naming is perforce on 'real' objects, rather than on subjective imaging. (The use of 'real' here is empirical – that which can be seen, heard, felt, tasted or smelt.) Language, in these early stages of the child's development, is for 'reality'. Drawing, painting are for imaging (the Imaginary).

As children are experimenting with naming whatever takes their interest, adults are establishing the difference between 'real' and 'imaginary'. (The use of 'imaginary' here refers to the images in a child's head which language is not sufficiently developed to express.) This process, these distinctions, assist the further development of Pre-verbal experience as an invisible 'pocket' universe. As the child differentiates self from other, the merged state – "me/mother/together = me? – becomes less 'real'. Mother/other insists, through language and its use, that mother/other and child are separate.

As the child reaches for the new "togetherness" of language, the old "separateness" of pre-verbality is what it strives to leave behind. The "pocket universe" becomes increasingly static and inaccessible within an expanding, complex and demanding "real" universe of communication (symbology). And, as the child becomes more reliant on symbology (narrative) to encode memory, the "pocket universe" becomes less and less available to memory.

The client who has suffered pre-verbal abuse may experience the 'pocket universe' as seemingly inappropriate compulsions, and untouchable, unjustifiable core beliefs driving them to react in certain ways. Metaphorically it is an unseen boulder, of unknowable size or composition, on the bed of a river, We can only deduce the existence of the boulder, by the flow of water around it, by the effect it has on otherwise undisturbed currents. The client may be able to describe how it feels to be the water, and even how the disturbance feels, but they cannot describe the boulder.

Pre-verbal (but not preconscious) experience can be narrated, by means of existing symbology, but it loses something in the process. It is transformed, in an essential way, by the process of narration, which uses language and symbology. The adult client's language and symbology, and degree of

identification with those existing symbols, was developed subsequent to the initial abuse. This, in itself, reinforces the "pocket universe" within which the experience happened, and which seems, to the client, to be inaccessible for narration – since the very act of narration involves processes which were unavailable during the experience.

For example: the client might describe a pre-verbal emotional experience, thus: "it was like being punched in the stomach."

The therapist and the client may have a mutual understanding of 'punched' and 'stomach', and even some agreement around the impact of the chosen words – but the fact remains that the symbol/simile, for the client, post-dated the assault and, therefore, is inadequate to transfer, to themself or to the therapist, the knowledge (whether partial or entire) of the experience.

Though conditioning would make this very unlikely, the client could punch the therapist in the stomach by way of description – affording the therapist, thereby, a more direct appreciation of the client's experience. The therapist might then be aware of pain, astonishment and anger associated with the client's behaviour. But for the experience to more closely mimic the client's pre-verbal reality, the therapist may vocalise, but must not verbalise the pain/astonishment/anger, nor protest the assault, nor seek an explanation from the client. In fact, the therapist should confront the prospect of NEVER speaking of the experience at all.

Even then, the therapist has an adult cognitive frame of reference for the assault. For what the client can never do is regress the therapist to a physical, emotional, psychological and mental condition of helplessness, identical in its genetic and environmental history to the child the client once was – and punch it in the stomach.

Nor can the client overlay on to the therapist, subsequent to the punch, the client's own developmental history, complete with meaning-making around physical or emotional assault.

Helplessness, for the pre-verbal child, is an essentially different experience from that of helplessness for the verbal child, or "helplessness" as a symbolic concept, associated with 'child-ness'.

Client A

Client A is around 40 years old, physically, socially and professionally functional. She was sexually abused by her grandfather from the age of 15

months to approximately 9 or 10 years. Through corroborative evidence from her parents, she is satisfied that the abuse took place. Her memories are primarily kinesthetic or visual, with very little chronological or physical context.

Hypothesis: since the initial abuse trauma occurred when the client was pre-verbal, this did not permit its inclusion in narrative memory, once narrative ability developed. What cannot be named is not "real".

Abuse that continued to occur after the development of narrative ability could still not be included in narrative memory. To do so would threaten both the existence and autonomy of conscious self, by threatening the merged-state of self/mother necessary for the development of conscious self. The child, in its preconscious merged state has neither the mental nor psychological development, nor the experience to evaluate fear (danger) or pain (damage) either quantitatively or qualitatively. Any threat or hurt is potentially lethal. ("What will kill me, will kill my mother ... What kills my mother, will kill me...")

Conscious self developed concurrently with language. What was not contained/defined by language belonged to the merged (unspeakable = unknown = unsafe) self, and therefore threatened the self who could communicate/relate to the parent/other.

The trauma of abuse is incomprehensible to the pre-verbal child: it will 'kill' her and her mother (merged state). To protect herself/her mother, the child developing language and consciousness of self, must not remember or verbalise the abuse.

The client continued to "store" the abuse experience "safely" in kinesthetic "memory". The fragments of visual and kinesthetic memory surfaced most acutely, in PTSD fashion, when the client began a new sexual relationship. In life situations, these symptoms were an inconvenience, and were well-managed.

However, because they continued to present in her primary relationship, she decided in session to work more directly on the "trauma". The therapeutic alliances were well established. Both the client and the therapist acknowledged that some of the abuse occurred when the client was pre-verbal, since this was corroborated by the client's parents.

The "flashbacks" initially presented themselves outside the session room, and were described, by the client, as physical "stuckness" or immobility, mental

"treacle" or slowing-down, and "tetanus" or lockjaw, an inability to speak or make a sound. "Stuck", "treacle" and "tetanus" were the client's own words, "code-words" she called them, used initially to describe the experience, but not the content, of flashback, and subsequently, to identify the onset or presence of flashback. These codewords were accepted and affirmed by both her partner and her therapist.

As session work progressed, the client was able to access these "flashback" experiences in the presence of the therapist. The therapist observed that the client could describe very little of the visual or contextual content of the flashbacks. Most of the describable content seemed to tell of her own physical or emotional condition, with only very occasional, extremely localised descriptions of anything outside of herself: the underside of a bed she hid under, the glans of a penis the size of a baseball ("like the close-up of a huge tongue sticking out"), or the subsequent unspoken knowing (later corroborated) that her grandfather wore boxer underpants. The therapist hypothesised that the client remembered the "hiding" and the terror, rather than the "terrible thing" she was hiding from. (She remembered how the water flowed, rather than the boulder.)

The therapist hypothesised further that the client's experience, as an adult, of saying No was primarily an experience of the power of symbol. In session, the client came to distinguish between the symbol No, and the feeling "no". She came to realise that the feeling of "no", was powerlessness, and guilt.

In intimate (sexual) relationship, the arrival of flashbacks (the utter powerlessness of "no", the ineffectualness of No from child-prey to adult-predator) conflicted painfully with her adult needs and wants. She felt "wrong" and "weak" in her memories of the abuse, because she hadn't acted on "no" (i.e. fought), and because she hadn't insisted on No. In fact, she remembered, on occasion, agreeing to place herself in the power of the abuser, in order to protect her mother from knowledge that "would kill her."

In session, work continued with the cognitive differentiation between primary statements of belief ("I'm wrong – bad – weak") and adult experiences of autonomy. The feelings of wrongness and helplessness were further identified as belonging to the primary constructs.

The client reported cognitive relief. However, the feelings of "wrongness" and the experience of "flashback" helplessness continued in the present. The client also sometimes reported "resisting" resolving the feelings of wrongness – and

"feeling guilty for choosing wrongness over health".

During one session, this reporting appeared to precipitate the client into a kinesthetic "flashback" (knees to chest, arms wrapping own body, unable to speak or move). The client and the therapist had previously established that, when the client was in this state, her need was to be "invisible", but she also needed to hear the therapist speak, in nonevocative language, in order to safely locate her.

The therapist's voice is part of what facilitates the client's emergence from "flashback". The therapist "follows" the client's timing around being able to speak, being able to be asked for information, or being able to offer it – this being the point where adult cognition becomes available again to the client.

When the client indicated that this point had been reached, the therapist held the therapeutic window open for any spoken description the client might wish to make of her kinesthetic awareness during the "flashback". This time, Client A said: "Turtle .... I'm a turtle."

Turtle, when threatened, pulls her head, feet and tail into her shell, and becomes immobile. Turtle, in her shell, is "invisible". Turtle, feeling "no", withdraws.

The discovery, for both client and therapist, was that Turtle represented her pre-verbal "no". Client A, during "flashback", couldn't say No, but she could *do* No. She had *done* No, when she felt "no". The sense of guilt and wrongness began to abate. "Turtle" was a first bridge between the "pocket universe" and the "real" symbolic universe. To discover that she had rejected her abuse and her abuser –*and to discover the evidence in her own body-memory* –was an essential, enormous relief.

Turtle continued to be empowering. Having established "Turtle" as a code, between herself, her partner and her therapist, to describe/announce a flashback or a feeling of "no", she could be affirmed in "no" in a way previously not possible. The resonance between "no" and No began also to be affirmed. Lacan's mirror-phase clearly operates.

Thus far, in terms of Client A's subjective reality, Turtle represented an absence of negative self-judgement. Some sessions later came another breakthrough. Anticipating a flashback, using Turtle to express "no" (by actually pulling her head into her jumper) and having this seen and affirmed by the therapist, Client A announced, from inside her jumper and with an

astonished sense of pride "Turtles know about things like that!"

The absence of negative self-judgement ("wrongness") had become confidence in the rightness of "turtle-no" – confidence, in essence, in the "rightness" of herself in the as yet still unknown pocket universe.

With this confidence, again recognised and affirmed by both partner and therapist, "Turtle" began to evolve from a single symbol into a symbol tree. Differentiating between flavours of Turtle, other words could safely be attached to "Turtle" to express these e.g. "Turtle-here", meaning awareness of present danger, or "Turtle-gone", physical, emotional and psychological withdrawal in response to danger. Turtle-gone represented the client's kinesthetic memory/experience of dissociation, Turtle was now not merely a bridge from pocket universe to symbolic universe – it became also a bridge back, so that the client's adult symbols could be imported and tried out against pre-verbal experience. Thereby, it preserved and promoted both the integrity of self and the increase of autonomy.

With the development of turtle-symbology as a tool, the pre-verbal pocket universe moves into the order of the Symbolic, and can be remembered and narrated. Now the pre-verbal experience can be integrated as part of the adult's life-story.

The Therapist

Pre-verbal knowledge is "held" primarily in the kinesthetic. It will evidence itself kinesthetically, express itself kinesthetically, and can usually only be accessed kinesthetically. The clues, for the therapist as well as for the client, that a pre-verbal 'pocket universe' exists, will be found primarily in kinesthetic awareness. The language used to describe this awareness has, by and large, escaped most of the judgemental loading which accrues to descriptions of emotional or cognitive processes, and is therefore more likely to include "pocket" as well as "symbolic" awareness. "I itch ... I scratch" has its psychological equivalent, but it exists more vehemently in the everyday of common reality. If the client elects to describe kinesthetic rather than emotional or cognitive awareness, the client's awareness may be of the incongruencies of kinesthetic behaviour in given emotional or physical circumstances. The therapist's awareness may be of the congruencies between the kinesthetic behaviour and their map of the effects of pre-verbal abuse. However, at all costs, the therapist needs to consider the dangers of interpreting

this to the client – of providing a symbolic frame for a universe that, as yet, recognises no symbology. NO MORE WORDS should be added to the client's language. The client is attempting to create a new language of their own.

The therapist cannot overestimate the momentous and exciting nature of what the client is doing. This is the birth of language, the creation of tools to communicate with self and other. We can hypothesise that for the client, this is true illumination. The process, for both client and therapist, should be one of mutual learning, entering unknown territory in which they are both pioneers. The therapist has psychological maps. The client has awareness of sensation and context – a shouting voice, violent movement, and the liquid bowels and chattering teeth of his/her own terror. The words which emerge to describe this context and sensation may initially be as disconcerting or seemingly inappropriate for the client as for the therapist. The challenge, for both, is to listen and learn.

The therapist may discover that the client's pre-verbal kinesthetic image for the imminent threat of assault is now expressed as "lizard-darting".

The client is learning to integrate the cognitive, symbolic map for "Daddy is angry. Daddy is/will hit me. Hitting hurts. I have to be still and invisible; I have to run very fast!" – and to rediscover/narrate more fully the experience of Lizard, darting.

As new neural connections form, the client can experience an excited sense of empowerment which pushes relentlessly for expansion of those connections – and integration of the thereby acquired knowledge into existing understanding. Much of this process will happen outside the therapeutic hour. The client's timing is not the therapist's! The therapist's most supportive role may be that of "safe house", "witness" and "cheering from the sidelines". **It cannot be overemphasised, in this, that the therapist's use of their own language/ symbology to "facilitate" understanding, may have the reverse effect, and obstruct the necessary development of the "pocket universe" from the Imaginary to the Symbolic.**

For the client, attempting to narrate a pre-verbal experience using existing adult symbology (trying to describe the "pocket universe" with the language of a common universe) can have various negative effects – even though the client may believe and have experienced narrative psychotherapy as a positive tool.

The client may feel fraudulent or inadequate in themselves. The words don't

touch the feelings/memories, don't represent them accurately. This may lead to a deepening sense of isolation and "wrongness".

The client may feel fraudulent and inadequate to the therapist/therapy – "I'm continuing to make a fuss about something we've already talked about/ we've already covered this, she/he will think I just want attention."

The client may feel confirmed in their "wrongness" – "See? I'm beyond help – none of the usual solutions work with me." Or "I'm so bad, he/she can't imagine/believe this really happened like I'm telling it."

The client may blame the therapist or the therapeutic process for "failing to understand" what she/he is saying – and withdraw the "pocket universe" from therapy. The unspeakable becomes "the unspeakable".

The client may, through common or therapeutic language, discover the commonality of his/her experience – but feel it as a loss of something so intrinsic, so personal to their knowledge of themselves, that they stop speaking of it, in order to protect their sense of identity. "To expose it to the common coin of language, is to expose it to the whim of valuation – it may be debased or appreciated according to a system I have no knowledge/control of." (Client A)

The process of truly narrating a pre-verbal experience, is the process of development from the order of the Imaginary to the order of the Symbolic. In order to achieve this, the client must be able to identify with, practise with, be affirmed with and finally claim her/his own personal symbol for each facet of that experience.

These symbols will likely, though not necessarily, need to be other than the symbols/language commonly used to describe such experiences. Symbols (language), used during the intervening years between abuse and therapy, will have accrued significance unrelated perhaps, except by social use, to the experience the pre-verbal child underwent.

Cassandra

Don't deny me
my monstrous –
don't tell me
you can't see
the crescent of

iridescent scaling green
my sleeve uncovers
inadvertently.
Don't refuse
the brief confused
revulsion in your lover's
fingers touching me
encountering
not skin
but a thin crispness
of chitin.

Do you understand?
I can bear
my difference.
Just – don't abandon me
to the loneliness
of again being
the only soul on earth
to know:
The aliens
have landed.

With thanks to Client A for her consent to my use of her raw fabric; to Sarah Calvert for helping thread the needle; and to Lindsay Quilter for "Cassandra".

Postscript

In session-work, Client A has added another branch to the symbol-tree of Turtle: "Turtlemove". This to describe something which had hitherto not happened:

Turtle, in the presence of danger, and having withdrawn and become "invisible", MOVED to accommodate/defend her own physical situation.

Hypothesis: The "pocket universe" is not static or inaccessible. It exists *concurrently with* the "real" symbolic universe, and is influenced by/evolves concurrently with the adult client's understanding/integration of the Imaginary with the Symbolic.

The challenge, for the therapist working with a client whose traumatic experiences include pre-verbal abuse, is not merely to be conscious and careful of their cognitive and emotional presence in narrative (Symbolic) psychotherapy, but to be equally aware of their kinesthetic (body/behaviour) presence in relation with the client's Imaginary, here-and-now "pocket universe."

Psychotherapy as a Post-modern Art Form

Charlotte Daellenbach

Abstract

As psychotherapists, we are expected to be familiar with a range of psychotherapeutic theories and techniques. The process of blending and integrating these different approaches brings richness to our work, while at the same time risking the loss of the truly unique culture which each therapy embodies. This paper will look at how we choose, in our moment-to-moment interactions, which therapeutic techniques we use, how we bring these techniques in line with our own intuition, and how, once a particular approach has been chosen, this choice influences the course of the therapy. How does a purist approach differ from an integrated approach – what are the advantages or possible pitfalls?

Introduction

How do we choose a topic for paper or presentation? There are probably two main pathways. The first is that we grab the opportunity to talk about something which we consider an area of special expertise. The second is to allow a theme to awaken some new questions in us which are attractive and exciting enough to lead us to venture into some new territory. This paper is the result of the second process, inspired by the theme of *Difference and Integration*. I am attracted to the concept of integration in psychotherapy, and am equally attracted to the concept of difference. I have from time to time felt uncomfortable by the efforts of some practitioners and theorists to fuse different schools of thought and attempt to make them the same. I see enormous value in comparing theories, noting the similarities and honouring the differences, while allowing them to coexist and to inform and complement each other.

Currently, in my own development as a psychotherapist, I am most strongly influenced by the teaching and writing of Richard Erskine and Stephen

Johnson, both therapists and authors who describe themselves as integrative psychotherapists. Although I was primarily trained in Transactional Analysis, I nevertheless also consider myself an integrative psychotherapist.

What does this mean, an integrative psychotherapist? In addition to my training in Transactional Analysis, I have had considerable training in psychodrama, more than superficial training in gestalt and bioenergetics, done extensive reading and study in object-relations and self psychology, in feminist therapy, in neuro-linguistic programming, trained as a relationship counsellor, and my personal analysis was Jungian, which in turn stimulated more Jungian reading As an integrative psychotherapist, I use all of these resources. Integration accommodates diversity.

The title of this paper, *Psychotherapy as a post-modern art form,* is not original. It is the title of Stephen Johnson's introduction to his book *The Symbiotic Character* (1991). I am using it because it expresses the crucial points at issue, namely that psychotherapy is an art form — an art form which is moving from a purist, isolationist, conservative viewpoint to a much less rigid stance, allowing different schools of thought and techniques to be used in an integrative and flexible way. It is also a post-modern art form.

How is post-modernism contributing to our understanding of what is required in psychotherapy today? Post-modernism invites us, or maybe even forces us, to find room for differing and often even contradictory viewpoints. In this age of rapid development and change, people capable of living with ever increasing ambiguity and complexity have the best chances of success and survival. It becomes necessary and even essential for all of us to widen our understanding of the world continuously, to accommodate discrepancies and polarities, to be enriched, challenged and excited by the diversity.

Psychotherapy as an art form

Stephen Johnson describes psychotherapy as truly an improvisational, theatrical art form, and states that, whatever theories are used in its execution, they must stay well in the background for this moment-to-moment interpersonal interplay. As with any art form, psychotherapy then relies primarily on the particular disposition, talent and temperament of the artist. Johnson is of course not the only one to describe psychotherapy as an art form. Michael Franz Basch (1988) subtitles his book *Understanding Psychotherapy* as the *Science Behind the Art*, recognizing that the science is secondary to the art. James Bugental in his book entitled *Psychotherapy and Process: the Fundamentals of an Existential-*

Humanistic Approach, (1978) writes:

> Just as an accomplished pianist (or any artist) is one who has thoroughly mastered the fundamentals of the craft in order to be free to be truly creative in expression, so the master therapist has incorporated the mechanics of the processes to the point that they are invisible. The pianist no longer "plays the piano" but only draws music forth from the instrument which has become integral to the artist. The therapist no longer "does therapy" but relates so authentically with the client because the skills are integrated completely into the professional's way of being.

While this sounds lovely, it may be a somewhat romantic view of both the pianist and the psychotherapist. Barbara Stevens Sullivan (1989), in her book *Psychotherapy Grounded in the Feminine Principle,* writes in a chapter entitled 'The Art of Psychotherapy' that psychotherapy is both art and science. She says that as therapists we need to be transitional, moving somewhere between art and science, and that our great social contribution lies in that transitional status. She distinguishes between the being, the art, and the doing, the techniques based on the theory, the science. She is critical of attempts at treating psychotherapy and psychotherapeutic theory purely as science. Science, she says, needs to be codified, sorted, clarified, but the main object of psychotherapeutic inquiry, which is the unconscious, can be neither codified, sorted or clarified. The moment the unconscious reaches the light of day, it ceases to be unconscious.

Language

Each theory is an attempt to create a picture of the human psyche, a map. These theories are best viewed as metaphors for making sense of that which cannot be scientifically or systematically explored. And each of these metaphors brings with it a culture in which the personality and the particular thinking of its creator are reflected. Most obviously this culture is expressed through the language of the metaphor. We all know that we are profoundly influenced by the language of the particular school of thought we operate out of at any given time. There is not just spoken language, the words we use in our interactions with our clients, but also hidden language, the frame of reference which helps us to conceptualize the therapeutic process. Think, for instance, of how different your subjective experience is when you set out to create a 'play space' compared with the task of "working through" an issue. 'Work' is radically different from 'play.'Creating a "holding environment" calls forth quite different images from being a "container." And just as our theoretical frame of

reference influences our being, it also guides our doing. As a transactional analyst, I am highly attuned to hearing early decisions, to spotting the introjects, and to noticing shifts in ego states. I am usually not consciously aware of looking for these points of reference, but my inquiry and my interventions are designed to elicit such information.

Language is, of course, a particularly powerful aspect of the kind of talking psychotherapy that most of us are engaged in. Freud apparently insisted on his patients speaking German although he was fluent in English, and only allowed a few of his special analysands to speak English (Roazen, 1995). Some of his patients are said to have experienced this as persecutory. I don't know what compelled him to do this, but I find it interesting. It made me reflect on the extent to which we force our clients into our frame of reference, and on how much flexibility we are willing to offer to accommodate the special needs of our clients. I am sometimes sought out by clients who choose me because they want to do therapy in their native tongue, and I actually enjoy meeting them in this way. However, I recently saw a young man from Switzerland who spoke the identical Swiss dialect to mine. In Switzerland you can virtually spot the village a person comes from just by hearing their particular dialect. It is rare for me now to meet people who speak like me. What I discovered in being with this man was an overwhelming urge in me to regress. Only in my childhood had I been around people who spoke this dialect. All my adult life I have lived in other parts of the world, speaking first French, then English. It was of course very helpful for me to recognize this invitation to regression, essential for the therapy, but also underlining my awareness of the power of language. Similarly, within a language, each metaphor, with its unique terminology, impacts differently on the therapeutic relationship. From this understanding, we consciously choose to mirror the words and expressions used by our clients to establish connection. At times, we will deliberately not reflect back the client's language to achieve a particular impact.

It is interesting to ask ourselves how we each chose the primary modality in which we trained when becoming psychotherapists. I am sure we all have quite different rationales. I, for instance, did not choose the particular theory, but the person teaching it. I have long known that I learn best from a teacher I respect and admire. So when the opportunity presented itself for me to train in Transactional Analysis, I decided to take it up because of the personality of the teacher who was somebody I could trust, respect, love, and therefore learn from. And yet, I am also convinced that the particular primary school of thought which we each follow in some important way must suit our personality.

And when it does not, a practitioner may change the theory to get a better fit. This may well be what leads to the creation of subschools, of a different stream within a theory. In Transactional Analysis I found a model which offers an elegant blend of a comprehensive theory with a respectful and highly effective methodology. This suits my need for supporting my intuitive responses to my clients with a clear thinking framework.

Choosing the frame

Assuming that we are thoroughly versed in at least one theory and have a good working knowledge of several others, including their techniques and methodologies, how do we choose, in our moment-to-moment interactions, which frame of reference we employ? Consider some of the polarities which offer choice points: we can be authentic/involved or neutral, directive or non-directive, strengthening defences or weakening defences, interpersonal focus or intrapsychic focus, current determinants or historical determinants, focus on cognition or focus on affect, prohibit transference or provoke and allow it, interpret a dream or just listen to it. We could think of many more.

I have been paying special attention to how I make these decisions, with a particular client, or in a particular moment. I have also asked some of my colleagues and supervisees. What I have discovered is that there are a number of different ways in which we make these choices. Some of the time we are truly the artist, as described by Bugental, intuitively and authentically being there in a particular way, not aware of any frame of reference, as one person connecting with another. At other times we make our choices quite self-consciously. We may deliberately tailor our intervention to the particular need, as perceived by us, of this other person, our client. Maybe not surprisingly most of us take our leads from our clients. The words our clients use to express their pain, concern or yearnings, will activate in us a particular frame of reference that resonates with them. For instance, a person telling me about her emptiness may evoke a Masterson (1985) model which will then influence the course of the therapy. Therefore, the more flexible we are in our repertoire or frames, the better able we will be to attune, to find the words and the context to respond from, which best matches the client's needs.

And that is not enough on its own. The repertoire or frame also needs to match the style and personality of the therapist. A few years ago, a man who had cancer came to me with the book by Lawrence LeShan *You Can Fight for Your Life* (1984), asking me to read it and to follow with him this particular therapy.

I read the book, was very much excited by it, and proceeded, as best as I could, to work in the way of LeShan. The result was that I was anxious, unsure of what I was doing, and undoubtedly not helpful to the man. Fortunately, I rapidly became aware of the source of my anxiety, stopped trying to be who I was not, and started a new and much more effective psychotherapy.

