Forum THE JOURNAL OF

THE NEW ZEALAND ASSOCIATION OF PSYCHOTHERAPISTS (INC.)

TE ROOPUU WHAKAORA HINENGARO

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Editorial

In the years since 1995 when the first issue of this Journal appeared, its purposes have been elaborated with increasing clarity. It came into being in response to members' recognition of the need for a medium

- located within Aotearoa New Zealand,
- to encourage the expression of professional creativity and reflection,
- to provide a forum within which members could make their work, and the thinking the underlies it, visible to one another,
- to stimulate dialogue and debate and
- to hold with respect the diversity of views contained within the association.

This fifth issue addresses each of these purposes. We follow the established custom of offering in printed form papers presented at this year's conference in Dunedin, whose theme was *The Unconscious: the Real McCoy of Psychotherapy?* Keynote papers by Brian Broom, Joan Dalloway, Sean Manning and Richard O'Neill-Dean take a variety of bearings on this theme. We are also pleased to include papers by Gill Caradoc-Davies, Betty Robb and Carol Worthington, who missed the opportunity to put their papers before participants as a result of the format and dynamic of conference, and from Philip Culbertson, Tony Coates and Jerri Bassi.

Five issues of the Journal bring us to a point when we can take stock of what has been achieved and what now needs to be addressed. The Association's strategic plan for 1999 identifies objectives for the Journal's future development. These will require the editorial group to move forward with the development of editorial protocols and to establish a system of peer review of papers submitted for publication. It is time now to extend the Journal's purposes: to use it to make ourselves visible to our peers outside Aotearoa New Zealand, and to invite them into dialogue about issues of common interest and concern.

We invite you to join us in this undertaking

- by responding—in letters or papers—to the issues raised in the Journal, thus developing its function of debate and dialogue,

- by continuing to offer both your own written work and your ideas for themes you would like to see developed and
- by engaging with us - perhaps at times bearing with us - as we work with you to develop an editorial style that will enable the Journal to take its place in the international literature of psychotherapy.

To this end, guidelines for contributors will be included in this and subsequent issues.

Jenny Rockel
Robin Riley
Tony Coates
Peter Hubbard

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The Ghost of Anna O

Seán Manning

Abstract

The origin of the Freudian notion of 'the unconscious' is examined through the history of 'Anna O' (Bertha Pappenheim) and the early mistakes of Josef Breuer and Sigmund Freud are highlighted. The theory of the unconscious, based on the idea of repression and conversion, is rejected as a mistake, caused by diagnostic error and the myth of 'hysteria'. With reference to the developmental theory of Daniel Stern and the brain research of Joseph LeDoux, an alternative view of the unconscious is approached.

1. The origin of the modern psychoanalytic idea of the unconscious—the Freudian myth—Anna O, Charcot and Hysteria.

The common idea of the unconscious emerged in the writing of Sigmund Freud and Josef Breuer, in their *Studies in Hysteria*, which appeared in 1895, preceded by a preliminary paper in 1893. It is based on an enormous misconception. The idea rested on Breuer's treatment of a woman known as 'Anna O'. We later knew her, through Ernest Jones' revelation in his Freud biography, as Bertha Pappenheim. Later she emerged as a politically active woman with an intense interest in the lack of preparation for real life in the education of young middle-class women, whom she thought had a responsibility in society far beyond their duties as wives and mothers.

So, I am going to briefly go over some old stuff here. The main sources are not psychotherapists, but historians (Ellenberger, 1970; Masson, 1984; Micale, 1989, 1990a, 1990b, 1993a, 1993b; Micale and Porter, 1994; Sulloway, 1979; Thornton, 1976; Webster, 1995).

As a young woman, Fraülein Pappenheim suffered from a distressing assortment of symptoms that brought her, in the year 1881, to the prominent researcher and neurologist Josef Breuer.[1]

1. Breuer had been jointly responsible in 1868 for the discovery of the role played by the vagus nerve in the breathing reflex—still known as the Herring–Breuer reflex, and in 1873 for the discovery of the role played by the by semicircular canals in balance. He was a prominent and brilliant researcher.

While nursing her father who was suffering from a subpleuritic tubercular abscess, she first developed a severe cough, then rigid paralysis of right side extremities, a convergent squint, double vision, a left side occipital headache, disturbances in hearing and sporadic deafness, and lapses of consciousness or, as she called them, "absences". She would stop in middle of a sentence, repeat her last words, pause and continue, apparently without awareness of what she had done. As her spells of confusion became more severe, she suffered from violent outbursts, throwing cushions, shouting abusively and tearing buttons from her clothes. She had hallucinations and disorders of speech, periodically losing the ability to speak her native German and using English without realising what she was doing.

