Forum THE JOURNAL OF

THE NEW ZEALAND ASSOCIATION OF PSYCHOTHERAPISTS (INC.)

TE ROOPUU WHAKAORA HINENGARO

VOL. 4 • June 1998

NZAP

Forum

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Volume 4, June 1998

Editorial

In this 1998 edition of the NZAP Forum, the fourth now to be published, the articles come largely from papers that were presented at the Auckland Conference held in February. The conference organisers chose as the theme *Boundaries and Space, Structure and Creativity*. The papers collected in this volume attest to this wide-ranging yet contained abstraction. They also mirror in their own way the Association's nature as an umbrella organisation which holds space for different creative expressions of psychotherapy, while holding firm to common core competencies of practice, and increasingly clear professional definition in the community it serves.

The Conference theme was also reflected in its structure. There were fewer formal presentations of papers and workshops in order to make space for us to come together in small groups and in the large group of the whole Conference. I suspect that in the life of the Association this was a necessary developmental process.

With the Association having grown quickly larger of recent years, there were impassioned murmurs that we were in danger of no longer knowing who we were as an organisation. In Auckland we were offered the creative opportunity to come together several times over the course of the weekend in order to engage the process of remembering ourselves for this time. The fact that we could all sit together was vital, as was the recognition that this was a process we had begun but by no means completed. We must take care now that we do not emulate the narcissistic splitting too often manifested in our profession when practitioners of different modalities have come together. There are healthier ways of developing our professional identity.

Our professional identity also needs a strong voice in the wider political environment in health. Political philosophies in this environment are characterised by the funding of treatment options that are outcome drive from a predominantly behavioural, because statistically supported, standpoint. As practitioners we do attend to our outcomes, but need to produce much more in the way of research material. I look forward to reports on such projects appearing in this publication in the future. In doing this we must take care that we do not compromise the need to preserve the space at the therapeutic core of our professional practice and become simply outcome driven ourselves.

We have to be mindful that in taking care with our professional identity, we preserve space around our professional constructs as well. This space is the essence of our professional creativity. We listen well. I hope that the articles in here will be read with this in mind. That way there can be some experiencing of what Theodore Zeldin has called a 'good conversation', characterised by a sense of real engagement, by a sense of being deeply satisfying, of being intimate, and being unafraid to manifest heart and humour. I would hope our clients and patients experience good conversation with us in their therapeutic sessions. I hope that we experience this collegially. I trust you will find it in these pages.

Peter Hubbard

Editorial Group

Contents

The Structuring of the "I"

Richard O'Neill-Dean

Abstract

A theory of the formation and nature of the "I" based on identification in the Mirror Phase is outlined. This theory is illustrated by reference to formative moments in the psychologies of two historical figures. Its therapeutic usefulness is shown in relation to a clinical vignette.

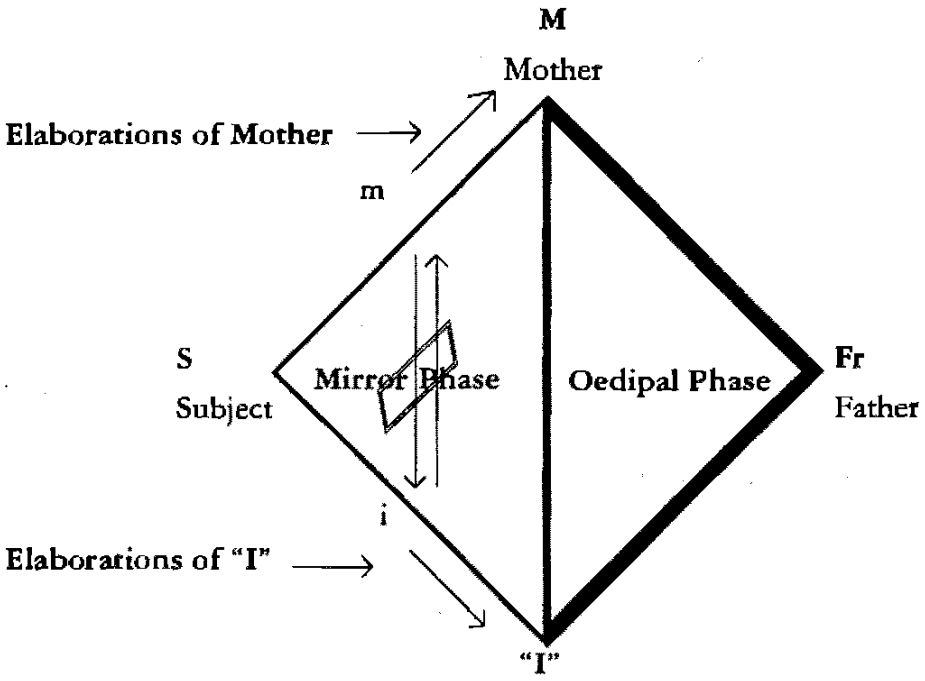
Introduction

To try to understand the structure of the Subject, (the person in analysis or psychotherapy), and particularly how their "I" has come into being, I make reference to Laplanche and Pontalis' *The Language of Psycho-Analysis*. Under the heading of 'The Mirror Phase' there appears:

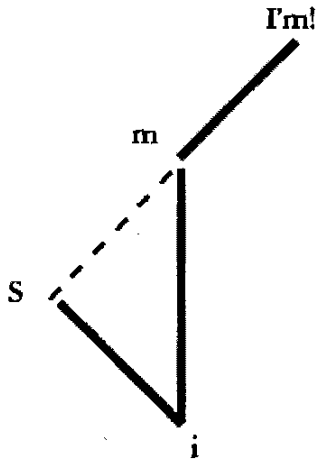
> As far as the structure of the subject is concerned, the mirror phase is said to represent a genetic moment: the setting up of the first roughcast of the ego. What happens is that the infant perceives in the image of its counterpart – or in its own mirror image – a form (Gestalt) in which it anticipates a bodily unity which it still objectively lacks (whence its 'jubilation'): in other words, it identifies with this image. This primordial experience is basic to the imaginary nature of the ego, which is constituted right from the start as an 'ideal ego' and as the 'root of secondary identifications'. It is obvious that from this point of view the subject cannot be equated with the ego, since the latter is an imaginary agency in which the subject tends to become alienated.

This can best be understood to mean that out of the raw material the infant begins to elaborate their experience along two axes. There is the development of a sense of the object world (see Diagram 1) from a very preliminary sense of Mother (m) in the merged state to a more filled-out and firmed-up sense of her (M) in the oedipal phase. Concurrent with this there is the development of a sense of "I" from a very preliminary state (i) in a mirror merger with mother (m) to a similarly more filled-out and firmed-up sense of "I" (I) in the Oedipal development, the entry into the world of Other-than-Mother (Fr). [Diagram 1a]

Diagram 1: The "I" in Development



The quotation I have chosen suggests to me, though, that there is one very simple but important detail in this original structuring of the "I" that often escapes attention. This is represented or highlighted in the lower abstraction from the upper more complex matrix of Diagram 1. First it must be emphasized that the Subject is born into an experience of "being-in-bits" or of not quite being joined-up, the pre-I equivalent of part objects in the development of the object world. The theory of the mirror phase points toward the idea that this being-in-bits is escaped from by a linking up imaginatively with a preliminary sense of mother (m) in the merged mirror relationship to form the first roughcast of the "I" (I'm!) So far, pure Lacan. [Diagram 1b]



What have others said? R D Laing said that "we have taken the other into our hearts and we have called them ourselves." D W Winnicott said something to the effect that the baby sees itself as the sparkle in the mother's eye. More succinctly, Wilfred Bion said that "in the analysis I aim to introduce the person to themselves!"

If it is possible to suspend disbelief and go along with the idea of this mirror phase (Primary) identification and take it seriously, then it has some very fruitful implications in terms of the underlying characteristics of the "I" that stem from it:

Characteristics of the "I" that stem from the Mirror Phase.

1. The desires of the "I" are the desires of the other, through mirror identification, and as such are destined to be frustrating to the subject. In other words, the desires of the "I" are essentially endless and unfulfillable.

   A moment's self-reflection will reveal this to be so. Indeed, that it is so underpins our whole consumer driven and advertising driven world. Here lies the source of the "shopper's high", that elusive promise of the achievement of Desire.

2. This mirror identification, as the very core and the basis of the "I', brings with it fantasies central to the merged mirror-relationship. These fantasies – of Omnipotence, Immortality and Bisexuality – are fundamental to the "I".

   Just to take one of these as illustrative, it has often struck me how difficult and beneficial it can be to be brought into close awareness of one's own mortality, at least to some degree. Those who have been, are deeply changed by it – often to the good in relation to their Narcissism.

3. When this "I", with its desires and fantasies, is put into question (as in a therapeutically induced regression), then anxiety and aggressive rage are unavoidable, in response to the threatened unmasking of the illusion of the "I" and its fear of an underlying state of being–in-bits. Indeed fantasies of this state are almost sure to emerge in the course of such a treatment.

   I like to think here of the story of Rumplestiltskin and his Narcissistic rage when his name, that best token of the "I", is taken out of his magic control. In such a rage he falls through the floor, an image for me of Regression towards a loss of the "I" structuring.

A British comedian was asked what he wanted for his epitaph. He suggested: "I knew this would happen." The reason we laugh is that in fact we *don't*, in our unconscious mind, 'know that it will happen' half as much as we might think we do.

In struggling with the thoughts for this paper it has come to me that, in a sense, our developmental task in striving for emotional growth is to be not so much tied up psychologically to our births but rather to our mortality, our deaths, and so make the best of our lives. In other words for emotional growth we need to free ourselves from the Narcissistic illusions of the "I".

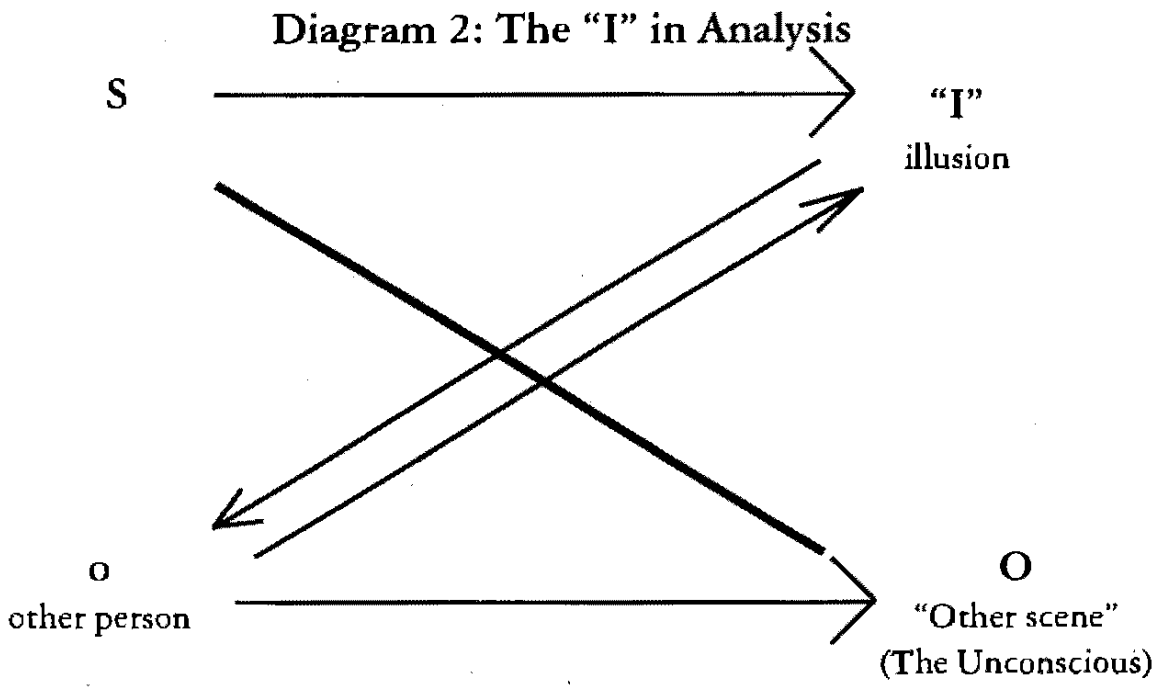
How can this be achieved? Here it is useful to look from a purely psychological perspective at the historical stories behind two cultural icons.

For me the story of Jesus' time in the desert, a productive self analysis, is to be taken at face value. A period of perhaps six weeks of fasting and meditation bring about the temporary overwhelming of consciousness by various hallucinations of a regressive nature to emerge as illusions of omnipotence in its various guises (being able to fly, create wealth, possess unlimited power etc.). These are recognized for what they are and renounced towards the goal of emotional growth.

A similar theme is revealed in the story of Prince Siddartha, beautifully portrayed in the film *The Little Buddha* by Bertolucci. It is well worth watching this film to see the moments that, very similarly to the Jesus story, lead up to his "enlightenment". Here more specifically the "I" (ego) is renounced as "pure illusion".

What has all this got to do with analysis or therapy? These profound resolutions of the "I" are not commonplace. It is interesting however to see that, using a slightly different language, many theories of psychopathology and of emotional growth put the resolution of Narcissism, itself a mirror metaphor, in the central place. Much of our clinical endeavour and also of our personal or self-analysis is caught in the tension between trying to achieve a resolution of Narcissism and, of course, trying not to (because it is so very painful).

What happens when the "I", seen in this way, is brought into the analysis? Diagram 2 shows that the Subject (S) in analysis has a view of themselves, ("I"), that is in important respects an illusion. Let us imagine something such as "I am an innocent and helpless victim of this cruel and heartless world". This is presented to the other person (o), the analyst or therapist and as such it seeks



affirmation or support: something like "Tell me 'Yes, indeed it is so.' " Perhaps the therapist would, if analytically inclined, be reserved in providing this affirmation, unseating the conversation towards that "other scene" of Freud's, the unconscious (O), so that the Subject is to some degree further informed of their nature and the illusions of their "I" from the unconscious. This is an "interpretation", (O®S). [Diagram #2]

A Clinical Vignette

I would like to tell a story from my own clinical experience to give some more ordinary clinical perspective on all this.

The person is a young woman who has suffered very privately, almost secretively, since her earliest years from a knowledge that her body is in fact rotting, decaying, crawling with bugs, stinking. She has lived in this persecuted, almost delusional world, driven to excesses of washing in a desperate attempt to combat this corporal putrefaction.

The analysis has been characterized by a mode that we have together come to know as "confetti thinking". Myriads of tiny scraps of individually more or less coherent image, experience, emotion and thought swirl in a snow storm that is, as a whole, utterly meaningless and, for great periods of time, impenetrable: fragments completely without order in time or place. I find myself dazed, confused, hopeless, sometimes almost put to sleep. This worries me and often I feel quite reprehensible, a disgrace to the profession, perhaps myself seriously ill. However, it is worth bearing with these difficult feelings of my own. When

I try to struggle against them it seems to make matters worse. If I give myself over to them, from time to time meaning coalesces in my mind as if, with stillness, the confetti fragments settle out to some coherent collage and enable me to give something back, say something useful so that a new part of the story or history may fall into place.

This cyclic process revolving between meaningless confetti and the emergence of meaning may be spread over weeks or even months. I have the feeling at this particular phase in the therapeutic work I am describing that the gradual development of meaning is again imminent. Somehow there is a sense of some hideous truth looming. Something almost too awful to be told in a story already wealthy with awfulness. Gradually the analysis is imbued with the actual smell of rotting flesh – not just "meat" but "flesh". Then suddenly one day it is visible there before us, utterly shattering, a vivid memory recalled from early childhood. Tucked away in a room at the back of the chapel, (this in an enclave of the community given over to the severest religious fundamentalism), the child stumbles on a hidden sack. Inside, groresque beyond words, infant bodies rotting, every detail visible despite the decay, It is hard to convey how shattering this is, even for me at one remove.

The next time we meet, rhere appears on the stage (for we must remember the analytic space is a stage) a shadowy figure who tells the child:- "that's where the farm-girls' unwanted babies go. You can see they're babies – look at their little hands". The recovery of this memory, in its two stages, is as compelling as it is dreadful. The smell is choking. The babies' bodies are crawling with maggots. There is an overwhelming sense of something terribly bad, sinister, going on. Here is organized infanticide.

I have remained attentive but quiet over these sessions but now, in my mind linking it with an earlier reference to life in the settlement, I voice my own association to the effect that small animals, when skinned can look very like a human foetus. This is vehemently refuted by the angry retort " but rabbits don't have hands!" I ask where the rabbits come from, since we had previously mentioned only possums in the life of this township. And possums do have hands, don't they?

It is time for us to finish our session.

At our next meeting, to my surprise we have moved to what seems to be an unrelated topic, the story of how this young woman had been tricked in her adult life by her husband, who had invented a whole falsehood around a murder

he claimed to have committed. When she discovered the fabrication, which had been used by him for years to exercise an abusive control over the direction of their marriage, she became so enraged she made a serious attempt to kill them both.

When asked why we are talking about this now, she says that after the previous session she had been unable to go to work but had returned home in a similarly blind rage – "blind" because she could not connect the rage to anything.

I say I think it must have had to do with what we had been talking about in the previous session: the rage and despair at having been fooled all her life about the possum carcasses being dead babies.

After this session I really fear for her that she might go out and kill herself. It is no longer a blind rage. The drama threatens to over-flow the stage.

Subsequent to these sessions, we came to realize that it wasn't a meaningless trick that had been played, but rather in that childhood moment in some out-house at the back of the chapel she had stumbled on an image, a distorted mirror in the shape of a neglected sack of possum carcasses that gave form in the "I" to a previously unformed feeling that she herself was an unwanted baby. "So that's what I am, one of those unwanted babies crawling with bugs (a childhood word for maggots) and stinking rotten". Nobody had even played the trick – ideation had been assembled from fragments of information in the child's mind, stories of women being "big with babies", then "not big any more". Where do the babies go? All of this against a background of Minnie Dean and the Southland lore.

As some measure of the therapeutic gain derived from this work, it was interesting to see that, in the working through, it became possible for her one morning in the succeeding week to organise unconsciously to miss the alarm and sleep in. This meant coming to see me without any morning shower, unheard of in her life till then. Remember this was a person who till that time had been compelled and 'lived by' her need to wash often for hours on end. Four to six weeks after the reported sessions she was able to say:- "there's no more filthy smells – no more bugs – it's all washed clean", and "I can tell a story and start at the beginning and tell the whole story right through to the end". These benefits have by and large remained.

But the point of this story is not to wave around one of those all too rare moments of striking clinical progress. Rather this story illustrates very well the way in which the "I" is open to change because it is structured in the way that

it is. In this example it is only one aspect of the "I" that is being worked with, a part based on a single moment of identification. A distorting mirror, the possum carcasses, allows the idea: "I" am that unwanted, rotting baby. When this disturbing aspect of the "I" can be analysed so that the illusory moment of its formation can be seen, it no longer captivates the subject. The desires of that "I" – here for an impossible cleanliness – no longer have a hold on the subject.

As an addendum, looking back over this work, I find myself a bit chastened. What if I contrast these above-mentioned therapeutic gains to the probably endless inventions in the Imaginary if I had been tempted, as I very well might have been, to affirm the "I" in its illusory aspect on the basis of my own fantasy world?: "Yes, we have uncovered a terrible crime. Here, indeed, is organised infanticide." It occurs to me that such a course may not be as unlikely or unusual in our work as it might at first seem, providing, as it would, a well-spring for stories of ritual abuse and the like. Do these stories in some cases bear a resemblance to material based on fantasies of the torments of a Body-in-bits?

Conclusion

This theory of the "I" and its first formation in the Mirror Phase, the characteristics that such a formation lends the "I", the differentiation between the "I" and the "Subject" of the analysis – all these have remained for me provocative ideas. If I was asked whether I believed the "I" was actually constructed in this way I'd have to say I don't know. And yet, as a way of thinking, there is no doubt that it can be most productive in clinical work. There is nothing as practical as a good theory.

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I also particularly wish to acknowledge my debt of gratitude to my colleague, Lorraine Scott, without whose help I would not have written these thoughts.

The Shadow of the Transcendent

Valuing Spirituality in Psychotherapy

Philip L. Culbertson

Abstract

A survey of spirituality as it is discussed in the training literature for psychotherapy reveals that spirituality is defined in a variety of ways which do not always complement each other. Spiritual themes in psychotherapy do not always present in spiritual language but instead may present in the language of values. As in the case of values, so spiritualities may be either constructive or destructive, though their evaluation must be contextually and culturally determined. The author describes the training programme in counselling and psychotherapy which he directs, and finishes with the claim that psychotherapists need to understand that they are as much charged with clients' souls as with their psyches.

"Where there is no guidance a people fall;
but in an abundance of counsellors there is safety." (Proverbs 11:14)

Introduction

One of the most famous stories in the Babylonian Talmud, a collection of Jewish legal and narrative materials from approximately the 4th century, is the story of four rabbis who made a mystical journey to paradise:

Four entered Paradise: Ben Azzai and Ben Zoma, 'Aher and Rabbi Aqiba. Ben Azzai peered and died; of him scripture says *Precious in the sight of the Lord is the death of his saints* (Ps. 116:15). Ben Zoma peered and went mad: of him scripture says *Have you found honey? Eat {only} so much as is sufficient for you* (Prov. 25:16). 'Aher looked and hacked down the plantation; of him scripture says *Let not your mouth lead you into sin* (Qoh. 5:6). Rabbi Aqiba entered in peace and

went out in peace; of him scripture says *Draw me after you; let us run* (Song of Songs 1:4).[1]

What is of interest here is that of these four men who attempted to make contact with the higher spiritual realm, three suffered a tragic fate. Only Rabbi Aqiba, who had adequately prepared himself in advance, could engage mystical spirituality without destroying himself. Ben Azzai died; Ben Zoma went mad; and 'Aher, a derogatory nickname which means "that nameless other guy," hacked down the plantation. In an expanded version in the Jerusalem Talmud, approximately one century later, we are given a further definition of "hacking down the plantation," that is, he converted to something considered to be religious heresy, in this case, probably Christianity, thereby destroying himself and all his biological future progeny, the little shoots in the plantation. What is of further interest in this story is the juxtaposition of psychosis and religious conversion. Ben Zoma, who "went mad," possibly became psychotic;[2] 'Aher converted to a form of religious expression which his culture considered to be outside the bounds of acceptability. As we will see later, one of the hardest tasks in dealing with spiritual emergency in psychotherapy is telling the difference between a psychosis with religious manifestations, and a spiritual experience with psychotic overtones.

As we approach the millennium, it is fitting that we find increased dialogue within the psychotherapeutic literature about the role and function of spirituality, for historically such themes have always gained urgency toward the end of each one-hundred years. Certainly the media are full of dramatic incidents which stem from humanity's intensified spiritual quest, including mass suicides by members of various cults, increased incidents of miraculous appearances and cures, and best-selling publications such as *The Celestine Prophecy* and Depak Chopra's *The Seven Spiritual Laws of Success*. New Zealanders have always had a particular affinity for things spiritual, from the pantheism typical to traditional Maori spirituality to the strong appeal among Pakeha of what are

1 This translation is a composite of four texts in six versions: Tos. Hagigah 2:3-4 (Saul Zuckermandel, *Tosephta*, Jerusalem: Wahrmann, 1965, p. 234 , and Saul Lieberman, *Tosefta Moed*, New York: Jewish Theological Seminary, 1962, p. 381 and commentary); J T Hagigah 2.77b; *Shir ha-Shirim Rabbah* 1.4.1; B T Hagigah 14b (including Steinsaltz); compare also Judah David Eisenstein, *Otzar Midrashim* (New York: E. Grossman's Hebrew Book Stores, 1915), vol. 2, p. 505. For further information, see Culbertson (1995a), pp. 41ff.

2 The Hebrew word here is "nifg'a," from the shoresh p-g-'a, a general term meaning "stricken [with dementia?]." We cannot with specificity determine the exact nature of Ben Zoma's mental illness. Howard Cooper (66) observes that the usual word to indicate a mentally-ill person in the Talmud is *shoteh*, "which contains the idea of walking to and fro without purpose."

sometimes called "New Age" religions. [3] In describing inherently spiritual cultures such as our own, Robert Fuller (245) writes "While their quest for harmonizing with nature's higher reaches sometimes smacked of narcissism and hedonism, it far more often bespoke a spiritual hunger for wholeness and union with a transcendent Other." Surely this statement holds true for New Zealanders from a wide variety of cultures. But in spite of the broad proclivity of human beings to seek the spiritual in their lives, the relationship between psychotherapy and spirituality has generally been tense and confusing.

In order to sharpen the focus of my presentation, I wish to make a clean distinction between spirituality and religion. In my remarks, I will treat religion and religious practices as if they are one way of embodying the spiritual, but not the only way. Certainly the great monotheistic religions of the world—Christianity, Judaism, and Islam—have had a tendency to assume that their unique expressions of spiritual truth are the only correct expressions. Yet even within these religious traditions, certain voices have recognized that spiritual truths transcend the boundaries of organized religion. For example, within normative Judaism lies the claim that "righteous non-Jews" will inherit "a portion in the World to Come." [4] Within Christianity of the 20th century, German Lutheran theologian Dietrich Bonhoeffer was deeply critical of aspects of Christianity as an institutional religion, and was quite receptive to the possibility of God being present in thoroughly secular persons and practices.[5] The popular Roman Catholic writer Thomas Moore, whose books include *The Care of the Soul*, makes clear that when he speaks of the soul, what he is proposing "is not specifically Christian, nor is it tied to any particular religious tradition."

Elliot Ingersoll captures succinctly this important distinction between religion and spirituality. He emphasizes two differences:

> First, religion's provision of a social identity may not necessarily be provided in a personal spirituality. Second, due to the corporate nature of religion there may be fewer variations in its stipulated behavioral correlates than those found in personal spiritualities... ..From this perspective, religion is conceptualized as a variety of frameworks through which spirituality is expressed. These frameworks would be viewed as heavily influenced by the

3 See Ellwood for a comprehensive history.

4 Babylonian Talmud, Tractate Megillah 13a; see also the traditions concerning the Bnai Noah.

5 *Letters and Papers from Prison*, ed. Eberhard Bethge, 3rd ed., New York: Macmillan, 1972, 357-363. For more on Christian thought concerning God's revelation outside Christianity, see Culbertson, 1991.

> culture in which they originate. Through this conceptualization, spirituality becomes an organismic, developmental dimension and religion, a "culturally flavored" framework that helps develop the organismic spiritual potential.[6]

As one group of writers observed, "Churches and temples do not have a monopoly on spirituality or on the values that compose it. These belong to humanity and are not the exclusive possession of organized religion or of traditionally religious persons."[7]

Defining Spirituality

It is easier, however, to transcend religious categories and assumptions by setting them aside than it is to define "spirituality." At present there appears to be no generally agreed-upon definition of the word. Rather, definitions fall into at least four categories: those which focus on the search for an external Transcendent, those which focus on the search for a Transcendent located within the person, those which focus on the personal growth of the inner self, and those which focus upon the integration of many aspects of the self, along with relationships, nature, and the cosmos. Definitions 1 and 2 have a certain amount of Biblical support. Definitions 3 and 4 are generally supported by world religions other than Christianity, such as Buddhism, Advaita Vedanta, and Taoism. Brant Cortright (26-27) classes the first two sets of definitions, then, as "theistic-relational" traditions, and the second two sets of definitions as "non-dual."