Michael Franz Basch (1987:368) said in an article in *Contemporary Psychoanalysis* that the repeated splintering of our field into various schools was, and is, unnecessary and counterproductive. He states that we are today in a good position to establish a unitary theory of psychotherapy. I will admit that on the face of it I find this an attractive idea. There is in me, like in most people, a yearning to make things simple, uniform, shared, commonly held. But then I come back to my understanding of the post-modernist contribution, and remember that making things simple and uniform is far from being the best or most appropriate way to cope with the complexities, paradoxes and ambiguities of today's world.

I am reminded here of the words of His Holiness, the Dalai Lama, who in a public talk spoke of the importance of spiritual pursuits, but was clear about the value of having many choices and different pathways. There is no one true way. Each person needs to find his or her own. He likened the multiplicity of pathways to the fingers on a hand. If you want to push something, he said, the thumb does a fine job, but for other purposes (like scratching in your ear) the little finger is far superior. To take this analogy further, we could say that the palm of the hand, which holds all the fingers together, represents in psychotherapy that intuitive way of being which is capable of making contact with another human being at a deep and authentic level, and which surely is common to all psychotherapeutic pathways, the hallmark of the true artist, as in Bugental's description of the artist.

In the editorial to the February 1997 edition of the journal *Psychotherapy in Australia,* under the title "I have my model and I am happy with it!" Liz Green writes:

> From where I sit, as one of the editors of this journal, I am amazed at the different and opposing truths held on what is "right and proper" in psychotherapy — all coming at me from a wide range of well qualified, intelligent, even likable, people. The problem with this field is that there is no agreed body of knowledge. . . And yet, is this such a problem? Perhaps it is a delight? Diversity and colour, different racial identities, personalities, cultures, languages, beliefs, species, landscapes, and climates all give the

> world interest, fascination and life. Who would argue for homogeneity? ... For me, the problems arise when I encounter narrow minded, closed, blind dogma, when groups malign one another without any basis, when groups become elitist and self-interested and begin to believe their own propaganda. How miserable life would be if we all believed that we had found out the truth about the human condition.

Like Liz Green, I favour diversity. However, in the context of diversity, let me make a plea for purism. In particular, I ask you to not lose sight of the culture of each modality. A psychodramatist who asks a protagonist to reverse roles with an auxiliary is not doing the same thing as a gestaltist who uses an empty chair, or a transactional analyst who lets his client externalize the introject or parental message in order to resolve the impasse. Superficially, these methods may look the same, but their specific intentions are different. Equally, it is important to know why a psychoanalyst chooses neutrality rather than involvement, and if we follow such a style of working, we need to do it with that clarity and commitment.

I grew up speaking German. I recently had the opportunity to see and hear a performance of Mozart's *Magic Flute* at the Sydney Opera House. Mozart wrote that opera, called *Die Zauberflöte* based on a libretto written in German. Yet the performance in Sydney was in English. It was a very impressive performance, while being profoundly different from the German version I had grown up with, not better or worse, but quite different in its emotional evocations. My point is that when you speak (or sing) German, do it as purely as you know how, true to its cultural heritage, and when you speak (or sing) English, you do the same.

Yet cultures change, languages develop, natural blending occurs. And we all form and reform our own idiosyncratic styles, much as we each have our own distinct accents. The importance is to be thoughtful in our blending, and to remain respectful of the cultures. As psychotherapists, we need to continually widen and deepen our repertoire of theories and techniques, and while developing our own ever-changing individual ways of working, we also need to remain alert to our particular professional identity.

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Science, Psychiatry and Psychotherapy

Philosophical and Ethical Issues of the Medical Model

Tony Coates

Abstract

The paper is a critical deconstruction of the medical model. I examine the medical model in medicine, and how it drives psychiatry and psychotherapy. Using the notion of 'structure determinism' as outlined by Humberto Maturana (Chilean neurobiologist and leading constructivist thinker) I demonstrate the confusion that inevitably arises in daily life when theories about, explanations of, and metaphors for, human behaviour and conduct are confused with physiological processes.

I suggest that such theories are about human conduct and therefore are a part of ethics and religion and do not belong to medicine proper. Considering such explanations, theories, and metaphors to belong to medicine, maintains a power of medical expertise to predict and control human conduct. To this extent the medical model in psychiatry and psychotherapy is an issue of power and control and hence belongs to ethics and morality, and not to medicine.

I also suggest that human freedom, responsibility, dignity, and integrity may lie in reclaiming such expertise for oneself.

Introduction

The purpose in presenting this paper is to restore the notion of human freedom, whereby we are free to choose to decide about issues of everyday life.

Much of modern language is peppered with medical explanations for everyday conduct. Depression, we are cautioned, is on the rise. 25% of people we are told

may suffer from it. As mental health professionals we are exhorted to be vigilant and hone our diagnostic skills with the implication that we might be missing a diagnosis that is all around us. We might ask ourselves: If I am getting mood swings maybe I should seek treatment before it gets any worse. How are my chemicals? Maybe I need prophylactic prozac or lithium maintenance for my depression just in case. Should I go for a jog to boost my endorphin levels? Am I exercising my right brain sufficiently? Maybe my cognition needs correcting. My great grandfather ended up in Carrington, my aunt in Porirua, and my uncle in Sunnyside[1]. I've obviously got mental illness in my genes and I need expert advice. Tell me what to do?

So go the pleas for expert 'medical' advice. We are becoming a people preoccupied; selves with an endless medical preoccupation with our own conduct, feelings and neuro-chemistry. We become unwilling victims of the new technology that subjects our everyday lives, our relationships, our gender, our intentions, our moods and concerns to medical diagnostic scrutiny. Our daily living becomes endless fodder for the mindless machinery of medical diagnosis.[2]

Everyday conduct, including our politics is seen in diagnostic terms. It is turned into a syndrome. Our anti-nuclear stance was described recently in an American newspaper as the "New Zealand Disease", to be pitied, the sufferers treated. We have these antinuclear beliefs through no fault of our own, and we need treatment. Successful treatment here, just as in psychiatry, means to abandon such beliefs, and 'insight' means 'realising' one is ill to have them. Of course any treatment can be justified because we are treating an illness, and ill people have a right to such treatment even though they might resist it. In this paradigm any means of eliminating resistance or opposition can be justified. People have a right to have their illnesses treated, and be given drugs against their will if a medical authority deems it necessary. They should not be denied their rights. So goes the psychiatric rhetoric.

Everyday we hear how our undesirable or problematic conduct is a function of abnormal physiology, or abnormal genetic structure. Our beliefs, our thinking, our emotions, our everyday conduct is teased out under the microscope by a medical gaze, searching for pathology. The self that is revealed by such a gaze

1 Mental Hospitals in New Zealand.

2 See for example a proposal to classify happiness as a psychiatric disorder. Major Affective Disorder, Pleasant Type Bentall, R.P (1992) A proposal to classify happiness as a psychiatric disorder. Journal of Medical Ethics, 18,44-98 in British Journal of Psychiatry (1993), 162, 539-542

is a self, we are told, conflicted, divided by genetic instinctual drives, primitive pathological defence mechanisms. It is a self, torn by conflicting personality types, a self at the behest of chemical imbalances, a self torn by hormonal dysphoric syndromes, in dire need of balance and correction. It is a self that construes everything chaotic or problematic about our behaviour to be the result of mental disorder and/or abnormal chemistry, and everything downright unpleasant or unwanted as an illness or disease. A self tossed about on a sea of biological instinctual unconscious drives, victim of its own genetic and cerebral chemistry. A self that requires the constant help and advice of those experts in psychiatry, physiology, behaviour, or psychology, who teach us what we suffer from, what illnesses we have, and what treatment we need, in the same breath.

I recall a colour therapist who did exactly this. He walked amid his houseful of seated patients waving a dowsing rod topped with coloured wool while he diagnosed their various ailments. His patients looked stunned as he reeled off diagnosis after diagnosis. They would exclaim "How did he know that? That's why I feel so bad! Now at last I know I'm not imagining it". They would sit there for the day, with wires trailing from expanding wire cuffs attached to their wrists. The wires from his seated 'patients' snaked in large cables to a central room and were attached to a large polished copper plate in which there were egg sized indentations filled with various bits of coloured wool. Attached to this large plate were four spark coils of the sort used in the model T Ford car. Under the table were three large car batteries. A series of four electric arcs from these coils formed the backdrop, an electric reredos, to this persuasive altar, the buzzing and crackling of which could be heard throughout the house. After one or two diagnostic passes of his rod he would attach a newcomer by a wire leaving him or her to sit among the enthralled, sometimes sceptical but always wondering conversations that were taking place. He would return after 30 minutes or so making more diagnostic passes, remarking, "Well I think we've got it this time" or "I think about another 15 minutes should see you straight" Many would stay the day, at $60 a time. Cheaper than their GP. They got a whole day treatment instead of 10 minutes from their GP who wasn't able to even diagnose their complaints let alone treat them.

The intention of this paper is to show that experts in the field of mental health are doing a similar thing to the colour therapist. The technology and expertise is a lot more sophisticated and the paraphernalia many times more expensive and elaborate, concealed in mountains of journal articles, but the techniques of persuasion and power remain unaltered. In psychiatry the EEG, MRI and

PET scan equipment has replaced the T-Ford coils, the DSM has replaced the coloured wool and dowsing rod, but the structure and techniques of persuasion are clearly recognisable once the aura of power is removed.

It is an enormous reverse placebo. Just as administering an inactive substance or prescription (placebo) is held to be curative and relieve symptoms, so can the administration of a physiologically inactive substance or prescription cause illness and generate symptoms, (a 'reverse' placebo). It is persuading someone else without a shred of physical evidence, firstly, that they do have an "illness" or "disorder" that causes suffering, and secondly that some expert has the answer; persuading people that you know what they need better than they do and therefore they should pay you to take away their unhappiness.

Medical pamphlets exhort us to seek medical advice before stopping medication. Before attempting exercise please see your doctor. If pain persists please see your doctor. For heavens sake don't do anything without consulting your doctor. Without denigrating the practice of medicine itself, I wish to examine this presupposition that in order to live our lives we should depend on so-called scientific medical expertise.

I wish to demonstrate that much of this persuasion is propaganda, a self-serving tautological rhetoric, and that the outcome of such rhetoric is the preservation of the medical viewpoint. I intend to show that this view in psychiatry and in psychology is neither scientific nor logical; that it is incompatible with the notion of human freedom and hence human dignity, integrity and responsibility.

In construing problematic or unwanted human conduct, contentious beliefs and utterances as symptoms of medical or physiological abnormality, biopsychiatry conceals its beliefs, actions, motives and concerns behind a cloak of spurious medical and scientific legitimacy. These beliefs are concealed from the scrutiny of others by the claim that a human self is divided, and is perpetually at the behest of strange, pseudo-scientific, out-of-control urges that compel and therefore can be seen to excuse one from the consequences of one's actions.

Structure Determinism

Chilean neurobiologist and leading constructivist thinker, Humberto Maturana, says that science can be studied by observing what scientists *do* when they say they are doing science.[1] He claims that science can only operate with structure-

determined systems.[2]

If we are to examine the implications of the medical model in psychiatry we need to consider what scientists do when they say they are doing science and the implications such actions have for psychiatry and psychotherapy.

Structure determinism is a notion he and his colleague Francisco Varela define in a book entitled *Autopoiesis and Cognition*[3]. Structure determinism is the idea that the behaviour of any entity we distinguish is determined by its structure, and not by the interaction with the medium in which it exists. Further, such an entity can only undergo those changes its structure permits. Like water to the fish or air to the bird we tend not to notice we operate in this way.

Suppose I hold out in my right hand an egg and in my left a tennis ball. I drop them both on to a concrete path. The egg will smash, the ball will bounce. While the interaction with the concrete is the same in each case, the outcome is completely different for each entity. The impact of the egg and the ball with the concrete *triggers*, but does not determine the outcome. The outcome is determined by the object's structure, not by the interaction with the environment. The interaction *triggers* but does not determine the changes the entity undergoes. That is structure determinism. It is a simple notion, but profound in its implications.

If I have a tape recorder and I push the play button but it does not play, I assume there is something wrong with the tape recorder, not with my pressing finger. Similarly, if my car does not stop when I put my foot on the brakes, I think there is something the matter with the car's braking system, not my foot. Thus I get my car fixed, not my foot. The same applies to living systems. A living cell or a human being can undergo only those changes that its structure permits.

Science deals only with structure determined systems. Science looks at the structure of entities and their behaviour in terms of this structure. Science says *nothing* about non structure determined systems. If the tape recorder fails to work when I put my finger on the play button and there in nothing the matter with the recorder, I can say that it fails to play because I put a spell on it. This is the domain of magic, miracles, the *super*-natural. Science does not say this cannot occur. Science remains mute on this point. There is nothing to be said, and no scientific explanation possible. In this sense the world of science is the world of everyday experience. Chemistry is an extension of cooking, physics of house repair. To explain a miracle in scientific terms which is concerned with the everyday world is to place it in the natural world. Miracles by definition are

of the *supernatural*. If it can be explained in terms of structure determinism it is not a miracle, and may have a scientific explanation.

Incommensurable Domains

If we then distinguish something from the medium in which it exists, we can observe that there are two distinct domains, areas, fields or realms. Such realms are generated by the very act of making the distinction we perform.

- The realm of the structure of the entity.
- The realm of the medium in which it exists.

Maturana sees these two domains as incommensurable. They do not intersect, and are operationally distinct.[4] They have become so in the act of distinguishing them. They have a generative relation between them through mutual triggering one of the other. For an entity such as a tape recorder the two domains are:

- The domain of the internal structure of the tape recorder i.e. the motor, printed circuit, silicon chips, plastic support, loudspeaker etc. This is coherent in that the pulleys, tape speed and electronic componentry can be explained in terms of their interactions.
- The domain of the medium from which the tape recorder is distinguished, the background in which it exists, the air and surrounding environment.

Each domain is coherent within its own structure but is operationally distinct from the other. No examination, however detailed, of the electronic and mechanical components of the recorder will inform you about the music it is playing. Similarly listening to the music will shed no light on the internal structure of the tape recorder. In the course of everyday living we do not confuse these two domains. We go about our lives knowing that this is the case. It happens to us without our thinking about it. At the same time we do not consider the implications of it. Humberto Maturana says; "We have the double look, but we do not always have the double think."[5] We have the double look, we make this distinction, but we do not necessarily reflect on its implications.

Our everyday actions demonstrate that we never confuse the structure of a violin with the music that it plays. We don't even have to think about it. Yet the wider implication of this is crucial in our lives, in the domain of mental health, and in particular in the domain of psychiatry and mental health.

Science and Scientific Medicine

Scientific medicine treats the human body as a structure-determined system. Textbooks in medicine all refer to the structure of the body to explain its physiology. The disciplines of anatomy, physiology, histology, morbid anatomy, haematology, biochemistry, cellular biology, endocrinology hang together as a coherent whole and can be explained in terms of how the body works the way it does. With respect to physiology none of these domains are incommensurable. Cells are common to the nervous system as they are to the haematopoietic system and to the endocrine systems. They are all part of the structure of the human body as a distinguished domain of coherences. They all interact together in specified ways that are coherent. The organisation of the human body does not change from continent to continent, with social class or race. Textbooks of anatomy are pretty much the same for the bushmen of the Kalahari as they are for the Inuit of Greenland. The medical practitioner is trained to look for abnormalities in this structure. Such structural abnormalities are construed as the bases for illnesses, and scientific medicine is the study of their investigation and treatment. The protocols of history taking, examination (inspection, auscultation, palpation, percussion) and investigation are repeated endlessly, until they become second nature to the practising doctor. The lay public relies on this specific training, that they do not have, to diagnose illness.

What the patient says and does are symptoms, guides only to the underlying physiological dysfunction. For example complaints of weight loss, passing excess urine, and intense thirst, may not mean diabetes. As patients we have no direct access to our own blood sugar, the state of our neurochemistry, our serum cholesterol or our blood pressure. Scientific medicine undertakes to find out what that state is and to correct it. Performing a glucose tolerance test may confirm or exclude diabetes. Medical treatment is aimed at correcting the physiological abnormality, based on the pharmacology and the biochemistry of insulin or other drug. All this is scientific medicine and lies in the coherent domain of anatomy and physiology.

What a person says and does, however, belongs to the domain of interactions between the person and the context in which they find themselves. This domain has no common measure with the domain of physiology. If it did have a common measure it would be possible to know the state of our chemistry at any time just by sensing or looking. Physiology and biochemistry as a separate study would be superfluous and blood tests unnecessary. We would automatically know that we had cancer or hypertension or leukaemia.

In the same way the domain of physiology has no common measure with the domain of interactions. How someone voted in the election will not be found by examining their brain. All that will be found in the brain will be neurones, neuroglia, connective tissue, neurotransmitters being released and absorbed, nerve impulses, oxygen being metabolised, ATP being converted to ADP and back, blood and so on. You will not find thoughts, ideas, beliefs, delusions or hallucinations there. You won't even find any information there. Information is not transmitted by nerve fibres. Nerve impulses are transmitted by nerve fibres. Nerve impulses are constitutively *not* information nor are they data. They are nerve impulses. Information, data, thoughts, ideas, beliefs, delusions or hallucinations belong to the domain of language which is the domain of our interactions in the context of our lives with other people.

As a physiologist I observe my quadriceps muscle in my right leg contract. I could formulate a coherent scientific explanation that describes contraction of actin and myosin fibrils, the oxygen uptake, the mechanics of the articulation of the femur with the tibia, the blood supply, the rate of carbon dioxide production. However this will not tell whether I am kicking for touch, kicking the cat or kicking the next door neighbour. Conversely if I kicked the winning goal at Carisbrook, no study of the game will inform me of the metabolism of my quadriceps.

Accordingly, structure determinism means that political beliefs, and theories, will not be found in the brain any more than the meaning of the Mona Lisa will be found in the paint, or found by subjecting the painting to a CAT or MRI scan. Political beliefs, theories and meanings are to be found and understood in the context or medium in which they are uttered.

Structure determinism means that genius will not be understood by examining one's genes. All one will find will be sequences of DNA. Operationally, a genius is an attribution conferred by a society on a person for what they do. Lenin was once a bright young man, then he became the genius who helped to found a great nation, and had a city named after him. Since his death he has been judged a misguided nonentity and the city that bore his name has been renamed. Biologically, we would accept that his genes remained the same. This is not to say that genetic structure has no impact on the ability a person has to succeed in our society. The word genius, in the course of everyday life, is distinguished in the context of its everyday usage, not by the genetic or biological structures through which it is realised.

Scientific medicine has been successful in almost all fields of medicine. Science not only gives reasoned coherent physiological explanations for illness and diseases, but also demonstrates day to day its physiological claims and assertions in the course of diagnosis and treatment of every patient seen.

Scientific Rigour and Biopsychiatry

This scientific rigour applies in all field of medicine except Psychiatry. As far as I know Psychiatry is the only field of medicine where a positive diagnosis of "illness" is made when all physiological investigations have been found to be negative. In most other fields of medicine negative physiological findings exclude diagnosis of illness. There is no other branch of scientific medicine that claims the ability to diagnose "illness" in the*absence* of demonstrable physiological evidence.

I came to psychiatry in the mid 1970s and at that time I was intrigued to read a book by Thomas Szasz called the *Myth of Mental Illness.* At first, I thought he was just an outspoken radical of the anti-psychiatry movement. I was astounded to find he was not only a Professor of Psychiatry at the State University of New York but a trained psychoanalyst who was also President of the American Psychoanalytic Association, and was still practising. I thought, would it be possible for a professor of orthopaedics to write a serious paper entitled "The Myth of Fractures" and still have any patients left, let alone hold the position.

I found another professor of psychiatry debunking diagnosis in psychiatry, Karl Tomm[6], and another eminent psychiatrist with doubt about diagnosis, the former President and Examiner for the Australasian College of Psychiatrists no less. In his 1992 paper entitled *New White Elephants for Old Sacred Cows: Some Notes on Diagnosis*, John Ellard says; "I feel strongly that the relentless pursuit of an authorised diagnosis for each patient is in many cases an exercise in pseudo precision and that the more axes there are the greater the error."[7]

Yet in psychiatry, we still continue to hear about the importance of an accurate diagnosis. We are told for example that there is a tide of undiagnosed "depressive disorders" present in society because they are not being "diagnosed". In the referrals to our Community Mental Health Centres we are asked to distinguish between depression and an entity called 'clinical depression' which is entirely the product of speculative thinking. This entity called *clinical depression* manifests itself only before the gaze of a trained specialist psychiatrist or mental health professional. The laity, comprising those who are supposed

to suffer from it, are unable to distinguish it for themselves. Since there is no physiological evidence that can be tested for in order to justify the diagnosis, patients have to be convinced of their illness, persuaded that they are "ill" by medical rhetoric alone. This applies to most mental illnesses.

Biopsychiatry claims to be scientific. My claim is that it is not. I claim that most psychiatry is a body of rhetoric that throws science itself into disrepute by making speculative claims that are unable to be substantiated, about origin and causes of human conduct. In my view biopsychiatry is a body of pseudo-knowledge that is an enormous tautology. This tautology not only throws doubt on the practice of orthodox scientific medicine but creates and disenfranchises the lay public by its confusing and unsubstantiated claims of expertise about what it is to be human. Such claims of expertise imply that the origins of human conduct lie in genetic structures, instinctual drives, and personality structures. I claim this constitutes a total disregard for the notion that *any* person could, and might be able to, have any say over their own conduct.

Our society, by being convinced that "mental" illnesses really exist, grants biopsychiatry permission to present its beliefs as fact, without scientific evidence, much as the society of the 15th and 16th centuries granted the Catholic Church the ability to present witchcraft as fact. This was an act of conserving power, not finding the truth.

I assert that the preservation of the medical view of human behaviour has nothing to do with the relief of suffering, or the care for human beings in need of relief, nor has it to do with the furtherance of scientific knowledge. Rather it has to do with the conservation of its own ideology and dogma. Such beliefs and dogma are maintained by misrepresenting them as fact, under the cloak of expert scientific knowledge or as caring for the "mentally" ill, and this to the very public who pay them to continue such rhetoric. The lay public who accept such expertise relinquish control over their own lives to the extent they accept the authority of such dogma. In this way an ignorant public is created whose lives depend more and more on the proclamations uttered by such experts. The extent to which this authority is not questioned or scrutinised, is the extent to which the power of such authorities is maintained. Such authorities can maintain their power with assertions that human conduct is at the behest of genes, biochemistry, heredity or whatever such authorities say it is. An ignorant laity accepting such authority as scientific, in the absence of verifiable

evidence, have little option but to live their lives according to the latest religion such "experts" put their faith in.

Diagnoses and the DSM

This is not a popular view. The popular view is that we can turn to those experts to tell us what to do and how to behave for the best. In biopsychiatry, the DSM IV justifies diagnosis based on the conduct and utterances of the patient. Most of these diagnoses can be made only in the absence of organic abnormality, when all physiological abnormalities have been excluded. In other words when one's physiology is normal. Biopsychiatry then deftly turns around and implies that such conducts *are* the result of abnormal physiology, when it has just defined normal physiology as a requirement of the diagnosis that it makes in the first place! This is a very crude attempt to cover all bases. Such thinking is not only oxy-moronic, but downright duplicitous when it makes claims to scientific veracity. Remember Mark Twain's observation of Christian Science, that it has: a perfectly astonishing talent for putting words together in such a way as to make inquiry into its intention impossible.

If biopsychiatry says that its theories suggest that you are depressed, psychotic, obsessional, anorexic, because your inter-synaptic serotonin levels, dopamine neurotransmitter levels, winter sunshine levels, hormonal levels, serum lithium levels, or genetic predisposition, cause you to be so, we need to understand that such claims are speculative, not scientific. They remain speculation until they can be demonstrated in the course of routine clinical practice, in the same way that science is practiced in all other branches of medicine. The reliance on such arbitrary "expert" authority enables such statements to be accepted by a laity as scientific when they are not. The patient in the psychiatric consulting room has no inkling that such statements are not backed up with scientific evidence. The lay public are then expected to believe fiction as fact simply because of the authority of those that proclaim it. No physiological proof or evidence is necessary or required, on which to base its claims, as it is in every other branch of scientific medicine.

Currently, biopsychiatry is involved both in a frantic attempt to turn the discomforts of everyday life into illnesses, and in a mad scramble of technological drug and brain research to justify these claims under the guise of scientific verisimilitude. This is all a bit futile when, by its own definition, no evidence other than the behaviour and utterances of their patients is required for the diagnosis of mental illness. This is none other than what seems so far, to be a

pretty successful attempt by biopsychiatry to save itself lest it be swallowed up by neurology on the one hand and social anthropology on the other, and would therefore cease to exist as a separate discipline.

Biopsychiatry suggests that research with PET scans and brain imaging will eventually provide biological evidence for its claims. Again this is speculation: speculation that mental disorders are expressions of physiological disease in the first place. Claims based on the supposed positive outcomes of experiments that have not been performed cannot be used as evidence to back diagnosis or treatment let alone be used to back speculative theory. This is neither biology nor is it science. Such thinking in biopsychiatry is used not only to make diagnoses but also to justify treatment. If speculation is accepted for long enough it tends to be seen as fact rather than fiction and any treatment to control behaviour can be justified.

I propose that the terms "mental illness" and "mental disorder" are metaphors for conduct and utterances we do not like or understand, conduct that is currently chaotic, inexplicable, or causes suffering to others. In my view biopsychiatry not only fails to distinguish between metaphor and the actualities of everyday living, but also fails to realise that behaviour occurs in the domain of human relations, *not* physiology.