Breuer diagnosed 'hysteria', a frequently reported condition which, it was thought, could mimic almost any physical symptom. After he had stopped seeing her, Breuer discussed the case with Freud during the following year, 1882. Freud later connected this story with what he subsequently learned during his studies with Jean Martin Charcot[2] at the Salpêtrière in Paris in 1885.

During the 1870s Charcot had become interested in a ward full of women suffering from 'hystero-epilepsy'[3]. Symptoms included convulsions, contractures, losses or distortions of neurological functioning for which no organic explanation was then available, chorea-form movements, somnambulisms, and amnesiac fugues.[4]

Recent reviews of Charcot's case histories confirm our suspicions that these were all neurological symptoms. The majority were suffering from various forms of epilepsy—temporal and frontal lobe lesions (Webster, 1995: 52–102) that did not cause *grand mal* seizures and were impossible to diagnose with the resources available at the time.[5] Charcot was looking for a hypothetical

2. Charcot was another prominent anatomical researcher. He detected excessive uric acid in cases of gout, recognised the lobular structure of the lung, liver and kidney, introduced routine temperature taking in everyday hospital practice, attempted, correctly, to differentiate multiple sclerosis from Parkinson's disease and, with another, pieced together almost the entire pathology of MS. He described the changes in the spinal cord characteristic of poliomyelitis. Motor neurone disease is still called Charcot's disease in Europe. In short, Charcot was an expert on degenerative diseases of the spinal cord.

3. In 1882, with the establishment of an outpatient department at Salpêtrière, he encountered a new group of patients—men who had had accidents or fights. Because the symptoms were similar, Charcot again diagnosed hysteria.

4. Note—the patients involved in Charcot's much quoted experiments with hypnotism and the transfer of symptoms were patients who regularly experienced convulsive siezures.

5. The lumbar puncture was not invented until 1891, and was not used in anything like the way it is used today; x-rays were only discovered in 1895 and the EEG was invented in 1929 and was not in general use until the 1940s.

lesion in the brain. He was right about that, but wrong about hysteria.[6]

By Charcot's definition, hysteria was caused by trauma, by which he meant *physical* trauma. Breuer developed a technique of associating each of Bertha's symptoms with an *emotionally* traumatic memory, and found that the symptoms eased with talking about the event in question. This he called the 'cathartic method'. It was to become, in the hands of Sigmund Freud, the first method of psychoanalysis, and is still current in psychotherapeutic practice today.

Based on Breuer's experience with Anna O and Charcot's ideas about hysteria, Freud began to formulate his theory of the unconscious. He applied this theory to a series of cases he saw between his return from Paris in the mid 1880s and the publication of *Studies in Hysteria* in 1895. In this work, Breuer and Freud claimed that Anna O had been cured by Breuer's 'cathartic method'. By this time, the theory of the unconscious was, to all intents and purposes, complete.

The Unconscious, Repression and Conversion

This, very briefly, is Freud's theory.

1. An emotional event leads to a quantity of *excitation.* [7]

2. This excitation seeks discharge. However, if the excitation is the consequence of an unacceptable cause, particularly, in late Victorian women, a sexual event, or even a sexual thought,[8] it cannot be discharged in the normal way. In this case, the excitation is *converted* to another channel and trapped in a body part, creating the symptom.

3. This occurs because something is unacceptable to the ego (a term used by Charcot) and is therefore repressed.

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6. The concept of 'hysteria' and its lack of any real clinical foundation, is described in a number of penetrating historical analyses (Astbury 1996; Micale 1989, 1990a, 1990b, 1993; Micale and Porter 1994; Thornton 1976).

7. One cannot read these old accounts without being aware of the current mores among upper middle class society where any kind of 'excitation' might be considered a bad thing.

8. Freud himself commented that these sexual 'frights' were often "astonishingly trivial". "In one of my women patients, it turned out that her neurosis was based on the experience of a boy ... stroking her hand ... and, at another time, pressing his knee against her dress ..." (Webster, 1995: 203)

In October 1895, in a letter from Freud to his friend, Willhelm Fleiss (quoted in Webster, 1995: 200), we have a clear statement of the sexual aetiology of hysteria and the sexual determinants of repression. [9, 10]

We return to Bertha Pappenheim with the work of the historian Henri Ellenberger, who published, in 1972, an account of his detective work concerning the famous case. Finding a photograph of her in a biography, thought to have been taken in 1882, he obtained the original from the author. The date was clearly visible, but the name and address of the photographer indistinct. Enlisting the aid of the Montreal police, who examined the photograph under special lights, the word "Konstanz" was made out. This led him to a sanatorium in Kreuzlingen, on the shores of Lake Konstanz in Switzerland, where he found case notes pertaining to the treatment of Bertha Pappenheim in 1882—the year after she had seen Breuer.