The category, "the Search for the External Transcendent" assumes the existence of some external authority, nurture, love or truth, which is often personified. It offers the believer a sense of "vertical security," of belonging to something within the universe beyond the immediate human dimension. This is the category which Cortright called "theistic-relational." This concept of an external transcendent is generally consistent with Christianity, Judaism, and Islam, but is not limited to them. For example, Alcoholics Anonymous speaks of a "Higher Power, however one chooses to understand it."[8]

The category "the Search for the Internal Transcendent" assumes that transcendence is found within or inside each human being. Once accessed, it

6 Ingersoll, 1994, 105-106.

7 Elkins, Hedstrom, Hughes, Leaf, and Saunders, p. 6. Lee Yearly has coined the term "spiritual regret," a somewhat unfeliticitous description of the condition which "arises from the sense, however implicit, that the traditional ways of dealing with distinctions among religions are deficient, that they fail to meet adequately the specific demands the modern situation produces"; see Kim, p. 61.

8 See Kurtz.

overpowers egocentricity and self-absorption. While the category refers to "transcendence," this does not necessarily imply a deity or higher power, for one finds the transcendent by going inward, not outward. Although Christians may find themselves somewhat uncomfortable with this category, it is strongly implied in Luke 17:20-21: "The kingdom of God is not coming with things that can be observed; nor will they say, 'Look, here it is!; or "There it is!' For, in fact, the kingdom of God is within you." Those who define spirituality in this manner often insist that it produces an observable behaviour or manner of being,[9] though many writers in other categories would challenge whether one's spirituality is so easily apparent.

The category "the Search for the Truth of the Personal Self" makes little or no reference to the transcendent, suggesting instead that the ultimate goal of spirituality is personal growth and self-awareness. This form of spirituality is essentially existentialist and humanitarian, resulting in a sense of well-being, maturity, and vitality.

The category entitled "the Search for Integration" emphasizes primarily the connectedness of all that is within one and the relationship of that connectedness to the whole cosmos, including or not including a transcendent being or power. Of the four categories, this is the only one which places a clear emphasis on the physical human body's role in spiritual wholeness, and thus is most closely related to what is often defined as "feminist spirituality."[10] This category assumes, as well, a relationship between spirituality and sexuality, which connection is not so readily obvious in the other three categories. Gay spirituality, like feminist spirituality, makes much of this connection. For example, Michael Clark writes:

> Men, whether straight or gay, must reconceptualize their sexuality as something that is not external, alienated, and merely functional. They must learn that the erotic—or, more concretely, our sexuality—becomes a meaningless, genitally reduced notion unless we come to understand the erotic as part and parcel of our urges toward mutuality and human(e)ness.

I find myself very weary with spiritualities which divorce themselves from the

9 See, for example, Everts and Agee, p. 292.

10 Though Levitt (305) asserts that there is no such thing as "feminist spirituality": "A chapter on 'feminist spirituality' as such is no longer feasible. The kind of 'objectivity' required to produce such an overview has itself been called into question by feminist activists and scholars alike. They have argued that it is no longer possible to speak of a single, universal feminist anything. As Adrienne Rich reminds us, such universal claims '[blot] out what we really need to know: When, where, and under what conditions has this statement been true?'"

human body, including most transpersonal psychotherapy. We need to incarnate, not transcend. The human body is a tool, a friend, and a home,[11] not a limitation to be overcome, and we need to concentrate harder, therefore, on both spiritualities and psychotherapies which help us cherish and respect our bodies, not deny them, despise them, or dissociate from them. St. Teresa of Avila reminds us, "We aren't angels; we've got bodies."[12]

The Values of Spirituality and the Values of Psychotherapy

All four of these categories make mention of values, and it is in the articulation of values that spirituality and psychotherapy seem to overlap most frequently. Lucy Bregman points out, "Because of its historical link to the medical model, psychotherapy could for decades claim value neutrality—nonendorsement of any particular ethical, social or political position."[13] At other times, neutrality is interpreted to mean not siding with one or another person in a dispute, or respecting our clients' unique individuality. However, in psychoanalytic terms, the word "neutrality" first enters our professional vocabulary to mean "not favoring the ego, id or superego," a significantly different meaning than the one now commonly received.[14] Carl Rogers attempted to set up a value-free method of psychotherapy, without realizing that "nonjudgment" is itself a value.

It was the programmatic work of Milton Rokeach and his colleagues in the 1970s that first began to clarify the definition and measurement of values within the discipline of psychology. As Rokeach defined, "A *value* is an enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state of existence."[15] To presume that psychotherapy is value-neutral is, then, self-delusional. We may not yet have reached consensus on the essential

11 See Rouner.

12 *Life*, quoted in E. W. Trueman Dicken, "Teresa of Jesus and John of the Cross," in *The Study of Spirituality*, New York: Oxford University Press, 1986, p. 366. According to Cortright (115), "All somatic approaches trace their lineage to Wilhelm Reich, ...now there are a number of body-centered approaches that integrate spirituality into bodywork. Some of these approaches include Hakomi, John Pierrakos' Core Energetics, Bodynamics, the Lomi school, Eva Reich's work, Jack Rosenburg's work, rebirthing, and, important to mention because of its great influence even though it is not psychotherapy, Charlotte Selver's sensory awareness." Cortright seems particularly impressed with the work of Hameed Ali, who writes of a "diamond approach" under the name of A. H. Almaas, a technique rather like the work of New Zealand native David Grove; see Cortright 90-93.

13 Bregman, 261.

14 Lovinger, 38.

15 Rokeach, 5.

values of our profession, or how these values should be implemented in a treatment context, but certainly values can be inferred from the way we work.

What could some of these values be? In a recent study of American psychotherapists reported by Allen Bergin, mental health included the following characteristics: being a free agent; having a sense of identity and feelings of worth; being skilled in interpersonal communication, sensitivity, nurturance, and trust; being genuine and honest; having self-control and personal responsibility; being committed in marriage, family, and social relationships; having a capacity to forgive others and oneself; having orienting values and meaningful purposes; having deepened self-awareness and motivation for growth; having adaptive coping strategies for managing stresses and crises; finding fulfilment in work; and practising good habits of physical health.[16] On some level we want our clients to be good, successful, and wise, just as we desire those values in ourselves. We want them to assume responsibility, to gain insight, to have personal integrity, to move toward more observable and functional individuation. Bregman comments, "therapists want their patients or clients to develop in certain ways, to become certain kinds of persons, to grow out of certain behaviors and attitudes."[17] Psychotherapy also seems to discount or downplay certain other values. "For instance, nowhere are purity, chastity, and righteous indignation therapeutic virtues, nor does reaching perfection appear as a valid therapeutic goal."[18]

In addition to attending to and understanding our clients' values, we need to do serious work on our own values, for repeated studies have shown that during the course of psychotherapy, clients tend gradually to adopt the values of their therapists, through the dual processes of transference and identification.[19] We need to discover and articulate both our professional values and our personal values. In the professional arena, we may look to our professional codes of ethics, for these often articulate values such as not exerting exploitative or injurious influence on someone with whom we have a fiduciary relationship, non-authoritarianism, keeping clear boundaries between our clients' lives and problems and our own lives and problems, and perhaps even "unconditional positive regard," itself a value as well as a technique. In the course of therapy, our clients' values change, particularly those values which brought them into therapy in the first place. If they are going to identify with and imitate us, we

16 Bergin, 394-395.

17 Bregman, 261.

18 Bregman, 263.

19 Worthington and Scott, 318.

need to pay close attention to the models of virtue which we are presenting. I am reminded of Paul Meehl's cogent proposition that "patients have a third ear too." Meehl was referring to the fact that patients identify value communications from their therapists, whether or not the therapist is aware of such communication.[20]

Some schools of psychotherapy are quite overtly value-oriented, though they remain the minority. These would include Ellis' Rational-emotive therapy, Glasser's reality therapy, Frankl's logotherapy, and Assagioli's psychosynthesis. But I believe that in the case of these schools of psychotherapy as well as all others, the question must be raised whether the values inherent in white Western psychotherapeutic thought are appropriate to any other culture, or indeed, even comprehensible. I will return to the issue of culture again later in this essay. In the meantime let me observe that in Aotearoa New Zealand, we live amongst many cultures for whom communal identity is much more valued than individuation, and indeed where the typical psychotherapeutic emphasis on individuation can produce significant cognitive dissonance. Every culture has some sort of religious or moral value system, and in fact, indigenous cultures of the South Pacific generally do not make a split between culture and spirituality, believing that their culture is inherently an expression of spirituality. Perhaps a future NZAP conference can be dedicated to cross-cultural issues in psychotherapy, at least for the benefit of those of us who live and work in the largest Polynesian city in the world.

Both spiritual and psychological traditions speak to what we are, to what is wrong with the human condition, and to the transformative possibilities open to us. Craig Ellison captures the overlap of psychotherapy and spirituality as they relate to values and well-being:

> It is the *spirit* of human beings which enables and motivates us to search for meaning and purpose in life, to seek the supernatural or some meaning which transcends us, to wonder about our origins and our identities, to require morality and equity. It is the spirit which synthesizes the total personality and provides some sense of energizing direction and order. The spiritual dimension does not exist in isolation from our psyche and *soma*, but provides an integrative force. It affects and is affected by our physical state, feelings, thoughts, and relationships. If we are spiritually healthy we will feel generally alive, purposeful, and fulfilled, but only to the extent that we are psychologically healthy as well.[21]

20 As quoted in Kelly, 172.

21 Ellison, 331-332.

Spiritual Themes in Client Narratives

In my teaching responsibilities at St. John's Theological College in Auckland, I often meet students who tell me that they are training just to deal with people's spiritual nature, and not their psychological problems, health problems, or social problems. I respond quite firmly that people simply cannot be compartmentalized that way. The many identities which human beings bear affect each other. It is very hard to be relationally unhealthy and spiritually healthy, for example, for the unhealthy aspects of ourselves tend to infect the healthy just as often as the healthy affect the unhealthy. From personal experience in therapy, I know that personal growth through therapeutic treatment almost always brings with it new spiritual insights, passions, and growth. So it isn't possible to treat someone spiritually without affecting other areas of their life, any more than it is possible to treat someone therapeutically without affecting their basic human values.

All this is to say that spiritual themes in psychotherapy do not always come in spiritual guises, and that some other material which is presented as religious is not about spiritual issues at all, but about psychological dysfunction. Let me illustrate:

> A homemaking wife and her retired husband present for long-term counselling. The wife's complaint is that her husband is possessed by demons and she is exhausted from repeatedly casting them out. She reports that just as soon as one demon is cast out, another takes its place. Upon further investigation, the therapist learns that their life together is otherwise extremely mundane, except for their involvement in a local charismatic Christian congregation at the wife's insistence. As each demon appears, the wife befriends it, learns its history, reads the scriptures to it, casts it out, and then can rejoice repeatedly with her church friends at her success, all the while complaining at how set upon she is by this repeating phenomenon. At last count, she had cast out over 175 demons from her long-suffering and extremely passive husband.

Is this a spiritual or religious issue, as it presents on the surface? My analysis is that it is not; rather, this is an issue of projective identification, with a highly bitter wife splitting off her own negativity and projecting it on to her husband, and then casting it out. The wife receives a great deal of attention from members of the congregation, has found a way to make her hum-drum life seem worthwhile, and retains extraordinary control over a situation which she describes as chaotic. While the therapist will want to address this couple, at least initially, in religious language, to look to the arena of spirituality for

insight will miss altogether the underlying dynamic of projective identification. In this case, a religious issue is at heart not a religious issue at all.

> A man in his mid-20s presents for treatment for mild depression. During the course of assessment, he mentions to the therapist that the only place he knows how to find a sense of calm is when he climbs to the top of a tree and sits alone for a long period of time.

This issue does not present as a spiritual issue, but in fact illustrates the deeply spiritual character of the young client. In this case, the therapist was able to help him explore the experience of climbing trees as a search for centering and inner strength.

> A woman in her 40s presents for therapy after the termination of her fourth marriage. The therapist works with her using a family systems genogram, which reveals a highly dysfunctional relationship pattern through at least three generations, focusing on her attachment issues. In the middle of a session in which the client is complaining again about how desperately she wants another husband, she suddenly interrupts the work, looks the therapist in the eye and says "What's the meaning of it all anyway? What's the purpose of living?"

The therapist, in this case trained in spiritual issues as well as psychotherapy, was able to recognize the woman's question as an expression of what Irving Yalom calls "existential loneliness."[22] Yalom's predecessor Carl Jung, at the end of his life, admitted that approximately one-third of the cases he had treated suffered "from no clinically definable neurosis, but from the senselessness and emptiness of their lives."[23] If, as some claim, spirituality is at heart "the confronting of existential questions,"[24] then when our clients express the meaningless and loneliness of their lives, we are again in the realm of the spiritual.

The client who climbed trees exemplifies a form of spirituality which is particularly common among New Zealanders. Joseph Price writes:

> Although nature is regarded by many monotheists as a manifestation of the sacred—as God's handiwork—it also can be perceived by secular persons

22 See Yalom; see also Allen, pp. 57, 336-340. In *Transformations of Consciousness*, Wilber classifies existential loneliness as an existential pathology, but one with the potential for great reward if treated properly; see Cortright, 69.

23 Jung, 1939, 61.

24 Shfranske and Gorsuch, 237.

> as an arena for spiritual encounter and rejuvenation. In and through nature, human beings can wondrously perceive modes and manners of life that differ quite markedly from their own. In so doing, humans have, at times, considered nature as a manifestation of Otherness, revering it as sacred.[25]

The use of nature themes, especially in guided imagery and in recollections of "peak experiences"[26] involving the out-of-doors comprise spiritual themes in client narratives.

For both men and women, athletic endeavour, sport, and the gym discipline may also indicate spiritual values. Sport provides an opportunity for an individual not only to leave a mark at least for the moment but also to assume control over personal destiny. The endorphin rush, the "running high," and the accomplishment of a "personal best" are all ways in which human beings learn to transcend themselves and touch the spiritual. One long-distance runner described it in this way:

> In the last half mile something happened which may have occurred only one or two times before or since. Furiously I ran; time lost all semblance of meaning. Distance, time, motion were all one. There were myself, the cement, a vague feeling of legs, and the coming dusk. I tore on ...My running was a pouring feeling. Perhaps I had experienced a physiological change, but whatever, it was magic. I came to the side of the road and gazed, with a sort of bewilderment, at my friends. I sat on the side of the road and cried tears of joy and sorrow. Joy at being alive; sorrow for a vague feeling of temporalness, and a knowledge of the impossibility of giving this experience to anyone.[27]

Spiritual themes in client narratives, then, are not limited to the overt discussions of spirituality or religion, but may also include stories of experience in nature, athletic achievement, existential loneliness, commitments and passions, and the journey toward an integrated sexuality.[28] For this reason, Mary Louise Bringle suggests the construction of a sixth DSM axis. To account for what it calls the *biopsycho-social* reality of any clinical disorder, the DSM presently structures client diagnosis along five axes:

Axis I - the focal syndrome being presented;
Axis II - any personality traits or developmental problems which seem to

25 Price, 417.

26 See Maslow.

27 Spino, 224-225.

28 The literature on the construction of narratives in psychotherapy is expanding exponentially. For those unfamiliar with this field, a useful introduction can be found in Murray and in Culbertson (1999).

undergird it;
Axis III - general medical conditions, including any aggravating physical problems;
Axis IV - stresses in the patient's social environment; and
Axis V - the person's degree of overall functioning or impairment.

What we might note as significantly absent from this axial diagnostic structure is the further dimension of *spirituality*, which Bringle calls Axis VI.[29] David Elkins and his colleagues provide a rationalization for Bringle's suggestion:

In their quest for a life of depth and meaning, it seems there is a growing number who are pursuing alternative spiritual paths and nurturing their spirituality in ways they are discovering for themselves. The spiritual development of these people deserves to be treated with respect and sensitivity by those studying spirituality. But if psychology uses definitions, models, and assessment approaches to spirituality that confuse it with religious beliefs and practices, it will only discount and misunderstand the spirituality of these people.[30]

Constructive and Destructive Spiritualities

Earlier I cited Craig Ellison's opinion that "If we are spiritually healthy we will feel generally alive, purposeful, and fulfilled, but only to the extent that we are psychologically healthy as well."[31] In this multicultural city, in a multicultural world, we must remain aware that the measures of both spiritual health and psychological health are culturally relative. Every culture has its own moral and religious or spiritual values system, and each understands the interplay between culture and spirituality differently.

Because we tend to understand best and to read most widely in our own white Western literary tradition, we may easily fall prey to the assumption that the emergence of spiritual consciousness in a human being marks an advanced state of psychological health. Certainly this is the assumption of Ken Wilber.[32]

29 Bringle, 332. Of course the DSM-IV provides a useful new category entitled "Religious or Spiritual problems" which merges two distinct reasons for a medical consultation—the psycho-religious and psycho-spiritual. "Psycho-religious problems are those restricted to the beliefs and practices of organised churches or religious institutions (e.g., Christian, Muslim, Hindu), such as loss of faith, intensification of religious practice and conversion to a new faith. Whereas psycho-spiritual problems include a person's reported relationship with a Transcendent Being or Force which is not necessarily related to participation in an organised church or other religious organization"; see Cox, 158-159.

30 Elkins, Hedstrom, Hughes, Leaf, and Saunders, 16.

31 Ellison, 331-332.

32 Wilber's schema is summarized in Cortright, 67.

Wilber's overall map is simple in structure, although complex in its details. In *Transformations of Consciousness*, Wilber links his basic spectrum of consciousness to meta-spectra of development, psychopathology, and psychotherapy. He uses the kind of developmental model that was pioneered in psychology by Freud for ego development and by Piaget for cognitive development, all of which were based on Western models of increasing individuation from family-of-origin, community, and other relationships. Wilber insists that people must pass through his first six developmental stages before they can be spiritually aware. Brant Cortright points out, however, that "Wilber's model is tantamount to saying that the only people on earth who can be spiritual are those middle- and upper-middle class Americans and Europeans who have the access to therapy, and the time and financial resources to allow them to spend years working through their wounds and neurotic difficulties. Individuals in all other cultures, classes, and periods of history are doomed to be unspiritual."[33] This, of course, is ridiculous; to believe that spiritual attainment is the right only of the psychologically "well adjusted," by Western standards, does not square with the facts. "Saints and sages come in all sizes, shapes, and diagnostic categories,"[34] and spiritual themes, needs, and crises can emerge at any point along someone's personal line of human development. In treating clients, we need to beware both simplifications and hierarchical schema of progression. Most are products fundamentally of Greek logic.[35]

So contrary to Ellison's opinion that spiritual health and psychological health go hand in hand, Cortright reminds us some of the greatest mystics in human history appeared to be quite psychologically unstable.[36] Cortright remarks:

> The greater the degree of connection with the spiritual foundation of consciousness, the greater the spiritual realization. It is important to note, however, that full connection to spirit does not guarantee perfect mental health. The spiritual literature contains many examples of highly unstable, tortured people who also had a high degree of spiritual attainment. The ideal would be both great cohesion of the conditioned part of consciousness, that is, the self, along with a free, unobstructed connection to the unconditioned, spiritual being underlying this surface self.[37]

33 Cortright, 76-77.

34 Cortright, 78.

35 Wilber attempts to distinguish between good ("actualization") hierarchies and bad ("domination") hierarchies, though his argument is less than convincing. In either case, the message of most hierarchies is that "we're not there yet," and they are thus quite disempowering for clients. See Cortright, 72.

36 For example, St. Francis of Assisi, who is usually pictured as a gentle man tending to the needs of the birds and small animals. Francis was in fact a highly eccentric person, given to fits of rage and acts of violence, however parabolic his intention. See Culbertson, 1995b.

37 Cortright, 48.

However, neither we nor our clients always present with the ideal cohesion in place. In fact, psychotherapists should be ready to admit that at times, it is by embracing the worlds of religion and spirituality that our clients provide enough structure to defuse their own pathologies somewhat. Worthington identifies four themes inherent in Western views of religion that seem equally relevant to spirituality. First of all, there is an attempt to relate one's self to powerful, determinant, or mysterious elements beyond one's control, to understand or deal with what is unknown or unanswerable. Second, religion or spirituality provides hope and reassurance, especially in the face of uncertainty or distress. The third function is the satisfaction of important personal needs. Religion or spirituality provides individuals with a sense of purpose or calling, with an affirmation of their efforts beyond immediate, extrinsic rewards (e.g., money, fame), and with a sense of self-esteem or "spiritual worthiness." Finally religion or spirituality provides connections to others. It often allows a person to identify with a community of "like-minded' individuals. In summary religion and spirituality usually provide meaning, hope, esteem, and a sense of belonging.

In the best of all possible worlds, a client's spirituality emerges, or unfolds, step by step, in a pattern consistent with his or her psycho-social development. The timing should be in synch so that the client can welcome the transformative power of the experience at work on the consciousness.[38] However, sometimes "spiritual emergence" becomes "spiritual emergency," when a client's spiritual awareness is quite out-of-synch with spiritual development, for reasons which range from the medical to the mysterious.[39] The wordplay "spiritual emergence/ spiritual emergency" is often attributed to Stanislav and Christina Grof, who have written a book by that same name. As widely known as is their systemization of types of spiritual emergency, other writers, including Ken Wilber, Jack L. Rubins, and Paul Pruyser, have also attempted to alert therapists to various types of emergencies and their appropriate treatments.

Cortright points out how seldom we stop to consider these "dark sides" of spirituality, or what might be called in another word-play, "the shadow of the transcendent".

> People generally think of the spiritual path as safe—if not easy, then at least a protective haven from the existential insecurity of life, a soothing balm from the inevitable anxieties, fears, and pain of living. But like any great

38 Cortright, 158-59; see also Perry, 67.

39 On the critical stages through which spiritual awareness unfolds, see Assagioli, 31.

> endeavour, the spiritual journey also has its risks and dangers. Spiritual traditions throughout the world speak of these dangers and over centuries of spiritual practice have evolved ways of dealing with them.[40]

Spiritual emergency refers to how the self becomes disorganized and overwhelmed by an infusion of spiritual energies or new realms of experience which it is not yet able to integrate. Alternatively, it can refer to a perversion of traditional religious values in various forms of narcissism, ego-inflation, ego-destruction, and despair. What usually precipitates spiritual emergency is trauma (including abuse as a child) or some sort of stress, a time when the person's defences and inner resources are weakened and more vulnerable. Cortright comments, "This seems comprehensible since it may be this very vulnerability or 'thinning' of the person's ego structures that allows spiritual experiences past the usual filtering mechanisms of the psyche."[41] In other instances, physical factors such as a disease, accident or operation; pharmacological factors such as conflicting interactions between medications; or prolonged physical exertion and lack of sleep can produce a spiritual emergency. One of the most important catalysts of spiritual emergency seems to be deep involvement in various forms of meditation and other spiritual practices.[42]

Episodes of "non-ordinary states of consciousness" cover a very wide spectrum, from piously exaggerated Christian self-sacrifice to encounters with UFOs. Some spiritual states have pathological or psychotic overtones and others do not. What is a symptom in one person may be a coping mechanism for another, depending on a variety of factors including culture, personal history, community values, and therapist bias. Grof and Grof point out that "While traditional [psychotherapeutic] approaches tend to pathologise mystical states, there is the opposite danger of spiritualising psychotic states and glorifying pathology or, even worse, overlooking an organic problem."[43]

Christians will not necessarily recognize their own spiritual practices in Grof's list of emergencies. However, a concentration on the symptomatic behaviour, rather than Grof's idiosyncratic vocabulary, reveals that some of these "emergencies" may well be within the norm of traditional Christian practices. The shamanic crisis can resemble the visionary journeys of the medieval

40 Cortright, 155.

41 Cortright, 160.

42 Grof and Grof, 8.

43 Grof and Grof, xiii. On the distinction between psychosis and mystical experience with psychotic features, see Lukoff.

mystics. The kundalini sounds like Shaker spirit dancing, charismatic ecstasy, or some of the manifestations of the Toronto Blessing. Unitive consciousness seems to parallel the Christian desire to merge with God, or perhaps Wesleyan pietism. The experience of the cosmic battle between Good and Evil describes some Christians' adult conversion experiences, and is a scenario familiar from the Bible and the Dead Sea Scrolls. Psychic opening resembles some forms of prophetic utterance, particularly known in charismatic congregations as "the gift of prophecy." Communication with spirit guides is not far removed from certain types of intercessory prayers to the saints and the Blessed Virgin, or from glossolalia (speaking in tongues). In 2 Cor. 12:2, St. Paul speaks of a person who was "caught up to the third heaven," which some commentators interpret as describing a Near Death Experience. Possession states are quite common among Pentecostal forms of Christianity, including the casting out of demons and being slain in the spirit.[44] Psychotherapists again must be careful to understand the prior religious or spiritual culture of their clients, for what is a spiritual emergency for one might be "normal" behaviour for another.[45]

The treatment of spiritual emergencies is generally reserved to skilled experienced practitioners.[46] Grof, Laing and Wilber all emphasize that while an emergency is a crisis, it is not necessarily a disaster. R. D. Laing comments: "Madness need not be all break*down*. It is also break*through*. It is potentially liberation and renewal, as well as enslavement and existential death."[47] The difference between breakdown and breakthrough is the same as between destructive and constructive spiritualities. Few of the above can always and categorically be described as destructive spiritualities, particularly if the therapist is already experienced in his or her own spiritual emergence. According to Grof and Grof,

> The most important task is to give the people in crisis a positive context for their experiences and sufficient information about the process they are

44 Interestingly, two of Grof's categories seem to me to be anathema to Christians. Past-life experiences seem to deny the forward thrust of heilsgeschichte ("holy history") as well as the process theology of Whitehead and de Chardin. Close encounters with UFOs clearly deny that humanity as we know it is the intended crown of all that God has created, though of course this "theology of subordination" is now almost completely rejected by those who are ecologically conscious.

45 Lowenthal, 164-165.

46 Rebillot (214) suggests that personal experience with spiritual emergency is the best qualifier for therapists working with spiritual issues: "The Buddhists say that one of the basic fears is the fear of unusual states of mind. We fear these in ourselves, and we fear them in others. A way to deal with that fundamental fear is to experience an unusual state of mind in a safe situation, in order to discover how to go into it and, most important, how to come out of it." When therapists feel unsure about their clients' spiritual material, consultation with trained religious professionals may be appropriate.