The focus then becomes physiological and medical in the face of no demonstrable abnormality. The domain of one's humanity in living one's life is ignored. Psychiatric referrals for assessment to local Community Mental Health Centres commonly contain the query: Psychiatric assessment please. "Major depression? Suitable for fluoxetine?" in patients who have extreme emotional disturbances. The fact that they have for instance had a marital separation, following the suicide of an adolescent child, is often seen as a side issue.

No competent physician would diagnose pneumonia relying just on what the patient said without listening to the chest, let alone taking a chest x-ray. No competent haematologist would diagnose leukaemia based on the patients statements and behaviour alone without examining that patient and taking a blood test and bone marrow biopsy. No competent doctor would do this let alone begin specific treatment. Yet biopsychiatry routinely treats patients on the unsubstantiated speculation of abnormal dopamine or serotonin neurochemistry without any check on serotonin levels let alone doing a PET scan of the limbic or pyramidal or frontal lobe systems. When all investigations are normal, explanations of chemical imbalances are trotted out. Such

explanations appear on brochures distributed by drug companies to the public[8]. When patients apparently recover, this explanation is taken as proved, if not by the clinician, then by the patients and their families who accept their changed conduct as a legitimate illness that has been properly treated.

In America 'psychiatric patients' are distinguished as patients (for the most part) on the basis that their conduct and utterances constitutes a "mental disorder" according to the DSM. The DSM is able to maintain a view that certain sorts of human conduct are 'disorders' by deleting, omitting or glossing over other contexts by which such conduct and utterances might be given some other meaning than that of 'disorder'. Firstly, the *context* in which patients' conduct and utterances occurs is deleted. The DSM makes no mentions of their lives, their culture, their day to day existence, their view of the world, or the issues they face in dealing with others. Secondly, criteria of what constitutes order from those of disorder are covertly implied or glossed over as automatic presuppositions. Thirdly, the declaration that disorders can occur in the absence of physiological abnormality, means that what is ordered, disordered or ill about human conduct lies solely in what 1000 or so psychiatrists agree to, simply because they grant themselves the authority to say so with each edition.

Biopsychiatric Diagnoses as Descriptive Tautologies

Treating human language and behaviour as if it reflects abnormal chemistry is to collapse the domain of conduct into that of physiology, as if these two domains were commensurable. This assumption that the two domains have a common measure and are therefore operationally indistinguishable means that:

- Structural determinism does not apply.
- Scientific explanations do not apply. Explanations will be tautologies (saying the same thing in different words).
- We are in the same domain as magic, or myth.

It means that biopsychiatric explanations that are made about human conduct are not scientific explanations, but descriptive tautologies. As a consequence in psychiatry it means that a committee of psychiatrists can declare certain human utterances and conduct to be symptoms of physiological disease simply because they choose to do so. No evidence is required.

The DSM IV evades the notion of an actual illness by specifying unwanted

conducts as 'disorders' rather than illnesses, yet the whole of psychiatric literature speaks about symptoms, and about psychiatric patients being 'ill'. The use of the term 'disorder' is a euphemism for illness without actually saying that. The word 'order' has an ecclesiastical origin referring to the various orders of angels and the religious orders that comprised the hierarchy of God's Church. To be out of order or disordered implied being out of the Church's order. Now, as then, this was to be an alien. That is why psychiatrists were and still are called 'alienists' in many dictionaries.

As human beings we sometimes act in strange and problematic ways. We have strange beliefs, act irrationally, and cause suffering, heartache, unhappiness to ourselves and others. Such suffering and distress may be alleviated with medication or even by involuntary restraint. Claiming that such conducts are an illnesses doesn't turn them into medical illnesses.

Categorising human conduct into what is ordered and what is disordered does not mean we have a whole new range of illnesses just because psychiatry categorised them. Such categorisation of behaviour reflects a view of psychiatry and does not necessarily reflect how human beings are. In our culture only the medical profession can make arbitrary claims about who does or who does not have a disorder. If a lay person insisted they were still ill after their GP pronounced all investigations normal we might say they were mistaken, misunderstood, or that their doctors were incompetent.

Not according to psychiatry. The patient may receive a diagnosis because they don't accept the word of the doctor that they are well. What do they suffer from? They have a disease whose specifications lie in disagreeing with medical authority. What disease do they suffer from? They suffer from 'hypochondriacal delusions', a mental disorder that can only exist in the complete absence of any physiological abnormality. Such is the appalling nonsense of biopsychiatry.

Why are such beliefs maintained and preserved in the face of the complete failure of psychiatry to provide any scientific medical evidence to back its claims and theories in clinical practice? Providing such scientific investigative evidence is not only everyday routine but mandatory in all other branches of diagnostic medicine. They are preserved because psychiatry construes the psyche not as a domain of how a human being behaves in the world but construes the psyche as biological part of the human body.

The 'Psyche' as part of the Body

The 'psyche' in everyday terms according to Dorlands Medical 'Dictionary is the 'human capacity to think, to make judgements, to feel emotions'. It is a process, something *we do*, but it is treated in psychiatry as if it were an organ of the body, as if it were a physiological entity, like our liver or heart. Psych-ology is the study of the psyche just as Neur-ology is the study of the nervous system and Endocrine-ology is the study of the endocrine system. Psychiatry, Psychological Medicine, and some aspects of Psychology convey the idea that the study of the behaviour of a human being as a whole is a part of medicine. We treat our conduct as if our conduct itself could become 'ill' and demonstrate 'psycho'-pathology, just as the functioning of an organ can show pathology.

Conduct we do not like, we diagnose and treat as if such conduct were *part* of the body rather than an expression of its totality. Biopsychiatry examines a person's 'mental state' as if their mental state could be compared to their stomach or spleen. Discovering that a patient has 'suicidal ideation' or a 'thought disorder' is treated by psychiatry as if it had the same implications for health as discovering that the patient has, say, a peptic ulcer or a pulmonary embolism. Statements such as: This person has poverty of thoughts; this person has grandiose delusions, this person has obsessive traits, are made in psychiatric case presentations as if they were statements describing physiological properties of the patient, rather than medically jargonised restatements of what the patient said and did. The ordinary English language of description that we all understand is turned into medical jargon that has the appearance of carrying some expert scientific meaning when it does not. For example, not being interested in sex becomes having a low libido, having difficulty sleeping becomes having insomnia, feeling good at certain times of the day and not so good at others means having diurnal mood variation, checking once or twice to make sure the lights are off means having obsessional traits, believing God has singled you out for special favour is having grandiose delusions, not wanting to do what your boss wants you to means you have issues with authority figures.

The list could fill a book. Such jargon is misleading and obfuscating because it has the appearance of saying something scientific and meaningful when it does neither. It is misleading because it is just a restatement of the original conduct that adds nothing. It is obfuscating because it misrepresents human conduct by depriving such conduct of the context which originally gave it

meaning. The medical model distinguishes conduct as an expression of disorder rather than an expression of who someone is in the circumstances in which they find themselves. The meaning of a person's being disappears in a welter of descriptive medical, psychiatric, and obfuscating psychological jargon.

This distinction is crucial. It is crucial because while it is makes sense to ask someone to stop what they are doing or alter their behaviour, it makes no sense to ask a person to lower their blood glucose to stop producing cancer cells. The medical model, in construing our conduct and behaviour in this way, creates an impression that we have as little say over our conduct as we do over our physiology. This is mistaking mental illness for medical illness. We are applying something that is metaphorically the case but not literally true. As Humberto Maturana says, we have the double look, but we do not have the double think. 'Mental illness' might be similar to a medical illness in that there is human suffering, problematic conduct that we do not understand in ourselves or in others, but this does not mean there is any physiological abnormality. By deleting context, the medical model is able to distinguish behaviour and utterances as individual disorders, characteristics of the individuals, rather than legitimate expressions of who persons are in the circumstances in which they find themselves.

In medicine, standards of laboratory accuracy are rigorously checked. Standards do not rely on opinion. An error in a result might mean either missing the diagnosis or giving a false diagnosis. Biopsychiatry however has blind faith in the patient's opinion of their own depression. If a patient says they have a belief that their TV set is sending out thoughts into their brains how can biopsychiatry tell if this is actually the case or whether the patient is mistaken, lying, or simply pretending? Conversely, if the patient claims they do not think the TV is sending thoughts into their brains how can biopsychiatry tell if the patient is just trying to mislead him, genuinely believes this, or is covering up. How can biopsychiatry tell whether the patient who claims to have no energy is telling the truth, is mistaken or just pretending? Do a PET scan? Take a lie detector test? It should be obvious that any answer to such questions will not be found in any physiological examination of the body, or the brain, but can be found in precisely that context of the patients life that biopsychiatry ignores, the domain of what the patient says and how they conduct themselves in the business of their everyday living in society.

Misrepresentation

Biopsychiatric beliefs and theories about the origin of problematic human conduct continue to be maintained because there is no way in the course of clinical practice to prove or disprove such ideas. Yet day to day psychiatric practice has the appearance of validating its claims. For example, a patient goes along to their doctor complaining about lack of energy. The GP, knowing that depression is a diagnosis frequently missed, asks a series of questions aimed at eliciting a diagnosis. How long have they had this lack of energy? Do they think life is not worth living? Are they sleeping well? Have they ever thought they might end their lives? Are they still interested in sex? Do they have a low mood? Have they lost weight? If the patient answers these questions affirmatively the GP proclaims "I think you are suffering from a Major Clinical Depression." Then the GP, not wanting to burden the patient with guilt might then say that according to modern theory, depression has to do with an imbalance of chemicals in the brain. They may explain that medication to correct this imbalance will help. The patient is very often reassured and accepts this speculation. The doctor then thoroughly examines the patient and gets a full blood picture. If all these investigations are *negative* the GP then reassures the patient that they indeed have an "endogenous" clinical depression and need treatment. However patients usually think the blood test results must have *confirmed* they have this imbalance; why else would the would the doctor test their blood and give medication. Few patients realise that it is a*normal* test that enables the doctor to diagnose psychiatric disorder not an abnormal test. This is the duplicity of Biopsychiatry because the facts the patients are invited to believe are quite the reverse. The blood test and investigations confirm not that there *is* an abnormality but confirms that there is *no demonstrable physiological* abnormality. In psychiatry the evidence itself demonstrates that it is not the creation of a chemical *balance* by the medication that has the patient recover but the artificial creation of a chemical *imbalance* by the medication. Pharmacological treatment does not correct an existing chemical imbalance but *creates* one. No person normally has fluoxetine, antidepressants, and their metabolites circulating everywhere in the brain. Any so-called *imbalance* that was supposed to be corrected is the product of research speculation. In my experience many patients on lithium think they have a deficiency of the substance, and that the frequent tests are to check if they are having adequate replacement to correct this imbalance. Again the *reverse* is actually the case. Lithium is a trace element in the body. Its natural level has nothing to do with

bipolar disorder or manic conduct. The onset of mania has nothing to do with low lithium levels. How many patients actually think this? The tests are required to make sure the patient's kidneys and nervous system are not damaged because the margin between the level at which it controls manic behaviour and the level at which it is toxic to the human body is so narrow.

I am not saying medication does not alleviate human suffering, nor am I saying that medication does not relieve the anguish of those who find themselves proposing attitudes and beliefs at odds with the society in which they find themselves; nor am I saying medication should not be used in circumstances where, in all humanity, the suffering calls for relief. But let us at least get the facts straight and not bamboozle the patient with pseudo scientific speculations about spurious chemical imbalances that lie in the minds of research scientists. In my view they should remain there and stay out of routine psychiatric practice until it can be demonstrated otherwise, as speculation is in all other branches of scientific medicine.

Currently, a patient officially has a psychiatric "disorder" when their conduct or utterances attract the attention of a psychiatrist. In other words, a psychiatric disorder is that conduct or utterance that a psychiatrist takes exception to. Currently, a patient does not have a psychiatric "disorder" when their chemicals get unbalanced, or their genes become expressed. That a group of around 1000 psychiatrists arbitrate what is and is not a disorder makes no difference to our neurochemistry.

Feeling "Normal"

At a seminar run by a drug company last year, a professor of psychopharmacology from California presented a case history of a woman who was depressed about her life and the state of the planet. She fulfilled the criteria for a major depression, and was given fluoxetine. In the course of the next few weeks she gave up her concerns and said that she felt normal for the first time in her life. According to the presenter, normal people don't respond to fluoxetine. He suggested that if she said she felt normal when taking fluoxetine then she must have had depression all along. He did not appreciate the bizarre presuppositions of his argument. Feeling well or normal has nothing necessarily to do with the balance of one's chemicals. Whilst taking cocaine Freud said "You perceive the exhilaration and euphoria of the healthy person. In other words you feel*normal*."[9] He said this over 100 years ago and recommended the use of the drug to his colleagues for neurasthenia. Freud seems to be equating

exhilaration and euphoria with feeling normal. The eminent professor from California was implying that if one did not feel normal one was ill. No one in their right mind would suggest that Freud had a cocaine deficiency or that taking sufficient cocaine in order to feel a normal euphoria was correcting a chemical imbalance. There was an elixir peddled in the middle of the nineteenth century that contained a mixture of arsenic and opium. It was good for everything, from cancer to arthritis, TB to syphilis. It was found that many of those who took it regularly and proclaimed its beneficial effects eventually died of arsenical poisoning. They died feeling great, feeling normal in all probability, but make no mistake, they died of arsenical poisoning. That someone in pain or distress feels better when they take morphine doesn't mean they are ill because they have a distress disorder caused by a morphine deficiency. Because someone cannot get to sleep doesn't mean they are an insomniac and that insomnia is a sedative deficiency disorder.

The domain of human conduct is a domain of language and relationship, ethics and morals—not medicine. Of course medication affects behaviour, and of course we as human beings behave in ways that cause suffering to other and to ourselves. This has been the case throughout history. But let us behave ethically and give medication advice and counsel to ease suffering, alleviate confusion and morbidity when we find this occurring, and not obscure our concerns about each other with vague, spurious and unproved speculative notions that some neuro-physiological imbalance that cannot be demonstrated must be the cause of human suffering. This is the same as locating the source of music we do not like in the piano, the upsetting and violent TV program in the TV set, and leads to the mutilations of leucotomy for depression or castration for sexual offenders. If we truly believe otherwise we must then equally explore the genetic behaviour of those psychiatrists who feel so compelled to write diagnostic and statistical manuals to which we are so wedded. We then end up as seeing through God's Eye [10], expert onlookers in some sort of genetic and chemical evolution that manipulates humanity to do what it does and in which we have no part. However we cannot escape the reality that it is human beings, not genes that are saying this. Everything said, is said by *someone.*[11]

One must draw a distinction between treating illness and controlling unwanted behaviour. Failure to make this distinction is the confusion the medical model engenders. This is not a trivial matter.

Psychology, Psychotherapy and the Medical Model

Just as biopsychiatry with its untested claims of abnormal physiology confuses mental illnesses with medical illnesses, so psychotherapy stops short of entering the strictly medical arena by using the *metaphor* of mental illness. The medical model in psychology and psychotherapy applies the medical lens to our conduct. Here groups of symptoms become not just syndromes, but illnesses in their own right without needing to be justified by demonstrable physiological abnormalities.

How does this happen? It happens through a process called *reification*.[12] Reification is converting an abstract concept into a material thing. Reification turns abstract ideas, products of human thought, into things that seem to exist independently of the thinking that invented them in the first place. In Humberto Maturana's view, we do this every time we distinguish an object or thing. Further, when we distinguish a chair we are also distinguishing our human capacity for sitting. We do not imply however, that the chair causes us to sit.

Reification in psychology and psychotherapy creates just this confusion. The "psyche" and the "mind" are examples of reification. Generally speaking, the psyche/mind is that human capacity for thought, judgement, imagination and feeling.[13] Thinking, judging, imagining, and emoting are all processes. When we treat this capacity as if it were an object in its own right, treating it as if it existed independently from us, we reify it. We speak of our mind as if it were an entity we possessed independently of our thinking. In psychotherapy we say "there is me, and there is my mind." We consider the interaction between the brain and the mind as if they were objects and therefore had some common measure and were operationally the same. We try to compare being aware, reasoning, feeling, and deciding, with neuro-physiological processes as if behaviour and physiology had some measure whereby we might determine some final sense and basic cause. This is like asking: What is the actual interaction between the run I went for down the street in the early morning light, and the actions of my legs running? As if such understanding were crucial to the understanding of what such a run actually "was" and what legs "really were."

The Id, the Ego and the Superego are all examples of reifications, conceptual structures that Freud originally invented to explain the behaviour and utterances of the patients he saw. Yet, once accepted, such reifications are seen as real. That is, they are seen as if they were fundamental aspects of all human

behaviour, rather than rich explanatory concepts. It is difficult to use Freudian theory and not believe that an entity called an ego really exists, and that there really is an entity called a superego that all human beings possess, that there really is something called "transference" that is a fundamental part of all human relationships. These are conceptual tools that Freud made up, to assist him in generating meaning in his observations. In this way such conceptualisations are a part of a culture of psychodynamic and psychoanalytic psychotherapy, that construes human conduct in this way. They are not necessarily an intrinsic and universal part of all human functioning.

Metaphor

"Psychopathology" is the medical metaphor of pathology carried over into behaviour. Just as pathological (morbid) processes are distinguished physiologically, so it is *as if* there are 'psycho'-pathological processes going on in our thinking and conduct. A metaphor is the application of a name or descriptive term or phrase to an object or action to which it is *imaginatively,* but not *literally* applicable. In psychology and psychotherapy it means that difficult and chaotic conduct in the human experiential domain is not the same as, say, a cancerous change in the physiological domain. Metaphors can be richly explanatory but are not literally the case. Once again we see the confusion between the physiology and conduct. Over the former we have little say but over the latter we hopefully do.

Thinking, speaking, feeling, and deciding are processes I perform as a whole human being. In the experience of deciding, I do not experience my cerebral cortex as making the decision for me any more than I experience my limbic or hippocampal systems as controlling my anger or my memory, in spite of metaphorical declarations by experts that such entities are controlling these functions. The actions of deciding, feeling, thinking, are all actions we perform as totalities, not actions that part of our anatomy performs independently of any other. Metaphorically it might be construed *as if* the parts of our anatomy did control such functions. Physiologically, however, as all physiologists know, they do not. What the cerebral cortex, the limbic and hippocampal systems actually do, is to perform certain operations in the physiological domain. Namely, they receive and send nerve impulses that project to certain cortical areas, metabolise glucose at certain rates, consume oxygen at so many cubic centimetres per minute and so on. Constitutively, these centres do not and cannot make decisions, determine whether we should fight or flee, or tell us to

kill ourselves or others, whether we construe such centres metaphorically as doing so or not. Such decisions belong to the life we live in the circumstances in which we find ourselves, not in the activation of synapses that might allow for such conduct.

Conversely, through what one says and does one may cause suffering to oneself or someone else. This does not mean however that one's cells are harmful. If one has violent thoughts, this does not mean that such thoughts are the expressions of disordered physiology or chemical imbalances. The way a person acts in society might be similar to how a cell acts in the body, but there the similarity ends. A person is not a cell, neither is a cell a person. A cell does not 'invade', is not 'hostile' in any human sense. Neither is a thought pathological.

As living beings we tend to go about our day to day lives under the compulsion to explain what we do. Yet events just seem to happen to us whether we explain our conduct or not. As therapists we know explanations are not trivial. We also know that the explanations we do make have a marked effect on the lives we live. In explaining actions to ourselves, we as therapists invent theories and explanatory concepts, such as unconscious drives, oedipal issues, acting out in the transference, irruption of narcissistic rage, poor ego boundaries, impulse control, traumatised will, role deficit, a negative introject and so on. Although such explanatory concepts generate rich and powerful theories, they are part of the *therapeutic* lingua franca of psychological and psychotherapeutic practice. They are explanatory metaphors to explain the domain of everyday living; they are constitutively *not* part of everyday experience.

The experience, and the explanation of the experience are in two separate domains that cannot be reduced one to the other.

People simply do not come to therapy complaining about their borderline personalities, their poor ego strength, their maladapted child, their acting out, their narcissistic needs, their grandiose delusions, their thought disorders, their hallucinations, or their co-dependent needs, unless they have accepted the theories of a therapist who construed their behaviour in such terms. Then they do.

Construing certain sorts of human conduct and beliefs on the basis of metaphorical reifications such as mental disorder, mental illness, psychological dysfunction or witchcraft for that matter, not only has the effect of invalidating human conduct, beliefs and expression, but also allows steps to be taken to control those who express such conduct. That follows from such labelling. For

instance, construing a person's indignation with their boss as a symptom of their 'psychological stress' rather than as a legitimate expression of indignation at the treatment they have received, invalidates any indignation, and enables it to be controlled by giving "stress" leave, or medication. Similarly, seeing an expression of what might be seen as deep emotional upset as an expression of mental illness rather than grief is likely to give rise to treatment and medication rather than sympathy and support. Construing a patient's unpunctuality as an expression of deep emotional conflicts, rather than the consequences of say, missing the bus, is likely to produce a whole range of personally probing questions in therapy, rather than simple requests to be on time.

It is my view that the search for a medical and physiological aetiology for understanding human conduct and language, is a degenerate research paradigm,[14] and, like the search for the aether, phlogiston, the edge of the world, witches, ghosts, mental 'health' and a genetic structure that produces genius, is a futile endeavour.

We are observers of our own conduct. As Humberto Maturana says "Everything said is said by an observer and that observer might be oneself."[15] As observers we see ourselves and others behave in various ways, and we reflect on this behaviour, describing it in reifications, explanatory concepts, metaphors, and theories. There are hundreds of such reifications in psychological and psychotherapeutic literature. Some such as "personality" have been around for so long we no longer question the obvious fact that we all seem to have one. Yet if we observe how we generate our personality we can see that a personality is also just another descriptive tautology for our conduct and offers no scientific mechanism for its generation.

Literal vs Metaphorical Meaning

The real trouble begins when these reified descriptions are used as physically causative agents that cause our behaviour in the first place. They become causal attributions.

When we refer to our personality as if it were a part of our body we can say "I didn't finish because I am a procrastinator," as if procrastination was an irrevocable part of our 'self'. Yet what we are actually saying is, I did not finish the job because I am a person who has a history of not finishing jobs. In the same way, "I don't like going out with people because I am an introvert;" means, I don't go out with people because I have a history of not going out with people. "I didn't speak out because I am a shy person", means, I didn't speak out

because I usually don't speak out. "I sit around all day because I have no motivation," means, I sit around all day because I usually sit around all day. Such sentences are uttered as if they mean that there was a "real self" that always behaves that way. Yet such statements mean and explain nothing. They are tautologies. They give the impression that they are saying something relevant about some "real self" that exists apart from the conduct we perform. Yet such statements only restate the obvious. They have the appearance of legitimate, scientific explanations about the way we as human beings behave when they are only restatements of human behaviour put in obfuscating ways.

Since the medicalisation and reification of depression, it is now considered legitimate to say "I couldn't go to work or get out of bed because of my depression". Most people now in our society will accept this as a literal, rather than a metaphorical explanation for why they did not get out of bed. What does this statement mean? It means that I didn't get out of bed because I didn't get out of bed. It is a descriptive tautology that explains nothing, and is not to be construed as being in the same domain as "I couldn't get out of bed because I have multiple sclerosis, because I have a stroke, because my legs were broken, because I am a paraplegic, or because I was strapped to the bed". The former explanation is metaphorical, the latter are literal. The use of the medical model in psychology and psychotherapy is metaphorical not literal. Such domains are conceptual, not biologically physical.

If we as psychotherapists are to help our clients and patients we at least need to operate in the same domain that we as human beings really do operate in, and not treat metaphors, however illuminating, as if they were the scientific verities of everyday life. Yet medical metaphors of 'disorder' are accepted in the course of our everyday living to justify sickness benefits, financial compensation, and time off work.

In the world of everyday physical experiences, we have issues and concerns with other people in the environment in which we live. We have arguments, come to agreements, make decisions and conduct our lives. As a therapist I might explain my behaviour or that of my patients in a way for example that presupposes that a human self consists of separate parts that not only act independently of each other but can actually be in conflict with one another. I can say "part of me wants to get married but there is another part of me that does not," or, "part of me wants to go to the movie but part of me doesn't." Yet, in the biological and physical world, this never happens. In the biological world of our everyday experiences, if I get married all of my biological self gets

married, my brain, my legs and my heart. If I go to a movie all of my biological being goes to the movie, I do not leave my spleen, my lungs or my brain behind.

The metaphor of "mechanisms of defence" and the "psychopathology of everyday life" contains the implicit notion that our day to day conduct with others is an "internal struggle" between various parts of our "selves" in order to avoid overwhelming anxiety. A metaphorical war with attacking and defensive 'mechanisms' is not an actual war where people get killed and blood is shed. The arrogance behind the designation of "psycho-*pathology* of everyday life" hides the notion that some expert has a handle on what behaviour is healthy and non pathological. In my view, determining what is "healthy conduct" is categorically and constitutively not a prerogative that science can distinguish, let alone medicine, however much we hope it might.

Another expression of the medical model in psychology and psychotherapy is the way the psyche is seen to be capable of being injured, as if it were an organ composed of organic tissue. We speak of emotional scars, of being emotionally wounded, and as having a "wounded child" within, that requires healing. The metaphor of the "Wounded Healer" is rich in its empathic connotations. In the world of everyday experiences a wound to our biological self is obvious and its healing also obvious. But what constitutes an *injury* to my psyche, i.e. my behaviour and utterances, my feelings and beliefs? How do I *heal* my conduct, my beliefs, my thoughts?. Is a feeling of shame, guilt or embarrassment an "injury"? Does being ridiculed give rise to a "psychological wound?" If so, in what respect? Exactly what does 'psychological healing' entail? If we observe conduct or behaviour in ourselves or others that is offensive or gives rise to suffering, can we legitimately attribute such behaviour to "scars" from past "emotional wounds". Do such labels say something about our reluctance to understand the conduct in the circumstances in which it is expressed? Medically a wound is a wound. Disagreeable, inexplicable conduct that gives rise to suffering is disagreeable, inexplicable conduct that gives rise to suffering. Behaviour is what one does. A wound is a wound, not a behaviour.

Scientific Explanations

A mental health professional, by embracing the medical model, can elicit evidence in support of their medical theory of behaviour by performing a "psychiatric assessment" in which the mental health professional asks pointed questions about past personal development, and childhood experiences. The unquestioned assumption of the medical model is that personal developmental

history explains present conduct. Such an assessment is performed as a knee jerk "psychiatric interview" (see any standard text on psychiatry) of all patients, regardless of the presenting issue, just as a clinical medical interrogation forms part of physiological investigation. Any emotional expression or reflection evinced as a reaction to such questioning in such an interview is taken as evidence of emotional 'scars' already there, rather than as a legitimate reaction to the pointed questions asked. Such emotional expression is then linked to presenting complaints as evidence that is supposed to explain them. Here the medical model deftly turns emotional expressions in the present into evidence of "dysfunction, emotional abuse, oedipal conflict, repressed memories, narcissistic rage, primal pain, faulty cognition", or whatever metaphor is used in the theoretical model that is flavour of the month. The patient who accepts this explanation offered by the mental health professional as a valid explanation for their conduct, is said to have "insight". If they do not accept the explanation offered, they are said to "lack insight" or are "resistant." Since these medical explanations are metaphors only, they cannot be proved or disproved in any scientific sense and therefore they tend to become labels that stick.

Literal scientific explanations can be proved or disproved. That is what distinguishes scientific explanations from metaphorical explanations.

In the same way that the medical model is able to explain mental illness in terms of chemical imbalances, unconscious genetic drives, and other metaphors, so too New Age thinking is able to explain astral travel, out of body experiences, telekinesis and astrology, in terms of atomic, particle and quantum physics. With their vision of a cure for the suffering of humankind and the advancement of knowledge of human behaviour through the study of genes or quantum particle physics, both Biopsychiatry and New Age thinking seduce the public into accepting their explanations as scientific explanations about human behaviour. However, in the course of everyday living, we do not grapple with our genes, or struggle with bad introjected self objects, nor do we order our groceries telepathically, or routinely tele-kinese ourselves to work. And in spite of knowing that matter is mostly empty space, we do not routinely walk through walls; we go out through the door. We perform only those actions in everyday life that our biology allows us to perform and no other.

Conclusion

As therapists we practise talking therapy. Meanings and stories are generated out of the conversations and actions we perform with our patients. The

meanings we generate have as their purpose the well-being of the people we see. Ours is above all an ethical profession in that we embrace human values. The explanations we accept for conduct are not trivial. If I have construed my self as a victim and through therapy now see myself as a hero there will be a difference in the life I will now lead. We talk constantly to each other, to our supervisors, we read journals, go to conferences, generate all sorts of experiences, from dramatising and role playing aspects of our past, our dreams, our future, to talking to whole rooms full of empty chairs, to drawing, painting, and dancing our feelings emotions and thoughts. We explore all the aspects of imagination, generating meaning about meaning, stories inside stories inside stories. I say we do this to enable the patients we see to live more fruitful lives, based on integrity, dignity, respect, well-being and accomplishment.

So we can ask:

- Do explanations of human behaviour, conduct and utterances in pathological and medical terms lead to futures of well-being, growth, dignity, integrity, accomplishment and increased possibilities for living?
- Does telling someone they have a clinical depression on the basis of what they are doing, help them? If the unpleasant nature of their behaviour is ameliorated by medication does such "treatment" lead to integrity, well-being, dignity and respect?
- Does construing a patient's conduct as an expression of their "borderline traits" or their "poor ego strength" or their "unfulfilled narcissistic needs" lead to their increased well being? Does it promote their future self respect, dignity, respect or personal growth? If you as a therapist construe your patients' conduct as borderline, narcissistic, or schizoid are you claiming something concrete about them, or are you claiming to have some special privileged access into how they will behave in the future?
- When you tell patients they are schizophrenic or have for example, schizoid traits, are you again describing something specific about them? Are you declaring your particular theory about their future behaviour; or are you stating your ongoing unwillingness to construe their future conduct in anything other than schizoid terms?

If you think you hold such 'truths' and your patients think as you do, their future is preordained by your own training of them. They will not only conduct themselves accordingly but interpret their ongoing experience as you construe it. They will take medication, and only take those actions in life that are consistent with the theory and explanations they accept from you as gospel. Can we as therapist be responsible for the outcome of the theoretical models we embrace, and what these might mean for the patients/clients we see?

A Possible Alternative

I invite you to consider a person who is already a "healthy" person, a person who is able to determine their own conduct as a domain of free choice. Such a person is free to choose, such a person knows that "instinctual drives" are nothing more than explanations for behaviour he or she already does; that "lack of motivation" is only a restatement of sitting around all day. A person who realises that reified explanations for feelings, thoughts, and actions arise from their own imagination in the here and now. A person who realises that providing explanations for conduct is not necessary for biological survival, but is a part of the social world we belong to. A person who realises that we are free to make up any explanation we choose for our behaviour and that there is not one privileged explanation for human conduct but many, all having different consequences and different outcomes. Such a person restores the possibility of change in the immediacy of the present, by freeing notions of change not only from past explanations, but from any theoretical notions, other than the actual physical capability of the individual themselves in the circumstances in which they find themselves. In this paradigm our utterances and conduct are no longer necessarily at the behest of pseudo-scientific psychological forces, unconscious genetic entities, instinctive drives, or chemical imbalances. Nor is our conduct at the behest of malign forces or evil demons which experts construe as causing our behaviour. As people we are free to use such explanations or not to use them. In this paradigm, to exercise the ability to choose, or to decline such explanatory notions that experts or others have of our behaviour means having the ability to think for ourselves and be responsible for the outcome of our own conduct in the experience of living.

> "If the diagnoses (explanations) we employ are useful then they will allow us to communicate more rapidly, and they may direct our attention towards something that we do not know. If they take on a life of their own, imprisoning us within the opinions of Committees, derived from the

opinions of yet more Committees then (Karl) Popper is still right and we are not moved by the methods of science, but of Aristotle." John Ellard.[17]

"Strictly speaking, the question is not how to get cured, but how to live."
Joseph Conrad

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A health professional's assessment interview - abusive or therapeutic?

Robyn Hewland

Introduction

A health assessment can be a collection of data, obtained in an impersonal objective manner, an inquisition by *'the rapist'* that leaves the person feeling 'stripped' of dignity and information, or, a consultation by a *'therapist',* who both obtains data and develops empathy, rapport and trust.

To be healthy, an individual is in a state of physical, mental and social well-being. (WHO) I have become concerned that more is being done *to people,* and not *with individuals* in need. My fears were aroused by my professional experiences, and by a conference report from 1996.

I have never forgotten a personal clinical experience in 1972, in a London teaching hospital. A group of trainee psychiatrists fired questions at a women patient. When they had their data, they dismissed her from the room. I would have felt "stripped, used, and abused", as if a monkey in the zoo. I forgot my anxiety as a newcomer, female, and from 'down under', and dared to speak. Then Consultant agreed to invite her to return, to be thanked, with respect for her own feelings and identity, and for her selfworth to be affirmed. Then she was encouraged to ask us questions.

Twenty-five years later, we are asked to collect clinical and statistical data and keep records on individuals, as specified by others, within limited time and finances. We are expected to provide treatments within the constraints of others' policies and procedures. Unique individuals do not fit into linear computer programs, statistics, benchmarks and a maximum number of treatments.

My paper aims to show that therapeutic assessments need to be a core competency for all health professionals. It encourages both the art of an individual approach, and the science of obtaining objective data. The desired outcomes include the person feeling heard, understood and respected, the diagnosis of any illness present, and participation in decisions on management

and treatment. It asks health service decision-makers to seek and respect individual patients' and carers' needs.

The Ministry of Health's Chief Medical and Chief Nursing Advisers described the skills and attributes needed by future health-care professionals in New Zealand. They did not include empathy, or its integration with clinical knowledge to establish rapport, arouse hope and trust, or to provide the care, compassion and therapy that are vital to promote healing, of body and mind.

Their CAPE conference paper referred to multiskilled health 'team-animals', who will have a broad-based general core education, with a training in business administration and economics. They will have a population focus to ensure that priority will be given to cost-effective interventions. They will gather, process and present information, and use analytical and statistical skills, (in order to) contract with public and private service providers, and be accountable for public money spent, and clinical services provided, as shaped by consumer demands.[1]

We need to assist consumers to demand an individual therapeutic approach, to say that it works. They will have learnt from us that therapy develops hope, selfworth, and resilience under stress. When the individual's mind is positive, the body heals quicker. Relationships and society benefit.

Psychotherapists and other health professionals are asked to address possible medical diagnoses. And, each patient or client we see, relies on us to recognise any illness which requires treatment. Clinicians can study various interview techniques and content to develop what works for them.

Aims of a clinical assessment to make or exclude a medical illness diagnosis

1. To gain enough information on which to base treatment or management decisions:

a) is immediate action needed? – e.g. bleeding, no airway, unsafe (suicidal, aggressive);
b) is non-urgent treatment required, and if so, what? – e.g. advice, support, prescription;
c) is referral indicated? – e.g. for admission, outpatient/service follow-up, to G.P, therapist?

1. Generic Substitution - only this time in the workforce. Reported by Vicky Tyler, *New Zealand GP Weekly*. 9 October 1996.

d) to make sense of symptoms, and advice, to patient, and to a relative or carer if relevant.

2. To develop a professional relationship to promote healing and recovery;

a) with listening skills, empathy, respect, non-possessive warmth, compassion;
b) which develops trust, arouses hope, and facilitates the patient's full story (i.e., join patient's space, move at patient's pace; affirm feelings and actions);
c) which leads to the patient's understanding, participation in decisions, and a positive partnership in treatment and management, to promote recovery.

3. To provide records, for current practical use, reports, and reference (personal/legal):

a) presenting symptoms & signs, their history, past personal and family history;
b) examination results, tests ordered/results, formulation, diagnosis, treatment, advice;
c) statistics & codes required, copies to send to appropriate persons/files/ legal.

An assessment to integrate psychiatric data collection and therapeutic interactions

On meeting, I make eye contact, and move to shake hands, but I am ready to stop – if he looks fearful, paranoid or aggressive – if she is shy, suspicious, or withdraws, or may have been abused. I say that he/she is welcome to be accompanied, or to see me alone, for part or all of the time. Some need my 'permission' to say "no" to a partner, a child, a friend, counsellor, volunteer. I point to a chair, but add that he is welcome to move around, and ask for a drink of water. The shy person sits as if stuck to the chair; a paranoid or agitated person may move around. I explain that I am a medical specialist, in mental health, but cannot read anyone's mind. I note that it is not easy to tell a stranger personal things, and especially a psychiatrist. I ask if there is anything they would like to know about me, and the interview?

I may be asked if we are being tape-recorded, who will read the notes, or is everyone crazy if asked to see a psychiatrist? I may be told they do not need to be there, and who they blame for it.

I compliment him on the stressful decision to seek help, and to make any changes needed. Motivation for anything requires recognition, respect and rewards. They help our clients too.

Basic details are sought & recorded; i.e. name, address, birthdate, referrer, reference number. This 'neutral stuff allows time to settle, and introduces a professional framework. It is like making contact at the bedside by saying the patient's name and feeling his pulse.

I ask what is the most important for me to know? Why are they here, and why now? I ask about any concerns. I ask what are they hoping for by the interview's end?

I may learn about their motivation, comprehension, word use, relationships, anger, despair, delusions, hallucinations, attitudes to doctors, and to medication, and about past reactions.

After talking about fears and feeling heard, a person is finally ready to listen and to think. A woman responds to affirmation of her feelings first. A man appreciates affirmation of actions.

I say that each person has an unique life-story, and that it would help me to understand if I knew some of it. I ask standard questions, to gently guide the assessment to finish within an hour. I look for patterns of triggers, problems, emotional reactions, defences, strengths, and supports. I elicit details of each symptom: specific duration, history, triggers, impact, treatment responses.

Is their central nervous system functioning more slowly, faster, or in a confused or agitated way?

- sleep? - from and to when, awake in night, tossing, overactive mind, nightmares, flashbacks?
- appetite changes? - when, why, weight change from and to what, when, vomiting, body image?
- attention/concentration changes? - TV, newspaper, cooking, shopping, work, conversations?
- energy? - different in morning, afternoon, evening; tired, restless, agitated, overactive, rituals? thoughts & talk? - logic, speed, content (pessimistic, guilt, suicidal plans/attempts, hopes)?
- perceptions? - "sees/hears" others judging or hostile, thoughts are influenced, e.g. by TV, Devil.

- alcohol & drugs? - since when, why, where, dollars spent, family history/ use, plans to stop?
- feelings? - How long have you felt like this? What was happening before you first felt like this? What might help you feel less sad, scared or irritable? What or who makes you feel more so? Any similar feelings in the past, and when? Has any family member had similar problems?
- For Post-traumatic stress disorder, I explore a typical day's feelings, activities and reactions. I start with going to bed, sleep, flashbacks, washing, dressing, food, telephone, travel, shopping, children, social, work, relationships. I have learnt so many traumatic details as I have listened to hundreds of sufferers, female and male, children and adults, since 1982, in hospitals, prisons, Department of Social Welfare, and for Accident Compensation. Each survived so much pain. For reports, I quote from their answers for examples of the avoidance, re-experiencing and hyperviligent symptoms of PTSD as described in DSM-IV 309.81
- relationships? - feel heard, understood, supported, ignored, unwanted, denigrated, hostility?
- physical? - headaches, vision, smell, heart, blood pressure, thyroid, diabetes, liver, infections?
- medication? - refused? - current type, dose, duration, response, problems, past experiences?

I make links for them as I learn about their birth, childhood, school work, and social life, including illnesses, relationships, problems, traumas, fears, and their achievements, interests and hopes. After facilitating delivery of 'ah ha' links I can feel as if I have been a 'midwife' to deliver insight. I ask their idea of their problems, their strengths, what changes are wanted, how and by whom?

I am aware if I feel sad, depressed, scared, angry, puzzled, or have concerns for anyone's safety.

I formulate my ideas on the predisposing, precipitating and perpetuating factors in their problems. i.e.: what makes that person 'tic'? What was stressful? Why? Is there an illness, mental, or physical?

Predisposing vulnerabilities include family history of personality traits, mental illness or substance abuse, personal nervous system injuries or infections, family dysfunction, neglect, abuse or loss.

Precipitating triggers include stress from a loss of security, self-esteem, health, work or support.

Perpetuating stresses are abuse, illness, inadequate support (housing, food, money, relationships).

Genetics can leave a person vulnerable to depression, schizophrenia, obsessional-compulsive and other anxiety disorders, some types of alcoholism, personality traits, and to physical illnesses.

Early nurturing, in rat studies, influences the growth of the number of post-synaptic receptor cells, both para-sympathetic (nor-adrenaline), and sympathetic (5 HT/serotonin) in the nervous system.

Early childhood experiences influence a child's trust/mistrust, beliefs about self and others, independence/dependence, intimacy or hostility, initial reactions under stress and coping style, (e.g. abandonment depression, general suspiciousness, poor self-esteem or resilience in adversity)

Dr Michael Rutter, Child Psychiatrist, researcher and author, wrote that by the time of starting school, a child needs to feel that it can trust at least one adult to love and care for him or her. That child then feels empowered to cope with challenges in the schoolroom and the playground. He added that before leaving school, the adolescent needs to have achieved in at least one area; e.g.: studies, sport, art, music, or friendships. That person will then be able to persist and be resilient under adversity, as he/she feels loveable, and knows that success is possible and worthwhile.

Severe stress, such as physical, emotional or sexual abuse, accidents, illness or feeling helpless and hopeless, after a loss or in domestic violence, can precipitate and perpetuate excessive use of mental defence mechanisms to defend against overwhelming anxiety. Depending on an individual vulnerabilities, a person may use excessive intellectualised explanations, or paranoid projection onto and blaming of others, or introject and blame themselves and become depressed, or deny reality and become psychotic, or access to awareness is blocked at that time, until are less fearful.

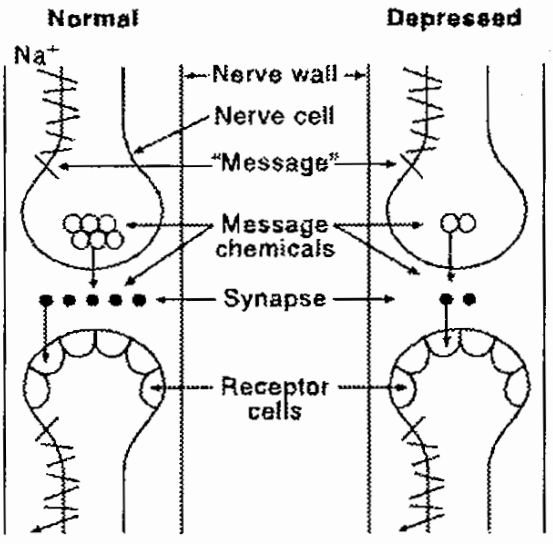
Depression provides a good example of the formulation, of a differential diagnosis of these three 'P's', of biological and environmental factors. It shows the value of integrating them in the dialogue with the patient, for each to understand, to make links between past influences, current stress and problems, and to participate in treatment decisions to aid their recovery overall.

If they remain, or still become severely anxious, or suffer from Post-Traumatic Stress Disorder symptoms, they often become depressed with exhaustion. I liken their body to a car with a flat battery or an empty petrol tank. It is as if they have been driving their car at 400 km/hour for a long time, using up more petrol and faster than they can refill, Then only a few messages can pass from one nerve cell to the next, as there are too few message chemicals ('petrol') for the demands on them or poor functioning receptor cells ('dirty spark plugs').

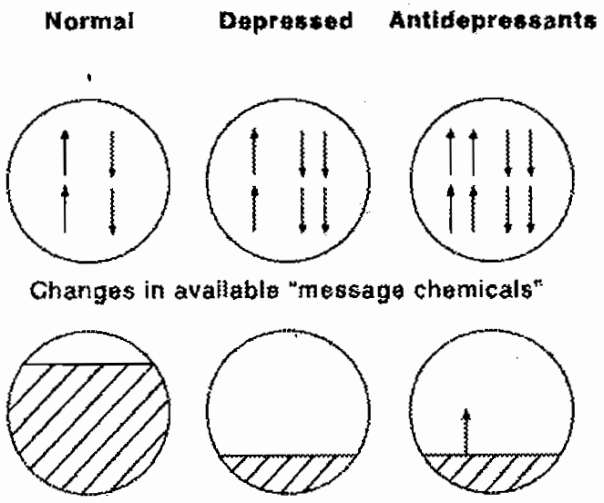
One in four women and one in six men suffer a depression episode at least once in their life. Most are not diagnosed or are inadequately treated. Depression precedes most suicidal feelings.

In the beginning, 'the car driver' needs 'a tow', joined by an empathic 'tow-rope', to borrow the therapist's caring energy, hope and skills, to even want to 'stay on the road and in gear'. But, communications need to be simple and psychotherapy to be supportive, until there are enough chemical 'messengers'. I add diagrams of the nerve's message and antidepressant functioning.

Usually after two or more weeks of taking an antidepressant medication, the 'driver' has a 'car' that will go where directed, and personal control and skills can be enhanced by psychotherapy.[2] It takes six to twelve months of antidepressants before the 'car can climb uphill and not stall'.



Transmission of message in nervous system



"Petrol level in mini-tanks"

2. Hewland, Robyn. *Psychotherapy in Depression.* NZAP Conference paper, 1975

Early paranoid psychotic suspiciousness, beliefs and reactions may be difficult to separate from substance abuse effects, and from post-traumatic flashbacks and fears of abuse and authority. It is easier if the psychotic person is receiving 'messages' on TV or radio and is very illogical. The teenagers' 'voices' after PTSD relate to feeling abused, and differ from in schizophrenia.

Physical illnesses with psychiatric symptoms include an over/under-active thyroid, diabetes, an infection or cancer, poor renal or liver function, anaemia, and inadequate oxygen to the brain.

We discuss a diagnosis and work out a treatment plan for recovery. It integrates any tests needed, medication, therapy, and life changes, and protective factors against relapse. Medication may have been refused before. Diagrams can explain why, if medication is needed. Reports are discussed.

Dr Richard Tillett[3] carried out medline and manual literature searches and over 1000 personal psychotherapy assessments. He found "substantial evidence for general efficacy of psychotherapy. Differential benefits were identifiable. Short-term treatments are appropriate and effective in a wide variety of situations, but chronic/complex psychopathology is likely to need longer term therapy".

> "Assessment of the individual patient and their problems enables both to answer the key questions:
>
> a) is treatment of any kind required?
>
> b) if indicated, what are the relative merits of medical, psychological and social interventions?
>
> c) if psychological is indicated, which types of approach might be appropriate, what depth of therapy is needed, and who should therapy involve?

He outlined the information required about personal, family and problems. He notes "the need for the experiential assessment of the person's psychological functioning". That includes: "an assessment of personality type, of the depth of emotional contact achieved, the patient's use of psychological defences, and the response to provisional formulations and interventions." He added that "it is unwise to recommend psychotherapeutic treatment unless it is based on a clear and appropriate formulation, which includes an evaluation and discussion of both dynamic and systemic factors."

3. Psychotherapy Assessment and Treatment Selection - a Review Article. *British Journal of Psych.* no 168, 1996, p 10-15.

He concluded:

> "Sound assessment provides a secure foundation for effective psychotherapy. It requires not only knowledge of the range of available psychotherapies and the research evidence of their differential efficacy, but also a careful evaluation of the patient presenting for treatment, both in terms of the problems presented, and the person presenting them. A number of different treatment approaches may be possible, and these options need to be discussed fully with the patient, who can then make an informed decision about treatment. This requires a logical and collaborative approach to assessment and treatment planning."

In summary, health professionals, in their assessments, need to combine the art of a therapeutic approach and the science of objective data, to respect each individual's dignity and feelings. They need to encourage the individual's participation in decisions as to how to address the assessed clinical needs, to promote healing and recovery, of body and mind.

Professionals and their patients and clients need to advocate for individual therapeutic needs, and show how these consumer demands are cost-effective, to the individual, the family, and society.

The New Zealand Association of Psychotherapists has fifty years experience in mental health. It knows the influences, links, problems and interventions, from birth to death, which contribute to the health of individuals, rallies and society. It can demonstrate and advocate for therapeutic assessments to be a core competency for all health professionals.

Working with Antisocial Personality Disorder

Seán Manning

Abstract

The antisocial personality has long been dismissed by analysts and psychotherapists as unresponsive to psychotherapy. This paper explores reasons for this, using the idea of Ego and Shadow. Transactional Analysis theory is presented to construct a theoretical foundation from which psychotherapeutic work can usefully proceed. The negative role of therapist empathy, the reasons why successful programmes are often run by non-professionals, and indicators for treatment are explored.

Introduction

One of the pairs of polar opposites in Jung's work is the idea of ego balanced by shadow (Hyde & McGuinness, 1992). He applied this idea to societies as well as individuals – ego and shadow – in the collective sense. Thus a society which experiences sexual liberation will bring to light the shadow of an organised sexual abuse industry. Economic liberation, coupled with a cult of the individual and a value system based on individual rights will show us a shadow side represented by psychopathic, criminal, antisocial individuals.

It is consistent with this hypothesis to imagine that the thing we fear most is in some sense the shadow we create. We enjoy the pleasures of an economic liberation, the rights to live as we wish, where and how we wish, unfettered by any particular "place" in society, or any particular occupation. If we are to have a society which so values individual rights, perhaps we must also live with what appears to be an explosion of crime against that society, motivated by the same basic ideas on individual freedom, and carried out by large numbers of people who appear to fit the criteria for antisocial personality disorder (ASPD). The

primary criteria for this "disorder" are all aspects of "... a pervasive pattern of disregard for and violation of the rights of others ..."[1] which may be seen as an extension of the individual rights mentioned above. Indeed, many of our most celebrated and successful citizens may be said to display such a pattern.

It is noticeable that middle class backgrounds rarely suit a person to work with this group, at least until the therapist has moved away from the middle class value system.

We would expect a different ego-shadow pattern in another cultural belief system, and we find that Māori approaches to criminal behaviour differ somewhat from Pākehā approaches. The New Zealand film *"Once Were Warriors"*, based on Alan Duff's bestseller, often provokes shocked reactions among Pākehā. This compares sharply with the reactions of Māori, most of whom take it more or less in their stride. Māori and bi-cultural approaches to antisocial behaviour are more embracing and tend to valueāroha and iwi, while pākehā approaches value exclusion, containment and punishment.