47 Laing, 54.

> going through. It is essential that they move away from the concept of disease and recognize the healing nature of their crisis. Good literature and the opportunity to talk to people who understand, particularly those who have successfully overcome a similar crisis, can be invaluable.[48]

This treatment approach demands an open and trusting relationship between therapist and client, a great deal of patience, and the wisdom to see a way ahead to integration of the spiritual experience in a manner consistent with the client's developmental stages in other areas of the wholeness wheel. It is the mutuality of response between us and our clients which often determines whether the outcome of an emergency is destructive or constructive.

Though Grof and others are often lumped with transpersonal psychology, many of the treatments for spiritual emergency demand a strong concentration on the needs of the physical body. Chandler, Holden and Kolander speak of "grounding" as the process by which spiritual emergence is slowed down to a manageable pace. They cite Ram Dass, who when asked the best response to someone overly concerned with spiritual pursuits, replied "Come on, get your act together, learn your zip code, go get a job!" In his inimitable way, Ram Dass was exemplifying the value of spiritual pursuit which is in balance with the other, personal dimensions of wellness.[49] Grof and Cortright both speak of the importance of changing diet, eating heavy foods to weigh the body back down, or sleep, or other forms of bodywork. They advise stopping all forms of medication, and all forms of meditation, until the emergency is back under control.[50] Treatment for spiritual emergency also often involves education, explaining to the client in complete detail what he or she is experiencing and how better to integrate it.

This emphasis on spiritual emergence and emergency within psychotherapy needs to be balanced with some basic cautions about bypassing, perseverance, and the possible conflict of values between therapist and client. "Bypassing" is a term which Cortright uses to describe the act of cloaking defensive avoidance in spiritual ideas or religious language. "Spiritual bypassing takes spiritual language and concepts to 'reframe' personal issues in the service of repression and defence, a kind of transpersonal rationalization."[51] Perseverance in this case refers to the client's attempts to prolong spiritual conversation and exploration as a form of resistance to the therapeutic task. Bergin reminds us that within the areas of values, religion, and spirituality lie many deeply-held,

48 Grof and Grof, 192.

49 Chandler, Holden, and Kolander, 172.

50 Grof and Grof, 196; Cortright 173-177.

indeed almost irrationally held, beliefs. This has even more potential for problem if the therapist and the client are both well-educated in religion or skilled in spirituality, but come from contradictory points of view:

> Although religious therapists often have a strong interest in value discussions, this can be problematic if it is overemphasized. It would be unethical to trample on the values of clients, and it would be unwise to focus on value issues when other issues may be at the nucleus of the disorder, which is frequently the case in the early stages of treatment. It is vital to be open about values but not coercive, to be a competent professional and not a missionary for a particular belief, and at the same time to be honest enough to recognize how one's value commitments may or may not promote health.[52]

What then does this "health" of which Bergin speaks look like? In order not to limit "health" to cultural imperatives which may be inappropriate for some clients, we must be careful how we answer. I suggest that on a universal level, health should be defined as integration, courage, self-awareness, commitment, creativity, and healing. You may wish to add your own terms. I have intentionally avoided words like individuation, differentiation, and self-determination, for while these may be very helpful goals for our Pakeha clients, I think we have to beware applying them to our non-Pakeha clients as therapeutic aims.[53]

Training In Spirituality And Counselling

Most of the training programs for psychotherapy in New Zealand do not include a component dedicated to the relationship between therapy and spirituality. This is surely due, in some part, to the medical model's influence within psychotherapy. But it must also be in part due to the types of people who chose to train as psychotherapists. Repeated studies in America, England, and Europe reveal that psychotherapists are for the most part much less religiously or spiritually oriented than their clients. Often this is termed "the religiosity gap."[54] John Cox draws our attention to the danger inherent in our

51 Cortright, 210.

52 Bergin, 399.

53 An excellent recent book which looks at how definitions of "differentiation," for example, might look across a variety of cultures is Matsumoto. The diagnosis and treatment of non-Pakeha clients is of great urgency in Aotearoa New Zealand. The recent legal case involving a defence of "makutu" raises questions about spiritual emergencies which are outside normal psychiatric diagnostic categories recognized by the courts. See Knight, Young, and Revington.

54 Shafranske and Gorsuch, 239-240; Bergin, 396.

generally disinterested professional stance: "It is evidence of an 'unmet need' for patients as the relevance of their own spirituality to the understanding of their 'illness' may not be recognized by an unsympathetic health worker."[55] Other therapists, sympathetic to spirituality but ignorant of religious traditions, may also shy away from parts of the client's narrative. Vicky Genia explores the reasons for this:

> Many therapists are empathic toward a religious perspective but do not feel competent to address religious issues with clients. This lack of confidence is due partly to the fact that secular psychotherapists receive limited, if any, formal religious training, education in the psychology of religion, or preparation for dealing with religious issues in clinical practice. Thus, the reluctance of some psychotherapists to tackle religious issues reflects a realistic response to their limited education and training in the area of psychology and religion. Indeed, responsible assessment of competency is in conformity with professional ethics.

Our training program, the MTheol in Pastoral Counselling, taught jointly with the Masters in Counselling training programme of the University's Faculty of Education, includes a required semester-long paper in counselling and spirituality. There, students address spirituality and religious issues in five ways: through formal lectures and seminars exploring some of the professional literature,[56] by identifying their own sense of "place," by writing and critiquing a spiritual autobiography, by interacting with each other's differing perceptions and values in the classroom, and by analysing case studies from their own practices.

In identifying a personal sense of "place," we begin with Professor Hong-Key Yoon's essay on what he calls "Maori geomentality."[57] We discuss how a people define themselves according to a particular mountain, river, or other geographical landmark. We ask students to name the type of place in which they feel most whole, and then to narrow the exploration through describing a peak experience which took place in a specific location. In this way they begin

55 Cox, 157.

56 Textbooks for the paper include *The Image of God: A Theology for Pastoral Care and Counseling* by Leroy Howe (Nashville: Abingdon, 1995), *Mental Health and Religion* by Kate Miriam Loewenthal (London: Chapman and Hall, 1995), *Working with Religious Issues in Therapy* by Robert Lovinger (Northvale: Jason Aronson, 1984), *Stories We Live By: Personal Myths and the Making of the Self* by Dan McAdams (New York: William Morrow, 1993), *Psychoanalytic Object Relations Theory and the Study of Religion* by John McDargh (Lanham: University Press of America, 1983), and *Religious Autobiographies* by Gary L. Comstock (Belmont, CA: Wadsworth, 1995).

57 Yoon, "Maori Identity and Maori Geomentality."

to develop a sensitivity to space, place, and "belonging" as spiritual narratives, and begin to understand the power of spirituality in their own lives.

Having taught the paper now twice, I find that students are fairly evenly divided between those who self-identify as Christian, and those who self-identify as deeply spiritual but ex-Christian. For some of the Christian students, this is the first time they have had to encounter directly others who identify as New Age, Wicca, or neo-Buddhist. Encountering and processing otherness in the classroom is a critical component of our educational program, and must be monitored carefully to discourage cultural imperialism and "spiritual re-colonization." In general, our stage 3 and 4 papers are taught from a interpersonal approach, on the assumption that some of the best training materials are already present in the classroom.

One of the most interesting exercises is the writing and critiquing of one's spiritual autobiography. Students are directed to complete a 3000 word, first-person spiritual narrative, usually concentrating on one to three seminal events in their personal spiritual development. They are then instructed to stand back from that written narrative and to dissociate from it enough to be able to see the narrator/client at work, and then respond as a counsellor or therapist to the narrative presented. Often students describe this as one of the most disturbing yet rewarding assignments of their educational career. Of course, to mark a graduate student's essay on something as personal as a spiritual journey is delicate. The stated marking criteria are not whether the marker considers the student's spiritual stance to be valid or defensible, but on how successfully the student has externalized that journey and then examined it critically.

Finally, as student sensitivity to spiritual and religious client narratives grows, they begin to bring case studies and summaries from their own practice to the classroom, protecting confidentiality of course. These are enriched by similar studies from my own experience, giving us an opportunity to share possible strategies, interventions, and goals in working with client spirituality.

Conclusion

Let us return to the story with which we began, of the four rabbis who sought to enter paradise. How can we understand their story in light of the subsequent content of this article?

Ben Azzai peered and died. Perhaps the meaninglessness and senselessness of his life—the existential loneliness of which Yalom speaks—became too much for him, and in his alienation he lost his will to live. Despair is a spiritual theme,

sometimes called "the dark night of the soul," and we all know that one solution to despair, too often chosen in New Zealand, is suicide.

Ben Zoma peered and went mad. We have seen how difficult it can be to distinguish between a psychosis with religious manifestations and a spiritual experience with psychotic overtones. As well, the dis-integration which results from spiritual emergency runs the risk of becoming more than temporary if it is not handled correctly. We know how many of our mental institutions are filled with patients whose overt expression of their madness takes on religious form.

'Aher peered and hacked down the plantation. Spiritual emergence which is unaddressed or misunderstood can be highly destructive. Without a container, without grounding, the client has no opportunity to integrate spiritual emergence into his or her self-narrative. Such lack of focus and wholeness can result in destruction of the client, and even of generations to come.[58]

Only Akiba went in in peace and came out in peace. Perhaps he prepared himself by understanding that spiritual emergence and spirituality are natural and integral parts of any developing human identity, expressed in many varying forms that are consistent with the surrounding culture and community and one's personal history and values.

I do not wish, in closing, to dismiss the value of traditional religious expression. After all, our four rabbis were attempting to engage the spiritual realm as it was understood by the normative religious tradition from which they derived their authority in the first place. But "Churches and temples do not have a monopoly on spirituality or on the values that compose it. These [values] belong to humanity and are not the exclusive possession of organized religion or of traditionally religious persons."[59] The spiritual narratives of our clients are more difficult to recognize because often they do not take on the forms and vocabularies which we ordinarily associate with religion. "They are secular reorderings of inner life and self-understanding, in an era when religious frameworks no longer can be assured of universal acceptance.[60] However, because these clients do not have the support or encouragement of institutional

58 One form which this intergenerational destructiveness might take is the "religious abuse of children." This may manifest as physical beatings ("spare the rod and spoil the child"), emotional abuse (using fear of damnation or expulsion from the community to control a child's behaviour), or mental abuse (the oppressive application of hierarchical and patriarchal structures of authority, justified by reference to the Bible). See Capps.

59 Elkins, Hedstrom, Hughes, Leaf, and Saunders, 6.

60 Bregman, 255.

directions and disciplines, we as therapists may become the available or preferred source of that safe holding environment within which they can mine the riches and dangers of emergent spiritualities.[61] This can happen only if we recognize the shadow of the transcendent lurking in the corners of our clients' lives, and then call that spirituality out into the sunshine.

61 See Ingersoll, 1994, 105-106, who argues that personal spirituality does not always provide a social identity, and by spirituality's tolerance of greater diversity, may not immediately help people feel rooted.

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The Value of the Educational Frame in the Development of the Psychotherapist's Professional Self

Rosemary Tredgold

Abstract

This paper arose from my own experiences as both student and teacher of psychotherapy. It examines the nature and importance of clear boundaries and a firm frame in developing the personality, experience, knowledge and skills necessary for the practice of psychotherapy. It will consider the nature of the psychotherapist's professional Self; what it needs to know, do and be; and how this can be taught.

I'll start by being practical. Although love *is*
And everything that is not love *is not* but is
Illusory, we have to cope with that illusion.
It is the source of suffering and what we call
Evil. The illusion that we are not love or loveworthy
Is a fist around the heart it constricts
The awareness that you and I are one.
Like waves in the ocean, each seeming separate.
Yet merely ripples in the same eternal sea.

Adam Curle

Introduction

The joy of education is, for me, when students learn that they can lift some of the 'fist around the heart' as Adam Curle calls it and can join with another in love. Yet together with this joy go the horrors of hatred and violence described by Freud (1905):

> No-one who, like me conjures up the most evil of those half-tamed demons that inhabit the human breast, and seeks to wrestle with them can expect to come through the struggle unscathed.

This was said of psychotherapy. I think it can also be said of education in psychotherapy. My journey as an educator in Person Centred Counselling has been to seek to enable students to live with the forces of loving and hating that are part of the counselling relationship and to be empowered in themselves as counsellors.

The impetus for this paper arose from my experiences as teacher, learner and psychotherapist, at a time of accountability and performance objectives. I am suggesting a model of education for the psychotherapist where the process is as important as the content and at times the process is the content. As the process has assumed greater importance, so too, has the place and nature of the frame. At times the educational processes unravelled themselves and I wondered at the enormity of the task I had taken on.

Personal Background

Before exploring my experience as an educator, I would like to share a little of my *whakapapa* in education so you can understand the context of this paper. I was born in wartime England, of middle class, professional, Anglo-Saxon stock. Both grandfathers were pioneers in their research fields, one in mental disadvantage, and the other in the forecasting of El Nino. These stars of academic brilliance both lit and shadowed the family's educational and academic expectations. Education was important for both men and women. But somehow the social mores of the '40s and '50s valued the post-educational work of women less than that of men. My brother and I were sent to boarding school, where we learnt to survive in the curiously emotionally arid environment valued by the middle classes. Family and school were essential influences in my early development of ideas and interest. Human behaviour and issues such as abortion were common family dinner table discussions in the early '60s. It is my father, a psychiatrist, that I have to thank for modelling respect and value for every human being. He was generous and energetic in his search to enable students to learn.

Failing to join the family train to Cambridge University, I followed instead my eugenically minded grandfather to King's College, Newcastle: a lively, challenging learning environment. In an attempt to remain separate, but yet connected, I chose psychiatric hospitals in which to learn and work as a social worker. One of these was Claybury Hospital in Essex, which was struggling with the concept of a therapeutic community. ECT was questioned by a psychoanalytically orientated psychiatrist, who asked us before each treatment

"Who is anxious?" A fellow student introduced me to *The Ailment* by Tom Main, as we attempted to unravel the staff dynamics affecting a patient's need to make continual suicidal attempts. From this I learnt of the strength of the unconscious for both staff and patients, together with the crucial need to separate 'I' from 'thou' and the meaning of systems theory in practice.

I continued my formal education at the London School of Economics' Diploma in Mental Health at a time of adherence to Freudian/Kleinian psychoanalytic principles. Behaviour was interpreted according to clearly defined rules. My 'Self' shrank as I sought to survive in this punitive, almost contemptuous environment, only emerging in the ambience of Winnicott's lectures. His warmth, humanity and human connectedness shone through, even if his concepts were somewhat difficult to understand. The shaming experiences of one of my two placements remained with my being for many years, only emerging into consciousness during my studentship in Self Psychology. This has led me to a real interest in the effect of previous learning experiences on current ones and the importance of a shame-free learning environment.

On graduation I worked in the East End of London for five years, where I grappled therapeutically with the myriad of disturbances of patients in community mental health care, as well as theoretically with the nature of responsibility and with the ability claimed by mental health professionals to forecast all behaviours. I was grateful to Jack Kahn for his limited view of the omniscience of mental health professionals, which was counter to the then generally held opinion. To face the unknown and the unknowing was validated by him.

After five years in Newham, I travelled through North America and came to New Zealand in 1970. Struck by the beauty and warmth of the country and people in Christchurch, I worked in the Psychiatric Unit of the General Hospital for six years before becoming the first counsellor in the Technical Institute. Gestalt and the human encounter movement were strong influences in the early '70s, and challenged many firmly held constructs, particularly those of the therapist's need to interpret all behaviour from an analytic stance. Instead they highlighted the importance of the 'here and now', the interaction between client and therapist, the power of group process and the ultimate wisdom inherent in people to do the best for themselves. All of this sought to use in teaching and psychotherapy. Working in the field of non-violence during the Springbok tour taught me more of the power of those demons of fear, violence and hate, both conscious and unconscious, as families were torn

asunder by the violence of the debate. Then in 1990 I became a student on the ANZAP Self Psychology course, and many of the dangling threads of understanding from the preceding years came together, given words and meaning. The centrality of Winnicott's emphasis on interaction and of Meares' and Hobson's paper on *The Persecutory Therapist* were balm to my wounded soul. It was a rich, torrid time as I was both student and teacher in similar yet different areas, having begun to develop and teach a Person Centred Counselling course at Christchurch Polytechnic, with many attendant difficulties.

Use of Terms

The delineation between counselling and psychotherapy is unclear. Often the words are used synonymously. So in this presentation I am using the words counselling and psychotherapy, student/trainee, patient and client interchangeably. As Edwin Kahn (1989) points out, there are similarities between the theories of Rogers and Kohut. Both were concerned with the subjective, experiential life of people as revealed to them in their work as psychotherapists. Both were concerned with the concept of 'self', the enhancement of 'self-regard' (Rogers) and 'self-cohesion' (Kohut). I am here assuming a similarity of core training for both counselling and psychotherapy. As graduates of the counselling course may work with long-term trauma in private practice, the course is taught with the unconscious fully in mind, if not in view.

The Nature of a Professional Self.

What is it that the professional Self of the counsellor or psychotherapist needs to know? What can she/he do and how can she/he "be"? NZAP enumerates an expected knowledge base as a recommendation for membership. I am aware that this is a subject in its own right, and has been the source of many disagreements in the past. It was once believed, for example, that only medical practitioners could be psychotherapists. Suffice it to say that this knowledge-base now has to include human growth and development and abnormal psychology. The skills needed in the 'doing' part of the requirements includes assessment, interviewing and the interpersonal interaction. The fundamental question, answered for me in the Self Psychology training after many years of professional work was "What is it that I do as a psychotherapist that affects my client?" or "How can I do what, to help clients?" I have talked to many well-trained people who have not known this and as a result, have been less confident in their personal effectiveness as psychotherapists. They have had a

clear cognitive understanding of pathology and psychodynamic theory but less clarity about the 'I:Thou' interaction. In some cases with so much certainty of their rightness, there was no room for the essential rightness of the client if it was different.

The beingness of the professional Self is the ability to be with another human being, and to stay in there for the long haul; tolerating disturbed behaviour, if that is necessary, and the intimacy of the interaction. This demands a quality of self acceptance and self knowledge which is essential to the psychotherapist working in the intersubjective field; a quality of maturity such that the therapist's own needs are not met by the client, and they have a sense of their own strengths and limitations. Mostly they will know the difference between self and other; always they need to know that there is such a difference, even if the boundary becomes blurred at times.

> They have a central ability to allow others to feel safe, because they are safe within themselves and their own emotions
>
> (Shapiro and Rugglewitz).

The Process of Education

So how can this packet of knowledge, skills and the integration of these into the person of the therapist be learnt or taught? As educators, do we teach or do we enable learning? This is a crucial difference. Clearly there is a need for the imparting of information. Is this the only way that people learn? I think not. We learn by doing. If we believe this, teachers have to give space to students to learn by the trial and error of doing. Many adult students have a wealth of personal experiences and wisdom to draw on and I have found students learn much from each other. I suggest that a process which focuses on the student as learner and potential masterer of skills is a crucial one if the whole Self is to be educated. This has major ramifications in practice and puts value on the place of the process.

Environmental Factors Influencing the Need for Well Defined Expectations and Boundaries

Other factors are now also influencing the style of education. Throughout my own training in the '50s. and '60s, the training process was hierarchical, with exams, orals and some practical assessment. Assessment criteria were unclear. The emphasis was primarily on cognitive learning. Lecturers, tutors and supervisors were the 'experts' and somehow students were made to feel wrong

to question or distrust their wisdom. The pressures and attitudes of the '90s. demand more from the educational system - the institution and those involved in it. Whereas in the '60s. I felt powerless to challenge a poor supervisor, students are less likely to tolerate a similar situation today, with the current emphasis on freedom of information and human rights. As education costs more, so students expect more from educational programmes. The New Zealand Qualifications Authority is demanding clearly defined performance objectives, learning outcomes and assessment procedures. Ethics and values must now be part of the curricula as professional behaviour is watched critically by consumers, and broken boundaries are no longer acceptable. All these influences make the existence of clear and known values and administrative processes essential, not just for the safety of the student, but also for the teacher as more students take legal action against educational institutions.

Selection of Students

I strongly agree with Wheeler (1996) that among other important constituents of the teaching process, the selection of students is crucial. Guy (1987) lists some of the aspects of a person that make them either suitable or unsuitable to be a psychotherapist. His functional qualities include: "curiosity and inquisitiveness, the ability to listen comfortably in conversation, emotionally insightful, introspective, capable of self demand, tolerant of ambiguity, capable of warmth and caring, tolerant of intimacy, comfortable with power, able to laugh". I would like to emphasise the need for a strong sense of self-care and respect; determination; perseverance; humour and creativity (Cade 1982); ability to deal with loving and hating (Tan 1997); and the ability to remain intact in the face of others' projections. Guy's dysfunctional qualities include "too much emotional distress, vicarious coping methods, loneliness and isolation, the desire for power and vicarious rebellion". Any selection process has to include a consideration of these personal qualities. I have discovered to my great discomfort that if these are not valued at this stage, the education process has to fail. Students cannot learn without a cohesive core self. Education can't do the work of a personal therapist. So we have a long selection process to ascertain the suitability of the applicant for the course and whether they think the course is suitable for them.

The Role of Being a Student

Bennis, Bennie and Chin note that as a student, each individual faces the task of continuously re-organising, remaking and relating his/her internal worlds.

Alonso and Rutan recognise the regression in the learning process. They point out that adult learners will have to tolerate confusion and ignorance for a while, and that having experienced themselves as highly competent practitioners in other fields, they will find this an anxiety-provoking experience.

> "The tension generated in the system can be easily a source of potential embarrassment and humiliation for even the most competent clinician before it is resolved."

The supervisory/tutor relationship triggers off transferences from archaic parental and educational figures. I mentioned earlier my own transference of experiences as a student at the London School of Economics in the '60s. It would have been helpful if this had been able to be recognised earlier. In an attempt to do this for others, I have designed a small exercise to enable first year students to at least recognise that this may exist for them, in the hope that they may become increasingly aware of the size and shape of their transference as the course progresses. It seems to arise particularly in reaction to assessment tasks. Some important learnings have taken place as they deal with their differing responses to tutor/assessor and tutor/enabler of learning.

For students coming into this work there is also a need to see if they like it and are suitable for it. They may need to experience this before deciding. Selectors also make mistakes: indeed it is the ability to admit personal imperfection that may be considered a key attribute to being a successful supervisor or educator. Is the purpose of a training programme to pass everyone that enters, regardless?, or is it to allow students to discover if this work is really for them? Can tutors/supervisors allow students to fail, or see other paths? In a training programme accepting inexperienced people, an atmosphere which supports another choice of career, if appropriate, seems crucial. Many have stayed in the field when they could have been happier elsewhere, having been kept in the programme by expectations. I have supported students to leave and go into other fields, facing the annoyance of administrators, as they have wanted everyone to finish and 'pass'. This leaving is a potentially shameful experience and our task is to support the core Self in its wisdom.

I remember my first class of social work students. Deciding that to practise what I preached I had to believe in student wisdom and self-fulfilment, I let them pass/fail themselves and said I would support whatever decision they made. I had a sleepless night before the decisions, probably more so than the students, one of whom failed herself. Although I do not now see this method as appropriate for assessments, I consider it has an important philosophy

behind it. Successful trainees in psychotherapy have to have claimed their own authority, owned their own power and faced their ability to succeed and fail. As they grapple with these polarities, they also grapple with issues of powerlessness and power and are more likely to be comfortable with their limitations and skills as a practitioner. In fact we find that students on the counselling course only meet the assessment criteria for their final audiotapes when they know within themselves they will do so. If they are still waiting for an authority figure to 'pass' them, they are not ready and do not pass. This leads on to the difference between supervision and the classroom as educator.

Supervision and the Classroom

The traditional model of supervision has been the place where inner conflicts and confusions have emerged. In psychoanalytic training supervision was the key element of the training programme whose task it was to focus on the person of the therapist, and the integration of knowledge in practice. Teitlebaum (1990) wrote:

> In this model the supervisor was viewed as an overseer, a more knowledgeable expert and one who could be helpful because he or she possessed supervision. The emphasis of the supervisory session was traditionally on deciphering the patient's material and/or arriving at a better understanding of the analyst's unresolved personality issues or over reactions to the patient, that is countertransference, which interfered with the successful handling of the case.

Alonso and Rutan write:

> The supervisor is expected to teach, mentor, to evaluate, to encourage, and contain the learning regression so that the safety and development of the students, patients and training institutions are ensured.

An enormous load for the supervisor and one which should be more evenly shared by the training institution in the person of the tutor.

I am aware the idea of the classroom being a place of interactional learning is foreign to some teaching institutions. Education in universities and medical schools has a history of teaching information by lecture and dialogue. The classroom/lecture theatre has tended to be a place for the passing on of cognitive material, not a safe place for the exploration of the self. Social work education diverged from this by involving its students in discussion and more recently, as psychodrama and Gestalt gained a greater influence, in experiential learning.

Bennis, Bennie and Chin (1961) point out that the teaching/learning process is a human transaction involving the teacher, learner and learning group in a set of dynamic inter-relationships. The relationships among learners and between teacher and learners have a great deal to do with the ultimate learning. The target of education is change and growth in the individual and his/her behaviour, and thus in his/her worlds. This is a deeper and broader goal than cognitive learning only. Whatever their previous professional training, the development of an assured, realistic, confident self in the therapist working in the intersubjective field is essential, and a core theme in psychotherapy education. I suggest that both supervision and the classroom can have much to contribute to this, particularly when the lines of communication between them are good and trusting.

Supervision and the Classroom as Play Space

Nahum (1993) writes of playing within the boundary of supervision. I suggest that this concept can be broadened to envisage the classroom as 'play space'. This is different from group therapy. I have no doubt group 'therapy' per se is as inappropriate in the classroom as personal therapy in supervision. However, there is a place for exploration and learning from the ongoing life experiences of the students, when they are able to share these. The realities of grief, stress, trauma, and chronic illness are some of the day-to-day issues faced by students. Their responses to each other have wonderful learning potential if handled with respect and tact. Students have to learn how to function as professionals. This means learning how to contain emotions inappropriate to the client relationship; when it is important to withdraw and have a period of self-care; how to deal with their loving, hating and conflict with each other. In other words, they must learn how to deal with the countertransference.

The 'play space' is also the place where it is possible to affirm the creative, effective Self of the student. The classroom can also become a place of group work, and part of the development of any healthy group is an increased independence from the tutor. It entails wisdom and courage on the tutor's part to be demolished, to carry many of the projective images of students and keep the frame. But this is also the work of psychotherapy. If the process of the classroom interactions are made overt, they become very powerful conditions of learning in the 'here and now' what happens in the psychotherapeutic relationship. It is only possible for the classroom to be a 'play space' if it is just that. So either the summative assessments have to be done by non-tutors, or the boundaries around a particular assessable event have to be rigid, clear and

adhered to, e.g. written assignments having well documented learning outcomes, and assessment criteria clearly stated.