To work with a syndrome apparently composed largely of shadow elements, perhaps we need a different ego-shadow alignment than that common to those who best make use of the benefits of the direction our society is taking. Psychotherapy training is lengthy and expensive and thus, so far, a predominantly white middle class occupation. It is not surprising therefore that this client group is not regarded hopefully by most psychotherapists – to the middle class, who make profitable use of the individual-centred value system, that is, incorporating it in a social ego, destructive antisocial behaviour by definition lies in their shadow area.

We appear to be much more comfortable working with victims than with perpetrators, or at least framing our work that way. If we can recognise a client's pain and inner conflict, if we can empathise, we are comfortable enough to develop a therapeutic approach. In this way the treatment of some personality disorders has been brought within our frame of reference. However, although antisocial people often have terrible childhoods – physical, sexual and emotional violence and neglect – resembling closely the aetiology of borderline and dissociative patterns, they characteristically display a disconcerting lack of either pain or conflict, and to regard them as victims is not a useful starting point for therapy.

1 DSM-IV, page 649 - the other criteria refer to age distinctions and the exclusion of other disorders.

I begin therefore with the recognition that these clients represent our nightmares, and that *we* often are *their* victims, but with a desire to penetrate the nightmare and accept the responsibility of dealing with the creation of our creation.

Therapy and conflict

It is very easy to find quotations like the following.

Manfield (1992), introducing his book on personality disorders:

> "In contrast to the eleven categories listed in the DSM-lll-R, the personality disorders will be divided here into three categories: borderline disorders, narcissistic disorders, and schizoid disorders, each with a distinct pattern of internal psychic organisation. *A possible fourth category, the antisocial disorder, is not addressed in this book because of the lack of an effective treatment method for these patients."* (p xviii) (Italics added)

Similarly, Ivey, Ivey and Simek-Morgan (1987):

> "Nowhere is the importance of underlying mechanisms of defence more key than in your understanding of the antisocial personality. This diagnostic classification is often considered the most difficult to treat." (p 167)

And Gabbard (1994):

> "Antisocial patients are perhaps the most extensively studied of all those with personality disorders, but they are also the patients that clinicians tend to avoid the most. " (p 527)

Certain difficulties arise when a person who fits the criteria for ASPD enters counselling or psychotherapy, particularly if the therapist's model follows an approach emphasising a combination of empathic response and minimal intervention. Manfield (1992, p xix – xx) emphasises, when working with certain personality patterns, empathic attunement is difficult. First, the client's experience is beyond the experience of the therapist, and second, an implicit understanding that is beyond the client's may frighten them away. The client cannot be relied on to experience anything similar to what the therapist experiences (unless the therapist has a similar history). Where the therapist might experience anxiety, pain or anger upon hearing a story of torture in childhood, the teller of the story may be experiencing boredom, amusement, or irritation with the therapist for continually getting it wrong. An attempt at empathic response will produce a disruption and a distancing between therapist and client. Treatment which involves a lot of these disruptions

will be quickly terminated by an even mildly paranoid, non-compliant client, often after a single session. The therapist is left wondering what happened, or with a reinforced idea that this kind of problem is untreatable, or that the client was not "ready". Also, our usual identification with the victim will place the therapist in the client's target group.

The approach recommended by Brandchaft, described by Jenny Rockel (1996) in a recent NZAP newsletter is relevant:

> "His view ... is that unwavering immersion in the affective content of a client's experience risks obscuring both therapist's and client's view of the underlying mental processing by which that experience is defined."

When the therapist is attuned to the peculiarities of the client's reactions, therapy based on empathic response can become collusive. The therapist's needs for affirmation and for excitement are easily exploited by the antisocial client, who will act out vicariously the therapist's fantasies, at the same time as stroking the therapist for staying with them, and offering an illusion of therapeutic relationship. White (1997) discussing the difference between "surface" and "character" relationships, points out that,

> "Often they can be very adept at moving at the surface level from the individual self to the relationship self and back. This can lead others to believe there is a relationship of some depth when in fact this is not the case.

When the therapist is fooled by these manoeuvres, the client will happily return for session after session, but without noticeable change. White:

> "The therapist will merely become another person who is experienced by the client as a "thing" in the environment."

In the rare instances where therapist and client are prepared to pursue therapy with an awareness of these difficulties, the transference problems which emerge can become a powerful obstacle. The therapist will have to put up with alternately being vilified, being one of *them,* being a target (for instance having items stolen from the office), and being idealised as the *only one who understands.* As with the treatment of borderline conditions, this powerful transference makes it difficult to maintain an accurate picture of what is going on psychologically.

A common clinical observation is that people with anti-social personalities display a lack of conflict. A client may approach therapy genuinely though

temporarily, seeking change because of a current crisis, or may pretend remorse in order to escape punishment, to get a lighter sentence from the court and accept therapy as part of the deal. Certainly, a reasonably bright antisocial will realise that sooner or later he had better change the pattern or else be prepared to die young, serve a long time in prison, or become so brain damaged or physically damaged that he has to slow down. This is obvious to both client and therapist. The difference between the antisocial and other clients is that there is no *sense* of conflict, outside of the immediate dilemma. Even where depression is a factor, as it often is, recovery from the depression will simply be a return to the original unconflicted state.

Therapists, depending on their persuasion, may respond by pushing the client through a cognitive skills programme, in the hope that something might rub off, prescribing drugs on the basis of a psychiatric diagnosis, often not hard to find[2], sit back in the analytic style and wait for developments, or for the client to go away, or simply refuse to see the client. Lack of progress is ascribed to the client's lack of motivation. For motivation, read conflict. There is not enough conflict, not enough anxiety for the therapist to work with.

So what do we have here? A psychological position that forever resolves conflict? No wonder it is hard to shift! This lack of conflict is the first of two questions to be answered in the formulation presented here.

Background[3]

This work developed out of twelve years of group therapy, in Moana House, a therapeutic community in Dunedin specialising in the treatment of clients who have significant criminal histories, often with violence and addiction. Many clients are serving an alternative to a prison sentence. Histories of childhood neglect, physical and sexual abuse, and of abusing others, are common. Both men and women have been in the programme, but for significant periods over the past twelve years, Moana House has taken only men. As well as a therapy group, I provide staff supervision, act as one of a governing consultative triad known affectionately as the 'Star Chamber', and under certain conditions I have residents in one-to-one therapy.

Since most of my clients in this area have been men, I will refer to men in the following, always using the masculine pronoun. I am open to the idea that the

2 I recently conducted an imaginary survey of "antisocial clients I have known" and found that all of them could be diagnosed as borderline, narcissistic, depressed or drug addicted, and some could be adult ADD.

3 The following has already been described elsewhere (Manning 1995). I here present a brief review.

experience of women is different, though Gabbard (1994) suggests that while men predominate in the antisocial personality group, this may be because women are more frequently misdiagnosed:

> "Clinicians may overlook the diagnosis in females because of sex role stereotypes. A seductive and manipulative woman who exhibits considerable antisocial activity is much more likely to be labelled hysterical, histrionic, or borderline." (p 532)

I began to formulate these ideas after exploring a series of very similar early scenes using psychodramatic methods. These scenes appeared to have the following seven elements in common;

1 The scene is from the man's life at around age four to seven, sometimes later. It belongs to the stage described by Fanita English (1977) as the "scripter", when earlier decisions about self, others and life are integrated into a more or less complete script, or life plan.

2 The scene involves an oppressive or abusive experience.

3 The scene is vividly remembered. There is often an acute awareness in the client, both of his own experience and that of the auxiliary egos (the other actors assisting in the enactment). The protagonist knows the scene well, though he is often not aware that it is important before the drama.

4 The initial scene is perceived by the protagonist, though not necessarily by others, as similar to an ongoing series of experiences in the protagonist's life up to that point, although the outcome is different. These experiences involve verbal, physical or sexual abuse, frequently a combination of these. Characteristically, men will describe verbal and physical abuse more readily than sexual abuse (Grubman-Black, 1990). The latter may not be apparent when a scene is enacted, but may emerge later, particularly in the sharing phase, when other group members react to the work, or in one-to-one discussion later.

5 The abuse history, as well as the scene itself, is remembered and easily identifiable. It is not vague, confused, or dissociated.

6 The scene involves a sudden and dramatic shift from a position of powerlessness to a position of power. Often the protagonist defies or confronts an authority figure. A new role emerges, incorporating fight/flight behaviour (Bion 1961), a triumphant payoff, a feeling of power,

a dulling of physical and emotional pain and a lot of energy, fuelled by a release of adrenaline. This feeling is experienced many times in the client's subsequent history.

7 There is a peer group somewhere in the background which will consolidate this new role by permitting membership and encouraging role development by modelling, coaching and positive feedback.

The seventh element, the presence of a supportive peer group, determines the scene's far reaching social consequences. The fourth element, the similarity to earlier scenes, suggests that we are witnessing a resolution to an old problem. This and the other five – the developmental stage, the role of abuse or oppression, the clarity of memories, both of the scene and earlier memories, and the sudden release of energy which will be repeated over and over, all invite further speculation.

Psychodynamic formulation – a detour in analytic country

What might a traditional psychodynamic view come up with? Gabbard (1994:530), drawing on Kernberg, suggests that antisocial personality is actually a subdivision of narcissistic personality and speculates as follows (Gabbard appears in places to use the terms "antisocial" and "psychopath" interchangeably):

> "Antisocial patients frequently have a history of childhood neglect or abuse by parental figures. ... psychopaths clearly have not attained the developmental level of object constancy ... Like patients with a narcissistic personality disorder, they form a pathological grandiose self. This structure differs, however, from that of the narcissistic patient in one important way ... In the psychopath ... the "ideal object" is an *aggressive* introject ... Unlike the self-objects of Kohut's self psychology, this version reflects an experience of the parent as a stranger who cannot be trusted and who harbours malevolence toward the infant. This threatening, internalised figure may derive from real experience of parental cruelty and neglect."

However, a childhood environment of parental cruelty and neglect is quoted as a precursor to several clinical presentations; for instance the borderline pattern, post-traumatic stress disorder (p 468 ff) and dissociative disorders (p 293 ff) Celani, writing on Fairbairn's work with the borderline pattern:

> "The self that emerges after a prolonged childhood of frustration-deprivation is bad for three separate reasons, two psychological and one reality based:

> first, because it is associated inexorably with the rejecting object and is therefore bad as well; second, because the child has taken the "badness" of the object into itself to keep the parent "good"; and finally, because the hurt, abandoned, ignored child feels demeaned and not worthy of goodness." (Celani 1993:19)

He also notes the mechanism of the negative introject:

> "The borderline patient manifests an inversion of the normative developmental process. Instead of taking in the positive object relations unit and rejecting the negative object relations unit, he takes in the negative object relations unit and rejects the positive object relations unit." (p 75)

Fairbairn, noted that children from the Edinburgh slums, from homes "in which drunkenness, quarrelling and physical violence reigned supreme" would only rarely be induced to admit that their parents were "bad objects", and would never volunteer this.

Fairbairn described this position, in which a child would rather be bad than admit that their parents were bad, as the "moral defence" – a decision that it is better to be bad oneself than to have bad people on whom one depends.

> "*It is better to be a sinner in a world ruled by God than to live in a world ruled by the devil.* A sinner in a world ruled by God may be bad; but there is always a certain sense of security to be derived from the fact that the world around us is good ... In a world ruled by the devil the individual may escape being a sinner; but he is bad because the world around him is bad. Further, he can have no sense of security and no hope of redemption." (op. cit. p 18) (Italics added)

Jenny Rockel (1996) again, reporting on the work of Bernard Brandchaft (Rockel exclusively uses the feminine pronoun):

> "Brandchaft recognised that the "pathological accommodation" such an infant must make for her survival is profound and enduring. She must learn, and quickly, to put aside her impulses towards self-discovery and self-delight and turn her attention towards becoming and remaining whatever her caregivers need her to be. ... Her sense of self and innate potentiality, her entire subjective experience, are all subsumed by the imperative of maintaining the needed tie, at all costs."

These formulations are descriptions of adjustment to childhood experience involving parental neglect, cruelty, violence and a disregard for the emerging

self of the child, and we can find here several elements common to the antisocial pattern; a negative parental introject, identification with the abuser and a self that is bad could all apply to either group. However, at some point the antisocial man has clearly departed from this formulation. Using Fairbairn's metaphor of the moral defence, he has moved away from the pathological accommodation of the "sinner in a world ruled by God" and somehow decided to live in the Devil's domain. How this comes about is the second question I am addressing in this paper (the first being the lack of conflict noted above).

Clearly there must be a certain level of integration already present to achieve this development. The consequences of the antisocial position are fearful in terms of punishment and rejection. A child who is still very dependent will cling, as Fairbairn and Rockel suggest, to an option which keeps the parental figures good. The antisocial position abandons this strategy. Therefore the crucial change may not occur before age about 5, and sometimes much later. This would explain why the scenes described above take place around this age or later, and why there are clear memories, both of the history and the scene itself. All the stories tell of a time before the present pattern began. All can recall a definite point of change, which I will refer to as a decision point.

So, allowing that we have an idea of the antecedents, and that a change in direction emerges at a certain point of development, not before, what happens to cause the change?

Psychodynamic Formulation – using Transactional Analysis.

Transactional Analysis describes the developmental sequence in somewhat different terms from the object relations and self psychology models, although many concepts from the latter are incorporated into integrative versions of TA theory. A central concept is that a "script" or unconscious plan for life, an observable behavioural pattern that a person will more or less stick to, is *decisional*. That is, as a child develops, the various issues that confront it are met by a series of decisions in the child. We are not passively programmed, but decide, at an unconscious level, with whatever capacities and information we have at the time, how we are going to meet each issue, how best to survive, to live in the world.[4] Early decisions are global, about life itself, about basic trust. Later decisions are about exploration, power, self-expression, our relationships to others. By a certain age, perhaps somewhere between five and seven, a more

4 The idea of making decisions, or choices, is not unique to TA. For instance, Symington (1993:13); "The ego ... is active ... you could say that choices take place at a very deep level."

or less complete picture has been formed, needing only elaboration, detail and reinforcing memories to keep it congruent with experience. A part of this picture will be an existential position concerning the child's relationships to others. Either I am generally OK, or I am not. Either you are OK or you are not. This gives us the famous "OK Corral" (Ernst 1971) illustrated in Figure 1.

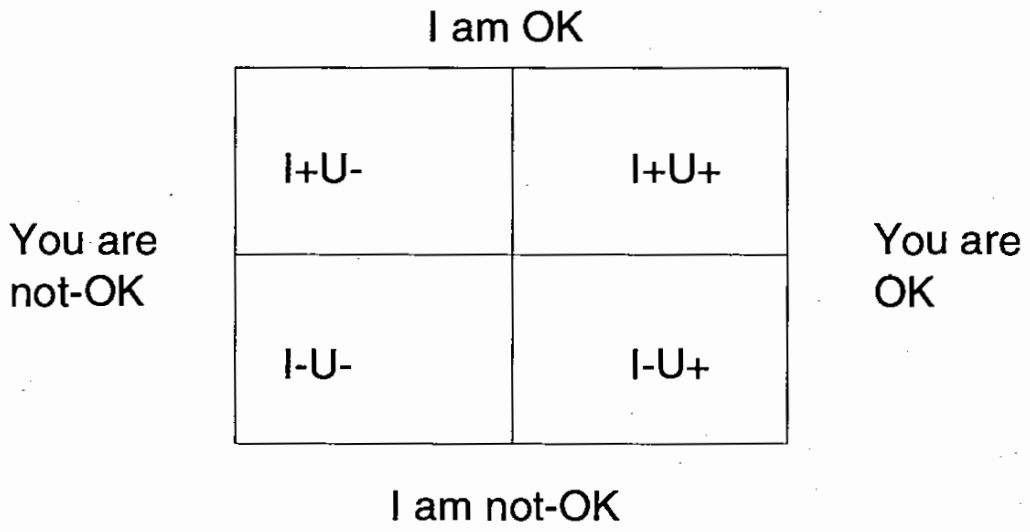


Figure 1

The scene described above appears to relate to an important script decision. At this stage, a normal child has already made many different kinds of decisions about themselves, others, the world and the relationships between these elements (English, 1977). Introjects are still split, but constancy is an achievable goal[5]. The little person is in the process of forming the more or less coherent picture of themselves, others and the world which will determine his life experience for some time to come, but at this point the picture is not complete. In TA terms, the script is still being written. Global existential decisions about how much "OK-ness" is attached to the little person, to others and the world are still being processed.

So far, history has loaded considerable "not-OK-ness" on the little person's view of himself, predictive of a "I'm not-OK, you're OK", or an "I'm not-OK, you're not-OK" existential position. However, this is not what happens. Instead, we see an elegant piece of problem solving which will leave him with much more "OK-ness" than he might otherwise have decided on. The result

5 For a discussion of TA theory on introjects, see Blackstone, 1993.

is not exactly an "I'm OK" decision, rather an "I'm still not OK, but you're more not-OK than me", which feels a lot better. (For developments of Ernst's "OK Corral", see White, 1994).

Phillips (1975) details the relationship between introjection of the early relationship (the "symbiosis") and script development. He describes the introjection of relationships between the big person and the little person in the form of an internal relationship between the little person's Parent and Child ego states.[6] (For these purposes the Parent ego state can be regarded as a recording of significant others, similar to a collection of introjects, and the Child ego state as a recording of the child's experience.[7]) The position before the crucial change is described by Figure 2a. Here the cluster of experiences, internal decisions, practised actions and memories which we may call the "victim" predominates in the little person's reaction to neglect and cruelty which is seen as originating in the big person's Child ego state.

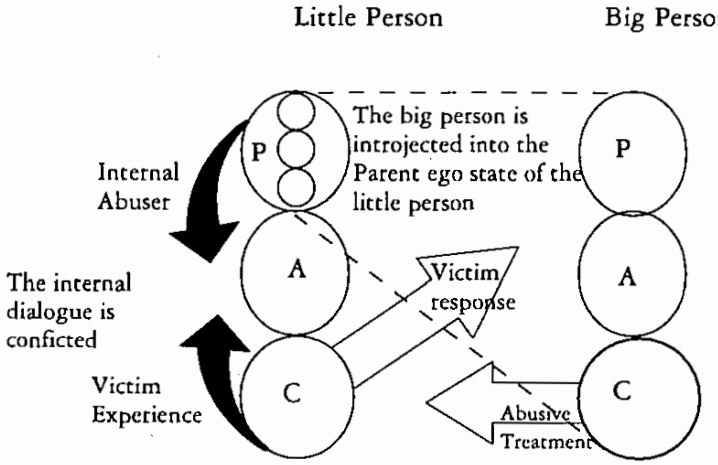


Figure 2a: The introjection and the internal dialogue

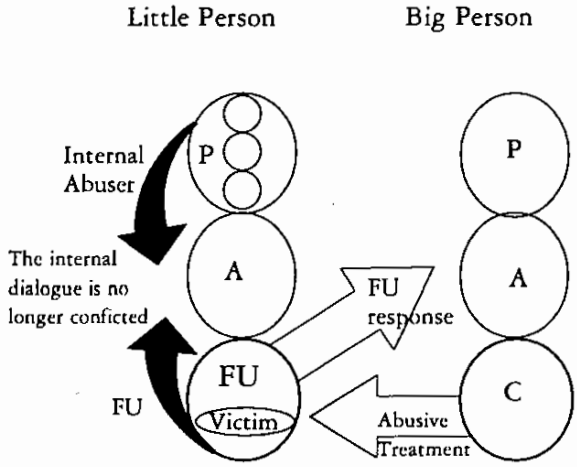


Figure 2b: The FU and the internal dialogue

Returning to the scene, I suggest that what happens is that a new role, which I am calling the FU (for "Fuck You"), has suddenly emerged[8]. It will be based on modelling from the abuser, and often resembles the abuser in language, tone of voice, gestures and other behaviour. Because of this resemblance, there

6 For an elaboration of the basic elements in Transactional Analysis used here, particularly the constructs of Parent, Adult and Child ego states, the reader is referred to Stewart and Joines (1987) and Berne (1961, 1977).

7 The TA convention is that, when spelt with a capital letter, "Parent", "Adult" and "Child" refer to ego states. Otherwise the terms retain their usual meanings.

8 I am using the concept of role in its psychodramatic sense - a behavioural/ thinking/ feeling cluster - for a discussion, see Clayton (1993, 1994).

is little difference between this new role in the Child ego state and the other side of the now internalised dialogue, stored in the Parent ego state. Prior to this, there was a conflicted dialogue between the Parent and Child ego states, one an abuser, the other a victim, who had produced the pathological accommodation referred to by Rockel. Now, because of the emergence of the FU role, there has been a sudden resolution of internal conflict. This is the origin of the lack of conflict which we notice later when this little person presents for therapy. After the decision, the internal victim becomes hidden, disowned, while a powerful new complex dominates the little person's reaction. The changed situation is represented in Figure 2b.

At the same time, we witness a massive release of energy, which is very reinforcing, and which may also help explain the clarity of later memories. There are a number of possible explanations for this.

1 A reduction in conflict, as already mentioned, is reinforcing, and allows more energy to be available for outward action.

2 The new FU role is by nature active, while the old victim role was passive, using now redundant internal mechanisms of defence. The enacted FU is by nature fight/flight, producing a sudden release of adrenalin, a physiological mechanism which will reinforce the role again and again in the future. Oppression becomes excitement.

3 The presence of peers, another factor in the scene, suddenly becomes important. Bearing in mind that we are considering a stage when peers carry a lot of potential for influence, when children are intensely interested in each other, the FU behaviour will immediately capture the imagination, and often the applause, of other children. This provides a massive external validation for the new role.

4 The dulling of physical pain naturally follows prolonged physical punishment. The FU role is likely to be followed by punishment, which in other little people might inhibit the role's reproduction. Physical punishment will have little effect on one inured to pain, and being made to feel "bad" will have no effect at all, as it is has been this little person's familiar state all along. The punishment which will follow FU behaviour will be processed as "strokes" – a further reinforcement.

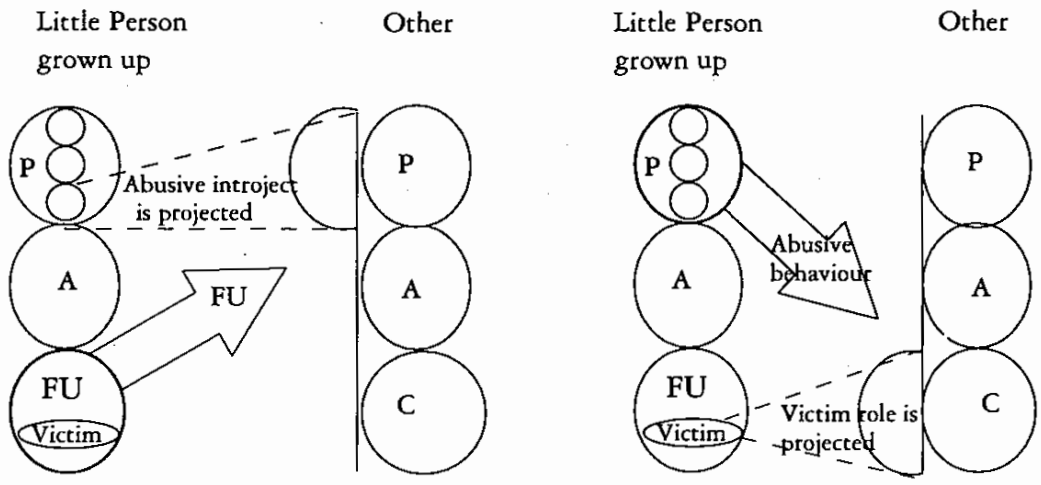
5 At this age, children are rapidly learning all manner of interpersonal and practical skills, and having learnt something new, will practise it interminably, taking pleasure in the experience of doing something new. If, as I have suggested, this event (actually more likely to be a series

> of events, though one may be remembered as significant) occurs at a time when script formation is almost complete, we could suggest that the FU role, reinforced by peers and by internal experience and practised over a number of opportunities, becomes the decision which puts the script together. This is the nature of the FU behaviour which emerges in the archetypal scene, where, as noted already, it seems to be a solution to an old problem.

Following any script decision a new role emerges. If it "works", if it provides more "OK-ness" for the little person, it will be developed further. In this case it "works" dramatically, drastically reducing anxiety and conflict. This decision will involve openly rejecting the perceived source of survival. From now on, punishment, together with peer approval and admiration, plus a pattern of hedonistic self gratification and adrenalin release, become good enough sources of strokes for survival. Hence the need to reach a stage of development when the risks are worth the reward; rarely before age five, and sometimes as late as ten, or even early teens. Where the abuse and neglect is more extreme, the decision will be made earlier. Such people will rarely come to, or stay in therapy, more frequently being found in prisons because their behaviour will be more extreme, their lack of capacity for relatedness makes therapy a scarcely conceivable idea, and they are truly fearful to most therapists. The exceptional therapist who is prepared to work long term in a prison environment (Thomas 1992)or in a specialised therapeutic community linked with the justice system may achieve good results with this group, but this level of commitment to such difficult and specialised work is rare, and most prisons do not offer such a facility.

The development of the antisocial pattern

As this pattern becomes habitual, two projection patterns can be observed. These are illustrated in Figure 3, drawing from the work of Moiso (1985). In the first, the abusive introject is projected, usually onto an older authority figure, and the FU response is directed towards this person. The antisocial's response to real or imagined authority figures is the observable result of this mechanism. In the other instance, the hidden victim, disowned but still present, is projected, usually onto a figure seen as weaker, smaller, or younger, and the response is an acting out of the old abusive introject. Abusive behaviour towards partners and children is one outcome.



3a: Projection of the Parent introject. 3b: Projection of the Victim role.

Figure 3: The mechanisms of projection (after Moiso, 1985)

After many repetitions, over a series of confrontations, dramas, excitements, adrenalin rushes, the FU role will develop complexity in cognition, feeling response and action, becoming a finely tuned response to many situations.

Similarity attracts, and as the little person matures, he will recognise others who have come to similar conclusions about life, about how to respond to a hurtful world. In this context, the FU role becomes sanctified and idealised in a set of values adopted by a criminal culture. A cognitive map of the treacherous environment and a corresponding code of ethics is constructed. With a pain response by now conditioned almost out of existence, cruelty, disregard for others, is congruent, understandable.

Thus we come full circle, from an individual centred, materialistic culture with God on its side, in the shadow of which we find parenting styles based on hedonism and impulsive self-centredness, producing in the following generation a shadow culture, still individual centred and materialistic, but on the side of the Devil.

The methods of working

Later in life, behaviour resulting from the FU decision will be considered dysfunctional by others – parents, others in authority looking after a delinquent child, then police, judges, therapists, probation officers, who must cope with the consequences of antisocial adult behaviour. Ultimately, it may become dysfunctional to the protagonist.

When a man with the antisocial pattern does come to therapy, a method is required which is at the same time dispassionate and engaging, which avoids boredom, but keeps the therapist out of the line of fire. Also, it must be an approach which raises the level of inner conflict which the client experiences as a result of contemplating enacting antisocial behaviour. Finally, it is probably a good idea if the therapeutic method recognises the nature and origin of the early decision.

Many action methods work very well like this. The two chair model for impasse clarification and resolution described by the Gouldings (1979) and the various psychodramatic methods (Clayton, 1993, 1994) serve to set the therapist aside, almost as if they are not a real person at all, more something like, as Charlotte Daellenbach (1991) puts it, a "traffic cop", directing, but not involved in the action. The client interacts with his own internal objects, or self-objects, not with the therapist. After a psychodrama or a piece of two chair or gestalt work, the protagonist is often left unaware of what the therapist, or director, has been doing. They may have no memory of having received certain instructions, which they obeyed during the action.

Another advantage is that there is always something going on. While avoiding destructive transference, the therapist is very active and confronting. The therapy is interesting. The client always has something to do. Men who have developed a strong FU defence are prone to boredom. FU behaviour, from either end of the relationship, is very active, exciting, and produces a lot of adrenalin. Activities which do not are often boring by comparison. This includes most one-to-one counselling approaches. The FU defence produces immediate results, so approaches which require patience and hard work, or which seem unstructured, leaving the client to work things out for himself, will not be attractive. Group methods are therefore more likely to be successful. Since the antisocial pattern as described above is pervasive in many areas of life, residential approaches may have more chance of success than weekly or daily programmes. Similarly, in a residential setting where there is always something going on, one-to-one therapy may be more successful.

Methods which involve only one hour a week will rarely work well, and antisocials do not go to workshops. There are three treatment environments of choice. The first is a cognitive skills programme. These are offered by the Community Corrections Department, and are based on development of cognitive processes in making decisions. These programmes can be regarded as working to strengthen the Adult ego state, building up the individual's

ability to circumvent the destructive projective mechanisms originating in the Parent and Child, but essentially leaving them untouched. The second are the many excellent addiction programmes, both in- and out-patient. These characteristically offer education, addiction counselling and group therapy, often in the context of a philosophy, like the 12-step programmes, or their competitor, the Rational Recovery programme (Trimpey 1992, 1994). The therapy groups often include action methods. The inclusion of a philosophy which structures these programmes may be an advantage, as by the time the client reaches therapy, the FU role has assumed a cognitive complexity resembling a philosophy. If it is to be displaced, an alternative philosophy is likely to help. Also, the group methods used in addiction programmes are often very active.

Therapeutic Community Treatment

The third approach, with which I am most familiar, is therapeutic community (TC) treatment. Essentially this is a reparenting programme. TCs differ from hospital-based and other professionally run programmes in two important respects. First, they are based on programmes which have been developed by non-professionals. Typically these are run by, or have significant input from, graduates of the same or similar programmes. Secondly, they use more innovative and often more confrontational methods than will be tolerated in hospital programmes. TCs appear to be successful with a wider range of clients, including antisocial people, and show improvements in a wider range of symptoms than other approaches, though they take much longer. More attention is paid to generating the conflict that is missing through approaches which generate empathy for the victim, and include the client in altruistic activity, such as working for the community at large. There is an emphasis on "script cure"; far-reaching changes in lifestyle, belief systems, thinking styles, as well as focusing on specific symptoms such as addiction. For this reason, and because of the confrontational methods favoured by the former clients who work there, TCs are often best run by their own graduates rather than by professional staff, though there are a number of models which use both, such as Odyssey and Moana House.

I have referred to therapeutic communities as reparenting programmes. Noce (1978) suggested a model based on two bipolar variables, derived from the idea of the Parent ego state, in the sense of a collective Group Parent. These are defined as Collective Nurturing Parent (CNP), and Collective Controlling

Parent (CCP). (This derives from the "functional model" in TA, where the Parent ego state is divided into Nurturing Patent and Controlling Parent.) Noce suggests that these functions can be represented as bipolar axes, one running between "appropriate structure" and "excessive persecuting" (CCP), the other from "appropriate permission" to "excessive rescuing" (CNP). He suggests eight possible environments as shown in Figure 4.

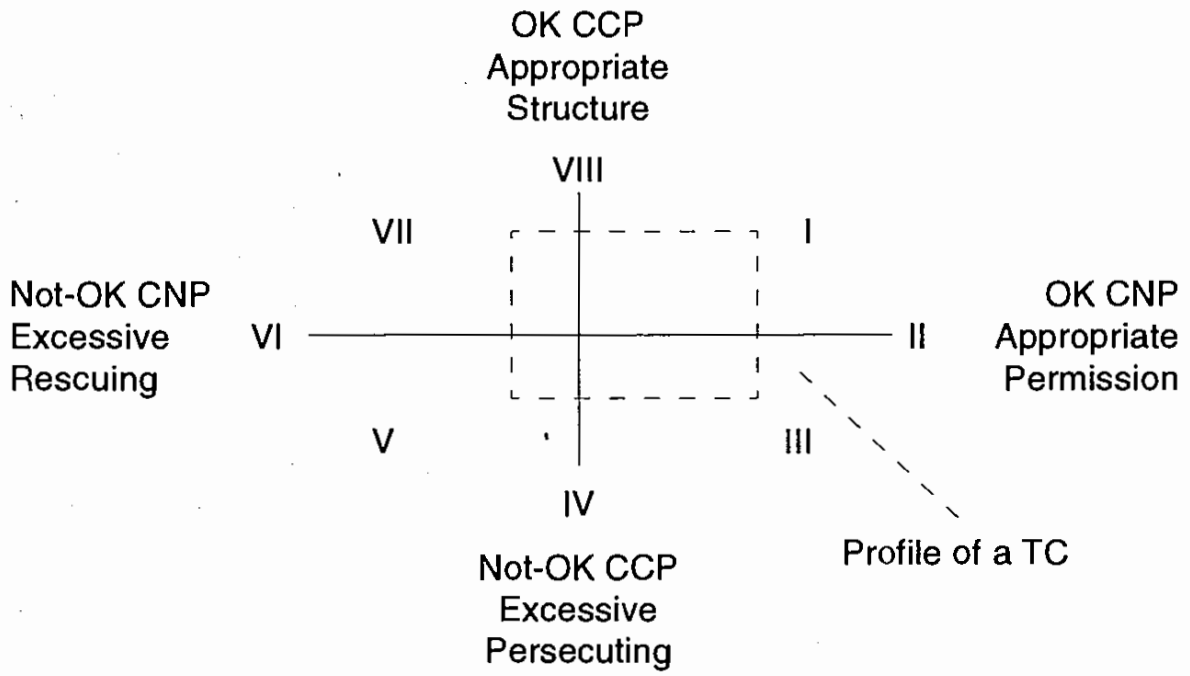


Figure 4

I Maximum positive potency	[appropriate permission, appropriate structure]
II Free school (free child)	[excessive permission, no structure]
III Strict, overly family-oriented (dependency)	[appropriate permission, excessive structure]
IV Prison-oriented	[no permission, excessive structure]
V Crazy-maker (double bind)	[excessive permission, excessive structure]
VI Chaos-oriented	[excessive permission, no structure]
VII Crisis-oriented	[excessive permission, appropriate structure]
VIII Rule-oriented (easy time)	[no permission, appropriate structure]

Caution

The ideas presented here are not intended to imply that psychodynamic group or individual therapy or psychodrama are sufficient treatments for these clients. The Moana House programme is a highly structured therapeutic community and includes education, work, a cognitive-behavioural stopping violence programme, development of empathy for victims, goal setting and monitoring, financial controls, voluntary restrictions on freedom, stages of increasing responsibility, co-operation and PR with the surrounding community and a graduation process. The preferred length of stay is six months to two

years (usually eighteen months to two years to graduate). Graduates are favoured for employment in the programme. All of these elements are considered essential.

A further cautionary note comes from the introduction to DSM-IV:

> "A common misconception is that a classification of mental disorders classifies people when actually what are being classified are disorders that people have." (p xxii)

Although I have referred above to "antisocials", "antisocial behaviour" and "the antisocial pattern", my experience with these men is one of contact with distinct individuals. These terms describe aspects of experience and behaviour which many of them have in common. They do not begin to describe the unique individuals who willingly provided the raw material for this paper.

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When Hetty Meets Betty Who Does Hetty Meet?

An exploration of therapist countertransference in response to issues of difference in the therapeutic relationship

Diane Clare

Introduction

I am a narrative psychotherapist. When I work with a client I attempt to use the language of the client to describe what is going on for the client. Narrative therapy considers not only the individual within the family context but considers wider influences by deconstruction of the understandings and stories about the self that come from society on a more global level. This process externalises problems and opens space for reauthoring lives. Countertransference is a psychodynamic term used in a fairly universal way by therapists of many different theoretical backgrounds. Rather than taking a blameful position (e.g. that the individual has the problem) the presentation takes a questioning position about the influence of the predominant heterosexual culture on the individual therapist's response (the countertransference).

The Oxford Dictionary describes *integration* as the intermixing of persons previously segregated. It also says that psychologically this is a concept that embraces the ideas of combining diverse perceptions within a personality. It draws our attention to the word 'amalgamate' as meaning to combine or unite to form one structure, organisation etc. The word *difference* is described as the state or condition of being different or unlike, a point in which things differ – a distinction; and a degree of unlikeness. It offers another meaning in that difference is often used with reference to a disagreement or a dispute.

Is integration an ultimate goal so that all elements of difference can be

embraced within an overarching sameness? Is difference still possible without being thus integrated? Can difference and integration coexist?

To me everyday interaction and relationship form the crucible of human development and it is, therefore, this arena of our experience that is the essence of the work in the psychotherapy relationship. When self meets other there is always difference to some degree and there is always similarity to some degree. In my work I am frequently assisting people whose sense of self is disintegrated and who struggle with differences both within the self and between the self and other in relationship. Such a sense of disintegration is frequently experienced by the client who belongs to a minority group.

Culture Shock in the therapy room

My purpose in this paper is to explore issues of difference in the therapy relationship. What happens when there is difference between you, as the therapist, and the other, the client? Holding countertransference as the focus, the discussion is about you as therapist rather than your client.

Consider that the differences between therapist and client are issues of cultural diversity. Consider culture in a wide sense as "the customs, civilisation and achievements of a particular people" (Oxford Dictionary). There are many ways that we differ from each other: age, class, physical or mental ability, religious beliefs, sexual orientation and gender are but some examples. What happens in the relationship between you when you, as the therapist, have little or no awareness of the issues of difference between you and the client?

When something different presents to us from outside our particular world view, the potential is for a form of trauma to occur in us as therapists, a type of culture shock in response to the difference in the client. Does such a form of culture shock limit therapy? Does this create a form of trauma in the client and the therapist? If so, how does this influence the therapeutic alliance? Consider the following scene: Two women are seated at a factory bench engaged in a monotonous and repetitive task and they have just met. They are having the sort of conversation everyone has had at some time in some form:

Hetty: Hello, my name's Hetty.

Betty: Hi, I'm called Betty.

Hetty: I don't think I've seen you before. Have you just started here?

Betty: Yeah, this is my first week. How long have you been here?

Hetty: I started about 3 months ago.

Betty: So what's it like working here?

Hetty: Okay I suppose. The money isn't too bad but it's pretty monotonous work.

Betty: So what did you do before you came here?

Hetty: I was working in quite a good office job in Auckland but I needed a change.

Betty: That was quite a decision to leave a good job and shift away.

Hetty: I split up with my boyfriend and it all got a bit much so I came down here. So how about you?

Betty: What do you mean?

Hetty: What brought you here?

Betty: I've been out of work for a while. Used to work at Brownlees but got made redundant so here I am!

Hetty: Poor you!

Betty: Do you think you'll stay here now?

Hetty: Yeah. Stu' and I had been together for about 2 years but it wasn't working out and I was getting sick of the pressure from him so I left him and came down here to live with friends for a while so I could sort myself out. Have you got a boyfriend?

Betty: My partner and I have been together for about 3 years.

Hetty: Are you married?

Betty: No we're sort of de facto I guess.

Hetty: Do you have kids?

Betty: Well my partner has a daughter and I have two sons so we're what they call a blended family.

Hetty: So you're a mother to three kids - how old are they?

Betty: Jenny is 8 and my two are Brent who is 6 and Joseph who is 4.

Hetty: What's your partner's name?

Betty: Chris.

Hetty: Does he work?

Betty: (pause) Chris is a nurse.

Hetty: I suppose that means shift work?

Betty: Yeah but it doesn't worry us. We've got used to it and have built our social life in spite of it.

Hetty: What do you two like doing then?

Betty: Depending on Chris's shifts we might have a meal with friends, go to the movies or to the pub. We both like the outdoors – day outings mainly - and we swim.

Hetty: Oh you should meet my new boyfriend John. He's right into tramping. He wants me to go with him next time. Hey why don't we meet and have a drink together then Chris can meet John and we could check it out?

Betty: (Pause) Well I'm wondering if there's something I should tell you ...

At closure Betty comes out from behind her bench in a wheelchair.

Consider that Betty is a lesbian and Chris is actually a *female* partner. Consider what this information means in terms of the assumptions Hetty makes about Betty and how Betty responds to her. Note how Betty is placed in the position of being interrogated and seems to close off more and more. Hetty is doing what we often do to explore ways to get to know someone so that she is not being blamed for how she is attempting to interact with Betty, although she seems quite unaware of the assumptions she is making. Betty having a disability may also be unexpected.

Assume that irrespective of your actual sexual orientation, that just for now you are heterosexual and that it is heterosexuals rather than homosexuals who are in the minority. As a group of heterosexuals you are 10% of the general population. Read what you, as that heterosexual minority, would hear on a regular basis about yourself.

When did you first realise you were heterosexual?

Does your mother know you are heterosexual?

You are going against society for being the way you are.

What do heterosexuals do in bed?

How many partners do you heterosexuals have at a time?

What makes you think you should have the right to marry?

What makes you think you should have rights?

What you do is sick and you need help.

I will have to keep my children away from you now.

You are no longer a fit mother.

You need psychiatric assessment for being that way.

You need a good fuck to put you right.

What was it like when you first came out as a heterosexual?

What did your friends say when you came out?

It is unnatural to be the way you are.

How will you tell your kids that you are heterosexual?

It must be because your mother or father was too dominant.

It must be because your mother or father was distant.

How do you think your kids' friends will handle it?

It's just a phase - you'll get over it.

You're just looking for love wherever you can find it.

You and I have shared the same bathroom, how do you think this makes me feel?

How can I trust you now I know this about you?

In these statements the whole self is attacked on so many levels that the person ceases to even be treated as human. All these are issues that have been raised by heterosexuals towards me and towards other lesbians, bisexuals and gays I have met. It is not simply an isolated experience although every one of these statements has been made to me personally about being lesbian and some of them by therapists.

It is common for predominantly heterosexual groups when confronted with this type of experiential exercise to express disbelief, anger, guilt, shame, sorrow etc. Such responses are similar to the mixture of emotions we call grief. Remember: this is the lived everyday experience of non-heterosexuals who hear these statements.

When you have met someone and assumed they are *heterosexual* consider what this assumption is based on. If that person turned out to be *homosexual,* consider what the similarities and the differences would be in your relationship and how you would handle the differences. If you believe there would not be differences how might this position influence the way you behave towards and how you are experienced by that person? If there are differences that you may be unaware of, how do you think you could attempt to identify these? In what ways do your answers to these questions influence your thinking and feelings about working with clients who identify as lesbian or gay? You may like to

consider whether heterosexual therapists should work with lesbians or gays and, conversely, if lesbian or gay therapists should work with heterosexuals.

Theoretical considerations

I am proposing that the heterosexual therapist responding to a client with a different sexual orientation can experience a form of 'culture shock' and this countertransference has parallels with the response to the client with PTSD. Wilson and Lindy (1994) describe two poles to a countertransference continuum. Type I involves avoidance, counterphobia, distancing and detachment. Type II involves overidentification, overidealisation, enmeshment or excessive advocacy. They speak of the process as being one of empathic strain (or rupture) taking four distinct modes. These distinctions help identify differences in therapists' reactive styles and are indicated at different times in the course of therapy. They are dynamic rather than static processes, enabling themes to emerge in greater detail and depth and directing the therapist to the locus of the work in order to remove the strain.

A modified outline of Wilson and Lindy's schema is:

Type I Countertransference: Avoidance, Counterphobia, Distancing or Detachment

a. Empathic Withdrawal

Factor for risk in therapist Therapist unlikely to have had personal catastrophic experience.

Impact Therapist's beliefs/world view is challenged.

Defence Withdrawal, denial, disbelief, disavowal, isolation. May rationalise the response on the basis of theory and technical orthodoxy.

Addressed by Education about trauma and PTSD (including effects of the trauma of heterosexism for the gay or lesbian client) can help resolve the countertransference.

b. Empathic Repression

Factor for risk in therapist Therapist likely to have experienced or continue to suffer from own related traumas.

Impact Overlap between therapists' own work yet to be addressed and the

client's trauma issues which is an area "out of bounds in an unconscious collusion between two victimised survivors" (e.g. if therapist has not addressed own grief for personal issues of ostracism or prejudice, the work is unlikely to address grief work for the client).

Defence Repression.

Addressed by Supervision or therapist's own therapy are useful ways to address these blindspots.

Type II Countertransference: Overidentification, Overidealisation, Enmeshment or Excessive Advocacy

a. Empathic Enmeshment

Factor for risk in therapist Therapist has had considerable trauma of own.

Impact Often client has much current-day re-enactment of danger which invites therapist to rescue. This reaction in the therapist discharges some of the strong affect still present in the therapist and can lead to loss of boundaries, over involvement and reciprocal dependency.

Common Defence Identification.

Addressed by Supervision or therapist's own therapy are again ways to address this countertransference (may be sexual orientation or other issues inviting enmeshment response).

b. Empathic Disequilibrium

Factor for risk in therapist Therapist naiveté about this element of trauma usually creates risk of therapist of becoming uncertain, vulnerable and overwhelmed (e.g. therapist who has never had any exposure to the devastating loss and grief often experienced by gay and lesbian clients).

Impact Therapist world view is ruptured and fatigue, despondency and despair follow. This in turn may result in empathic withdrawal or enmeshment and burnout.

Common Defence Withdrawal.

Addressed by Rest, recuperation and support along with limiting exposure.

Further Enquiry

What happens in the relationship between you when you as the therapist have little or no awareness of the issues of difference between you? How does this influence your approach? How does your approach influence the client? And what of the transference that thus develops? Conversely, what happens in the relationship between you when you as the therapist are aware of the differences between you? How does this influence your approach? How does your approach influence the client? And what of the transference that thus develops?

If you go to your workplace with three ways of raising lesbian/gay awareness there you may find yourself wondering if others will think this means you are gay. Or you may develop a theoretical stance as to why you should not do this. What kind of countertransferential response might you be elaborating?!

The following may be of assistance (perhaps with modification for male readers) when your client has a different sexual orientation to yours.

Hints for the Heterosexual Woman When First She Meets a Lesbian

1. Do not run screaming from the room. This is rude.
2. If you must back away, do so slowly and with discretion.
3. Do not assume she is attracted to you.
4. Do not assume she is not attracted to you.
5. Do not assume you are not attracted to her.
6. Do not expect her to be as excited about meeting a heterosexual as you may be about meeting a lesbian. She was probably raised with them.
7. Do not immediately start talking about your boyfriend or husband in order to make it clear that you are straight. She probably already knows.
8. Do not tell her that it is sexist to prefer women, that people are people, and that sheshould be able to love everybody. Do not tell her that men are as oppressed by sexism as women, and women should help men fight their oppression. These are common fallacies and should be understood as such.
9. Do not invite her some place where there will be men unless you tell her in advance. She may not want to be with them.
10. Do not ask her how she got this way. Instead, ask yourself how you got that way.

11. Do not assume that she is dying to talk about being lesbian.
12. Do not expect her to refrain from talking about being a lesbian.
13. Do not trivialise her experience by assuming it is a bedroom issue only. She is a lesbian twenty four hours a day.
14. Do not assume that because she's a lesbian she wants to be treated like a man.
15. Do not assume that her heart will leap with joy if you touch her arm (condescendingly? ... flirtatiously? ... power-testingly?). It makes her angry.
16. If you are tempted to tell her she's taking the easy way out: THINK ABOUT IT.

Source: Lesbian Connection, Wellington

Judy Small's song: *No Tears for the Widow* addresses the disparity between the sympathetic response by society for the widow who loses her male partner and the lack of such a response for the woman whose female partner dies. One has the status of widowhood while the other has always been referred to as single and thus the initial existence let alone the subsequent loss of the relationship goes unacknowledged. In narrative terms, the dominant story has swamped the neglected story of the self.

Returning to my initial questions regarding integration and difference, I wonder to what extent dominant narratives restrict the degree of personal integration a person with difference can hope. to develop particularly if the therapist holds the dominant narrative. Just as I have to make coming out decisions in other everyday situations, in writing this paper I had to consider whether to risk expressing and identifying my difference within the Association. I believe that silence would rob my spirit and would ignore the rich mix of threads that combine to make our one cloak.

If you tell the truth you are in trouble
But if you see the truth and you keep quiet.....
.... your spirit begins to die

Ben Okri in his novel: Dangerous Love.

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Not A One-Sided Being

A Jungian Perspective On Therapy With Gay Men

David Thompson

Abstract

This paper examines ideas on therapy with gay men drawn from the essay *Not A One-Sided Sexual Being: Clinical Work with Gay Men from a Jungian Perspective* by Scott Wirth[1], a Jungian analyst who works in San Francisco.

Introduction

My aim in presenting this paper is to highlight the main ideas of Wirth's essay, to encourage discussion of these ideas, and to find how they fit with our experience of working with gay men. I write as a gay man and hence acknowledge the bias this introduces. For me sexual attraction between members of the same gender is normal for an appreciable percentage of the human race. I am interested in a Jungian perspective because I find comfort and inspiration in the works and ideas of Jung. I mention ideas from Sigmund Freud, Carl Jung, Scott Wirth and others.

Difference and Integration, the title chosen for the 1997 conference to celebrate the first fifty years of the Association's life, is particularly apt. Each of my gay clients has without exception described growing up feeling different, (although they are not alone in this). Integration of these feelings into their psyches, and integration of themselves into society or into some subset of it, is a common goal which many seek.

I use the word "gay" rather than "homosexual" because the latter has strong clinical connotations and has been largely rejected by the people to whom it applies. Both words are to a degree unisexual, unlike the phrase "men who have

1 In Hopcke, Carrington and Wirth, (1993).

sex with men" which is sometimes used today. You might wonder why, after the passing of the Homosexual Law Reform Bill in 1986, gay men need help from counsellors and psychotherapists. Ingrained societal attitudes do not instantly change when a law changes. Prejudice and homophobia still exist in New Zealand and still harmfully influence the lives of young gay people. Prejudice and homophobia explain why there are men under forty in our society who, as teenagers, were placed in mental hospitals and sedated because they were gay[2].

My awareness of being different and my integration of this difference took longer than it takes many young gay people in today's society. As a teenager my sources of information about different sexualities were encyclopaedias and newspaper reports of the trials of paedophiles. The latter suggested homosexuality and paedophilia were identical; the former, perhaps biased by interpretations of Freud, seemed to suggest I had suffered arrested development based on some abnormality in relationship with one or other of my parents. When I eventually read *Memories, Dreams, Reflections*, the biography of Carl Jung, I discovered that psychology had something other than suggestions of arrested development, behaviour modification and aversion therapy to offer the gay man.

George Weinberg, in *Society and the Healthy Homosexual* suggests that Freud believed there were four ways a person could become a homosexual[3]:

1. Fixation resulting from the failure to develop along the natural course.
2. Castration fear based on a man's fear of putting his penis into a vagina.
3. Narcissism which results in moving the love of one's own body to another man.
4. Too close an identification with a member of the opposite sex, usually a parent.