The Role of Tutor

The authority and functions of the tutor are complex. The tutor is supporter, encourager, affirmer of the core Self, and boundary keeper. As direction indicator the tutor assists with the map of possible learning resources, papers, articles, books, etc. He/she needs to keep abreast of new knowledge. The tutor, like the supervisor, also has the task of supporting the preconscious parts into consciousness. One way of doing this is to recognise and value both verbal and non-verbal behaviours. An example of this was a student giving a seminar on the resistant client. She arrived late and left her script at home. She was aware of the consequences of not giving her seminar. Would I delay the presentation? "No", I said. I thought she was giving a brilliant demonstration of the topic. She went home in the lunch hour, arriving back one minute late. She gave a very clear, concise, integrated seminar, including her own experience in the presentation. I was aware that I needed to maintain the frame for the integration of her learning to deepen.

Another example was facing the powerful forces of hatred and envy in the class. We in New Zealand are struggling with meanings and ramifications of a bicultural environment: the place of Maori as *tangata whenua* and the meaning of this for Pakeha. We have all learnt to talk about this in a politically correct manner. It was only when the tutor suggested that a Maori student had the right to present and be assessed for her seminar according to Maori tradition, involving more time, that the rest of the class had to face their anger and envy at being treated differently. The Maori student was given more time, but also had to face the daunting expectations of culturally appropriate assessors! The Pakeha tutor's job was to standardise these very demanding expectations of the visiting Maori assessment team with those applied to other students.

Similarities Between the Psychotherapeutic and Educational Frames

Lyndsey Fletcher, writing on the frame in 1989, says this:

> The ground rules of the frame continue to be defined in much the same way as Freud suggested. It seems to me that what has changed is the way in which we conceptualise the frame and the deeper appreciation we have of its essential, integral role as the frame delineating boundaries, to a more three-dimensional concept of a vessel with holding and containing

> connotations. To this graphic we could perhaps add a shadow area to represent a fourth dimension—the illusory, unknown, unconscious aspect of the frame. The basic ground rules are no longer just seen as a set of tenets to safeguard the transference and to preserve the integrity of the therapeutic relationship. The frame in itself is seen to embody important therapeutic experiences. If this aspect of the frame with its multi-dimensional qualities can be more fully appreciated, then it is easier to understand and accept why it is so important to respect all aspects of the boundaries in maintaining the frame.

I would like to attempt to translate this into the educational field. There is a need for ground rules, for assignments, attendances, etc, which clarify expectations of performance and standards of behaviour, engendering an atmosphere of safety, trust and certainty. The known, in which the unknown may emerge. The educational frame is more than the ground rules of assignments and exams. It is also the expectations of the nature of the student-teacher relationship: education, not therapy. It is the safety net under the tightrope between trusting the process to allow the students to learn all they need to know, and the need of the tutor for the content to be covered. It seems important in the current climate of concern for learning outcomes and performance objectives, to remember the power of the 'teaching moment'. But there is a place for the learning of information and lecturing. It seems to me possible to combine the two, given wisdom and confidence.

What is the balance? I have no answers, only questions. But of one thing I am certain: the relationship between teacher and student needs to be out in the open and clear. A group contract needs to be entered into and kept. Administrative procedures have to be well documented and adhered to. The shadow self needs space and it will be contained within this space only if all the human connections can be acknowledged and valued. This integrity of the educational relationship is as important to preserve as that of the therapeutic relationship. Boundaries and rules are needed to define the limits and that which is off limits, what is contained within and that which is outside. Picket fences are easier to see than ha-has, those ditches of England built to preserve the view, but when stumbled into, producing humiliation and injury. We need sturdily built picket fences, maintained by tutors, so that students are clear when they are being unsafe for themselves and their clients.

Looking back at my placement at the London School of Economics, with the wisdom of hindsight, how could it have been a different, non-shaming experience for me, and probably my supervisor? It transpired later that my

supervisor had countertransference issues with my family and was severely depressed. She was very anxious, and dealt with this by refusing me information about the clients I was to see. Her depression did not enable her to affirm my work in any way. We needed a super-supervisor. She needed a choice in taking me as a supervisee, and I needed clear guidelines as to what to expect from a supervisor and a person to discuss it with. I needed to have my appropriate expectations as a student clearly delineated. We both needed clearly defined boundaries and a frame.

Components of the Educational Frame

Some elements—such as fees, length of course, number of hours, resits and content—are set by the training institution's own academic requirements and assessment criteria. The tutor has more/less input into these depending on the particular institution. In a polytechnic in New Zealand, for example, assignments must have clear marking criteria and named assessors. The separation of functions is a crucial factor in safety both for students and tutors. The British Association of Counsellors has very clear ethical guidelines on this, and holds to a policy that the tutor should not also be supervisor or counsellor to the same students. Educators should be clear as to how these different functions operate in practice. If one is teaching a class where personal material is shared, this sometimes becomes very difficult, and a fine balance needs to be maintained between recognition of the existence of archaic emotional material and exploration of this. I have found that most students enter personal therapy during the course, but it is not the business of the tutor to know this or whom they are seeing. I suggest that educational boundaries are more easily maintained if there are no other social relationships clouding the horizon.

Conclusions

Teaching is both a difficult and rewarding task, particularly when one focuses on process as well as content. It is a place where I have experienced the magic of interpersonal connection, shame and horror. As tutors we have to be at times judges of safe practice. We have to be able to use our power, authority and expertise and to stand our ground. The demands of this task require us to remember the needs of teachers. We too need 'holding'. While we need to be held accountable when the process and boundaries are not kept, we also need a functional institution where those in authority will trust us. We need to know that if there are complaints from students in the midst of transferential learnings, the tutors' side of the story will also be respected. And we need the support and validation of colleagues.

But the last word belongs to the students, who are essential for our teaching. As we celebrated her achievement in passing the course, a student paid me the highest compliment "Thank you for staying with me, as I gained my confidence. For not doubting me, for hanging in there and for sharing of yourself at times, not perfect, just human". She knew she was 'love and loveworthy' and powerful. What more could I ask?

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Paper delivered to ANZAP 1997 Conference, Sydney, and NZAP 1998 Conference, Auckland.

The Teacher's Headache

Stephen Appel

Abstract

This article considers a psychosomatic symptom - migraine - produced in the author while teaching a course on psychoanalysis. Referring to a dream and to case material, the article reflects upon 1. the teaching relationship, 2. migraine headaches, 3. countertransference and 4. the nature of inquiry itself.

The Teaching Relationship

I have about three or four migraines a year. One particular year, however, I managed to get migraine symptoms on four out of the thirteen Mondays on which I teach an MA course at the University, *Psychoanalytic Perspectives on Education*. Typically I would suspect by the mid-seminar break that a migraine was underway and would then respond by denial, procrastination, or taking medication. The first two of these would lead to a full-blown migraine attack, and the latter to side-stepping it. For the purposes of this article I will leave aside any constitutional bent I have for migraines. Rather, I take this unusual frequency as proof of a psychosomatic element.[1]

The first migraine I can remember occurred was when I was five years old. But I am aware too that by that age I was already familiar with the migraine and how it would happen; my migraines have always been very similar. They begin in the late afternoon and last until the next morning. I don't have distortions of vision - except for sensitivity to bright light - instead I have the typical very painful headache in my left temple, a need to lie down quietly, and, usually, nausea. As I've got older the headaches have become more intense and I now feel washed out the next day. My migraines fit Oliver Sacks' delineation of five stages of the typical migraine.[2] Now and then I will have a twinge or a light

1 Illnesses and symptoms are designated 'psychosomatic' if (a) the symptoms are accompanied by demonstrable physiological disturbances of function, and (b) the symptoms and the illness as a whole can be interpreted as a manifestation of the patient's personality, conflicts, life-history, etc, (Rycroft, 1968: 133).

2 Initial *excitement*, perhaps accompanied by aura, heightened emotion, or ocular symptoms; *engorgement*, visceral distension and stasis, vascular dilation, etc. and emotional tension; *prostration*, affective apathy and retreat as well as physical nausea, drowsiness, etc; abrupt or gradual *resolution*, vomiting or sudden excess of emotion or more gradual melting away of the symptoms; *rebound*, euphoria and physical well-being (Sacks 1992).

feeling of being touched on my migraine spot without it developing into a migraine.

It shows itself in the therapeutic room too.

> Before an initial interview I read the notes made by the receptionist. The new patient had told reception that someone close to her had been sexually abused, but that she didn't know whether she (the new client) would be prepared to talk about this with a therapist. Thus, I was prepared for something. In the course of the first session she said: "When I was fourteen - although I only found out about it years later - my sister was raped by two boys down the road." Immediately I felt that I had been 'hit' on my left temple; I felt a very intense, concentrated cramping there for about five seconds - so strong that I had to rub the spot. I've never experienced this before. "She's communicating something to me," I thought, "But what?" Driving home after the session I again felt a sensation, milder this time, and thought: "Oh-oh, am I getting a headache?" Then I suddenly realised that I had completely forgotten to mention the incident in my notes after the session.

There is much food for thought here. For now I will not try to analyse this acute bodily response. Rather, I pose the question: can we as therapists and teachers use our own pathological 'weak spots'[3] as sensitive transference/countertransference receptors and decoders?

I write here as both psychotherapist and teacher. While a therapist is better trained to venture down the paths I indicate here, in principle they are open to the teacher too. This article tracks the course of my inquiry into four areas: 1. the nature of the teaching relationship, 2. migraine headaches, 3. using this symptom in one's work, and 4. the nature of inquiry itself.

A few words about the course in question. I established it and it has run for four years now. It is structured in such a way that the first half is spent studying Freud and the second considers a range of writers (from Klein to Althusser) and concepts (from transference to interpellation). A wide variety of students have attended the course (e.g. a writer of educational textbooks, an experienced psychotherapist, a sculptor, a science educator, and a couple of budding philosophers). My impression is that the first - Freudian - part is the most intense and stimulating part of the course for both the students and myself. I

3 I use the term 'weak spot' very loosely to refer to the connection between the domains of psyche and soma: to make some reference to disposition. Oliver Sacks puts it beautifully: "We must interpret situational migraines as if they were palimpsests, in which needs and symbols of the individual are inscribed above, and yet in terms of, the subjacent physiological symptoms" (1992: 223).

expect the students to take Freud seriously as a thinker; sometimes they arrive with simplistic, dismissive prejudices about his work. I don't let flip, careless statements pass by and I encourage students to consider even Freud's most outlandish-sounding notions: thanatos, penis-envy and castration-anxiety, the primal horde. I try not to be a zealous defender of a doctrine which is immune to criticism, but rather insist that criticism involves serious reflection. By the end of the Freud section I have been satisfied each year that I have succeeded in getting students, not to be Freudians, but to take his ideas seriously in all their intellectual and personal difficulty, and even to enjoy them. To be able to move on to the question, "Why do I dismiss/accept this so readily?" After much wrestling each week with Freud (and with me) one student said: "I've made friends with Freud." I find that I am far less concerned that students be as earnest about the authors and ideas in the second part of the course. Perhaps this is because that material just isn't as challenging or because I let up, my main task having been accomplished. But in any event in the latter part of the course the classes lose their edginess and, perhaps, some creative tension too. So it will be clear to readers how much of myself is invested in Freud's work. (Why this might be so is a question for another day.)

Frieda Fromm-Reichmann (1937) articulated the classic psychoanalytic position; migraine, she said, is the bodily expression of unconscious hostility to consciously beloved persons. The difficulty here for me in trying to understand my own migraines is that the destructiveness she speaks of *is not experienced as anger* - it is unconscious; how is one to verify its existence? Nevertheless, if we can entertain her explanation, perhaps we will see what it is in my class that would generate such unconscious rage and set in motion the migraine solution; and, extrapolating outwards, get a glimpse of something which is a feature of pedagogic encounters generally.

To this end, I have undertaken some self-analysis, therapy, supervision, and reading between then and now. One day when out walking I recalled a vivid dream I had had in early 1994, the first year of the course in question.

> **Dream.** I am a junior member of staff at a university/psychotherapy centre and I have arranged for Freud to be awarded an honorary doctorate. Everyone is in the hall next door where Freud is giving a lecture; I am not there because I am to organise things in this room where he will be awarded the degree. The doctoral gown is hanging on a rack and I am rather disappointed with its colour: dull orange-mustard instead of, say, bright scarlet. The procession begins to fill up the hall. I am on stage with the other members of staff. With a start I realise that I'm wearing short pants, but

> figure that people won't notice because I'm not in the front row. Freud and the other dignitaries walk slowly in. He is very old, like in the photographs of him in London. Suddenly he trips on the carpet and falls heavily - I know that he has broken his hip and that it is a fatal injury. He bellows in agony. Everyone stands watching quietly as the paramedics attend to Freud. He is given an oxygen mask (which looks like a plastic bag over his face) and placed on a stretcher. As he is taken out he smiles and waves weakly to us. I am devastated and wake weeping.

So, an unconscious phantasy that Freud's work needs resuscitation - indeed he needs the paramedics! - and also a fear that my small efforts to keep him alive in my classes are in vain. The other face of idealization too, destructive envy. There is a lot more to think about here, but what struck me as I remembered this dream was the difference in attitude between myself and the rest of the dream's audience. I was the keeper of the flame, the loyal disciple, whereas for the others Freud was one old-time writer among many: they were respectful seeing him dying, I was absolutely desolate. Perhaps this is something like what happened in my class. It is as though I was a Talmudic scholar while the students *seemed* intrigued but nonchalant by comparison. (I emphasize 'seemed', a different picture emerges later). To me the students were reluctant and, thus, I became unconsciously resentful.

And this is where the conflict became intense and intolerable. I was their teacher and (I now realise) for me a teacher has a triple responsibility: to hold the group[4], to provide some of the excitement, and to model intellectual rigor. The problem with this phantasy of the ideal teacher, of course, is that this teacher can't be himself - I *had* to be enthusiastic and positive. But in this particular class it became too difficult because of my suspicions about the attitudes of the students and because of my particular attachment to the central figure of the course itself, Freud. Sacks describes the case of a migrainous nun: "Irritability, anger, sulking, etc. were not permissible in the convent, but migraine was" (1992: 167). The same was true of my classroom. As Bruno Bettelheim said:

> It is not even enough to do the right thing at the right moment, it must be done with emotions that belong to the act. Again and again in our work we have found that what counted was not so much the hard facts as the feelings and attitudes that went with them. (1950: 7)

4 'Holding' here refers to Winnicott's (1965) notion of 'the holding environment.' See also Wilfred Bion (1962) on projective identification where the therapist 'contains' the patient's projection which is in turn designated 'contained.'

(I should say again that I really don't expect my students to become devoted Freudians. Actually, I'm not put off by the student who remains sceptical. It is something other than agreement and disagreement that I find hard to tolerate.)

To get back to the problem of teaching. M. Robert Gardner's work is useful here. He has been a teacher of psychoanalysis for many years and he speaks about the affliction of the "true teacher": the paradox of the "furore to teach."

> What is a furor to teach? It's a menace. It's a menace to teachers, to students, and to innocent bystanders. Teachers possessed by that furor are in trouble. Teachers devoid of that furor - if such can be called teachers - are in more trouble. Teachers are damned if they have it and damned if they don't. (1994: 3)

> Appoint any energetic man or woman to the teacher's job and in short order that teacher will regard as indispensable whatever he or she chooses to teach and whatever method by which he or she chooses to teach it. (4)

> Without the furor to teach, true teachers are most unlikely to move themselves or their students. But the line between helpful furor and harmful is full of lost edges and, consequently, of lost teachers and students. (6)

And then Gardner says something which rings true for my feelings with regard to my own teaching of Freud. He says:

> I have found myself subject to the fullest furor to teach when consumed by the notion that *I know something . . . that my students not only need urgently to learn but are able to learn only from me* (1994: 9, my italics).

This is the knot as I see it thus far. Full of the furore to teach I put a lot of myself and my narcissism into the teaching of Freud. Students, naturally, responded with various and varying degrees of interest or lack of interest, antagonism, irreverence, industry, and slothfulness. Now comes the kicker; because of the furore to teach and my ideas about what it is to be a good teacher, I tried to engage enthusiastically while a part of myself, it seems, was hurt and furious at any signs of lack of interest or apathy mixed in with the students' response.

An earlier version of this article, presented to psychotherapist colleagues, ended at this point and with a speculation about developing my personal experience into a theory about hate in the teaching relationship, along the lines

of D W Winnicott's (1947)*Hate in the Countertransference.*[5] Could it be, I asked rhetorically, that in the apparently selfless and charitable act of teaching there is a built in hatred of others and of self? Or in Jacques Lacan's words:

> We place no trust in altruistic feeling, we who lay bare the aggressivity that underlies the activity of the philanthropist, the idealist, the pedagogue, and even the reformer. (1949: 7)

In Winnicott's well-known article he said that there is good reason for the therapist to hate the psychotic patient, just as there is good reason for the mother to hate her baby. Surely it is plausible to build a similar case with regard to teacher and students? Students wear the teacher out physically, emotionally and mentally; students are ruthless and expect the teacher to satisfy all their desires; students have to be loved unconditionally, even their poor work and bad behaviour; students suck one teacher dry and then move on to the next one; students sexually excite the teacher who cannot act out these feelings; students resist Teacher A's strenuous efforts, but sing the praises of Teacher B to Teacher A; the teacher envies the students' freedom to be serious or not; and so on. Like the therapist and the mother, the teacher must learn how to hate the student. More of that later.

Expressed as a syllogism my thinking at this point went as follows. Teaching contains within it the teacher's hatred of the students; migraine headaches are produced by the non-expression of unconscious hateful and rageful feelings; therefore, it was the unconscious nature of my hatred as a teacher for my students which produced my migraine headaches. The strain of trying to adopt a false self[6] and not retaliate was too great, and I fell ill. (Consciously, of course, this is all most unreasonable.) This model throws light on the pedagogic relation - the teacher is, among other things, hateful - and it is also wholly in line with classic psychoanalytic theories about migraine; two good reasons to feel self-satisfied.

Migraine

What does the psychoanalytic literature say about the dynamics of migraine? Fromm-Reichmann, as we have seen, spoke of her migraine patients as

5 I knowingly elide here any differences between aggression, hostility, anger, and hatred. See Akhtar, Kramer, and Parens (eds.) (1995) *The Birth of Hatred.*

6 For Winnicott a 'False Self' relates to the environment "on the basis of compliance" (1960: 149). He says that the False Self may exist at any of five levels ranging from health to deep pathology. Winnicott also makes a point which is relevant to the issue of relationship which I am about to discuss: "*It is not possible to state what takes place by reference to the infant alone*" (145).

suffering from "unresolved ambivalence; they could not stand to be aware of their hostility against beloved persons; therefore they unconsciously tried to keep the hostility repressed, and finally expressed it by the physical symptoms of migraines" (1937: 26). While the average person "feels conscious anger against an adversary," "the migraine patient . . . represses his hostility against consciously beloved persons" (28).

R E. Money-Kyrle understood migraine as a defence against seeing something about oneself, for example, envy. Interestingly, he spoke of a patient "losing the ability to have migraine" (1963: 491). In other words, migraine is not something that attacks one, but something that one does.

Melitta Sperling said that " repression of rage and of the impulse to kill serves to protect both the object in the outer world and the patient himself. At the same time, the gratification of the impulse is achieved unconsciously in the symptom" (1952: 161). One of her patients reported beginning to develop a migraine on the way to analysis, but then the headache stopped. "So," said the analyst, "you decided to let me live" (1964: 554). Sperling noticed that a manic-depressive pattern alternates with the migraines. It occurs to me that perhaps the migraine is a temporary alternative to depression.[7]

The writings of our psychoanalytic predecessors, then, suggest that "each migraine attack represents a repetitive unconscious killing of the frustrating object. There is no conscious awareness of this, no guilt feeling, and no depression" (Sperling, 1964: 550). The migraine is "a specific and early acquired attitude of the patient towards dealing with overwhelmingly strong destructive impulses" (556). A narcissistic injury, in Sperling's view, produces destructive impulses which have a few possible means of expression: 1. attacking the object, 2. attacking the self (depression), and 3. somatic expression. This destructiveness, then, threatens to destroy the object relation, but the psychosomatic solution not only retains the object in reality, "but the tie is strengthened by the illness". In short, through secondary gains, "it pays to be sick." "By the very fact that he is sick, [the patient] can indulge himself and be indulged by others" (555). She puts it succinctly:

> The onset of migraine in certain types of personalities . . . occurs in a situation which provokes intense rage *and at the same time does not permit the discharge of this rage in overt behaviour*. (1964: 551, my emphasis)

7 Sacks confirms this. Not all migraine suffers fit the stereotype of the obsessive "migraine personality," neither are migraineurs particularly neurotic. "In many cases . . . the migraines may replace a neurotic structure, constituting an alternative to neurotic desperation and assuagement" (1992: 172).

I have found this most illuminating on the subject of my pedagogy. However, this formulation - let us now call it Model A - does not ring quite true. It smacks of premature theorization with regard to my migraine. For one thing, as its focus is only on the teacher's internal world, Model A is theoretically unsatisfactory in terms of explaining the pedagogic *relationship*. Model A addresses the teacher's countertransference but ignores the student's transference - the student's efforts to re-enact in the pedagogic setting relationships which have been learned in early childhood.

Sometimes we need to be hit over the head, as it were, before we can see something which was before our eyes all along. Migraine for me occurs in relationship with others.

> In a co-therapy session Rebecca - a vivacious young women, paraplegic after an accident which occurred after her marriage - was confronting her husband yet again: "Why don't we have sex any more? I'm still interested." Yet again, her husband hung his head, saying little. Then a sudden change; he raised his head, looked directly at his wife, and out poured a stream of cruel, cold truth-telling. "I'll tell you why. You think you're normal, but you're not. You won't hear this, but you're disabled. You just lie there, I have to do all the work. Do you know what it's like having sex with a handicapped person? It's not fun, I can tell you." Glancing at the therapists, "She's dead weight." "You're hard work, Reb, you're hard work." And so on for some considerable time. Then a tearful silence broken eventually by Rebecca in her characteristic up-beat, appealing voice, "Yes, but that's just an excuse, we can try can't we?" The session came to an end, and as the couple left the room I was struck by a powerful and debilitating migraine.

Here the pain, rage, humiliation, sweetness, desperation, frustration, fear, horror, and heartbreak in the room became too great for me to handle. Taken aback, I identified with everything, it seemed: his feelings about living with a paraplegic spouse, her hurt at hearing herself described in this way, and his desperation at her denial. Stunned into silence by the suddenness and the sheer magnitude of this emotional load, I was unable to relieve it. (Interestingly, while I got a migraine for my troubles, their relationship began to improve shortly afterwards.)

This ties in with another weakness in Model A which is that I have in fact never been a complete stranger to my anger. It is true that the teacher-role discourages the acknowledgment of angry feelings towards one's charges, but, nevertheless, I have often felt angry with a student. Sometimes it's hate, yes, but at other times it's other emotional circumstances which can produce

migraine. During the period when I was pondering this question it happened that a small and not uncommon therapeutic incident caught my attention and enabled me to disrupt the initial explanatory model.

> Sitting with a patient I remarked, "I wonder whether being the responsible oldest son in a large family has something to do with your only feeling good when you are helping your friend with a problem." As I said this he glanced very briefly at me out of the corner of his eyes. Immediately I felt a tightening in the migraine spot on my left temple.

This type of interaction must have happened many times inside and outside the therapy room, but for once I was able to notice it and think about it. What did his glance suggest? He is angry with what I have just said; it is wrong, unwelcome, or mis-timed. Although he is not about to let me or himself know that he is angry with me, he communicates it nonetheless. As Freud said in the case of Dora:

> He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If his lips are silent, he chatters with his finger-tips; betrayal oozes out of him at every pore. (1905[1901]: 77-78)

What happened in the little incident with my patient? It may be, of course, that my detection of his anger produced an equal and opposite anger in myself, anger which because it was unconscious could not be expressed and therefore became a migrainous symptom. This explanation is in line with Model A.

But this might be quite wrong. Is it not equally plausible for an angry signal to produce a fearful, self-protective response? What I now think occurred is the product of my strenuous *post hoc* picking apart and piecing together of what was but a momentary spark of quite banal human interaction. Here is an alternative analysis of that instant:

> I made the interpretation.
>
> The patient briefly, and probably largely unconsciously, felt angered, his glance showing this for he who has eyes to see.
>
> I only just picked up on the anger but, because of the unconscious nature of the perception, was quite unable to adopt either a fight or flight response, so froze.[8]
>
> I felt pressure in/on my temple.

In the case of the young woman telling me about the rape of her sister, it might be that her hostility produced an unconscious fearful response in me. (This interpretation fits with her distinctly psychopathic tendencies which revealed themselves as the therapy progressed.)

Let us call this Model B. Although one can never *know* about such things, this thought has enabled me to move beyond the confines of Model A.

Based shakily, it is true, on an $n = 1$, it occurs to me now that migraine is a psychosomatic response to unsuccessfully repressed material in an intersubjective context.

I have found Sacks's comprehensive *Migraine* (1992) a most useful read. On the incidence of migraine: "A substantial minority, perhaps one-tenth, of the population experience fairly common and readily-recognised cephalgic migraines" (120). He notes the variety of symptom occurrence in migraine - headache, nausea, aura, lethargy, *et al.* occurring in a variety of permutations - as well as the variability of duration and level of the nervous system which is affected. Migraines lie "in the middle range - between the vegetative disturbances and the cortical disturbances" (109). Sacks reviews the vast array of external and physiological stimuli which may produce migraine. "Migraine is conspicuously a psychophysiological event" (1992: 110). I do not concern myself with "circumstantial" migraines in this article, but rather with "situational" migraines; what is important for our purposes is the *psycho*somatic nature of migraine. Migraine, says Sacks, is an "eloquent and effective . . . oblique expression of feelings which are denied direct or adequate expression in other ways" (226). He speaks of chronic migraine sufferers (of which I am not one) as being "caught in a malignant emotional 'bind'" (1992: 165).

Perhaps Sacks is right when he asserts that "migraine may be summoned to serve an endless variety of emotional ends . . . . If they are the commonest of psychosomatic reactions, it is because they are the most versatile" (1992: 166).[9]

8 Sacks speculates that migraines are instances of the "passive, parasympathetically-toned, protective reflexes such as many animals employ to environmental or internal threats - cold, heat, exhaustion, pain, illness, and enemies. All such reflexes, like migraine, we have seen to be distinguished by regression and inertia, *in contrast to fight-flight responses*" (1992: 226, emphasis added).

9 Sacks lists six uses of migraine: recuperative, regressive, encapsulative, dissociative, aggressive, and self-punitive (1992: 213-216).

Countertransference

Psychosomatic psychopathology in the therapist must be the subject of ongoing analysis and self-analysis. Quite obviously, I must continue my efforts to transform my migraine responses. But I now wish to talk about the possibility of productively employing a psychosomatic response such as migraine in the therapy room and the classroom. This brings me to countertransference, and the definition I wish to use is that of Joseph Sandler: countertransference is "a compromise between [the therapist's] own tendencies or propensities and the role-relationship which the patient is unconsciously seeking to establish" (1976, 47). Let's be clear here. Countertransference, Sander is saying, does not belong to either the patient or to the therapist; it is a joint production, the nature of which depends on what each unconsciously brings to the interaction. The patient tries to get the therapist to behave in a particular way (a role), and the therapist responds in a way which is dependant on his or her own characteristics ('stuff'). To generalise (unless we cling to the spurious notion of the completely analysed therapist) the tendencies or propensities of the therapist necessarily include his or her own pathological bits. These must and do get activated at times by the patient. And, what is more, these activated symptoms are signs which have meaning.

But we therapists are trained to recognise positive and negative transferences. Also, it is increasingly becoming accepted among psychotherapists that countertransference can be a useful tool. Why is it that in the examples cited in this article I was knocked out of kilter in the way I was? It is not the case, I believe, that I am generally poor at coping with transference and countertransference. Much of my work involves listening with my third ear [10] Rather, in these particular instances I was caught unawares: blindsided, mugged, if you like. It is as though there is a bandwidth of unconscious communication which I detect only preconsciously, psychosomatically. The unconscious can by definition not be observed, but its effects can seep through because repression is never complete.

The powerful disavowed feelings sneaked up on me precisely because they had been imperfectly repressed. Unexpectedly and indirectly semi-expressed, I not-quite-noticed them out of the corner of my eye - like a phantom. It is important not to limit this failed repression to the patient alone. I would reconstruct a quote from Sacks (1992: 26) as follows: Migraine is an eloquent and effective oblique expression of feelings *arising between me and someone else* which are denied direct or adequate expression in other ways.

10 Theodor Reik (1948), *Listening with the Third Ear.*

Winnicott (1948) speaks of 'impingements' as another's interruptions to our going-on-being - like when a ringing telephone disturbs one's sleep. In the instances I have given, though, it is like being woken by a telephone which *has been* ringing but, by the time one wakes, is silent. Startled awake, what's going on! As Sacks says, migraines "represent disorders of *arousal*" (109). There is a retuning of mood and autonomic status over the course of the migraine. That is its function – to return me to a condition of going-on-being where I can work. Think of a spinning top. A small tap in the wrong direction causes chaos in the movements of the toy; it must come to complete rest before it can resume going-on-being. [11]

In order to be able to deal with such affective situations one needs to be able to have enough distance to be able to perceive what is going on. Then there will be the possibility that one can help oneself as well as help the patient.

Here is an example:

> During a session I developed a sensitivity in my migraine spot following the patient's description of a powerful dream he has had since childhood. The dream is of the huge planet earth whirring very fast only inches from his face and body; it is an overwhelming dream of awe and insignificance. A little later in the session he described an old symptom of his – a difficulty breathing, a snatching at breath. He had subsequently found out that it is a medical condition, but one brought on by 'stress,' he said. (In my words, it is a psychosomatic expression at a physical weak spot of some emotional difficulty.) It is less debilitating for him these days, he continued, because 1. he relieves it by taking a few deep breaths, and 2. he realises that he's stressed, something that he has been unable to recognise in himself although others do notice it. I silently put all this together with my own self-work and then commented: "It has meaning, then, and you're learning to read it."

Remarkably, as this discussion progressed, so my migrainous sensation lessened, then disappeared, accompanied by a sense of well-being. My patient too reported feeling calm at the end of the session. I understand it as follows. Initially I was unconsciously possessed by the helplessness and destructiveness of my patient. Just as he was unaware of his 'stressful' feelings, so I did not experience the feeling, rather a substitute: a migrainous sensation. Able to

11 This image fits with the developing cybernetic model of psychosomatics: 'psychobiological disregulation' which integrates developmental biology, developmental psychology, and the biomedical sciences with relational models of psychoanalysis. For a review see Graeme Taylor (1992).

reconstruct this in my mind I could offer the affirmative intervention[12] which, small as it was, provided relief by promising some hope to each of us and by allowing me some analytic distance from my own helplessness (and my destructiveness). Our exchange functioned affirmatively for myself too with regard to my own psychosomatic situation. (Harold Searles [1975] has written movingly about the patient as therapist to the analyst.)

A question raises its head: could this not all simply be a projection on my part and have nothing to do with my patient? Thomas Ogden has made the distinction between projection and projective identification clear. Projection is like the first stage of projective identification, viz. "the fantasy of projecting a part of oneself into another person and of that part taking over the person from within" (1979: 358). Experientially, though, projection is different to projective identification. In projection one feels psychological distance from the object, while in projective identification, one feels "profoundly connected" with the object (359). In the case in point I would say that I identified with my patient's projection of his helplessness and the destructive part which threatened to obliterate him.

We have dealt a lot with hatred in this article. Winnicott, that most maternal of therapists, insisted that hate be acknowledged by the mother in order for child to feel real.

> What happens is that after a while a child [here of a broken home or without parents] gains hope, and then he starts to test out the environment he has found, and to seek proof of his guardians' ability to hate objectively. It seems that he can believe in being loved only after reaching being hated. (1947: 199).

Meeting hate with consistent love is worse than no help. In his book *The Art of Hating* (1991) Gerald Schoenewolf says that the way to hate well is as follows: 1. distinguish between 'subjective' and 'objective hate,'[13] 2. risk verbalizing the hate, and 3. bear the consequences of that verbalization. Subjective hate belongs to the mother (teacher, therapist) and needs to be resolved through self-analysis, supervision, or further therapy. On the other hand, "hate *that is justified* in the present setting has to be sorted out and kept in storage and available for eventual interpretation" (Winnicot 1947: 196). "Objective

12 An affirmative intervention is, according to Bjørn Killingmo, "a communication which removes doubt about the experience of reality and thereby re-establishes a feeling of identity . . . . Affirmation and interpretation address different experiential modes" (1995: 503).

13 Let us leave aside for now the myriad of philosophical problems inherent in the word 'objective.'

hating resolves the conflicts that breed hate and transforms hate into its alternative feeling state, love" (Schoenewolf 1991: xii).

There are many ways to deal with hate. To hate well—thereby transforming subjective hate to objective hate—one can use: questions, commands, explanations, puzzles, out-silencing the patient, out-crazying the patient, or one can use what Hyman Spotnitz (1976) calls the "toxoid" response. This is like immunization where individuals are injected with a mild case of the disease – "carefully 'treated' to destroy their toxicity and to stimulate the formation of antibodies" against the disease proper (1976: 50). Here is an example of employing the toxoid response in the classroom.

> A year after the semester of the high incidence of migraines in my masters class, I taught the course again – this time more self-aware about my own phantasies. One day during a discussion with the students about the progress of the course I figured out how to express my hatred. "Sometimes I catch myself lecturing and advertising as though I need to convince the class of something. I'm not sure what it's about but I really don't like feeling like a used car salesman. How does it seem to you?" A student spoke up: "It doesn't feel to me that you're trying to sell me something, but I do have some anxiety about how vast the field is and whether I'll ever get on top of things."

Others joined in expressing their worries. It became apparent that my furore to teach was making the students more anxious, and that I was misreading their anxieties as reluctance. Needless to say, the flow of the class was set in motion again without my having to resort to migraine.

Although my learning experience is far from over, there may be a lesson here about a potential therapeutic ability. My own weak spot may be tamed in the sense that its (transferential) meaning will be accessible enough so that as a therapist I can illuminate or contain something for myself and the patient and simultaneously stop the migraine. Further, it may be that the migraine symptom will become such a refined tool that its waxing and waning can be used to measure the extent of repression and denial or insight and relief in both the teacher (therapist) and the student (patient). Countertransference is a deep pool.

There is an old joke that goes:

> A man goes to a doctor and says, "Everything's wrong with me, but I don't know what it is. I touch my head and it hurts. I touch my chest and it hurts.

> I touch my leg and it hurts. What's the problem?" The doctor examines him and says, "Your finger's broken."

Sometimes I think our work as therapists is a bit like this, except in our case the patients do have hurts and we are the ones with broken fingers. The head, chest, and leg come to stand for what the patient brings to the therapy, and the hand with its broken finger represents the flawed person of the therapist. Now the joke is at the expense of psychotherapy and the paradox of the therapist's own psychopathology.

The Nature of Inquiry

Is it necessary to add a note of modesty here? Far from a solution to what Freud called "the mysterious leap from the mind to the body," this article is simply an account of how my thinking has developed with regard to my own psychosomatic experience.

I walk a fine line here in that I might be seen to reveal more of my own psychopathology than is seemly, but how else could I have demonstrated my point? I've shown quite enough of myself here and it may be unwise to go further in public. The psychoanalyst Rivka Eifermann (1987) has written about how a friend called her "crazy" for discussing her self-analysis before an audience. (Where is the line between collegial discussion and acting out?)

In writing this article I have found it useful to borrow some methodological considerations from Jane Gallop's *Knot a Love Story*. To paraphrase her, I wager 1. that I am not a paranoid or a hypochondriac, and 2. that the incidents I describe are representative of a range of pedagogical and psychotherapeutic experience. Gallop introduces the term "infantile pedagogy" by which she means that "teaching in general is informed by largely unconscious reactivations of powerful childhood pedagogical configurations, which of course, in their specific forms vary with the individual" (1992: 6).

I fear that, if I tie up more threads of my narrative, what remains of its spontaneity and openness will be compromised. Let me summarize this work-in-progress for now: certain emotions, when imperfectly repressed and thus indirectly expressed in the classroom or in the therapy room, function as impingements to my going-on-being and produce migrainous symptoms in me. I have ventured to suggest that this says something not only about myself, my students, and my patients, but also about migraines, pedagogy, and psychotherapy. Stated as three aphorisms:

The world of the classroom is full of hate, but very few teachers know how to hate well. [14]

The migraine is both an intersubjective event and an encounter with a poltergeist.

Countertransference is feeling another's pains with one's own broken finger.

I said at the start that I have tried to use my psychosomatic response to a teaching situation in order to learn more about four things: the nature of the pedagogic relationship, migraine attacks, actually using this symptom in psychotherapy work and teaching, and the inquiry. A few thoughts on the last of these.

In the process of developing a question (Why am I getting migraines in this class?) into a line of inquiry and then into a research article I have for many months alternated between floundering aimlessly and grabbing onto passing debris (personal experience of migraine, pedagogy, and psychotherapy, as well as reading in these literatures). That process has been one of intuitive leaps, serendipitous happenings, rational thought, as well as the creative activity of writing.

When a story is too neat in construction, too smooth in the telling, we may suspect over-intellectualization. Indeed, the Nobel Prize-winning biologist P B. Medawar once famously asked whether the scientific paper is not a "fraud" because "it misrepresents the process of thought that accompanied or gave rise to the work that is described in the paper" (1963: 228). So in this article I have tried to convey the development of my thinking, but the result does gloss over the backtracking, the leaps, the pauses—there is a limit to how much one should test the goodwill of one's audience!

There is no way to do research, i.e. what we call "research methodologies" are stories told after the fact to try to make rational a substantially irrational process.

I have found that conducting research is a bit like going for a swim: floating, getting out of one's depth, diving below, treading water, swimming strongly. This is not like swimming in a river which has a source and a mouth: hypothesis, experimentation, results. Rather, it is like swimming in a large pool. There is no beginning or end, just water and endless shoreline. One gets in, moves around in the water, and after a while one gets out. I do so now with a final aphorism *à la* Winnicott: [15]

There is no such thing as a research method.

14 Adapted from Gerald Schoenewolf: "The world is full of hate, but very few people know how to hate well" (1991: xi).

15 "*There is no such thing as a baby*" (1952: 99).

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The Process of Dreamwork

Margaret M. Bowater

Abstract

Dreams can present the current central issues in a client's world, beautifully encapsulated in metaphor and story. If therapists are alert to their significance, and include them in the therapeutic process, new insights emerge and opportunities are presented for personal change. This article demonstrates a step-by-step process of working with a dream, using drawing, associations, simple action methods, redecision work and self-reflection, to facilitate personal growth in a dreamer.

Introduction

Since 1986 I have been working with clients' dreams, and running dream workshops in the public arena. Over this time, I have gradually synthesised a particular way of working which draws elements from a number of different modalities. I have found no single approach sufficient in itself, but a combination of methods most effective in revealing the meanings of the dream to the dreamer, and facilitating growth. I use drawing, verbal association and theory of the psyche from Jungian therapy (e.g. Hall, 1983), simple action methods from Psychodrama, script analysis and redecision work from Transactional Analysis (Thomson, 1987), and the perspective of the soul's journey from the ancient Christian art of spiritual direction (e.g. Sanford, 1984)—not necessarily all of them with every dream.

I regard the dreamer as the owner of the dream, and the ultimate interpreter of its meaning. My role is to facilitate the interpretation process, in much the same way as a bilingual interpreter might assist someone to read a letter in an unfamiliar language. The author in this case is the inner Self or Spirit of the dreamer, who is far better acquainted with his or her life-experience than I am. Therefore, if I offer any insights or interpretations, I do so tentatively, in a joint process of exploration. If I am close to the mark, the dreamer will work with it; if I am wrong, we let it go; if I have made a connection that is possibly accurate but the dreamer is not ready to accept it yet, we also let it go, but it will probably hover in the background, waiting for other confirmation,

perhaps in another dream. Always the process is respectful of the dreamer's being. The deeper the dream, the more sacred is the territory in which we are working.

Levels of Interpretation

I find Ann Faraday's concept of levels helpful (Faraday, 1972) when I am hearing a dream for the first time. First is the **literal** level, in which things are taken at face value, just as they are presented. This may apply to elements based on direct memory, as in repeating dreams of trauma, or warnings of danger perceived at a subliminal level. I check this level first. Thus, for example, fear of a fierce dog may refer literally to fear of the neighbour's dog. There is also the whole group of telepathic and clairvoyant dreams, which I have described in my book, *Dreams and Visions – Language of the Spirit* (Bowater, 1997). Often, literal and symbolic elements are both present in a dream, in which case we proceed as if it is symbolic, and discover which is which as we go. Often a dream figure literally identified carries another level of symbolic meaning as well. A dream, like a poem, may have multiple levels of meaning.

Ann Faraday refers to her second level as "through the looking glass" – the dreamer's perceptions of reality out there, filtered through his or her own unconscious processes. I simply refer to this as **outward metaphor**, in which the dream figures, or some of them, symbolise external realities which the dreamer has to deal with. Thus, the fierce dog may symbolise Dad in a bad temper. Recent research suggests that this level has been greatly underestimated in analytical work with dreams. I normally do the initial work with a dream at this level, in order to draw out as much language as possible about the dreamer's experience. I listen for echoes and patterns in the dream which reflect some aspect of the dreamer's life or personality. I call this "thinking double."

Faraday's third level is the Jungians' subjective level, in which elements of the dream symbolise elements of the dreamer's psychic structure or internal world. I refer to this as Level 3, **inward metaphor.** This level often enables major insights to come through, but it is also susceptible to abuse by the therapist (or group), according to his or her theory of the psyche. For example, if it is assumed from the start, without first checking out the other levels, that the fierce dog represents the dreamer's own aggression—which is a possibility, not a given—the dreamer may feel coerced into accepting a self-picture which does not intuitively fit. I have strong concerns about this kind of assumption with clients who have been abused. They have not necessarily introjected the abuser

at all; the dream may be focusing on the issue of how to relate to the abuser in a healthy way.

I also distinguish a fourth level, **archetypal**, in which the imagery, or some of it, makes little sense in terms of the dreamer's experience of the world, but seems to connect with mythology or religion. Now the fierce dog may be huge, with red eyes, guarding a castle gateway; or it transforms into a dragon as you get closer. The dreamer finds that s/he is among very powerful energies, or a strange landscape, with a sense of awe, fear or amazement. Such dreams usually come at times of sharp transition or spiritual growth in a dreamer's life, and require even more sensitivity from the interpreter. At this level, acquaintance with mythology is useful, although archetypal figures are well able to speak for themselves, even if we don't know their background. They are often powerful symbols of confrontation, encouragement, or transformation (Clift & Clift, 1989).

As the dreamer tells the dream, I am also making a clinical assessment of his or her emotional state, and how much protection may need to be established as we proceed. I check whether s/he is ready for each new step. In group situations with inexperienced people, I may not ask the dreamer to do more than "talk about" scary figures in the dream, if I assess that the dreamer is in a fragile state.

Applying the Process

I teach beginners a systematic step-by-step process which is time-consuming but reliable. An experienced dream facilitator may select and rearrange, to move more swiftly. Let me take for my example the work done with Marion, a sensitive woman of 50, in a dream group. She has just told us her dream, as follows:

Dream report: Open Heart Surgery

> I am out in the garden with my father, in a sort of half-light, picking berries from a tree. They are hard to pick and it's scratchy on my hands. Everything is strange and grey around me, the garden plants and bushes quite still and close. I know that my father needs open-heart surgery.

I ask Marion to **sketch** the dream onto a whiteboard or flip-sheet, so that I get as clear an impression as possible of what she is seeing, hearing, feeling, sensing in the dream, including the relativity of each element to the rest. Otherwise, I will imagine my own scene, and miss crucial aspects of hers. I keep in mind

that this is not actually the original dream experience she had, but a report of it, and that it may be evolving even as we work with it, which is a normal part of dreamwork (but a problem for academic research). She now sketches up a vague impression of a garden, with two figures separately gathering produce. I notice that she is puzzled about the dream, and I notice my own responses, including a sense of the mysterious.

I ask Marion when she had this dream, and what was on her mind at the time. This is because every dream springs from its own **context**, which contributes elements that have then been connected with other elements in the unconscious. She tells me that she recently visited her elderly parents, and picked grapefruit in the garden at dusk, while her father gathered vegetables. She realised how much more frail her father was getting since he'd had a second heart attack. So we recognise a recent memory as providing the setting, except that the quality of light is different in the dream, and her father is not actually in need of surgery. Such differences are significant.

Next, I **track the dream ego**. That is, I identify what she (as the dream ego) is feeling and doing in the dream, e.g. being active or passive. From here on, we work in present tense. Marion tells me she is feeling okay, a bit uncomfortable, and a bit separate from him—which is accurate, as they live in very different worlds of experience. Her action-line is simply picking fruit, and getting a bit scratched in the process. As I listen to her, I think "picking berries" is a form of gathering resources, in her father's garden—what might this mean? But I keep this to myself, while I continue to open out the dream.

Fourthly, I ask her what other relevant memories and **associations** come to mind.

The setting is a garden, a place of peaceful natural growth. She recalls fantasy stories in which the half-light has this quality of strangeness, of something other-worldly, even eerie. She sometimes has this feeling about nature, that it's communicating something she can't quite catch. Open-heart surgery seems to have a double meaning, about being open-hearted. I ask, "Why berries instead of grapefruit?" She recalls picking raspberries for her first job away from home in her student years, a time of becoming more independent in her life.

By now, she is thinking about her relationship with her father. "I've been thinking about how little time we may have left before he dies," she says, with a catch in her throat. "I wish he would talk more about his feelings – so we could share more." Ah, I think – sharing resources.

Action Methods

I ask if Marion is willing to do **role-work** with some of the roles, and explain that I will simply interview her as one of the roles in the dream, to discover what it's thinking and feeling. This allows material to rise directly from the unconscious, and is often surprising or enlightening to the dreamer. I suggest she takes her father's role, just as he is in the dream. She agrees. (If she had not agreed, I would simply have asked her to observe him closely and describe him in detail, so as to guess what he is thinking. I contract with the dreamer separately for each role, and explain that she is free to come out of role at any time by returning to her chair as "observer of the dream.")

I ask her to move out of her observer chair, and take a position in the space on the floor. She moves out and crouches down. I move out too, adopting the role of action-director: "Tell us what you're thinking, Dad, as you're picking the vegetables." As Dad, she says, "I'm getting old – my knees are a bit creaky, but I can still grow good carrots for dinner." I ask, "How do you feel about getting old, Dad?" "Oh, I know I've got to go soon. I'm not afraid to go, but I don't want to upset anyone before it's time." "Do you think it would upset your daughter there?" "Oh no, she's got her own life. I've had a good innings." I notice that she's coming out of role now, so I direct her back into her observer chair, and she says, "That's how he is, kind of practical and stoical. He doesn't want to talk about his feelings to anyone." There is a pause as she takes this in at a more conscious level.

I ask if she's willing to be the light, since it seems to have a particular quality here, setting the tone. She looks surprised, but agrees to have a go, standing with outstretched arms in the middle of the space. "Describe how you are, Light," I suggest. "I'm still and peaceful. The balance is shifting. I'm fading out. Things look different. I'm in transition towards darkness." Pause. I thank the Light, and she goes back to her seat thoughtfully. "That's like him too," she says, "in transition. Our relationship is changing."

"Are you willing to be the tree?" I ask. "Okay." She stands at the side, with her arms bent sideways, conveying roundness. "Tell us about yourself, Tree." "I'm a berry-fruit tree, heavy-laden. I'm glad she's picking my fruit, or it would go to waste." "Why are you so scratchy, Tree?" "That's just my protection. And all my sap's in the fruit, so my leaves are dry." "Is there anything you'd like to say to her, Tree?" Pause. "Yes. This is the time to pick my fruit. Don't mind the scratches." "Thank you, Tree." And she goes back to her seat, smiling, saying, "Of course! This is the time to share what Dad is willing to share with

me – not what I think he should. He's never talked about feelings, anyway. Grapefruit and berries – they're both good food."

This is a good time to invite any speculations from the group. I offer my thought about gathering resources from Dad, maybe wisdom. Marion nods, but redefines it. "Not so much wisdom, as recognition – love – a deeper sort of contact between us. An open heart." Others contribute: "Perhaps your Dad gets scratchy when you want too much of him?" She nods. Another: "I wonder about the eerie light – is there another presence in the garden?" She considers this, and replies, "No – not directly – it's in the light itself, neither day nor night."

I decide to test Level 3. "Are you willing to be the heart that needs open-heart surgery?" "Okay." She chooses to sit on the floor with her arms around her legs and head resting on her knees. I move in and sit beside her, speaking gently: "Tell us about yourself, Heart." "I'm all closed in, and only half as powerful as I could be if my arteries were less blocked up." "What do you want to happen, Heart?" "I want to clear the way through." I echo the words, to make sure she hears them, and pause.

Extending the Dream

We are now at what I call the edge of the dream, where the dreamer woke up. There are now several possibilities. One is to take her back to the observer chair, to reflect on what she has discovered, and recognise that she is now talking about herself, or to be more precise, the emotional pattern of restraint she has learned from her parents. Another is to move into dialogue between herself and her Heart, or herself and her father. A third is to visualise or enact an extension of the dream-story, coaching her if necessary towards a healthy redecision.

In this case, I intuit that the decision has already been made unconsciously, by referring to the need for surgery, so I say, "Heart, how can you make this happen?" and wait. Instead of speaking, however, Marion sits tight, then begins to unfold her arms and legs, and rises from the floor in a kind of slow dance, which is very moving to watch, and glides slowly around the whole space with a smile. "I can let go!" she says quietly, and goes to her observer seat. We all smile back at her. Someone says, "Wow!"

Her solution has arisen out of her own spontaneity in physically feeling the role of the closed heart. There is also a mysterious sense of spiritual growth made visible in her actions. Here we see the power of action methods to express far more than words.

Integration

The final step, relating the dream experience to real life, requires sensitive reflection by the dreamer and the facilitator. Group members may also contribute any further observations. In this case, Marion listened, then summarised for herself: "When I started the dreamwork, I was thinking that the problem was Dad, his unwillingness to talk about what life is like for him now. That may be true, but I've found a lot more in the dream. I can open my *own* heart to him, how *I* feel about him. And time's running out. I'll do it next weekend." She smiled through wet eyes as she said it, and the group responded warmly.

This is called "honouring the dream," (Savary, Berne and Williams, 1984), making a practical decision to follow through on an insight from a dream. This can range all the way from a slight shift in perception through to making a major life-change – though the latter is more likely to be from a final dream in a series. In my experience, any dream with clear imagery or sensations has something relevant to tell the dreamer; and even if immediate dreamwork does not arrive at a new insight, the meaning is often much clearer a week later, after further reflection.

Redecision Work

What has happened here, in clinical terms? Marion's dream-maker (inner Self or Spirit) has selected a recent memory and collated it with some further associations. Why? I do not regard this as a haphazard coincidence. The scene portrays her in the garden with her father at dusk, with a knowing that all is not well. This is borne out by her own comments about their difficulty of communication. In psychodrama terms, she seems to have an underdeveloped role as an open sharer of herself. In terms of transactional analysis, she has been living with an injunction: Don't express your feelings. She now faces a life-situation, encapsulated in the dream, where she is ready to break the injunction and develop the new role. The dream extension work enables her to make a spontaneous redecision for change in symbolic terms. The practical decision afterwards will test the new role.

If this had taken place in a therapy sequence, I would have followed the dreamwork with a piece of 2-chair work in which she practised the new role in a dialogue with her father, anticipating his probable responses. In fact, I heard from her later on, to say that she had managed to have two satisfying conversations with her father before he died, and was very grateful for her

"breakthrough" in the dream group. This kind of outcome from dreamwork is not uncommon.

Different Processes

Psychotherapy is often accused of being too full of talk, assuming that words are the only or primary vehicle of meaning. But many of the major difficulties in our lives began as survival decisions or learned habits from childhood, before we had many words to express ourselves at all. Dreams are multi-modal expressions of our being, usually involving images, sounds, actions, feelings and other physical sensations, often based on collated memories; so they offer our clients unique opportunities to express their inner world.

I regard drawing as an essential step, to give us a joint "map" of the territory to be dealt with. No artistic skill is needed; sometimes a few impressionistic lines convey the essentials with great clarity, and coloured pens or pastels may help to convey emotions. Words are valuable in bringing up associations, buried thoughts and finer shades of meaning. But physical actions, miming those in the dream, add a fuller dimension of experience, often bringing out strong unconscious connections. You do not have to be an expert in psychodrama to use simple action methods with dreamers, one to one in your office. They will not be embarrassed as long as you are willing to stand up or sit on the floor alongside them while they take the roles. And you may share some of your client's discoveries too in being a tree, a mouse or a tidal wave!

Conclusion

By describing this piece of dreamwork in detail, I hope I have demonstrated some of the effectiveness and excitement of working with dreams in a multi-modal way, whether in a group or one-to-one. Readers who want to know more are welcome to come to a workshop, or buy a copy of my book – or both! I believe that dreams are everybody's spiritual heritage, and therapists can greatly enrich their work with clients by including dreams in the process.