Freud, believing homosexuality to be a pathological condition with causes as above, contributed to the idea that homosexuality can cured. Yet, late in his life he wrote to the mother of a homosexual boy saying she should not expect analysis to eliminate his homosexuality. "What analysis can do for your son runs in a different line. If he is unhappy, neurotic, torn by conflicts, inhibited in his social life, analysis may bring him harmony, peace of mind, full efficiency,

2 Stansfield, Gavin. (1995).

3 Weinberg, G. p 24 26

whether he remains a homosexual or gets changed."[4]

Jung has approximately a dozen references to homosexuality in his entire collected works. Hopcke[5] summarises Jung's attitude as follows.

1. Homosexuality ought not to be the concern of legal authorities.
2. Homosexuality is best understood when put into an historical and cultural context.
3. An individual's homosexuality needs to be distinguished from other personality and behavioural traits.
4. An individual's homosexuality has a meaning peculiar to the individual in question; psychological growth involves the person becoming aware of this meaning.
5. Homosexuality being a result of psychological immaturity is abnormal and disturbed.

The belief that heterosexuality represents psychological maturity, while homosexuality represents psychological immaturity, has been fostered by the Judeo-Christian religion, and is still held by some Christian sects today. This belief would almost certainly be behind the thinking which resulted in gay teenagers being hospitalised and medicated in New Zealand up until the 1970s.

Jung[6] had three theories about the cause of homosexuality.

1. Homosexuality is nearly always a result of a particular relationship with the feminine, usually an unresolved dependence on the personal mother.
2. Homosexuality may result from an incomplete detachment from the original archetype of the Hermaphrodite, the unbroken state of non-differentiatiion that comes, psychologically and mythically, before all else.
3. Homosexual orientation is determined by genetic or biological factors.

The first of these links with Jung's view of homosexuality being a result of psychological immaturity, while the second involves the concept of archetype. What is an archetype? Jung observed basic psychological patterns emerging in people irrespective of their culture. He believed these patterns were similar because all people have deep psychological imprints which he chose to call archetypes. Archetypes are not directly observable, we can only see the

4 Weinberg, G. p. 39
5 Hopcke, R. (1991).
6 Hopcke, (1991).

patterns which develop because of them. Jung always maintained his psychology was scientific and, as with all science, a theory cannot be easily proven but can be held as true until a result occurs which contradicts it. Jung postulated the existence of archetypes and in particular the existence of a hermaphroditic archetype. What did he mean by the hermaphroditic archetype? I suspect this is a primordial psychological unity in which male and female are unconsciously conjoined before differentiating into masculine and feminine. The hermaphroditic or androgynous self is one which can respond to men or women at any level, emotionally, spiritually, or sexually without threat or damage.

Jung's third theory is close to the modern view. As a consequence, if homosexuality is innate and determined genetically, its cause is psychologically irrelevant. This view was given a boost in 1973 when the American Psychiatric Association stopped calling homosexuality a mental disorder. Now, even if someone finds it disturbing to be homosexual, we do not classify homosexuality as the illness.

Wirth prefaces his paper with this quotation from Jung:

> "In view of the recognised frequency of this phenomenon [homosexuality] its interpretation as a pathological perversion is very dubious. The psychological findings show that it is a matter of incomplete detachment from the hermaphroditic archetype, coupled with a distinct resistance to identify with the role of a one-sided sexual being. Such a disposition should not be adjudged negative in all circumstances, in so far as it preserves the archetype of the Original Man[7], which a one-sided sexual being has, up to a point, lost."[8]

Jung accepted the existence of homosexuality and because of its frequency chose not to call it a pathological perversion. The existence of archetypal bases for this pattern of human loving is borne out by observable similarities, such as attraction to members of the same gender as oneself, which exist in the erotic, emotional and psychic lives of gay men.

7 Hopcke (1991) p.37 "Jung links homosexuality with the archetype of the Hermaphrodite or the "Original Man", an archetype of psychological wholeness - indeed the Self. If homosexuality results from resistance to a "one-sided" sexuality, if it is connected to the hermaphroditic wholeness of the Self, it can scarcely be condemned."

8 Jung, C.G. CW 9/1 para 146

Gay Male Subculture

Freud's notion of universal human bisexuality, Jung's notion of contrasexuality and Kinsey's notion of the homosexual-heterosexual spectrum[9], all suggest we can talk of the "gay aspect" of a person rather than a "gay person". We could avoid labelling and be content to describe a particular behaviour. For brevity, I will continue to use the term "gay man", where the psychological/cultural identity called a "gay man" is the blending of inner archetypes with outer sociological realities.

Wirth's clients know he is a gay man and assume they will not encounter significant unexamined homophobia. He discloses little about himself and endeavours to remain neutral. My own gay male clients come to me assuming I am gay because I advertise in the gay press. Those who ask about my sexual orientation do so in the first session, when I am prepared to discuss such issues, but in fact few ask. While psychotherapy with a gay man follows the same general pattern as with any other person, Wirth lists some characteristic syndromes and problems presented by gay men, which reflect qualitative cultural and intrapsychic differences between gay and non-gay men. This is his list of characteristic symptoms:

a. Splitting of different gender-associated personality components one away from the other.
b. Gay stylised "anima possession" e.g. the diva, the bitch, the smothering mother, the sexual toy.
c. An inflated, grandiose, narcissistic sense of self as "everything" – this may be exhibitionistically shown off in various bold gay liberationist stances or perhaps kept as a fairly private fantasy of quasi-shamanistic healing powers, artistic grandeur and the like.
d. Intimate relationship problems, especially involving
   (i) the disappearance of desire
   (ii) the separation of desire from emotional closeness
   (iii) the inability to stay in a committed monogamous relationship
   (iv) age disparity or racial difference in a relationship.

9 Freud used the term bisexual to mean equal sexual attraction to either sex. Jung viewed many things in pairs of opposites, hence contrasexuality contrasts the opposites of masculine and feminine. Kinsey postulated a seven point scale from zero to six with heterosexuality at one end and homosexuality at the other.

e. Puer problems of

(i) overidealizing
(ii) compulsive rebellion against authority figures
(iii) superficiality or flightiness.

f. Sexual promiscuity or compulsive sexuality.

g. Social isolation and loneliness.

h. Grief and feelings of being overwhelmed by the HIV epidemic.

i. Gay ghettoization and social "ethnocentrism"[10].

j. Chemical dependencies and/or eating disorders.

k. Inability in adult life to leave behind the position of child vis-a-vis mother and/or father.

l. Masochistic allowing of the gay or some other aspect of the self to be exploited by others.

m. Psychotic delusions of belonging to another (gay) "species".

n. Gay stylised forms of paranoia, hysteria, depression and anxiety.

o. Post-traumatic stress syndrome stemming from abuse.

p. Getting stuck in various gay roles, personae, stereotypes.

q. Spiritual malaise or an overspiritual, disembodied religiosity or "goodness".

r. A tawdry depersonalised, self-destructive underworld sexual slinking around (sometimes including unsafe sexual practices).

s An overpreciousness, oversensitivity, or delicateness, including hypochondriasis.

t. Fetishization of certain body parts and surfaces, especially the penis, testicles, anus, chest, body hair.

u. Hatred of men, keeping only the company of women; or hatred of women, keeping only the company of men.

v. Heterophobia, including envious hostility toward procreativity, marriage, and nuclear family life.

w. Homophobia, internalized and/or externalized.

x. Destructive sadomasochistic sexual rituals and fixations.

y. Fixation on youth and beauty; untoward fear of ageing.

z. An overstudied, false masculine posing and posturing.

10 Ethnocentrism: belief in the intrinsic superiority of the nature, culture or group to which one belongs.

Much on the list is also commonly found in non-gay clients. Wirth states that knowing these characteristic problems of a gay man's psychology may help get psychotherapy started, but to get further it is necessary to have some understanding of the intrapsychic structures and archetypes of a gay man's psyche.

Male and Female Elements in Gay Men

Winnicott[11] postulated the existence within each human of pure and distinct male and female elements which could be described by Jungians as archetypal masculine and feminine principles. How any particular man defines his own personal sense of "feminine" and "masculine" depends on environmental factors and on innate endowments of male and female elements. Edward Carpenter[12] wrote that inner psychical affections may not always be related to outer bodily form. Both Winnicott and Carpenter suggest the strength of intrapsychic male and female elements may vary from individual to individual and may not necessarily correlate with biological gender. This view, which depends on the acceptance of the original postulate that within each person there are pure and distinct female elements, is supported by others.

Jung postulated the ideas of anima and animus, anima being the feminine component in a man's personality and animus the masculine component in a woman's personality. Recent Jungian thinking seems to fit more closely to Winnicott's idea by saying that each human may have both anima and animus.

Nearly all boys who become gay men have an inner feminine aptitude called by Winnicott a "pure-female-element potential". The gay boy may not have language or symbols to honour and express his feminine True Self and almost always his caregivers and peers empathically fail to nurture and stimulate his feminine self. Joseph Henderson believes that in a gay man the anima often develops before masculine identity, leading to imprisonment in the anima, leaving the man with no way of finding his masculine identity.[13] In a gay male the anima develops precociously. Healthy gay male development of masculinity usually needs periods of separation from the feminine. Erich Neumann wrote "Even today we almost always find in cases of male homosexuality, a matriarchal psychology where the Great Mother is unconsciously in the

11 Winnicott, D.W. (1989), pp. 168-92

12 Carpenter, E. (1984), p. 186

13 Hopcke (1993), pp. 231

ascendent."[14] Wirth takes issue with this, believing ego development in gay males follows both feminine and masculine lines. A gay male feels, perhaps unconsciously, both masculine and feminine as his own; separation of the two is alien and unfavourable for him.

While in heterosexual males maturation and wisdom are accompanied by a late-stage deep integration of femininity, for gay men maturation and wisdom has more to do with what Jung[15] called "a detachment from the hermaphroditic archetype."

Wirth discusses the Oedipus complex as a prologue to the relationship between gay men and parent figures. Freud believed the "complete" form of the Oedipus complex to be two-fold, positive and negative, involving both an "ambivalent attitude towards the father and an affectionate object-choice towards the mother. At the same time the boy also behaves like a girl, displaying an affectionate feminine attitude to his father with corresponding jealousy and hostility towards his mother."[16] Later Freudians claim it is even more complicated.

Gay Men and the Mother

Many psychoanalytic writers suggest close mother-son relations are somehow related to homosexuality and it seems true most gay men have closer relationships with mothers than with fathers. Wirth asks why the link need be seen as causal and suggests as another possibility that a gay boy, with precocious anima development, finds in his mother a much needed source of mirroring for his inner feminine qualities. As he develops, these feminine images and ideas become clustered round his anima archetype and form a strong feminine complex[17] which is thus produced from inside the gay male psyche rather than from outside through too much mothering.

Jung extended the idea of the mother complex beyond the psychopathological idea of involvement with injury and illness to its positive effects. "A man with a mother complex may have a finely differentiated Eros ... [with] a great capacity for friendship ... have good taste and an aesthetic streak which are fostered by the presence of a feminine streak ... he may be supremely gifted as

14 Neumann, E. (1954), p. 50

15 Jung, CW 9/1, p.71.

16 Sigmund Freud (1961), Vol 19, p.33

17 A complex is a collection of images and ideas, clustered round a core derived from one or more archetypes, and characterised by a common emotional tone. Samuels at al. (1986)

a teacher ... endowed with a wealth of religious feelings... "[18] Many gay men use and have used these qualities to advantage in careers, although their gay aspect is often ignored, exploited or degraded.

The positive mother complex shows up in many positive feminine ways – a love of home; a flowing movement; a patient or caring gesture; a passionate defence of vulnerability; acceptingness of the "other". The negative mother complex may also show - too nice; too sweet; too self-effacing; inhibiting his aggression; masochistically sacrificing himself to serve others and so undermining his full vitality; fearing conflict or competition; arranging his world to avoid encounters with his shadow; well liked but not intimately known; his overall personality lacks roundness; his sexuality may shrivel or project into the "other" man.

In extreme cases the negative feminine complex may inundate the psyche of a gay man and hysterically dominate his personality. He may become "anima possessed" in a gay male False-feminine Self syndrome. Winnicott believed the function of the False Self is to protect and defend the True Self. In a gay male, whose femininity takes refuge in effeminacy, the False Self may thus expose him to outer abuse and humiliation. Wirth observes that "the greater the neglect and abuse his True-feminine Self has sustained the "queenier" the false and hysterical presentation a gay man makes." When a gay man's False-feminine Self fails, he may suicide showing that his true feminine soul never found safe conditions in which to thrive.

Gay Men and the Father

Wirth talks of Freudians showing a homophobic bias with homosexuality regarded as pathological. Nicolosi[19] writes, "I do not believe that the gay life-style can ever be healthy, nor that the homosexual identity can ever be completely ego syntonic." Regarding those men seeking his reparative therapy he says: "They refuse to relinquish their heterosexual social identity." The patriarchal "father knows best" tenor of some psychoanalytic literature aggravates a problematic relationship of gay men to the Father. Any heterosexist bias in psychiatry constitutes abusive "soul murder"[20] of gay men who, seeking healing and self-discovery, meet with manipulation, deception and assault.

If Freudian psychoanalysis has abused gay people then Jungian analysis has

18 Jung, CW 9/1 p.71

19 Nicolosi, J. (1991), p. 13.

20 Shengold (1989). "the deliberate attempt to eradicate or compromise the separate identity of another person."

neglected their souls. Wirth claims most gay men have had poor relationships with their fathers often with grief, hatred, bitterness, fear and intimidation. He postulates the father problem of gay sons is a problem of misfit between the two. Male elements predominate in the father's psyche with the feminine side perhaps only developing in later life, long after the gay son is grown up. The gay son, during childhood and adolescence, needs a father figure with well developed femininity, something a heterosexual father is least likely to give him. We can paraphrase Jung and say gay sons resist identifying with their one-sidedly masculine fathers. The son may critically and angrily write his father off. He may unconsciously take up the task of living out his father's anima. The son's door may be closed to the father despite powerful unconscious longings for intimacy with him.

Wirth says the father-son transference in therapy may be particularly volatile and sensitive, requiring qualities of equanimity, fortitude and clarity in the therapist. Both the negative transference and the positive transference need careful handling. The feminine aspects need a haven in the father's accepting and holding. The therapist as father must handle erotic longings for the son as client with particular care, neither rejecting nor stimulating these desires. The feminine elements of a gay male may have developed earlier than masculine ones, which may have become split off to remain of one age. Such parts may mature slowly, or not at all, and a therapist working with gay men needs to be adept at recognising and holding fixated or split off part-objects.

Gay Men and Detachment from the Archetype of the Hermaphrodite

In-depth analytical psychology involves working with archetypes. For gay men this particularly refers to working on detachment from the archetype of the hermaphrodite. The idea of the hermaphrodite came through Freud from the androgyny of the Egyptian deities and many of the Greek gods. Freud says, "Only a combination of male and female elements can give a worthy representation of divine perfection."[21] Wirth quotes Jung discussing the hermaphroditic psychic condition.

Jung said:

> "the underlying idea of the psyche proves it to be a half bodily, half spiritual substance, ... an hermaphroditic being capable of uniting the opposites, but

21 Freud, S. 1961 v 11, p 94.

> who is never complete in the individual unless related to another individual. The unrelated human being lacks wholeness, for he can achieve wholeness only through the soul, and the soul cannot exist without its other side, which is always found in a "You". Wholeness is a combination of I and You, and these show themselves to be part of a transcendent unity... "[22]

Applying this to gay men, with body and spirit two parts of the same being, Wirth argues that a gay man may experience his body as masculine and his spirit as feminine, or vice versa. Gay men commonly enter states in which they experience psychological unions of masculine and feminine, unions which may bring ecstatic or transcendent qualities but which may also bring narcissistic or mesmerising conditions. Masculine and feminine opposites can become merged or too close, forming a kind of hermaphroditic union. Did Jung mean this when he referred to "an incomplete detachment from the hermaphroditic archetype" in male homosexuality?

Perhaps a gay man cannot detach from the hermaphroditic archetype while remaining unconscious of the proportions and intentions of his constituent male and female elements. To enter a close relationship with another man he may need to become conscious of these proportions and detach from the hermaphroditic archetype. Such consciousness involves much work on one's Oedipus complex, one's childhood drama, one's love and hate of mother and father. He will need to be touched by the archetype of initiation. Meanwhile there will be constant alternation back and forth between the masculine and feminine strands of his make up, so he can separate them to differentiate and individuate out of the hermaphroditic blur into which many gay men lapse. As Joseph Henderson says:

> "If the homosexual patient in analysis successfully meets the conflict of opposites and works with them by separating them so that he or she feels the tension between them, acknowledging both sides, and experiences that as a kind of initiation, then the person becomes mature."[23]

22 Jung, CW 16, pp. 244-245 (In a section on alchemy.)

23 In Hopcke "Same-Sex Love" (1993).

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Difference and Integration in Groups

"Sitting in the Fire"

Kay Ryan

Introduction

Many of us are called on to lead groups – seminar groups, business/organisational groups, therapy groups, support groups and what are termed growth groups, family groups, school groups and others. There are many ways of leading these groups. Groups can be challenging and also frightening, for both leaders and participants, especially larger groups and ones that are less easy to control. Many of us prefer peaceful behaviour in groups where one person speaks at a time, where one sentence is finished before moving onto the next, where staying seated in an orderly fashion is the norm, and efforts are made not to be too loud or outspoken and not to be too quiet as both attract unwanted attention, judgement and even analysis.

In this paper, I present a way of working with groups, group diversity and conflict, that provides a possible direction we could follow to fully harvest the potential of our turbulent and challenging times. I will draw on the work of Arnold Mindell, originally a physicist, then Jungian analyst, who developed the framework of what we now call Process Oriented Psychology or Process Work. His work became known in the 1970s and it has been in the last five years that he has focused on large and small groups developing what is called Worldwork. Mindell himself states:

> "My teachers told me to avoid large groups: they are unruly and dangerous. The only way work can be done, they maintained, was in small groups where law and order prevail. But the world is not composed of docile little

> groups. Enforcing law and order can't be our only strategy for resolving problems." (1995, p 11)

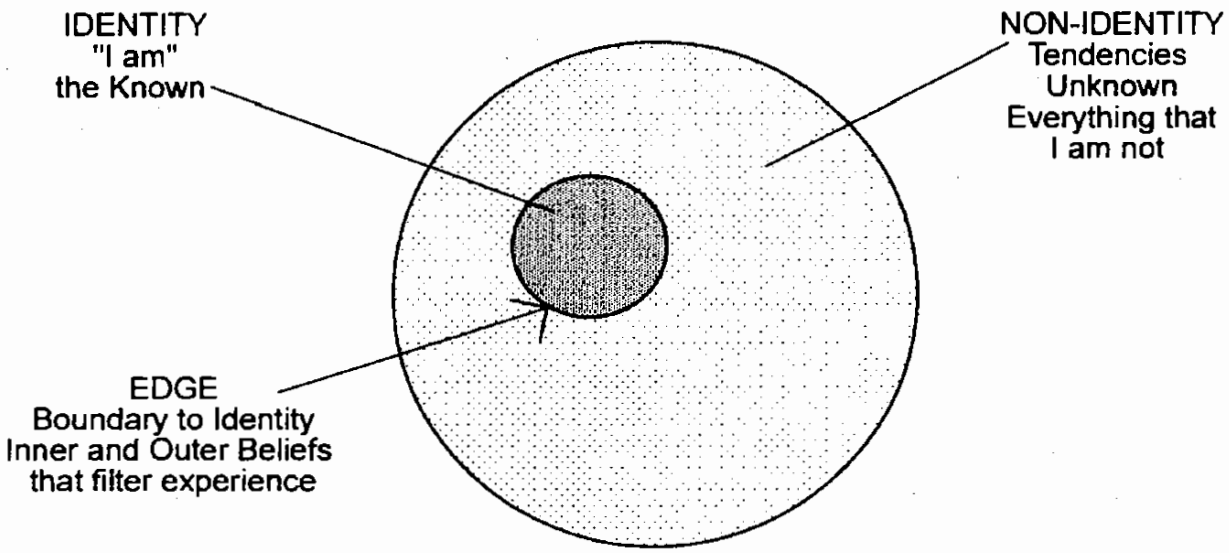
Mindell says that creating freedom, community and viable relationships has its price. It costs time and courage to learn how to sit in the fire of diversity. It means staying centred in the heat of trouble. It demands that we learn about small and large organisations, open city forums and tense street scenes. He says that if we step into leadership or facilitatorship without this learning, we may spend our time recapitulating the blunders of history. (Mindell 1995)

I want first of all to give a brief overview of the main ideas and philosophical base of Process Work. I will then focus on groups and group process. The second part of the paper focuses on the role of the leader, with an emphasis on the emerging role of eldership, and the notion of rank and privilege.

The Origins of Process Work

Process Work began with individually oriented dream and bodywork and has grown to include family and group work. It has its philosophical roots in physics, alchemy, Shamanism, Taoism and Jungian Psychology. From Shamanism it draws a basic concern with the potential of unexpected and unintended events, thoughts and perceptions for producing solutions to problems. Alchemy contributes the insight that raw experience gradually yields meaning and becomes useful when it is "cooked" or processed in a manner appropriate to the situation, as determined by constant observation of the effect which the "cooking" produces. Taoism points the way to an appreciation of the nature of all things and faith in the inherent "rightness" of events, no matter how painful or pathological they may appear at first glance. The Taoist view of life assumes that the way things are unfolding contain the basic elements necessary for solving human problems. Physics contributes analogies with concepts such as Field Theory and Quantum and Holographic Theories. Jungian Psychology provides some of the basic techniques to amplify and reveal the meaning of human experiences. It also provides a teleological view of reality - that human processes and external events are patterned towards a final unfolding of meaning.

Individuals usually find it difficult to give equal value to all aspects of their experience. We tend to identify ourselves in a particular way: we may be strong or weak, spiritual or worldly, social or more solitary. In so identifying ourselves, we tend to disavow those parts of our experience which conflict with that identity.



To live all aspects of our wholeness may bring us into conflict with the culture in which we live, it may violate our basic belief systems, or we may lack the skills to live these parts of ourselves in a particular life situation. The reluctance to live the less valued parts of our experience is called the "edge" because it is in a sense the edge or boundary of our personal identity. Edges are experiences of confinement. An important goal of Process Work is to help the individual explore the edges of their identity and to experiment with ways of gaining easier access to those parts of ourselves which are beyond that edge.

Process Work With Groups

Just as individuals may disavow parts of their experience which conflict with their identities, groups also are disturbed by their disavowed parts. To find a group's identity, ask it "who are we?" Members of a group who got together to work for world peace might say, "We are a group of peace-loving individuals". Students at University might reply, "We are here to learn and to respect our teacher's wisdom". The "We" of a group's answer tends to define its identity.

A group which identifies itself as peace-loving might then find itself in a heated and nearly violent debate between *two* factions that disagree about the proper path to world peace. University students may become dissatisfied with their teachers and express strong opinions about how they should be taught.

In the first case, a group which says "We are Peaceful" is experiencing

something close to war. However, it typically does not perceive this part of its experience. Conflict is beyond the boundaries of the group's identity and is disavowed by its members, even as it is occurring in their midst. The students in the second example may actually be trying to teach their professors how to be better teachers, but teaching staff may see this as a disturbing and unwanted rebellion. Both groups are having experiences beyond the edge of their identities that are therefore disavowed and are experienced as a disturbance which, if not processed, may lead to the destruction of the group.

Applied to Psychology, Holographic Theory implies that the whole can be found within each individual and that any person in a group setting is potentially capable of taking up any role in that group. Seeing the world through this analogy suggests that we change individual difficulties by working with world issues, and change world issues by working with an individual. Process Work gives us the concept of the "Global Dreambody", a multi-channeled information system, which like Jung's collective unconscious, and the anthropos myths of various cultures, assumes the fundamental connectedness of all things. It is from this base that we can make interventions at different levels of relationship – individual, couples, small or large groups. Mindell says that if we experience the world only as a disturber of our fate, we will never have that feeling for the world which is necessary to change it through changing ourselves. (Mindell, 1987, p 92)

Field Theory is also an important concept for understanding the Process Work way of working with groups. Imagine this organisation of NZAP as a large iceberg. Imagine that it floats in a sea or field, sometimes freely, sometimes connected to other groups and organisations. The leading people are placed high in the organisation, above the water, and they look to the future in order to direct the iceberg's path, while the members live below, supporting the whole group. Organisational development is based in part upon helping the whole iceberg work as a single unit. When trouble comes, the whole organisation is affected. A consultant is called in to analyse the problem and recommend solutions. The organisational development model works well for many situations, though some of its methods are based in the assumption that people behave in a mechanical fashion like parts of a machine.

Mindell proposes another approach, one that takes into account the jungle in which we live, a jungle of inexpressible emotions, and unnamed forces – the field or atmosphere Within which all our activities and communication take place. In order to depict the reality of a group or organisation, a new dimension

needs to be added to the iceberg. It should also include the influence of emotions, feelings, moods, spiritual visions and even paranormal events that permeate group life. These invisible influences have been described as shadow energies in physics, as the collective unconscious in Jungian Psychology, and as a morphogenetic field in Rupert Sheldrake's concept of the universe. The disavowed, dreamlike feelings that create currents and undertows under the surface would be included. Organisations need to be identified not only by their overt and identifiable structure, purposes and goals, but also by their relationship conflicts, jealousy and envy, as well as their altruistic drives, spiritual needs, and interest in the meaning of life.