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Reducing the Other to the Same/Sane

Tom Davey

'Our desire to find our origins is our desire to find the origins of our desire'

Lacan

'Both dying and philosophizing are a journey beyond'

Plato

Abstract

I have been intrigued by my very different responses to two uses of the word method. The first, commonplace and currently popular, suggests that psychotherapists should have a number of methods at their disposal. This could be called the ballast argument. The second, from a statement by Laplanche, is that what Freud predominantly gave us was a method. I am rather disturbed by the former, but take the latrer very seriously in my own practice. My sense of intrigue comes from the belief that both examples contain radically different notions of what psychotherapists are engaged in. The ballast argument enlists a technological approach, the application of knowledge, where one is engaged in a particular kind of *behandlung* (treatment); a kind of violence. But Freud's method is also a technology, so why should I favour that? Perhaps, because it is a method that opens up and contains particular kinds of spaces. I wish to explore these ideas by sharing some of the ideas that have been helpful to me in feeling and thinking through this issue over the years; in order to wonder about what kind of spaces are being offered by psychotherapists in these differing positions. What are psychotherapist's responsibilities in such spaces?

Introduction

I am a foreigner, a stranger, an outsider. As a foreigner I am constantly in the business of translation. The task for translators is very difficult and much debated. According to Laplanche (1996), it involves registering the foreignness/strangeness of the text as opposed to providing an easily assimilable gloss; to be violently moved by the foreign language, instead of taking the contingent status of one's own language as fixed and solid. Some would say this is the job

of psychotherapy, where we can substitute text for the patient's material, and certainly involves the mourning of loss of the familiar. (Davey and Snell, 1997)

There is a game you may have come across at dinner parties that is used as an icebreaker. The idea is that each person should suggest three people who have had the biggest influences on humanity. For my purposes I suggest Copernicus, Darwin and Freud. According to Young (1997), these three were the messengers of the three great blows to human arrogance. Copernicus, in as much as the heavens do not revolve around us. Darwin, in that we are not the pinnacle of special creation. Freud, in that we learnt we do not even have direct access to the greater part of our own mental processes. These are narcissistic blows on a huge scale.

Without the solace of the beliefs exploded by these messengers humankind has turned more and more to technology to answer its questions, still reeling from its grief. As Nietzsche (1933) puts it through his character Zarathustra, "God is dead" and what follows is the attempt by man to make technology god, in his own image, and signifies the loss of the status of the special child, a loss that has not been adequately mourned. If this is one of the contexts for the birth of a profession of psychotherapy it leads to a question of whether we are a symptom or a cure. Particularly as Nietzsche suggests that the response to the death of God is the creation of Superman, the turning of grief into triumph.

If this is what we have been left to grapple with, our response has been strange. New psychotherapies have proliferated during this century as new generations have come to feel that previous theories and methods do not adequately represent them and therefore have produced their own, in their own image (or desired image). Liam Clarke (1990) writing in the *British Journal of Psychotherapy* suggests, "there is a lack of humility about these 'secular priests' with their proud and insular claims to dampen human misery" (Clarke 1990, 86). Clarke notes that there are suspicious commonalities between these new therapies such as disenchantment with psychoanalytic theory and practice, with a charismatic leader pronouncing a new way. They are like that most western and arrogant of creations, the self-made man. Chasseguet-Smirgel employs the notion of the *autonomous magic phallus*, which she sees as the rejection of the family line, an attempt to break generational links and to give oneself a new and crucially false identity (1974). It is only through the breaking of generational links that one is able to see one's own development, as the unfolding of new ideas where it is possible to be continually amazed by one's own discoveries, rather than grounding struggles in the context of other's past

struggles. To counterpoint this I am reminded of a friend saying that whilst he realised it was useful in keeping his narcissism balanced, he was always disappointed when he got to the pinnacle of some piece of understanding only to find the inscription, 'Lacan was here' scrawled at the top. What he seemed to me to be saying was at that point he is freed from what was in part a narcissistic endeavour, after which he can take up his place. Not a self created space. Of course it does not need to be Lacan. It is an acceptance of having therapeutic parents (of castration) or forebears, who came before and shaped the world for us in some ways, and through that developing an understanding of what is handed on to us. I now wonder if this is particularly a challenge in countries where the early developments took place on other continents and it feels difficult to know how much they are relevant. In the frontier countries the existential issues were more immediate and different, making it difficult to believe that those in the old countries had anything to offer (and maybe at the same time feel they were the only ones with anything to offer). What I am left wondering is, what happens to the mourning? My fear is that it is ditched in favour of a brave new world, superman/woman approach.

Methodological arguments normally make particular truth claims based on some version of the technology of the day or a politically valent ideology. Or one could say, hold up the kind of mirror that is desired by society. Of course there is always a counterculture for those who want other kinds of mirror. As we approach the end of the 20th century one way to map the desired mirror is by scanning the advertising hoardings, cinema and television. What kind of subjects do these images construct? One constructs a narcissistic subject. By narcissistic I mean one that is concerned with creating images of itself and therefore particularly concerned with surfaces, where questions of identity are located in external consumables and feeling good follows the constructing of an external self that is desirable. If you like, it is a movement from Descartes' *cogito ergo sum* to *I consume therefore I am*. Such a narcissistically challenged culture would try to construct psychotherapy in its image, as a product to be consumed in a user-friendly way, easily understandable and digested, a technology. Consumerism preys on people's desires, or to return to Lacan, the sense of lack that generates desire.

The closest we can get to our dream scenarios is through the yearning, pining and emptiness of desiring something that we can never hold onto: something we once saw in a mirror or in our mother's gaze, and searched for in adulthood in our counsellor's eyes; in endless quests for wholeness, fulfilment and achievement to become once again the Holy Child.

Lacan argues that our inability to make our selves whole in consciousness through keys to fulfilment such as self-image, work, or other people leave us permanently wanting: "This lack is beyond anything that can represent it. It is only ever represented as a reflection on a veil" (Lacan, 1988). At bottom we are constituted by lack and desire. No image, words, thoughts, action or position can represent that which we are not, and this, as the source of all our strivings, is the most important thing about us. Our sense of ourselves comes not from fulfilment but from unfulfilment, from castration not the phallus. (Loewenthal and Tame Wall, 1998)

It is the lack that defines us.

This raises fundamentally difficult questions for psychotherapists. What kind of mirror do we show our patients? Is it possible to be free of the culture we live in? It certainly points to the need for psychotherapy to be grounded in an understanding of the society in which it operates, to be able to map out the forces that operate on it.

One of the most popular mirrors for psychotherapists to use currently is the eclectic mirror (i.e. I have a number of methods at my disposal). The demand for eclecticism comes, at least in part, from the therapist's experience of the patient's demands. In the language that I have been using the patient's demand is something like, "You must hold up the kind of mirror that I can tolerate" At that point a technologically influenced profession turns its questions into a methodological debate rather than facing the demand of the patient. The history of psychotherapy in general shows a proliferation of answers. There are over four hundred differing forms of psychotherapy, a good indicator of a narcissistic profession (i.e. I do it my way).

To turn to my abstract, so as to approach these questions in a different way. My previous constructions have been from the outside, a kind of sociological approach. This is not how my struggle with these ideas started. It was much more a case of what we call an internal struggle, it took me a long time to contextualise it and maybe a change of country. As I said in my abstract, I have been intrigued by my very different responses to two uses of the word method. The first, commonplace and currently popular, suggests that psychotherapists should have a number of methods at their disposal. This I am calling the ballast argument. Because it seems to suggest that we need to be ballasted against the demands of patients. The second, from a statement by Laplanche (1996), is that what Freud predominantly gave us was a method. I am rather disturbed by the former, but take the latter very seriously in my own practice. My sense

of intrigue comes from the belief that both examples contain radically different notions of what psychotherapists are engaged in. The ballast argument enlists a technological approach, the application of knowledge, where one is engaged in a particular kind of *behandlung* (treatment); a kind of violence, a closing down of space. But Freud's method is also a technology, so why should I favour that? Perhaps, because it is a method that opens up and contains particular kinds of spaces.

In this view I am constructing psychotherapy as a continuum of response to the patient's demand to reconstruct the ego (das ich). The question for psychotherapists is how much we turn towards the anxieties that produce these demands and help people see the kinds of binds they are caught in, or do we find ever increasing technological responses for servicing such anxiety by fixing or building bigger and better egos. Is it possible to separate these demands so clearly? The ballast argument enlists a bulimic defence, where therapists take in, ingest their methods which at some point are regurgitated. It may be that it is necessary to be ballasted against the demands of the Other but the question for me is more, what do we need to feel inside us when under such demands? Therefore, an intimate understanding of the ways of defending against those demands. Of not feeling something that is too difficult. Otherwise methods become the tools of psychotherapist's hate. By that I mean that we give something to the client in the same way it can be tempting to give a child sweets when it is demanding, to shut it up. When putting my 3-year-old daughter to bed recently and putting her dummy in her mouth she asked me if I gave her a dummy to keep her quiet. Now, I would much rather she did not use one but at that moment I was shutting her up, I was too tired to do anything else and she was right. At that point I had little or no space for her and am left wondering how often this process happens in psychotherapy with all of the methods available to us now. I am reminded of Heidegger's warnings about what he termed 'technology', that particular attitude that allows our relational space in the world to be fixed in a certain manner which is for us, open to our use of the world, as if all that exists is but 'stuff' waiting to be consumed. (Spinelli, 1998)

Space, Mental and Otherwise

As a child of the '60s. I cannot hear the word space without also hearing William Shatner's voice saying 'the final frontier'. Space holds the possibility of the infinite. Spaces between us and spaces inside us have possibility, infinite possibility, but only if they are maintained.

So what is space? It is the opening up of the lack to allow desire that cannot be satisfied. It is a methodological abstention, which frustrates the ego's demand to reduce anxiety, which allows the lack to come into view. For there to be space for the patient I have to abstain from accepting the client's demand that I be or do anything in particular and that was what Freud (1976), the Freud of Irma's injection, where there are 20 pages of the unbinding of associations, started with before all of the metapsychology closed him in. It is a refusal to treat the other as the same as us by fitting them into our view and a refusal to allow them to do so to us. In Bion's (1970) terms, "without memory and desire". This is to take up an ethical stance, without which methods close down space. If we are to offer space to others, it is necessary to regulate this abstention. The psychoanalytic answer has always been, it is only through the analysis of the countertransference, the working through of the countertransference, that we can be in any way sure of what we are offering. Therefore, it can only be done with hindsight. In the clinical situation methodological considerations are at least countertransferential.

Another way to have this conversation is to turn away from psychotherapy to philosophy.

One of the most popular views of the development of culture, society and ideas has been attributed to Hegel. It is so well known now it is often seen as common sense.

SYNTHESIS

↗ ↖

THESIS ANTITHESIS

This is known as Hegel's dialectic and describes the development of knowledge as thesis combining with antithesis to produce synthesis, which then becomes a thesis and so on.

One of the things that Freud (1955) showed us is that the ego (das ich) is engaged in synthesis, the synthesis of competing unconscious desires into single actions. Hence all symptoms are overdetermined. Laplanche (1996) argues that this is also the case within the world of psychotherapy, that some psychotherapists are attempting to synthesise the differing therapies. This, he argues, would be a mistake because it is to go along with (act out) the defensive action of the 'I' (das ich), rather than an attempt to return to the original demands that produce the need for synthesis by tracing the dialectic: synthesis

versus analysis. Are we in the service of the ego or something more unconscious or unknown, such as the psyche or soul, which Bettelheim (1982) argues Freud was originally writing about? Is it possible to separate things that clearly? Here are a few contexts to develop these ideas:

Synthesis and Analysis

If synthesis is always in the service of speaking with a single voice, then it is repressive. Discourses of power always silence the kind of associations through which it is possible to have multiple meanings (Laplanche, 1996). The binary myth being described is of the synthesising force of the ego (das ich) versus an analysing force, which separates out competing aspects allowing multiplicity, possibility and space within and between people. Synthesis silences associations.

Autonomy and Heteronomy

Frank Sinatra's song 'My Way' has been a joke in my family for a long time, coming to signify a particular kind of egocentric disregard for the Other. There is little sense of responsibility to others in it, of negotiation or relating. It is a song about an ego looking back on a self-created world, of which it is the centre. This kind of autonomous self -delusion is much feted. Hence, it is one of the most popular songs of the last 30 years, much in evidence at funerals. To think in these individualistic, autonomous ways is very striking, some would say masculine (Gross, 1995). The other end of the spectrum according to Levinas (Levinas, 1967 in Peperzak, 1995) is heteronomy where one has a sense of a place in the world with others, where one is subject to others, responsible to and for others, some would say a more archetypically feminine way of thinking. Once again Copernicus comes to mind. Does everything revolve around me, or am I part of a small constellation in a much larger universe, subject to Other's laws, some of which I am not aware of, but live by. Levinas criticises all of Western philosophy for its adherence to the former at the expense of the latter (Peperzak, *op cit*).

Implications Versus Applications

Technologies employ methods that are applied to things, machines. When patients demand, there is a sense in which they treat me like a machine, in their desperation. The challenge for me is whether I respond like one. If we employ the machine analogy we do violence to each other. I can only say that a number of people have helped me to feel and think through things in the way they have

offered their work to me and I can only talk about the implications for me and my work. As Oakely (1990) writes, "Implicated has resonances of 'being folded within', which generates a sense of interiority; 'application' presumes a relation of exteriority."

A Joni Mitchell lyric comes to mind: *"I guess it seems ungrateful with my teeth sunk in the hand that brings me things I really can't give up just yet"*

I take it to mean that there is an important aspect of what I am writing that remains hidden to me. This line represents a continuing sense of lack that could easily be turned into action in my anxiety. Many people have helped me to feel and think my way through and I am populated by them, inhabited. In one language they are internal objects. They are also a continual reminder of my insubstantiality and lack, of how much I needed them and continue to need them. Without this grounding I am in danger of forgetting Copernicus, Darwin and Freud. Without a sense of narcissistic balance one enters into Conrad's *Heart of Darkness*. That opens up the possibility of the self-made man, or 'I did it my way'. Everything I have written today comes from conversations with, or readings of, others that have helped me understand and feel more in connection with others and myself.

Ethics

> What are our responsibilities? 'Our responsibility is for the Other's responsibility'
>
> Levinas (1985)

My title refers to a statement by Levinas (Peperzak, *op cit*), where he suggests that the application of theory is the fitting of the other into my world view, a way of doing violence to them, of reducing them to the same, translating them into my world. Levinas calls this narcissism. It is to treat my own view as the solid and fixed point about which all else turns. A kind of pre-Copernican vision that is denying of the relational nature of communication. It is without ethics and fundamentally about the exercise of power. If so, it is my job to often feel destabilised by the Other and want for that discomfort to go away by reaching for something to ballast me, to make myself the centre. It demands a need to be in touch with the state of my internal world and how it is affected by the client, both what ballasts me and my insubstantiality. This is the work of de-translation and of journeying to the beyond. It requires a de-translation, not a retranslation where we are left to wonder how we got where we are today.

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The Use of the Reflective Team in a Psychodrama Therapy Group

Sandra J M Turner

Abstract

In this article, the development of the reflective team process is traced, and the concept is applied to a psychodrama inpatient therapy group in which the focus was noticing role development. A format for conducting a reflective team process in an inpatient group is described, and the particular benefits to both the protagonist and group members are identified.

Introduction

The concept of reflective team process has undergone many developments since it was first described by Tom Anderson and his colleagues in 1987. Theirs was a creative response to working with families in which an impasse had been reached. A reflective team as used then comprised a team of counselling professionals who observed a family therapy session behind a one-way screen. At a time of impasse in the session the family and the therapist would watch as the team assumed the roles of the family members and acted out the conflicts that the team perceived to be the cause of the impasse. The emphasis was on creating a variety of ways of viewing the problem thus shifting away from identifying any one position as right or wrong. The therapy session would then continue. Both the therapist and family benefited from the intervention, being able to move on in a fresh way.

Young et al. (1989) further developed the concept, this time with the focus on giving on-site supervision to developing trainees. The supervisor and other observing trainees would discuss their hypothesis and reflections about the interactions between the family members and the trainee therapist in the presence of the therapist and family. The supervisor facilitated a training situation in which "the systemic principles of non blaming circular multi-descriptive view of family members and their problems" formed the basis for the team's reflections. (p. 74)

In 1990, Prest, Darden and Keller reported on their extension of the concept to the supervisory process. While a supervisor, supervisee and several therapists met for supervision, a reflecting team comprising other colleagues watched from behind a one-way screen. After a period of time, the supervision group watched as the reflective team discussed their observations about the process of the group. The two groups then came together for further processing. The researchers found that the dynamics evident in the supervisee's work were further highlighted in the processing and that supervisees were able to receive feedback in a less threatening manner. They also benefited from seeing themselves talked about without having to be directly involved. To date, all applications had been in response to clinical situations in which supervision or training was the goal.

The Concept of the Reflective Team

In 1992, Dr. Antony Williams, a family therapist and psychodramatist from La Trobe University in Melbourne, conducted a series of training workshops for psychodrama trainees. In those workshops he used the concept of the reflective team in a substantially different manner from what had been previously reported. His purpose was not to offer different perspectives on a problem when an impasse had been reached but to focus on the role development that had taken place in the drama. The focus was now on noticing the new script that the protagonist was writing for himself or herself. The new emphasis also served to bring to greater consciousness in the protagonist the possible effects on his or her social atom of the protagonist's role development. Again, reflections were systematically based and non-judgmental and offered a multidescriptive view of the system.

Following a psychodrama enactment and after the completion of the sharing phase as an integrative technique, a reflective team of six to eight people would be drawn from the group. They would sit in a circle within the horseshoe shape of the group, like a fish bowl, with the protagonist remaining in the outer group. The reflective team would then remember out loud the story of the drama, noticing in particular the movement that had taken place from that which was restrictive to that which was enabling. The respectful and attentive processing served to strengthen the protagonist in his or her new development. With Williams' procedures, the one-way screen was not used and the membership of the reflective team was drawn from within the group.

For many who encounter psychodrama, it is the expression of the thinking and

feeling self in all its raw honesty that creates a lasting memory. Yet the well-trained and disciplined psychodramatist knows that development, congruency and integration of the thinking, feeling and action components need to be achieved in order to effect lasting change and true role development. The fullness of role enactment provides the experience necessary for reflective thought. For many, the ability to experience themselves in a "here and now" context and be thoughtful about that is underdeveloped. It is in this regard that the use of the reflective team process has been beneficial.

Principles Undergirding the Functioning of the Reflective Team

Anderson (1987) identified the need for the team to remain positive, respectful, sensitive, imaginative, and creatively free. In his training seminars, Williams stressed the need for all comments to be presented as speculative, tentative offerings that are made to raise the protagonist's consciousness about the nature of his or her functioning in relation to others. In particular, the team strives to identify those aspects of the drama in which there is movement away from the restrictive ways of being to the development of greater spontaneity and creativity. When moments of spontaneity and creativity are noticed and remembered by others, the protagonist's view of himself or herself is enhanced and enlarged. Being able to see one's behaviour in a nonjudgmental manner and to notice the effects of that behaviour on others enables a person to make hoped-for changes.

Guidelines for a Reflective Team

Williams developed further the guidelines given by Anderson and provided a framework by which the team can shape its responses. Williams' suggestions for a reflective team include the following:

1. Team members do not speculate about the truth of what is presented. Instead, the focus of inquiry is on how meaning is given to the experience.
2. All remarks demonstrate genuine respect for the protagonist, and in general, statements are turned into questions; for example, "It was surprising for me... I wonder if it was as surprising for John."
3. Use terms that suggest possibility rather than certainty; for example, "as if", "could it be that", "perhaps", and "possibly." In this way, authorship of other people's lives is avoided.

4. Ideas and speculations are put in terms of the protagonist's beliefs, not the team members' beliefs; for example, "When Pauline stopped being a best friend to her mother, I wonder what . . ." "When Susan identified all the feelings that she swallows down, I wonder if . . ."
5. Most of the curiosity of the reflecting team needs to be focused on identifying the moments of spontaneity and creativity within the drama and the subsequent role development. Inquiry can be made about what might be the consequences if things were to stay the same.
6. What does the protagonist make of the changes in terms of a new consciousness of self, morally, professionally, emotionally, and spiritually?
7. How do these changes fit in with the protagonist's view of himself or herself historically?
8. How do other people in the protagonist's social atom relate to the new performance of self, and what was the protagonist's response to their reactions?
9. Assist the protagonist to become more curious and fascinated by his or her own life, supporting the protagonist in the reauthoring of his or her life to a preferred way of being:

   "If this is an important way of being for John, 1 wonder how he might ensure that he gets the support he needs to help him continue this way."

   "I wonder if Anne was as surprised as I was by her determination to be heard. What might happen if she were to keep going like this'? Who would be encouraging, and who would be the one that would undermine her?"

The Reflective Team in an Inpatient Psychodrama Group

The application of the reflective team to an inpatient psychodrama group is a later development. The psychodrama therapy group in which that application occurred is part of the programme at Ashburn Hall, a small psychiatric hospital in Dunedin, New Zealand. The hospital functions as a therapeutic community in the manner described by van der Linden (1982). The staff retain responsibility for the essential structures and therapeutic activities that take place in the community and delegate, rather than relinquish, authority to the patients.

Patients attend a daily community ward meeting, group therapy, individual psychodynamically focused psychotherapy; take part in recreational and work activities; and share in the day-to-day decision making in the hospital. A patient's length of stay varies; many are there for six to ten weeks, whereas others may stay for 12 months or longer.

In the hospital, the patients live together and form relationships that provide the human warmth, support, and understanding that is necessary for healing. Appropriate limits are set in a non-authoritarian manner, and mutuality and respect between people are encouraged (Adams, 1988).

The Psychodrama Group

The group includes ten patients and two staff auxiliaries, and each session continues for $2^1/_2$ hours. A majority of the group could be described as having a "disorder of the self" with anorexia nervosa, bulimia, alcohol and drug abuse being significant features. A history of childhood sexual abuse is found among approximately half the group. The primary task of the group is to enable people to strengthen their sense of who they are in the world. For most members, adequate mirroring of their essential self has been largely lacking.

Membership of the Group

The nurses, psychotherapists and psychiatrists who are part of the clinical teams determine the membership of the groups. The teams take the following points into consideration when selecting group members.

1. The degree of a person's attachment and relatedness to fellow patients, the nursing staff and his or her therapist is the most significant factor. That attachment factor gives a good indicator of the person's ability to be held and cared for when vulnerable. If that ability is not present, then the risks of acting out increase manyfold. The attachment factor implies that group members have usually been in the hospital for at least 2 weeks and have begun to settle in. During that period, the staff has had a good opportunity to assess an individual's ability to participate in activities and form relationships. The staff can assess whether, even with their considerable difficulties, patients are able to be engaged and "held" well enough by their involvement in therapy and the life of the community.

2. Self-selection is also an important consideration. For example, many people volunteer for the group because they are eager to use all the resources of the programme to assist them in their healing.

3. Anticipated length of stay is the last factor. People coming into the group need to be able to commit themselves to a minimum of four sessions. That commitment ensures that issues of inclusion and safety are not continually needing attention and that the work of the group is consequently able to deepen. It also allows sufficient opportunity for group members to contribute to as well as receive from the group.

Nursing Staff

Two nurses are part of the team and function as auxiliaries. Well-experienced in being members of the therapeutic community, they have learned how to use themselves; that is, they know what to share of themselves and what to withhold. They are aware of the transference process while still participating with a "presentness" in the group that allows them to take up auxiliary roles to the fullest. New graduates and student trainees are not included in the group.

The Reflective Team in Action

The reflective team process can be used whenever there has been an enactment. It may immediately follow the sharing phase or be held over until the beginning of the next session.

Typically a session will begin with an inquiry to the protagonist of the previous week's psychodrama session about what he or she has made of the work that was done, about what stayed with the person and what effect that has had so far. This review establishes contact with the protagonist, assists the person to become curious about himself or herself, and ascertains the person's willingness for a reflective team process to take place.

The reflective team is drawn from the group and consists of patients, staff and the director. There is a call for volunteers, and people are usually willing to be involved. It is particularly useful to have those who take auxiliary roles in the drama to be members of the reflective team because they are often able to bring insights peculiar to the roles they played. All members of the group are available to be members of the team. That option is congruent with the ethos of the therapeutic community and dispels the myth that the wisdom and knowledge about human beings is held exclusively by the professionals.

The team sits in a closed circle inside the group, like a fish bowl. While it is functioning the team maintains a clear boundary between itself and the rest of the group members, who form the audience. The protagonist maintains a seat in the group.

At the beginning of the session, a general summary of the principles of the reflective team process is restated. Members are reminded that all comments are to be respectful and stated from a position of tentativeness. Team members notice what new roles and behaviours were emerging in the protagonist during the drama and consider systematically what might be the consequences for the protagonist if the behaviours were to continue developing in that manner or if the protagonist were to stay with the old ways of being.

The process begins with the team members remembering the story of the drama – who was present, where they were, what happened and what roles were taken up. As the story unfolds, the team begins to speculate in an open-ended and systemic manner about what might happen should the protagonist continue with the old way of living or with the new way that was developing in his or her work.

Example 1: At the end of Tom's work I saw him strong in his decision to do things differently. I wonder who in Tom's family would be the most surprised to see him choosing something different from what his family wanted, who would be the most supportive and who would be the most undermining.

Example 2: It seems that in the past the way that Mary had her life with her Dad was in fighting with him. I wonder what other ways she might have her life with him, whether he would be responsive to that or whether he would want to keep the fight going.

Many sides of the question are given, with no fixed answer being proposed. The reflections are raised for the protagonist to consider and to accept or reject as he or she may wish. The team members frame their responses in terms of different sociometric criteria related to the drama and then work systematically to inquire about what the responses of significant others would be toward change or no change in the protagonist.

After approximately 10 minutes, the team finishes and members return to their seats in the group. The protagonist is then invited to respond to what was said. Protagonists may comment on what confirmed/affirmed their own thinking, or what woke them up to something new in themselves, and on that which they wished to refute. No debate is entered into, no discussion of different points. It is crucial that the protagonist be the last one to comment on the story and that the authority stays with him or her.

Impact on the Protagonist

The reflective team process helps the protagonist at the beginning of the next session to keep his or her work going and to stay in the position of an open learner. It gives the protagonist an opportunity to work with the reactive fear that can often be present. It also allows the protagonist some time and structure to integrate the experience and to begin to develop as a systems thinker. The process greatly enhances the protagonist, who gains from being treated generously and from having his or her story thoughtfully considered and remembered in detail. That attention is particularly poignant when there has been considerable neglect and deprivation. The protagonist is exposed to fresh perspectives on the situation and has his or her development acknowledged through the reflective team process.

Example: John had had a very full and painful drama. In it he had visited the time of his early adolescence when trust was betrayed and he was abused sexually. In the session, he had found new ways to be with himself and have others be with him.

The following week he returned to the group, and though valuing the work he had done, he was feeling ashamed and self-conscious. Old fears of not being accepted had begun to take hold. He readily accepted the invitation for a reflective team process and was deeply moved to hear his story related back to him with respect, compassion and understanding. Having his story mirrored in such a way enabled him to let go his shame and to claim his legitimate place in the group. He knew his essential humanness and individuality had been recognised and was seen to be separate to the acts he had had to perform.