We need to deal directly with these currents and undertows, with the atmosphere of the group – is it thick, jovial, tense, still, avoiding? A field can be felt or someone can make a picture of it. The field is made up of the issues we all bring, our moods, our background feelings, and our environment.

Fields are natural phenomena that include everyone, are omnipresent, and exert forces upon those in their midst. We think we manage or organise our lives and groups, but actually fields create and organise us as much as we organise them. Fields permeate everything and can be perceived through a variety of senses and experiences. They are in our dreams, body experiences, relationship problems, synchronicities, in the group and in the world around us. This multichanneled manner in which fields manifest means that when we work with fields and help them evolve, we must do so on many levels: through feelings, visions, movement, innerwork, relationship work and large group interaction.

If we are going to work with conflict then we need to have an appreciation of chaos. Chaos Theory, or the theory of non-linear, dynamic systems, has recently gained wide attention in the Social Sciences. Prigogine states that the ideas from Chaos Theory of instability and fluctuation are entering the Social Sciences. Human beings, groups and societies at large are "non-linear dynamic groups". Chaos Theory talks about "attractors". Attractors organise and make sense out of chaos. Attractors predict what type of order will appear out of chaos. For example in groups, the drive toward balance, freedom, and harmony, may be an attractor for our individual development. In Worldwork, conflict and moments of chaos are valued within group process because these can quickly create a deeper sense of community and a temporary resolution. Indeed Worldwork sees conflict as a profound teacher. Worldwork stresses recognition that we ourselves are part of every conflict around us and it utilises

our self-awareness skills to become part of the solution.

Following the Process

Some of the main ideas that help us follow a group process include first of all, the idea of roles and different polarities, through which the field expresses itself. We may feel strongly on one side, and then another. You may find yourself fluctuating between many roles. Another way to describe roles is timespirits which attempts to show that roles come and go over time. A role can indicate a more static state, but once we get into it, it flows and develops and changes, frequently disappearing after a time, especially if it has been fully expressed and represented. Viewing roles as timespirits means that during a group process we can move from role to role as the process 'cooks'. At times we can identify with one part of ourselves and at others times another part. Process Work states that the role is always bigger than the person and the person is more than the role. This means roles may be occupied by any individual in the group. It also means that the individual need not stay locked into one role but can move in and out of several roles according to how the individual is responding to the group process. Switching roles is a group intervention based upon the individual's awareness of their own changing experiences within the group, and is a means of awakening individual awareness and fluidity.

The term Ghost Roles means those roles that are not directly represented in the group. They are like ghosts or spirits which hang in the atmosphere and which the group finds itself reacting to. For example, when people are afraid of speaking up because they may be criticised, there Will be a Ghost role of a critic in the field that, if not represented, will continue to disturb the group.

Deep Democracy is a respect and love for nature in its deepest sense. It recognises the importance of representing the disavowed parts, the minorities, in order to make the situation whole. We support the parts of ourselves and our groups which we know well, but we need also to support the parts which we do not know and which we fear or reject. Deep Democracy, with its metaskills of compassion, love and respect, creates a safe container for all parts to come out.

Hot spots are extreme moments and emotionally charged encounters that come up again and again. They usually occur at the edge of the group's identity and way of operating. They are moments in a group when something is trying to happen and it doesn't. Instead a sudden, and sometimes subtle, disturbance comes and goes quite quickly. After the group the gossip might sound like "did

you notice what happened when so and so said that .... ?". The basic identity of the group remains unchanged and the unknown, disavowed aspects remain outside most of the participants' awareness.

Consensus means that all people present agree to go along with what the group is doing, for at least a short period of time as long as they later have a chance to disagree. Consensus accepts disagreement. However the disagreement is put off for the moment and can be picked up again if it hasn't been resolved by the previous process.

The methods of worldwork have been applied in city debates around political issues, in international conflicts, in businesses struggling for economic survival, in educational and spiritual organisations. They have been tested, changed and taught in more than thirty countries, in organisations including the military, multi-ethnic groups in conflict, and indigenous groups. They have had a surprising success with children under five and with people in psychotic and comatose states. Worldwork can be applied in groups ranging from three to a thousand.

Leadership

What then are the requirements of a leader in these non-linear, dynamic groups that we are part of? What skills and metaskills are needed for a person to sit in the midst of often turbulent and chaotic situations in group processes without getting destroyed, or the group disintegrating? By metaskills, I mean the feeling skills and attitudes that the leader brings to the group.

The majority of people deal with tensions in a group in three ways:

1. They repress the tensions and try to be nice to each other
2. They analyse the tensions and try to change themselves and others
3. They get into the tensions and hurt one another

Worldwork comes up with another way which calls for the following requirements in a leader. First of all we need information about the group we are facilitating. We also need awareness. Awareness of the field, its communication edges and hot spots. Over and above information and awareness we need metaskills. They are crucial. It is not so much what we do that brings success, but how we do it. Mindell points out that those of us who do worldwork, do it because we have an interest in people and a love for them. We care about who they are and what is happening to them. This is, he says, the metaskill of the Elder (Mindell 1995).

The traditional role of the leader is that the leader leads. In the Process Work model there are a number of different things about a leader:

1. The leader is the follower of the process. The process itself is the leader. "New order can always be discovered in apparent chaos if we have the tolerance and patience to follow instead of programming nature, if we learn to live with the moving ground instead of pressing for solutions" (Mindell 1992).
2. The leader needs to bring awareness to the process and to help it to unfold.
3. The ability to do this depends on the degree of awareness that he/she has.
4. Leadership within this model is a role that can be shared and occupied by anyone who happens to have the awareness at the time.
5. The leader must have the well-being of the whole at heart and have a feeling of compassion for all the parts, those that feel alienated as well as those that alienate. The meta-skill of compassion is developed through such things as inner development, outer role models and personal gift.

Mindell likens training for leadership to that of training to be a martial artist. It is basically about awareness training – learning to follow a field's energy, ki or process. This training enables the leader to sense the field in order to discover hidden and ghost roles. It takes practice in reading signals and fine-tuning intuitive powers to discover those roles.

Allied to this is the leader's ability to do inner-work. Without the ability to process our own complexes and conflicts on the spot, we are likely to contribute more to the problem than to its momentary solution. Inner work also enables us to develop the abilities of tolerating chaos and metacommunicating in the midst of it. It also helps the leader to develop the capacity for detachment. It is difficult to remain detached if we want to be loved, correct or successful. The Process Work concept of Detachment refers to the ability to remain neutral in the heat of conflict. This ability comes from being "shot at" several times and is a result of having worked through my own unresolved rage. This brings about a natural detachment from my own identity that enables me to respect the courage I see in the most impossible person and be open to what he/she can teach me. When we have something personal to achieve we cannot be neutral and accepting of the group's process.

Elders have more than leadership abilities. They have the feeling skills and attitudes needed to be of service to others and the process. The following is a summary of what differentiates elders:

- The traditional leader follows the rules of order; the elder obeys the spirit.
- The leader seeks a majority; the elder stands for everyone.
- The leader sees trouble and tries to stop it., the elder sees the troublemaker as a possible teacher.
- The leader strives to be honest; the elder tries to show the truth in everything.
- The democratic leader supports democracy; the elder does this, too, but also listens to disturbers and ghosts.
- Leaders try to be better at their jobs; elders try to get others to be elders.
- Leaders try to be wise; elders have no minds of their own. They follow the events of nature.
- The leader takes time to reflect; the elder takes only a moment to notice what is happening.
- The leader knows; the elder learns.
- The leader tries to act; the elder lets things be.
- The leader needs a strategy; the elder studies the moment.
- The leader follows a plan; the elder honours the direction of a mysterious and unknown river. (Mindell, 1995, p 184)

Rank and Privilege

I cannot talk about leadership and Worldwork without mentioning the concepts of rank and privilege; power and abuse. This is an important aspect of our work. I once facilitated a personal growth group with a colleague. In that group were some very outspoken and strong men and women as well as some quieter ones, as is fairly typical. This was in the early days of my learning about leadership of "growth groups" and I was apprehensive about the whole experience. I was first of all somewhat intimidated by my colleague even though he was a good friend and we were both experienced therapists. He was more outgoing, more engaging than I and I found myself becoming more and more reserved in the group as the weeks went by. I was also scared of the strong people in the group and feared being attacked by them. I found myself supporting the quieter subgroup. I did not feel good about the job I did there but it has taught me so much. I realise now that I was unaware of my rank as

a leader and a therapist, and so left myself open to attack from the group and from my own inner critic. I was also caught up in my personal abuse story which involved long term public shaming and attacks from parents and teachers that I had no way of defending.

"Rank" refers to a person's power position in any given system or social/interpersonal context. There are different types of rank – economical, social, psychological, spiritual. "Privilege" refers to the benefits and advantages of a person's rank/power position. Thus rank is the sum of all the privileges a person has. One of our central tasks in creating sustainable change in our communities is to become aware of our rank and privilege, to value it and share it. Everyone who belongs to the mainstream has in some way certain rank and privilege. We might ask what are some of the privileges of a Psychotherapist? Appreciating our privileges means that we are less likely to abuse our rank.

Being unconscious of our rank and power, means we are less effective in leadership and more vulnerable to our own roundedness and the roundedness of others by tapping into our own abuse stories which leaves us very one sided and unable to support the whole. This is what happened to me in the group. It can also lead us to keep out or ignore those who are different, or difficult, anyone whom the mainstream feels is too angry, radical, crazy, vengeful or weird. Worldwork includes helping individuals and groups embrace these disavowed parts of themselves against these labels. Thus, racism, sexism, homophobia, for example are given the opportunity to do more than look for legal and political solutions, that are opened up to do the identity work, the healing and the education required for sustainable change.

Process work focuses a lot on issues of abuse in order to secure the participation of all groups and members of groups, knowing that deep democratic change requires the participation and consensus of all. Abuse is "the unfair use of physical, psychological or social power against others who are unable to defend themselves, because they do not have equal physical, psychological or social power." (Mindell 1995, p 107). My experience in the above group and in other consequent groups has also taught me the importance of doing my own abuse work to enable me to support all parts of the group field and when necessary to "sit in the fire" of the group's conflict.

In Conclusion

Mindell says: "New patterns are trying to emerge, but if we are not prepared for turbulent situations, these patterns will create pain and chaos instead of new lifestyles." (1992)

I believe, as therapists, we need the courage, the discipline and heartful metaskills as facilitators so that new patterns can emerge which care for and honour difference and work towards at least temporary integration in groups.

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Logotherapy and Existential Analysis

"Man's Search for Meaning" 51 Years On

Christopher Wurm

Abstract

50 years ago NZAP was founded - one year after the publication of Professor Viktor Frankl's book, *Man's Search for Meaning* published on his release from a Nazi concentration camp in 1946. Initially inspired by Freud, Frankl later tried to integrate the biological and psychological dimensions with a specifically human dimension, the noetic or spiritual dimension. Logotherapy and Existential Analysis aims to counter some of the self-fulfilling prophesies, introspection and therapeutic nihilism inherent in other treatments. Logotherapy aims to enable the patient to identify and fulfil meaning potentialities, such as by bringing out their capacity for self-transcendence.

Logotherapy and Existential Analysis can be used clinically in situations as diverse as mid-life crisis, fear of death, phobias and anxiety, alcohol dependence and other problems of living. There has also been some research interest in existential approaches over many years in New Zealand.

Historical Background

Viktor Emil Frankl was born on March 26th, 1905 in Vienna. His father had begun as a medical student, but soon had to get work as a public servant in the Department of Education due to economic pressures, as his father was a bookbinder. (Bazzi and Fizzotti 1986)

Viktor Frankl's mother came from a family with its roots in Prague, but with frequent contact with Viennese culture. He had very happy memories of being indulged by his parents and their friends. (Frankl 1981)

WWI and the downturn in the fortunes of the Austro-Hungarian Empire brought hardship to the family, and Frankl and his younger brother and sister

(both born in South Moravia - Südmähren, the same part of the Empire as Freud's birthplace, Freiburg) begged for bread and stole pumpkins from the fields. After WWI he returned to Vienna and entered Sigmund Freud's old Grammar School (Realgymnasium) where he suddenly showed his interest in Natural Science. However, Frankl tells the story that he disagreed passionately with his chemistry teacher, who said that ultimately life is nothing but a process of oxidation and reduction, and the thirteen year old student broke with etiquette and sprang to his feet without putting his hand up, saying "But what then is the meaning of life?"

His concern at reductionism and nihilism intensified when one of his school companions was found having committed suicide with a book by Friedrich Nietzsche in his hands. Soon after this, Frankl began to write to the now well-known neurologist, Sigmund Freud. ... And Freud kept writing back.

Frankl's first articles were published in the youth section of a Vienna paper, followed shortly (1924) by an article in the *International Journal of Psychoanalysis* (edited by Freud, who had already had his first operation for oral cancer in 1923).

In 1925 Frankl had an article published in Adler's *International Review of Individual Psychology* with the title 'Psychotherapy and World View'. Frankl was already moving away from Freud, believing that Individual Psychology was much better suited to consider questions about the meaning of life than Psychoanalysis, especially when Freud said "The moment someone asks himself the meaning of life, he is sick."

Logotherapy and Existential Analysis

Key concepts in Frankl's approach are the existence of the 'Noetic' or spiritual dimension, and 'the Will to Meaning'. He defines the 'Noetic' dimension as the dimension which gives rise to the specifically human phenomena of self-transcendence, conscience and humour. It is related to, but distinct from the physical and psychological dimensions. While some disorders may be due to physical changes, such as thyroid overactivity causing irritability and tremor, Frankl affirms the usefulness of psychodynamic theory and learning theory in explaining other conditions, such as hysterical conversion reaction. However, without the noetic dimension, Frankl asserts that it is not possible to explain many important aspects of human experience and behaviour.

While he acknowledges the existence of the unconscious, including drives such

as libido, Frankl emphasises that humans have a capacity to choose to go against their instincts and drives, in order to act in ways that are compatible with their personal values. "We are concerned above all with man's freedom to accept or reject his instincts." (Frankl 1973) Frankl sees the conscience as an important part of the noetic dimension – not the internalisation of parental reinforcements as in Freud's superego. In terms of the "Will to Meaning", Frankl highlights the significance of this being a will, rather than a drive as in Freud's *Lustprinzip* (Pleasure Principle).

Empirical Research and the Noetic Dimension

By definition, the Noetic Dimension relates to intangible processes and can therefore not be directly measured. Yalom points out the irony of the consequences of limiting research to those phenomena which are readily observable and measurable. "Again and again one encounters a basic fact of life in psychotherapy research: the precision of the result is directly proportional to the triviality of the variables studied. A strange type of science!" (Yalom 1980 p 24)

> "...an entire class of potentially important variables is being overlooked in current research and (to a lesser extent) practice in the area of addictive behaviours. These are *spiritual*variables. By "spiritual" I refer to transcendent processes that supersede ordinary material existence. This includes, but is not limited to, systems of religion... At our present state of understanding, we are accounting for only a minority of variance in addictive behaviours and treatment outcomes through psychological, biological and social variables combined. That is, most of the variability in the onset, process and outcome of addictions remains unexplained at present, and we can ill afford to ignore any class of variables with potential explanatory power." (Miller 1990)

In spite of Miller's comments, there are several research tools which can be used to examine existential constructs empirically. Probably the best known and most widely used is the Purpose in Life test (PIL). (Crumbaugh and Maholick 1964). Thirty three years after its development, it has been cited in many research papers. I will quote from just two in this article, and refer readers to the work of William Black for a more detailed assessment.

The PIL is a test consisting of 20 items with a seven point Likert-type scale. One Australian study where 58 university students completed the PIL contrasted this with their written response to an open ended question designed

to assess their world view. (Sharpe and Viney 1973) Their responses were evaluated by 3 clinical psychologists who assessed each response as either positive or negative on 3 criteria relating to evaluation of the world, purpose, and self-transcendent goals. Inter-rater reliability was measured. All three judges agreed strongly for purpose and self transcendent goals, but two of the judges sometimes gave contrasting ratings on evaluation of the world. Even on this point, they agreed more often than they disagreed (chi = 6.79, $P < 0.01$). Four factor ANOVA was carried out examining the effects of subject and ratings for PIL scores and ratings for evaluation of the world, purpose and self transcendent goals. The three characteristics of the world view protocols were calculated to account for 61% of the variance of PIL scores.

However, Dyck has expressed concerns that the original design of the PIL is flawed. (Dyck 1987) He argues that the test was designed to examine two sets of criteria, namely existential relevance and the ability to discriminate patients from non patients. As well as citing other instances from the literature, Dyck cited his own research which showed significant correlation between the PIL and the Beck Depression Inventory (r = - .58) the Centre for Epidemiological Studies - Depression Scale (r = - .53) and the Automatic Thoughts Questionnaire (r = - .58). He refers to other evidence that indicates that the PIL is not just a measure of depression. He concludes that the PIL may reflect a construct related to existential vacuum, although he feels that it would be better to development a replacement measure, perhaps drawing on related constructs, such as anomie.

A new psychometric test developed in Vienna has recently been translated into English, but only the German version has been validated at this stage. It is called the Existenzskala (Existential Scale) and its authors designed it to measure levels of self-transcendence, self-detachment, freedom and responsibility, as well as giving an overall score. (Orgler and Längle 1990, 1996)

Dr William Black has written an excellent review of the research literature on Purpose in Life and addictive behaviour. (Black 1991) His keynote address in Sydney at the 5th International Conference on the Treatment of Addictive Behaviours (ICTAB-5) gave a fascinating overview of the relationship between philosophy and psychology. He drew parallels between existentialism and social learning theory, particularly Bandura's reciprocal determinism and self-efficacy. Whereas Existentialism and Behaviourism have always been considered to be diametrically opposed on the issue of free will vs determinism, Bandura

postulated a "continuous reciprocal interaction between behavioural, cognitive and environmental influences." (Bandura 1978) This is in contrast to BF Skinner who apparently viewed human behaviour as totally determined by the environment.

I found Black's observations a great help in formulating my own ideas on the application of Frankl's work in the area of alcohol dependence and related problems. (Wurm 1997a) I have also been greatly influenced by Dr Leslie Drew's concept of Alcohol Dependence as a "Way of Life Leading to Predicaments." (Drew 1986) This takes into account the role of choice when a person decides to find and use alcohol, while acknowledging that social, psychological and physiological consequences such as withdrawal symptoms may make it hard to choose differently. Sometimes the pattern of drinking becomes so entrenched that it is hard to see that there are conscious decisions involved. (Wurm 1997b)

Some of Black's earlier research examined existential issues in prison inmates and people with alcohol dependence. He was also Honorary Secretary of NZAP for several years. His paper also introduced me to the work of Emmy van Deurzen-Smith, who gave one of the 3 keynote lectures at the opening ceremony of the 1st Congress of the World Council for Psychotherapy in June 1996 in Vienna. Originally from the Netherlands, she later studied in France and then came to England to work with RD Laing. She subsequently became Dean of Psychotherapy and Counselling at Regent's College in London and chaired the Society for Existential Analysis for several years until 1993 when she became more involved with the UK Council for Psychotherapy. Her work differs from Frankl's in its emphasis, but still has much in common. The "Existential Analysis" promoted by the Society for Existential Analysis in the UK is based more on Binswanger's *"Daseinsanalyse"*, rather than Frankl's *"Existenzanalyse"*. Both terms have unfortunately been translated from German into English with the same phrase, "Existential Analysis" which leads to some confusion. Each, of course, contrasts with Freud's Psychoanalysis.

Frankl first spoke of *"Existenzanalyse"* in 1932. He distinguishes his approach from Binswanger's by pointing out that "Daseinsanalyse" accentuates " the illumination of existence understood in the sense of being. Existential Analysis, on the other hand, over and above all illumination of *being,* dares to make the advance to an illumination of meaning. The accent thus shifts from an illumination of ontic-ontological realities to an illumination of the possibilities of meaning." (Frankl 1967 p. 133-134)

The current Chair of the Society for Existential Analysis is Dr Ernesto Spinelli, and his writing also elaborates on the work of Husserl, Heidegger, Binswanger, Laing and van Deurzen-Smith. (Spinelli 1989, 1992, 1994)

Another important figure in the development of Existential Psychotherapy in New Zealand was Dr R W Medlicott from Ashburn Hall. (Medlicott 1969) This paper was quoted by Frankl in his discussion of the treatment of anxiety, with particular reference to the technique of "Paradoxical Intention." (Frankl 1978 p. 142) "Medlicott (1969) used paradoxical intention to influence not only the patient's sleep, but also his dreams. He applied the technique especially in phobic cases and found it extremely helpful even to an analytically oriented psychiatrist, he reported." While many modern (and "post-modern") therapists express enthusiasm for paradoxical strategies, Frankl was one of the first to systematically describe the therapeutic use of paradox. (Frankl 1967; Ascher 1989)

More recently, David Simpson has spoken about the relevance of Existentialism to contemporary New Zealand. (Simpson 1996) He believes that many New Zealanders see Existential philosophy as irrelevant and outdated, "Colleagues remind me that the writers I quote, from Kierkegaard to Heidegger, Sartre, Kafka or Frankl were all born in a Europe characterised by invasion, revolution, holocaust or war." Simpson, however sees considerable scope for the application of key Existential ideas in New Zealand, particularly at a time when the teenage suicide rate is the highest in the world. He quotes Irvin Yalom, Viktor Frankl and Carl Jung all recognising lack of meaning as a major clinical problem, distinct from other recognised forms of psychiatric illness. Simpson emphasises that not all existential writing is necessarily helpful. He acknowledges Sartre as a highly gifted writer and psychological observer. However, he adds; "I find his psychology pessimistic. Like Viktor Frankl, I see working to help clients resolve existential crises as a most positive, pragmatic and useful endeavour".

Philosophy and Psychotherapy

Existential fears are part of what it is to be human. Anxiety is not viewed simply as a symptom to be obliterated with tranquillisers, but a part of life, which may be an important way of bringing attention to discrepancies between one's goals and reality. "Decisions are difficult for many reasons, some reaching down into the very socket of being..... for every yes there must be a no."
(Yalom 1991 p 10)

> "The aim of existential counselling is to clarify, reflect upon and understand life. Problems in living are confronted and life's possibilities and boundaries are explored... Clients are considered not to be ill but sick of life or clumsy at living...
>
> The assistance provided is aimed at finding direction in life by gaining insight into its workings. The process is one of reflection on one's goals and intentions and on one's general attitude towards living. The focus is therefore on life itself, rather than on one's personality." (van Deurzen-Smith 1988 p. 20-21)

> "The majority of so-called mental illnesses encountered by family physicians, however, are existential crises, and these are problems of the human spirit rather than illnesses." (McWhinney 1989 p. 68)

Existentialism shares its historical origins with Phenomenology, but relatively few psychotherapists have any formal training in philosophy of any kind. Professor PJV Beumont has written about the importance of Phenomenology in the development of psychiatry, particularly in Australia and New Zealand. (Beumont 1992) Phenomenology is named after the Greek word for appearance. This reminds us that we only know about anything through our experiences, and these only relate to the external appearance, rather than things as they really are. This whole approach has been refined by Husserl and Heidegger. Spinelli emphasises the benefits in clinical practice of listening and exploring with an open mind. (Spinelli 1989) Then it is possible to obtain a clear description of what that patient has experienced. It is still crucial to avoid jumping to conclusions. If carefully observed, these guidelines can help avoid some of the pitfalls of making grossly misguided interpretations based on the therapist's enthusiasm for any theoretical system. I should immediately confess that it is equally possible to make this kind of mistake in existential psychotherapy!

One of Frankl's key techniques is the use of "Socratic Dialogue". This is, of course neither new, nor exclusive to existential psychotherapy. However it illustrates clearly the importance of the therapist taking care to offer questions, rather than answers.

> "The client should be asked, what he or she anticipates would occur if drinking continued unchanged. The purpose of this question is Socratic: to elicit awareness, which is then consolidated by reflection." (Miller 1983 p. 163)

> "Education is more than teaching, and Socrates' chief aim was not to impart information but to make the other man think, and thus to make him a better person. .....He practised 'midwifery', his mother's profession, in bringing men's hidden thoughts to life." (Ehrenberg 1973 p 381)

Similarly today the Professor of Psychiatry at Stanford University, Irvin Yalom exhorts us to do the same in his classic textbook, "Existential Psychotherapy" when he says: "The therapist's *raison d'être* is to be midwife to the birth of the patient's yet unlived life." (Yalom 1980 p. 408)

Much has happened over 51 years, but despite the passage of time and the diversity of cultures, philosophy has always had much to offer psychotherapy, whether in Ancient Greece, wartime Europe or contemporary New Zealand. Once, the closest thing to psychotherapy was a discussion with a philosopher. Later people brought their concerns to priests, who were also the first doctors in many cultures. As clinicians, we would now expect a non-clinical counsellor to recognise the limits of their training and refer on clients who appear to have more serious psychological problems. If clients come to us with serious spiritual or philosophical questions, don't we have a similar obligation to develop our own expertise or refer accordingly?

Perhaps it is time for psychotherapists to consider the origins of their role and reflect on the parallels with philosophy and ministry. There are, of course, major differences, but what do we risk, if we forget - or deny - the similarities?

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