Protagonists, in re-visiting their work, do so this time from the role of a systems thinker. In so doing, they are quietly challenged to give up any of their dependency or narcissistic traits, to consider the impact of their behaviour on the different people in their lives, and to make choices based on their enhanced self-knowledge. The role of the self-change agent is further developed.

Impact on the Team Members

Choosing to be a member of the reflective team is yet another way of stepping into the action space and being prepared to present oneself. For some, it is a step they are not able to take for many weeks. When they do participate, however, it often signifies a shift in their willingness to contribute to the life of the group and a capacity to be generous with others. It also suggests that they value their own comments and believe them to be worth hearing. Team

members take the roles of the naive inquirer, reflective thinker, self expresser, and systems thinker. The ability to think systematically and to consider the consequences of one's actions, albeit for someone else, is of great assistance to the person who is self-absorbed and self-centred. Likewise, learning to be a naive inquirer is essential for the person who holds tightly to a fixed position and is judgmental or opinionated. Roles pertaining to adult functioning must come into play.

As might be predicted, the comments made by team members often have a bearing on their positions in life. Coaching and modelling are used to assist team members to expand on a comment or to balance out the picture. Typical comments from team members are as follows:

> *Patient Team Member:* I could see Jim getting rid of his anger, and now that he's done that, I'm sure that he'll be able to get on with his life and do really well.
>
> *Staff Team Member:* Yes, he did express a lot of anger. I wonder what it's been like for him to have powerful feelings and not hurt himself or someone else.
>
> *2nd Patient Team Member Picking up the Theme:* I wonder if there has been any times over the last week when he's been feeling angry or sad and has been able to let someone know about it.
>
> *2nd Staff Member Expanding on the Theme:* I wonder who he'd go to to do this, whether he has thought about the people on the ward who would be most helpful, and who would be unhelpful given his statement that he wants to stay in touch with his feelings.

As a result of living in a therapeutic community, many of the patients quickly become psychologically orientated. As members of a therapeutic team, their contributions are often of a high quality, giving perspectives that may elude staff.

Summary

The reflective team process provides an opportunity to further extend and concretize the therapeutic work achieved in a psychodrama session. The effect of having one's story thoughtfully remembered and reflected upon constitutes a significant mirroring experience and is of particular value for those people who have suffered physical and/or emotional trauma and neglect. Bringing into greater consciousness all the different nuances of a protagonist's system

enables the protagonist to be clearer about the choices he or she makes. That in turn leads to a stronger self. For the participants it calls into play healthy adult-functioning roles that they may not have been aware of otherwise. For the group it promotes generosity and respect.

Note. All case examples have been significantly reconstituted to protect the identity of those people who have participated in the group.

Acknowledgements

The author wishes to thank the nursing staff and patients at Ashburn Hall who have been part of developing, refining, and implementing the reflective team process and Dr Antony Williams of La Trobe University, Melbourne, Australia, for his teaching and workshops on the use of the reflective team.

The *International Journal of Action Methods, Psychodrama, Skills Training and Role Playing* v 50 no 1, Spring 1997, p 17–26.

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Fifty Years of Psychotherapy, But What about Infant Mental Health and Early Childcare?

Peter S Cook

Abstract

In addition to quality psychotherapeutic treatment, primary prevention was, from the beginning, a parallel concern of those who founded the New Zealand Association of Psychotherapists in 1947. This arose both from theory and the experience that many emotional problems were essentially preventable. They sought to apply insights gained during psychotherapy to prevent emotional trauma and promote mental health, especially in infancy and early childhood.

Empirical confirmation came with Bowlby's 1951 Monograph, published by the WHO [8]. Like Suttie and Every, Bowlby was led to adopt an evolutionary perspective, which can illuminate the diagnosis, treatment and prevention of emotional disturbance in infants, young children and their families, with implications for healthy childrearing. This approach also led to critiques of Freudian theory, with calls for it to be reformulated.

Some preventive achievements are outlined, but it is suggested that the most significant failure has been the widespread denial of the emotional consequences for the infant of prolonged early non-parental childcare, underpinned by the now discredited ideology of cultural determinism.

Introduction

I am delighted to join in celebrating the 50th Anniversary of the founding of the New Zealand Association of Psychotherapists. I was present as a fourth year medical student when the NZAP was formed at a conference in December 1947. It was partly held in the Cranmer House Clinic, which was also our family home. The people involved and the ideas they shared have influenced my personal life and professional activities, and the importance of good early nurture was one of their central concerns. Their ideas were at variance with accepted customs in many ways, and they worked for a healthier society. Over

the last 50 years there have been dramatic changes in professional and community attitudes to pregnancy, childbirth, breast-feeding, sex education, and child-rearing practice, mostly in directions urged by the founders of the NZAP, but the most conspicuous exception has been the move to early non-parental childcare.

The Founders

If Dr Maurice Bevan-Brown, or B-B as he was universally known, were here today, he would be astonished and deeply gratified. He had a lovely smile [6], a merry laugh, and I remember him with gratitude. I have outlined elsewhere his background in natural sciences and medicine; his return to Christchurch in 1940, after being a consultant physician/psychotherapist at the Tavistock Clinic in London from 1923 to 1939; the situation he found on his return to New Zealand, and his teaching activities and concern for primary prevention [15]. (Since that paper was circulated with the conference papers this material is not repeated here.)

My parents were early disciples, and with others they welcomed the opportunity to learn what he was glad to teach. My father, Frank Cook, left the Anglican ministry in 1945 to practise psychotherapy, and my parents bought a large house at 58 Armagh Street, overlooking Cranmer Square. Some rooms were soundproofed for consulting rooms, and we lived in other parts of the house. Here, the Cranmer House Clinic was established as a centre for clinical service and training in psychotherapy. With Bevan-Brown, my parents were involved in convening the conference at which the NZAP was formed, and those who attended, coming from many parts of New Zealand, are shown in the photograph in the paper referred to above [15].

My parents and Bevan-Brown set about producing educational pamphlets. Though their lives were overshadowed by World War II until August 1945, they wasted no time, and during that year five educational pamphlets were published, some reflecting concerns about returning servicemen. Two each were by Bevan- Brown and my mother, Dr Enid Cook, and the fifth by Frank Cook. They were called The Lighthouse Series, with the cover showing a lighthouse beaming into the darkness, and they sold for nine pence each [29].

By 1948 eleven pamphlets had been published, and some found their way to Mrs Gayle Aiken, of New Orleans. She asked for a book, and by December 1948 *The Sources of Love and Fear* was written [5]. Bevan-Brown was the principal author, with Enid Cook contributing sections on sex education,

childbirth and breastfeeding. He recorded his "indebtedness to his colleagues at the Cranmer House Clinic without whose encouragement this book would not have been written". This was literally true, as my mother used to go with him to Kowhai Bush, where he worked to protect his precious remnant reserve of native forest. In his hut, after dinner, he would light his cigarette, sit back and dictate. By the light of a kerosene lamp she wrote down his words. It was a small book but it was unique and met a great need. By 1950 it was published in Christchurch, New York and Toronto, and there was a third edition in 1960.

Theoretical Perspectives

Bevan-Brown belonged to the pre-war, eclectic, analytic tradition at the Tavistock Clinic, which included Drs. J.A. Hadfield [22] and Ian Suttie. This tradition dissented from some Freudian teachings, and it held that much emotional disturbance, neurosis and personality disorder, need never occur if infants and young children were given good early nurture.

In *The Origins of Love and Hate*, Ian Suttie, who died on the day it was published in 1935, adopted an evolutionary and cross-cultural perspective. While valuing psychoanalytic treatment, he said its results were not adequately explained by Freud's theories, of which he offered a detailed critique [38]. He entitled one chapter 'The Taboo on Tenderness' and another 'Freudian Theory is itself a Disease'. He argued that "... all the errors and shortcomings have one general tendency. ... in all these cases the failure of theory seems to be due to its denial of the existence of love and to its depreciation of the social significance of the mother." (p 175). He argued that Freud had "a grudge against mothers and a mind-blindness for love, equal and opposite to the mind-blindness and repugnance that many of his opponents had for sex". He asked "Why should we not as analysts ask ourselves what was the reason for the original oversight (i.e. whether we ourselves were biased), and why, as scientists, not overhaul the whole theory so as to make the correction systematic?" (p 179). This call went largely unheeded, but it is remarkably similar to the challenge which Dr John Bowlby, as a psychoanalyst, was to make 38 years later in 1973 (see below).

The *Times Literary Supplement* [38] said that Suttie's book

> "offered the first really comprehensive and constructive criticism of Freudian psychology in its social application ... It shows how all the admitted errors of Freud, the contradictions and dissensions within psychoanalysis, and the problems that have defied solution, are not just the accidental mistakes and oversights inevitable in a new science. On the contrary, they proceed from

> one definite and consistent bias affecting Freud's theories far more than his practice. His fallacies and failures, therefore, form one coherent system; his positive achievements another. ...This book offers a biological and psychological conception of Infancy, Sociability, Love and Interest."

Hadfield, in his preface to the 1960 edition of Suttie's book, said:

> "His [Suttie's] system may be styled as essentially Matriarchal, as distinct from Freud's obviously Patriarchal system. ... He concentrated on the concept of love, rather than of sex. This in itself was not new; for, in my lectures both in the University and at the Tavistock Clinic, I had maintained, as against the Freudian view, that the fundamental need of the child was for protective love, and further, that the psychoneuroses were not primarily the result of sex complexes, but were due to insecurity resulting from the feeling of deprivation of love."

From this eclectic Tavistock milieu, Bevan-Brown's psychotherapeutic technique and experiences also led to his emphasising the importance of the first year of life, with a loving and mutually gratifying breastfeeding relationship being of fundamental value. A small book which he often said was worth its weight in gold was *Baby's Point of View* by Dr Joyce Partridge, published by Oxford University Press in 1935. It was out of print in 1948 so he quoted from it in *The Sources of Love and Fear*. At the end of his book he wrote a conclusion which seems as relevant today as 50 years ago. He wrote :

> "What, then, is the conclusion of this matter? For unless this book contributes to a better understanding and practice of child nurture it is of little value. The main conclusion is that we must try to produce a better race of parents than now exists, and better parents than we have been ourselves. 'Good' parents do exist in our generation but they are in a minority. The first requirement for a 'good' parent is to be emotionally mature. The majority of parents are emotionally immature - that is, they still retain in some respects the emotional attitudes characteristic of children. Therefore their children, lacking real parental affection themselves also remain emotionally immature when they become adult. We must try to break this vicious circle at as many points as possible by educative measures applied to: (1) Parents with young children, (2) Prospective parents, (3) Adolescents, (4) Educationists and (5) Doctors.
>
> "The whole matter cannot be condensed into rules, but rules are not without their value. We have contended that the first year of any individual's life is the most critical for mental health. Concerning the first year, I know of no code of rules as good as that given by Joyce Partridge in her little book,

Baby's Point of View. I understand that unfortunately this is out of print: otherwise I would recommend everyone interested in the care of children to buy a copy and keep it. Here are Joyce Partridge's rules (quoted by her permission):

(1). "Try to recognise before your baby is born that in the matter of sex the chances are even.

(2). Don't be afraid to follow the maternal instinct and intuition: in other words, give scope to your love for your baby and don't bring him up by rule of thumb.

(3). Breast-feed your baby.

(4). Never leave a baby alone to cry.

(5). Be as much as possible within earshot of your baby in the early weeks and months of life.

(6). Never in any circumstances scold a baby of whatever age, and never allow anyone else to scold him for wetting or soiling napkins or for wetting or soiling any other place whatsoever."

"Joyce Partridge is a first-class psychiatrist, a Fellow of the Royal College of Surgeons (England), and a mother. I commend her rules to you.

"It is the daily lot of the psychiatrist to meet and endeavour to relieve people who have experienced years of disability, ill-health, distress, and often of utter misery, all, or nearly all, of which need not have happened if they themselves and their parents had had more understanding.

"There are two highly emotionally-toned words in this connection – 'IF ONLY.' 'If only I had come to you ten or twenty years ago'... 'If only my mother and father had understood these things... If only I had understood these things when my children were younger.'

"If this little book is able to mitigate in any degree some of this widespread distress it will have fulfilled its purpose."

Though infancy was a central concern, *The Sources of Love and Fear* covered a much wider scope. Bevan-Brown's papers, collected in *Mental Health and Personality Disorder* [6], included his 1936 Presidential Address to The Medical Society of Psychology in London, called *A plea for correlation* between the different schools of psychodynamic thought [7].

Initiatives in Primary Prevention

The importance of early childhood experiences, let alone the idea that breastfeeding should involve a mutually enjoyable *relationship*, was not echoed in anything I heard in medical training at Otago University – nor was there any guidance in diagnosing or treating emotional disorders. So a number of doctors and medical students welcomed the training courses, organised at the Cranmer House Clinic. The ideas about natural childbirth led to the formation of the Parents' Centres movement [35; 29,9; 29,10)].

In 1951 I read Bowlby's classic Monograph *Maternal Care and Mental Health* [8] which presented empirical evidence that early experiences were important, and maternal deprivation in institutions could be damaging. In 1952 there was a worldwide shortage of child psychiatrists, and I went to London, to get on with training before I might get caught up in the Korean war. I was able to hear such luminaries as Anna Freud and Margaret Mead, but I heard little about primary prevention. I got to know Hadfield, who had been Director of Studies at the Tavistock Clinic, and his continuing concern for primary prevention through healthy child rearing was spelled out as late as 1962 in his Pelican publication *Childhood and Adolescence* [23]. However, the schools of psychodynamic thought which had become dominant were generally remarkably inert, and even pessimistic, about the possibilities of preventing emotional disorder through any educational or environmental measures affecting infancy and early childhood.

I was back in New Zealand from 1957 and, with others, was concerned to counter official proposals to institutionalise all moderately retarded children for life [10]. Later, I became aware of the distress and sometimes gross separation reactions presented by toddlers when their mothers' went to maternity hospital to have another baby. The stay was routinely two weeks, and children under twelve were the only ones not allowed to visit. The toddlers might go to stay with a relative or stranger, and two weeks was long enough to develop a major grief reaction. I suspected that much of what was regarded as natural sibling jealousy might be culturally induced by this practice. The policy had no scientific justification, since the toddler was unlikely to carry any infective organisms which mother did not already share. So in 1962 I wrote *A Two-Year-Old's Mother Goes to the Maternity Hospital* which was widely quoted, and soon this misconceived custom died out [11].

Like Bevan-Brown I wished to make available to ordinary parents the knowledge gained by treating disturbed children that could help them avoid

such problems with their own children. Classes such as those run by the Parents' Centres to prepare mothers for more natural childbirth might also offer education for parenthood. As there was almost nothing in the literature about what might be covered, I offered curriculum suggestions in a paper *Antenatal education for parenthood as an aspect of preventive psychiatry: some suggestions for program content and objectives* [12]. This placed in a medical journal many of the ideas in *The Sources of Love and Fear.*

The 1971 Position Statement of the Australian and New Zealand College of Psychiatrists, *Admission of mothers to hospital with their young children* [2,32] expressed similar concerns, suggesting that "the psychological and emotional damage caused in one year through lack of application of available knowledge about the care of children in hospital greatly exceeds that which all available child psychiatrists can undo in several years".

There was also in 1971 a *Memorandum on some aspects of the welfare of children under three years, whose mothers are in full-time employment* [33]. This concluded that "full-time work of mothers of children is undesirable" and said "it is doubtful whether there are any circumstances in which mothers of children under three might be encouraged to go to work for national reasons".

Evolutionary Perspectives

The idea that there might be cultures which were more conducive to emotional health, was touched on in *The Sources of Love and Fear.* The example of the indigenous society described by Jean Liedloff in *The Continuum Concept* has become well known [28], but the American military psychiatrist Dr J C. Moloney had much earlier linked to their early nurture the emotional stability of the indigenous Okinawans, whose culture he contrasted with that of the Japanese [30].

The doctrine of cultural relativism, developed by anthropologists to counter ethnocentrism, taught that whatever customs prevail in a given society are to be accepted as appropriate for those people, and one should not make value judgements about them. On this basis, the customs which prevail in New Zealand are ideal for New Zealanders. But are there any basic biological "givens" which form a basis for evaluating customs in matters relating to physical or mental health–for example with respect to childbirth, early nurture and childrearing?

Bowlby came to see that his explorations of the nature of a child's tie to its mother could only be understood by adopting an evolutionary perspective. In

fact, tucked away in an Appendix to Volume 2 of *Attachment and Loss*, in 1973 Bowlby [9] wrote these challenging words:

> "On reflection it becomes clear that Freud's increasingly deep commitment to a Lamarckian perspective, to the exclusion of Darwinian ideas about differential survival rates and the distinction between causation and function, has suffused the whole structure of psychoanalytic thought and theory. With the remainder of biology resting firmly on a developed version of Darwinian principles and psychoanalysis continuing Lamarckian, the gulf between the two has steadily and inevitably grown wider. There are thus only three conceivable outcomes. The first, which is barely imaginable, is for biology to renounce its Darwinian perspective. The second, advocated here, is for psychoanalysis to be recast in terms of modern evolution theory. The third is for the present divorce to continue indefinitely with psychoanalysis remaining permanently beyond the fringe of the scientific world".

As a psychoanalyst, Bowlby was subject to much alienation from his colleagues for his stand. When asked how he had withstood such attacks he replied "I had the evidence!" He died in 1990, but that evidence continues to accumulate. On 21st October 1980, as Freud Memorial Visiting Professor at the University of London, he gave the Freud Memorial and Inaugural Lecture *Psychoanalysis as a Science* [9], and said:

> "I believe that all the developmental concepts of psychoanalysis will have to be re-examined and that most of them will in due course be replaced by concepts now current among those who are studying the development of affectional bonds in infants and young children by means of direct observation. ... Put briefly, I believe our task as psychoanalysts is, when researchers, to render unto science the things that are scientific and, when clinicians, to render unto persons the things that are personal".

Derek Freeman, a New Zealander, who is Emeritus Professor of Anthropology at The Australian National University, points to the same problem today in the social sciences. He documented as false, the account (based on a hoax) which Margaret Mead published as research into adolescent behaviour in her 1927 "classic" text *Coming of Age in Samoa*. She was eager to please her supervisor, Franz Boas. He was an ardent believer in the ideology of cultural determinism, and wanted Mead to find support for his denial of significant genetic and evolutionary factors in human behaviour. Thus, says Freeman, Margaret Mead, the world's most eminent anthropologist, misled generations of anthropologists into denying genetic influences in human societies and the

value of an evolutionary perspective in studying human behaviour, perhaps the most serious scientific misinformation of this century [18]. I think this denial of an evolutionary perspective in the social sciences has contributed to the serious social problems with early childcare today.

Dr R G Every, Thegotics and Evolution

An evolutionary and cross-cultural perspective is implicit in *The Sources of Love and Fear.* However, my own realisation of its fundamental importance came through Dr Ronald Every, a Christchurch dentist, who died in 1996 - a family friend to whom I pay tribute. He was in Bevan-Brown's training groups and is in the NZAP founding photograph [15]. He showed how dental and medical trauma could be caused by extreme movements of the jaw, which presumably occurred during sleep, since his patients were completely unaware of them.

As with Bowlby, his quest for an explanation was answered as he adopted an evolutionary perspective. He compared the skulls of many species and showed that these movements, demonstrable in most mammals, are normally tooth-sharpening behaviour, often associated with situations involving threat and intense emotion. He termed this activity *thegosis*, from the Greek *thego* "I whet", and he founded the discipline of thegotics. He held that, through evolutionary natural selection, our pre-human ancestors' teeth had been progressively improved in their functions as tools and weapons, to achieve in humans the "segmentive" and lethal "bite to kill". This deadly weapon evolved *with natural control mechanisms* to inhibit inappropriate use. He had irrefutable evidence in dental enamel—the hardest of all biological substances—showing precise behaviour of which his patients and colleagues were not aware, and which must be genetically programmed [17]. Here was demonstrable evidence of genetically hard-wired instinctive behaviour in human beings – an unprecedented discovery! He may yet be recognised as a genius—a "Darwin of oral aggression"—but in his lifetime he was subverting the "dominant paradigm", and it is sad that his death denied us the opportunity to celebrate together.

An Evolutionary Perspective in Childrearing

In the 1960s I began to explore the relevance of an ethological-evolutionary perspective to healthy child rearing and clinical child psychiatry. If there are genetic influences with natural control systems for oral aggression, then what about other human behaviours required for the survival of our species? What about the parent-child relationship? If babies are the refined outcome of this

long process of natural selection, what is the significance of their wants and behavioural urges? I observed the development of our four babies, adopting an attitude of respect for possible biological givens, and looking for natural control mechanisms in infant interpersonal behaviour and socialisation. After all, humans evolved and survived as social animals. Perhaps they are innately social; but the current theories of "socialisation" were based on quite different views of the nature of the child.

Traditional childrearing assumed that children were born basically anti-social. I wearied of hearing fearful parents, perplexed that their threats and best efforts to chastise their children into conformity seemed futile. Contemporary notions of discipline were very much a concern to the founders of the NZAP. Bevan-Brown wrote: "Corporal punishment is dangerous to mental health. This is a statement that can be made unequivocally. ... The earlier in life it is given the more dangerous it is" [5 p 46]. This is not yet a dead issue and I was appalled to read the 1991 book *Spare the Child* by Phillip Greven [21], which gives a history of some religious roots of corporal punishment. He often refers to *Spare the Rod*, by Jane and James Ritchie of The University of Waikato [37]. They had reported that in New Zealand in 1970 "punishment, frank, direct and physical, or verbal in the form of threats, shouting and scolding or berating" were regarded by mothers as "being as necessary for child rearing as the mid-morning cup of tea is for sanity". No wonder that 40% of them felt that the burdens of caring for young children balanced or outweighed the enjoyment they received [36].

In the late 1960s I realised that the childrearing ideas and practices of many parents who consulted me formed a logical contrast in almost every way with those by which my wife and I were rearing our children. They arose from different views of the nature of the child and the childrearing process. I compiled a table of these contrasts, and found that many of the "traditional" childrearing ideas stemmed logically from the doctrine of Original Sin as formulated under Manichaean influences by Saint Augustine [14]. His dogmas were incorporated into the Thirty Nine *Articles of Religion*, to which Clergy in the Anglican churches have long been required to assent. Article nine teaches that Original or Birth Sin is "the fault and corruption of the nature of every man ... whereby man is very far gone from original righteousness, and is of his own nature inclined to evil, so that the flesh lusteth always contrary to the spirit; and therefore in every person born into this world, it deserveth God's wrath and damnation." It concludes that sensuality, "concupiscence and lust hath of itself the nature of sin" [*The Book of Common Prayer*, 1662].

This doctrine has been clearly reflected in psychoanalytic theory. Edward Glover, an authoritative figure in British Psychoanalysis, wrote in his paper *The Roots of Crime* "In fact, judged by adult social standards, the normal baby is for all practical purposes a born criminal" [20].

From an evolutionary perspective, this dogma makes no sense for a social primate like *Homo sapiens*, where the selection process must favour qualities required for individual survival, but counter-balanced by the imperative to do so in ways that gain full acceptance by a breastfeeding mother and *also* a co-operating social group. I suggest that if children's emotional needs are met, they may be constructively be regarded as naturally age-appropriately "socialised" from birth onwards, but they need help to manage their conflicting impulses to gradually become civilised in ways that meet the requirements of citizenship of an over-populated planet which is losing its biodiversity through human exploitation. Ainsworth and Bowlby in their 1989 APA Award Address [1] said:

> "In regard to socialization, the findings suggest that infants have a natural behavioral disposition to comply with the wishes of the principal attachment figure. This disposition emerges most clearly if the attachment figure is sensitively responsive to infant signals, whereas efforts to train and discipline the infant, instead of fostering the wished-for compliance, tend to work against it."

Yet historically, ideas deriving from the above interpretation of original sin have determined the whole way that babies and children were perceived and reared. These ideas readily generated self-fulfilling prophesies, whether perpetuated through Susanna Wesley's 18th century advice to beat babies without mercy to break their wills in order to save their souls [40] (fearing they might die unsaved in infancy and spend eternity in hell), or as transmuted later throughout New Zealand in the teachings of Sir Truby King [26], who advocated strict regimes to mould the infant from birth. In the 1950s in New Zealand and elsewhere, there were widespread fears of children becoming increasingly unmanageable. To avoid 'spoiling' children it was essential for mothers, also, to be disciplined — for them to win the inevitable battle of wills and suppress their impulses to pick up or respond to their infants' cries, except for feeding at four-hourly intervals. Babies should sleep in their own rooms from birth, and routine toilet training should begin at six weeks. Corporal punishment in due course was often a natural sequel. And so on.

In many of the problems presenting clinically, the pathogenic parental behaviour was under-pinned by such fears, combined with the belief that it was

necessary to intervene early, with coercion and physical punishment, to prevent future delinquency. Such notions were widely disseminated in the English-speaking world and elsewhere. By fostering a basic distrust in the human biological "givens", the doctrines led to a mis-match between many Western childrearing practices and these biological givens, often leading to parent-child frustration, conflict and later rebellion or personality distortion. The history and long-term impact of the Augustinian doctrine of original or birth sin on the mental health of children in Western societies is an important topic waiting to be well documented. An account of this mis-match was published in 1978 in *Childrearing, culture and mental health: exploring an ethological-evolutionary perspective in child psychiatry and preventive mental health* [14], covering the areas of childbirth, lactation, early mothering, attachment, childrearing and the social settings in which we expect these functions to take place.

A biological perspective suggests areas for corrective action, and ways to make our culture fit our genetic biological givens. A corollary of Darwinian theory concerns the outcome of those deviations from the conditions of the environment of evolutionary adaptedness which cut across important biological mechanisms. If the changes are not severe enough to cause extinction, or gradual enough to allow genetic adaptation by natural selection, then they may lead to stress and maladjustment, first affecting the more vulnerable, like the canaries in the coal-mine. Much medical and psychological illness may be understood in this way. In such cases, corrective remedies to deal with the cause of the maladjustment are generally better than antidotal remedies which just aim to treat the symptoms [14].

Early Childcare as a Symptomatic Remedy

Institutional early child care may be viewed as a *symptomatic* remedy for certain social problems, such as poverty or maternal isolation, and, like many symptomatic treatments it can bring its own complications. *Corrective* remedies are usually preferable, and in the care of young children they are both healthier and possible.

It is paradoxical that while many practices towards young children have improved, academia, the bureaucracy and the media have been largely dominated by people committed to universally available early non-parental childcare as their preferred way of advancing the cause of women. Underpinned, in part, by the ideology of cultural determinism, a corollary has been a denial

of the importance of good mothering for emotional health in the early years, as was central to the teachings of the founders of the NZAP.

To promote optimum emotional health and wellbeing, parents, students and policy-makers need to understand some of the issues involved in early child care from the point of view of what is best for infants, young children, their mothers and families. Non-maternal care in early childhood by unrelated women having no lasting commitment to the child, is without successful long-term precedent in the history of our species. A child can spend 12,500 hours in day care by the age of five (50 hours X 50 weeks X 5 years). This is more than he or she will spend at school by the age of 17. Concerns about the impact of this on infants and young children have been countered by assurances that there is no evidence of harm from quality early child care, and that in some cases it might be beneficial, but the evidence certainly suggests that mediocre child care—which is widespread—can be harmful.

In fact, there is accumulating robust evidence to suggest that risks of a variety of serious and perhaps lasting undesirable outcomes are associated with early group child care as it exists in reality, even in 'high quality' child care [16], and infants' actual experiences in real life child care situations are often very different from the ideal picture. The many contributions that home-caring mothers or fathers make to society are currently undervalued. Society offers them little in return, and they are handicapped on seeking to re-enter the work-force.

Thus, in 1992 Belsky, noting the quality of childcare used by increasing numbers of parents from early infancy, and reviewing evidence of associations between early child care and increased risks of insecure infant-mother attachment, later aggressiveness and non-compliance, said: "On the basis of this developmental and social ecology of daycare in America, I conclude that we have a nation at risk" [4]. In 1995 a survey of 400 American child care centres concluded that "most child care is mediocre in quality, sufficiently poor to interfere with children's emotional and intellectual development." [25]

A Swedish study showed that, despite a national reputation for the world's best childcare, many Swedish infants starting long day care in the second half of the first year reacted "with a significant negative change in mood, sadness, and a low activity level", and at one stage half of them were assessed as sad and depressed in the day care setting. Some infants fell behind in tests of speech and cognitive development, with a few remaining depressed at the end of the five-

month study period. All these findings were in comparison with matched controls who were cared for at home by their mothers [24].

In 1996, a multi-million study sponsored by the American National Institute for Child Health and Development validated the Strange Situation procedure for assessing infant-mother attachment security/insecurity, and clarified the interaction of various child care factors associated with this security. Findings included: boys are more vulnerable, and boys in more than 30 hours of non-parental care per week had the highest proportion of insecurity; the 25% of infants whose mothers rated in the lowest quartile in "Sensitivity" had increased risk of insecurity in more than just 10 hours in childcare, regardless of childcare quality, and "low quality child care, unstable care, and more than minimal hours in care were each related to increased rates of insecurity when mothers were relatively insensitive". It appears that children who are already disadvantaged are the ones most at risk to be further disadvantaged by early day care, in some cases independently of the quality of care [34]. The second NICHD Report, with findings to 36 months, confirmed that non-maternal childcare carries increased risk of adverse outcomes in many facets of the mother-child relationship [34].

A meta-analysis of *all* the 88 adequate childcare outcome studies published between 1957 and 1993 showed "significant and robust evidence of undesirable outcomes associated with non-maternal care in the areas of socio-emotional development, behaviour and infant-mother attachment. The findings gave no support for the belief that high quality day care is an acceptable substitute for parental care" [39].

Though a causal relationship is not established, the evidence is becoming stronger that these disquieting outcomes are indeed *effects* of early day care, and the risk of adverse effects on infants certainly exists.

This material is presented in *Early Child Care - Infants and Nations at Risk* [16], where I suggest some remedial measures including community recognition of infants and their parents as a discrete and vulnerable group, with special needs during a limited period. With early long day care, as with young children in hospital in the 1970s, it is arguable that far more emotional disorder is being initiated by the placing of infants in non-parental early childcare—as it mostly exists—than all the psychotherapists and child psychiatrists could undo if they did nothing else!

Conclusion

Primary prevention is in the best traditions of those who founded the NZAP, with a role for psychotherapists to use their insights as a basis for advocating reform. I have been much encouraged by Dr Elliott Barker [2], a Canadian forensic psychiatrist, who, after long experience with criminals and psychopaths, decided that early primary prevention is imperative, with emphasis on good nurture during infancy. He founded The Canadian Society for the Prevention of Cruelty to Children, and for 18 years has produced its journal *Empathic Parenting*, which is reminiscent of the *Child Family Digest* mentioned earlier. For more information, or to subscribe, see that Society's Internet Home Page on http://cnet.unb.ca/corg/ca/e/pages/prevention_cruelty/ I hope some of you will read the evidence and be willing to publicly raise concerns. You will be in good company, as shown by a large *anonymous* survey of members of the World Association for Infant Psychiatry and Allied Disciplines, to which 450 members responded. It was outlined in The Anna Freud Centenary Lecture by Dr Penelope Leach in London in 1995 [27]. When asked what was best from infants' viewpoint, most of these professionals thought that, until infants are at least 12 months old [with a mean of 15 months], it is "very important" for them to have their mothers available to them *for most of each 24 hours;* and it is best for them to be cared for *principally by their mothers*, until they are over two years [with mean age of 27 months]. By 2yrs 6 months 94% still did not think that full-time group care was the best arrangement. Leach said "the findings were consistently at odds with the kinds of care infants in Western countries now receive and which parents and policy makers desire for the future" [27].

A 1996 British review *Who Needs Parents: the Effects of Childcare and Early Education on Children in Britain and the USA* by Dr Patricia Morgan also gives much evidence for concern about child care [31]. She demonstrates (p 109). that the goal of "...'affordable, universally available, good-quality, easily accessible childcare' (to use the popular mantra) is a chimera, unrealisable in the real world. Affordable care is *low-quality* care. Universally available *high-quality* care is achievable nowhere on earth". Our society must abandon the fictive goal of universal, affordable, high quality child care for very young children, and do whatever is needed to help parents provide high quality mothering and fathering without unduly jeopardising their own futures.

I thought of rephrasing the title of a book and calling this paper "Fifty Years of Psychotherapy - and the world is getting worse!" So I hope the present generations of professionals will consider these matters, and continue the tradition of speaking out in the interests of the emotional health of the infants and young children, who will be the young women and men of tomorrow.

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Touching in Psychological Practice

John Gamby

Abstract

This summarises some core research on touching in human development. Rules of touching are discussed, in Pakeha, Maori and professional psychology cultures. Examples are given of touch gone wrong in terms of these rules. Possible rationales for touching and not touching are offered, followed by some fairly conservative guidelines. It is assumed some of these would be mutable over time.

"... a patient was unable to bring herself to touch a chair which she regarded as contaminated. The therapist and a nurse who was assisting modelled touching the chair, but the patient was unable to do so. The therapist asked whether the patient knew of a children's game, in which people put their hands, one after another, on top of the previous hand; the bottom hand is then pulled out and put on top, and so on. The game was played on the contaminated chair (with a great deal of laughter); the patient had touched the chair several times, and the programme was begun."

(Salkovskis & Kirk, 1993).

Touch as Crucial to Human Development

Two great bodies of research have established that touch is a requisite of primate and human development.

The first was by Harlow over 35 years from 1931, demonstrating the importance of clinging and holding in young primates. During the same period Bowlby and others demonstrated the catastrophic effects of touch-deprivation and separation from parents upon infant children. There is a need for continual interaction with one or a few adults during infancy.

Anna Freud (1965) proposed that the skin as a sensory organ facilitates the embodiment of the child, a theme elaborated at length by Montagu (1971), Fisher (1986), and Pruzinsky (1990).

Infants held, handled, fondled, cleaned and rocked thrive better than those without such experiences. There is of course interplay with taste, smell, proprioception, hearing and vision.

Weaning initiates a series of withdrawals of intimate touch; exploration and social training initiate children into culture-bound patterns of interaction, including touching. Self-touching behaviours appear.

Touching is sanctioned along age, gender, power and local culture lines, e.g., sand and mud play, handshakes, hongi, applying facial makeup, ritually-patterned in contact sports.

In preschool years the number of adults touching the child may increase, then taper off in the years from 6-12. These children may resist or avoid adult touching. During these years physical contact among children increases.

In middle and late adolescence there is emergence of bonding behaviours among other and same-sex peers.

Rules of Touching

Spatial and Temporal Expectations

Social stimuli connoting intimate interaction have a bearing on expectation of touch. Middle class Pakeha have fairly clear expectations about the conditions of one-to-one therapy, acquired from reading, media, cartoons and discussion with other clients. Other Pakeha, Maori, Polynesian and immigrant groups may not be familiar with the conditions of psychological therapy.

Small interview rooms may create expectation of intimacy. Among Pakeha 1-2 metres of personal space is usual in a casual or business meetings; 75-120 cm is a natural distance to discuss personal issues as friends; 45-60 cm implies a close bond, as between spouses, or parents and children. (Hall, 1966). In the long run propinquity and privacy will raise expectancy of greater intimacy, and possibly greater touch. It is therefore common for therapists and clients to state the conditions of intimacy early on.

When two or more people set aside 40-50 minutes for private discussion without an obvious agenda there will be a strong connotation of intimacy. When they withdraw to a small room and close the door for that long (the therapist being aware of the conventions and the client maybe not) some mismatch of experience and expectation is possible.

Are There Norms Of Touching?

There may well be generally accepted rules of touching, but they are often unstated, and certainly depend on context. Friends or relatives who have not

seen each other for some time may embrace, then spend much time together and hardly touch at all.

Individuals vary widely in their use of their own and others' personal space. Psychologists, too, will vary.

In Aotearoa/New Zealand little work has been done on prevalence of touch in ordinary social interaction. There has for example been no replication of the work of Jourard (1966) or his successors.

Jourard's exploratory study of body-accessibility presented young unmarried students with front and rear views of an asexual body and asked them to show on which of a number of different body regions they had touched, or been touched, by various designated persons (see Fig 1) - namely Mother, Father, Same-sex Best Friend, Opposite-sex Best Friend.

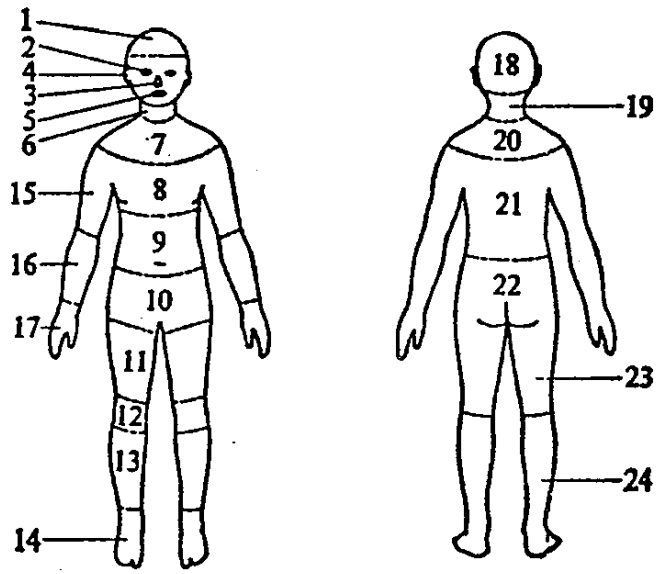

Figure 1 - The front and rear view of the body as demarcated for the Body-Accessibility Questionnaire. (Jourard, 1966)

For that group, touching was most frequent between opposite-sex friends, followed by same-sex friends and parents.

Jourard's article should be read, and followed up by reading Henley (1977) who replicated the work in the US, focusing on the politics of power and sexuality in nonverbal communication, including touch. She concludes that

> In this male-dominated society touching is one more tool to keep women in their place, another reminder that women's bodies are free property for

> everyone's use. We can further project a picture of the way touch, in combination with other nonverbal behaviour, must work to perpetuate the social structure in other status areas though we have fewer data showing the details of this function. (p.123).

The writer finds an ethological stance useful for increasing sensitivity to patterned touching behaviour. One can for example observe age and gender variations on touching behaviour in or outside coffee shops.

Aversive and Variant Touching Histories

Many clients of psychologists, and at least some psychologists, will have such touching histories.

Sexual Abuse

Writers on sexual abuse offer figures of 10-50% for women clients and 5-20% for men clients, at some stage in their development. (Colgan & McGregor, 1981). People who have had their need or powerlessness exploited will tend to scan powerful others for cues that will help them identify, estimate risk from, avoid, placate or challenge the risky other.

Therapists are merely a special group of risky others, and must respond with sensitivity to their own and clients' motives, recognising the inequality built into the therapeutic encounter.

Violence and Intimidation

It is safe to assume that every person has been physically and verbally attacked by a parent or peer, at some time.

As with sexual abuse psychologists should be aware of the research on spatial norms (Argyle 1988, Henley 1977). Clients with histories of abuse by violence, observation of violence, intimidation and terrorisation should be asked about their preferred distance.

Some present with anger problems, and seem fairly confident about proximity until invited to breathe less deeply, or adopt a vulnerable position to relax. Those who have experienced assaults as life-threatening, or whose fears are continuously re-aroused, will require an available personal space of 2-6 metres, i.e., a large room, even though they may be able to sit through a meeting at 12 metres distance.

Neglect And Avoidance

Clients with histories of neglect may have suffered interruption to bonding with caregivers in infancy and childhood (Bowlby, 1969; Karen, 1994).

Others may have been touched seldom, and have little recollection of observing adults' touching behaviours during their development. Disabled clients may simply lack opportunities to touch or be touched as they would like.

Such people come to psychologists with a wide variety of physical contact needs. They may express those needs without being aware enough of the aversive or attractive effect this has on others.

Conditions for Which Touch is a Primary Issue

We began with an intervention with a patient suffering from Obsessive-Compulsive Disorder, a condition in which patients often show unusual patterning of touching behaviours, many involving notions that the touch of others is contaminating to person or object.

Child psychologists will be familiar with children who are distressed by touch, and distress others if touched as in autistic and near-autistic disorders. Frequent sexualised touching by children is a strong cue to consider possibility of sexual abuse by an adult.

Psychologists' Cultures of Touch

Most Aotearoa/New Zealand psychologists are Pakeha or come from other North European tauiwi backgrounds. These groups are seen as infrequent touchers compared with, say, Argentinian, Greek, or Spanish nationals. Indeed visitors from the USA and South Africa comment on our relatively inhibited touching behaviour in casual social situations. (Older, 1982).

It may be that local psychologists are relatively inexperienced in this area. Nuances of proximity, intimacy and touch known by tauiwi may be inaccessible to us without training.

Professional Touch Culture

At the onset of work psychologists offer clients a package of conditions.

There are rules about duration and frequency of sessions; about privacy and confidentiality; about informed consent.

The relationship will be respectful, dispassionate, and holding. The psychologist will try to do no harm.

There will be a proposed plan of treatment. The psychologist will use interventions and practices which are validated by scientific knowledge and backed by clinical experience.

Absence of touching is usually a part of the package.

Psychologists asked whether they touch their clients will usually say they do not. They will then usually offer an exception. Men will mention handshakes; women will speak of a spontaneous arm or shoulder stroke with clients in extreme distress.

Psychologists working with disabled people may need to guide a hand or arm. Psychologists using biofeedback methods may touch or handle clients, as when attaching electromyograph pads.

It is probable that most psychologists touch their clients from time to time. As far as we know most avoid touching clients or students most of the time.

There is a folk belief that touching by female psychologists may be less risky than touching by a male psychologist. True or not, this misses the point.

Clinical psychologists advise against touching most clients. Their rationale is that clients may misconstrue the therapist's intention, or construe touch in terms of their own previous experience. Some clients may not be aware of such experience if preverbal; some dissociate to modify awareness; acutely anxious clients may be unable to dispassionately review it.

New knowledge of the prevalence of sexual and physical abuse, and some widely-reported criminal, civil and disciplinary actions (Loates, 1991; NZPsS, 1997) sensitise us to the potential harmfulness of touch to clients, and the risk to our reputation and livelihoods.

Touching and Children

Psychologists who work with children can make use of play, and displacement activities, using sand, water, paint, pencils, solid toys and soft toys. They can also observe children with caregivers and form an impression of touch repertoires and styles which has some ecological validity.

An educational psychologist comments that testing very young children may require sitting the child on her knee, to reduce stress, maintain task focus and enable access to a table surface. Another psychologist comments that this would be risky for a male psychologist to do. The writer asks, from whose point of view?

Again, anxiety about risk to our reputation may override debate about utility, professional technique, and the effect of such touching given the experience of child *and* caregiver.

At all events, child psychologists also tend to work from a principle of keeping touch to a necessary minimum.

Touch Gone Wrong

From time to time psychologists who shake their client s hand, pat a shoulder or move as if to, will notice lack of participation, a startle reaction, recoil, o change of facial expression.

At such a moment it may be timely to respond with

- 'I noticed when I did that you did not seem comfortable'
- (followed by) an enquiry about client experience
- a reassurance about respect for boundaries
- an apology if that is seen as necessary.

The psychologist can then or later reflect on the incident, and discuss it with a colleague if it poses issues for worker or relationship.

Responding promptly and reviewing such issues early is one of our best safeguards. Loates (1991) in her account of the Davidson case, describes a sequence of interactions, rests from contact, and shaping encounters spanning eight years before actual sexual exploitation began.

When touch goes wrong the psychologist can take the initiative to clarify goals, boundaries, and to review with colleagues. The earlier this is done the better.

Space does not permit review of cases but the reader is referred to Loates (1991). In May 1997 *Connections* reported the outcome of charges of professional misconduct by Pierre Beautrais. To that report are appended useful comments on psychological practice.

Beyond the Fringe

Many healers use touch as a matter of course. GP's, physiotherapists, osteopaths, chiropractors, bodywork therapists, and gestalt therapists do use touch and appear to have conventions that enable them to use touch safely. Older (1982) presents persuasive arguments for wider use of touch in psychological therapy.

Psychologists sometimes argue that it is avoidance of touch that differentiates them from GP's, forgetting that many GP's are excellent listeners who get the diagnosis more or less right, and have some advantages in formulation because they may be the family doctor.

Stroking and handling can be soothing to people; even the hoariest bedside manner may be moderated by unexpectedly non-aversive, or healing touch (Heylings, 1973).

Avoidance of proximity does limit our awareness of the variety of body behaviour, texture and odour. It can also make us poorer observers of the repertoire of self-touch in our clients and ourselves. Such activities as finger tapping, hair-play, rhythmic kicking, twiddling, chin-stroking, minimal rocking, self-hugging, adam's apple tugging, arm-folding and preening are seldom found in our notes.

Summary

Psychologists work in a variant culture of non-touch when they address issues of behaviour, affect, cognition, fantasy, interpersonal issues, and sensory experience.

This culture of non-touch is not immutable and may be modified to some extent by personal preference and experience, technique, necessity, conceptual framework and the behaviour of the client.

And the contextual culture(s) of touching.

Touching and Maori

Pakeha probably cannot be Maori in the heart. Very ordinary Maori values may be in conflict with academic and professional psychology style. For example aroha may imply more readiness to touch than would be socially comfortable for a Pakeha, let alone a Pakeha psychologist.

We can however use opportunities to experience Maori values of touch in Maori context. It is relatively easy to participate in a powhiri as manuhiri.

Essential to Maori mana and identity is the concept of tapu. In tapu are included elements of godlikeness, perfect essence, being set apart, and contamination. Some beings and some entities may not be touched.

Manuhiri are tapu as they come on to the marae.

The karanga affirms the common destiny and fate of tangata whenua and manuhiri alike. More links are made through invocation of the spirits of the dead, and the whakapapa links are explained. Speakers are each followed by a waiata led by women, which removes the tapu from his oration while standing, and allows him to resume his seat on the paepae (Walker, 1992).

Only after the ritual alternation of speeches do manuhiri cross the marae to shake hands and hongi with tangata whenua. In this ritual a Pakeha is confronted with the extraordinary variety of personal styles of ritual touching in a very short time.

This raises issues about local replication of Jourard's study of body accessibility. Perhaps use of the terms tapu and noa would provide a vocabulary at once respectful and precise, since we often deal not only with cultural values but also individual histories of non-respectful touch.

Some touch is non-negotiable, as in Maori treatment of the crown of the head as tapu (you don't touch the head of a child either); some touch is negotiable, as in exploring the stages of intimacy; psychologists may always choose to declare certain body areas tapu in dealing with their clients.

For some areas and purposes, touch may be negotiable, even in psychological practice.

Rationales

For Not Touching

Intimate touching, enjoyed or not, has no place in psychological interventions. In the context of therapy it is an abuse of power.

Unsolicited touching may be highly aversive for the clients.

It is hard to elicit comprehensive information on a client's touch history, regardless of the duration or depth of the work. Our knowledge of the meaning of touch for any client will always be incomplete. (Courtois, 1996, APA 1997). Touch may signify bonding, reassurance, invitation, intimidation or chaos.

If 'psychologist' is substituted for 'client' in the paragraph above, that is true too.

Exploration of reasons for seeking or avoiding touch will result in a different type of learning about it. Exploring *meaning* in a context of non-touch may give clients more access to implicit memory than would gratification of touch-hunger, or avoidance of the matter altogether. (Langs, 1975).

For Touching

Some touching is noa, or ordinary, with a substantial number of clients. An example would be a handshake with a client who appears to have no discomfort with it. Such rituals may be experienced as safe by some social groups, e.g., business people.

In acute distress, refusal to touch may be experienced by a client as rejection. This does not imply the psychologist must touch, but that the want, and the meaning of refusal to meet it, should be dealt with in some way.

Some conditions may require an extension of touching repertoire (Salkovskis & Kirk, 1993, quoted at the start of this chapter).

Further, some touching may be required as part of intervention supported and validated by research, e.g., clients who self-harm continuously and habitually; clients who cannot complete a necessary movement without guidance.

A psychologist who has moved closer to a client, asking, 'What might help you just now?' will sooner or later be told, 'Hold me'. This answer does not commit the psychologist to doing so, but requires at least a follow up question such as, 'How would that help you just now?'

Some Guidelines

- Other than ritual behaviours (e.g., handshake if that is your ritual) and necessary behaviours (touch without which treatment could not proceed) do not initiate touch as a matter of course.
- The setting in which you work may not always respect your client's comfort zones about propinquity and privacy. Talk and ask about client's preferred personal space. Be sensitive to nonverbal cues.
- Learn the touch history of your client as far as you can. With children, much can be learned from direct observation in interview. Helping caregivers discuss and modify touching behaviour can be highly effective.
- Learn and review your own touch history and behaviour, including self-touch, as far as you can.
- If clients seek physical contact it is helpful to discuss with them what benefit they think would result. This can initiate useful work on awareness of need, and ways this might be met. Issues of dependence, neediness, resentment or sensuality can be worked on without therapist use of touch.
- Should any intervention requiring touch seem indicated, work out your rationale for this, and review it with a colleague. Be sure the client understands the rationale. Negotiate permission to touch, if necessary session by session.

- Do not initiate any touch with a client that you would not be prepared to discuss in senior or peer supervision.
- Record touch interventions in session notes, outlining your rationales.
- You can make provision for an auxiliary therapist to join you; as in the extract which begins this chapter.

If your touching manoeuvre is brilliantly innovative, remember, there's nothing new under the skin. It is easy for us to fantasy about receptivity, tractability, accessibility and improvement in your client (Brock, 1985).

Take your own needs seriously and provide for them in other settings. We are trained to address issues of suffering and joy rationally. The most rational of us is susceptible to an unexpected lapse of self-awareness.

Reprinted from *Practical Issues for Clinical and Applied Psychologists in New Zealand,* published by the New Zealand Psychological Society, 1997, by permission of the Editors.

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Your Clever Mistake Forgot

Should I smile when shows your Freudian slip wit,

Or, blushing bright red on your behalf, seek

Not to show to what degree Lethe split –

Let burgeon through those drifting lids a peek

Of penetrative wisdom from that pool

Unfathomable – like a little fish

That startles, darting up to play the fool

And make your forbidden delicious wish

Gleam forth and glow incandescent – as blows

Wind fiery coals to make fancies image

Flicker through which for a moment so throws

Us to ourselves, and disbelief presage

All, 'til hot head denials fill the day.

And forgetfulness holds lost sight at bay?

Malcolm G T Bagnall

Book Review

Angela Stupples

Brian Broom. *Somatic Illness and the Patient's Other Story.* London, Free Association Books, 1997. $48.95.

It was a pleasure to be asked to review this book, published by Free Association Books, London. I congratulate Brian on having found a place to express his clinical experience and ideas in the wider world of Europe and North America. It reduces the sense of isolation and self-absorption which I experience in our current cultural climate, as we struggle to come to terms with the events of our past.

The book is subtitled 'A practical integrative mind/body approach to disease for doctors and therapists'. The focus of seven out of the ten chapter divisions is on the assessment and treatment of patients presenting with a range of somatic symptoms which have failed to respond to traditional treatment regimes. Dr Broom, a consultant physician, a qualified psychotherapist and member of NZAP, begins with the premise that these patients are failed by medical professionals, including psychiatrists, because they are not 'seen' as unique individuals whose disease processes are influenced by disturbances in both mind and body. He is critical of the current diagnostic criteria for Somatisation Disorder, indicating that it narrows the focus to an extent that excludes a wide range of patients whose 'other story' holds the key to their successful treatment.

This 'other story' and its unfolding during the course of treatment, is told throughout the book using case vignettes to illustrate the emergence of clinical issues, the understanding of which Dr Broom shares with the reader as he discusses his thinking about his patients. In this way his method of engaging and working with somatising patients in short term psychotherapy is rigorously and painstakingly described. This is a book which leaves one in no doubt about what to do and how to do it. It is written with the force of personal conviction and, I would guess, some considerable experience of the difficulties met when

trying to convince medical colleagues that an integrative mind/body approach to treatment is necessary.

The practising psychotherapist will generally require less convincing of this need for integration, but as we are reminded, somatising patients are not easy to engage in psychotherapy and their non-psychological mindedness is a struggle to work with. We are apt to concentrate on the mind and to ignore somatic symptoms or regard them as part of the resistance to treatment, thus "skirting around matters of the body" due perhaps to an underlying anxiety about our lack of medical knowledge. In this way we too are apt to fail our somatising clients who are left to "look for answers in the wrong place".

For this reason I think the book has value for the non-medically trained therapist. It is easily accessible and interesting to read and has been written for a variety of health professionals. Inevitably some of the medical terminology may be mystifying to the non-medical therapist but this did not detract from a deep understanding of the text.

The book is imbued throughout with Dr Broom's philosophical view of the nature of "personhood". The final chapters of the book are given over to a philosophical discourse in which he confronts and challenges the commonly held dualist concept of the compartmentalisation of mind and body, biological and psychological. Instead he proposes a revisioning of the core of the problem, advocating a comprehensive "gestalt" in which the meaning of the parts can only be fully understood by an attempt to "see" the whole person i.e. body, mind and spirit. He is supported in his thinking particularly by the writing of A. Shalom whose work is extensively quoted.

The final message is that if we can free ourselves of dualist thinking about the nature of illness and begin to listen to the language of body, mind, and perhaps spirit, the unique story within the multidimensional unity of each patient will emerge. The process may be difficult but the therapeutic results as described are impressive.

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