The Kreuzlingen case notes describe trances, hallucinations, convulsions, severe facial neuralgia, recurring loss of ability to speak German and also, not mentioned in Breuer's or Freud's accounts, a severe addiction to morphine, prescribed by Breuer. *Anna O was not cured* as Freud and Breuer claimed 14 years later.

Today, we would not for a moment doubt that Bertha Pappenheim suffered from a neurological disorder. A series of papers, several by neurologists, have variously diagnosed sarcoid, encephalitis, meningitis and temporal lobe epilepsy. The best guess is a localised infection or a lesion in the frontal lobe, just above the sylvan fissure—Broca's area—associated with language, and with the usual involvement of the adjacent motor cortex that occurs in such cases. Allowing for the difficulty associated with retrospective diagnosis after 100 years, there is still a consensus that she was very ill.

9. The controversy over the 'Seduction Hypothesis' (Masson, 1984) arises out of this, but is beyond the scope of this short paper. Note that Webster casts doubt on Masson's hypothesis that Freud abandoned the seduction theory because he could not tolerate the idea of child sexual abuse. Webster suggests that Freud looked for, but did not find the evidence he needed. Among the evidence he cites is the following, from the Standard Edition, Vol 2: 154, taken from Freud's notes about the treatment of 'Elizabeth von R':

    I no longer accepted her declaration that nothing had occurred to her, but assured her that something *must* have occurred to her ... perhaps she thought her idea was not the right one. This, I told her, was not her affair ... Finally I declared that I knew very well that something *had* occurred to her and that she was concealing it from me; but she would never be free from her pains so long as she concealed anything.

10. The emphasis on sex was a movement away from Charcot. It could be claimed that it was also a powerful reason for Freud's later popularity, particularly in America.

Why did the symptoms ease with Breuer's 'cathartic method'? Because, especially in cases of encephalitis, that is what happens—symptoms come and go. Also, talking with someone who took an interest was undoubtedly a relief for the very sick and distressed Bertha. There was also the morphine, which will take away a lot of symptoms.

As to Freud's cases between 1886 and 1895, there is not space in this short paper to describe each of these. However, in all of these cases of 'hysteria' there was, as we might now suspect, evidence suggesting a physical aetiology, often of a form that contemporary medicine could not diagnose. Because the analyses were lengthy, symptoms did come and go, and Freud might be excused for taking credit for that, though, by Freud's own admission in a series of letters to Fliess in 1896 and 1897, there were no cures. None of them got better with the cathartic method (Webster, 1995: 207).

So much for the misconception—the Freudian myth of the unconscious. I believe, however, that there is a way to conceptualise human unconscious processes that is based on real evidence.

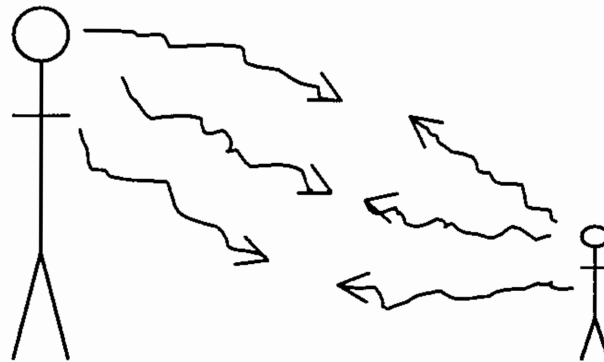
2. *The Real Nature of Human Unconsciousness*

Joseph LeDoux, a psychologist and brain researcher, suggests that the important question is not why something should become unconscious, but why we should be aware of it in the first place (LeDoux, 1996: 42–73). Of all the mechanisms that lead to us becoming aware of a thought or a feeling state, most are and will remain forever beyond our conscious awareness. Consciousness of the self is even more mysterious. We tend to think of 'fragmentation of self' as being abnormal, yet we take for granted thinking, feeling and behaving one way when we are with an intimate partner, another when we meet a colleague, another when we perceive danger, and so on. Fragmentation therefore seems the norm, yet we have an awareness of continuity, of a self that remains constant throughout these changes, a self that transforms only slowly. The person I was thirty years ago seems quite different from the one I am now, yet there is a connection, and the closer we get to the present the greater the similarity. Thus Kim Chernin wrote:

> ... the sequence of provisional selves through which we pass in the course of our lives, each lived for its season then sloughed off, leaving behind fossil traces (memory), but no immediate, felt sense of the living being who once occupied one's life. ... This sense of fragmentation, this discontinuity, may or may not be a condition peculiar to me. (1995: 10)

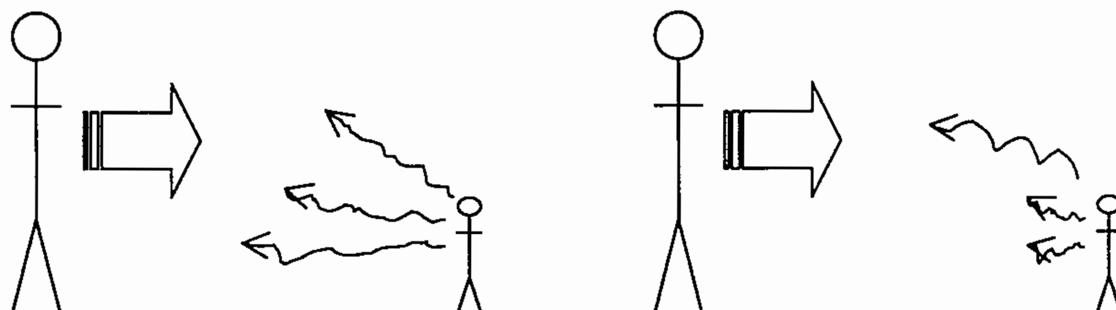
So, rather than think of the presence of a mechanism like *repression,* perhaps we must consider fragmentation, the lack of consciousness of self, and other absences of consciousness as being due to the *absence* rather than the presence of something.

Daniel Stern and his colleagues show us convincingly how we are born giving a fair impression of seeking interaction with others. Far from being autistic, or lost in a symbiosis, we seek contact with the other and are born acting as if we have, at some level, a knowledge of ourselves and of the other. When the other matches us, attunes to us, our responses, our feeling states, felt but *as yet unknown to us*, take form and substance in the relationship. By means of over and over matchings and attunements in the magical world of intersubjectivity we get consensus, affirmation and finally names for the ways we experience the world—in other words, a sense of self, incorporating many emotional states, styles of thinking and behaviours, and a similar sense of the other, and a sense of ourselves *with* the other.

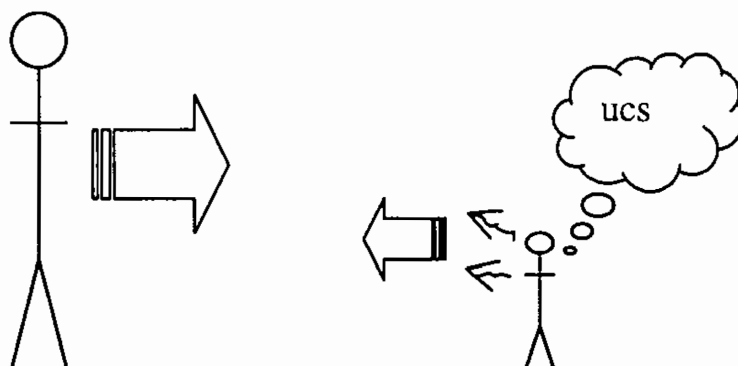


For instance, when a child is sad or upset, perhaps because of some fright, this is taken to the mother and the mother matches the feeling state, with a serious appreciation, approximating the intensity of the feeling and the rhythms of the child's distress. At some point she will name the experience, and later perhaps explain and reassure. The result, over many repetitions, is consciousness of something like, "When I feel like this, it is called 'sad and upset', and it is because I was frightened." In this way, a process that starts as unconscious, merely an emotional state, achieves a conscious form, is named, and a naturally occurring means of expression is affirmed, with modifications according to the way it is expressed and responded to by the other over time. In the future, a variety of stimuli associated with 'fright' will precipitate a similar feeling state and this consciousness and a means of expression, modified *because* of consciousness, will be available.

When this fails, when the attunements are erratic, or skewed, when responses are limited to a few, or when these are punitive, when our experiences and expressions are not affirmed, then their nature is only vaguely felt. With no matching response to assist in naming them, discriminating between them, they remain out of awareness, to some degree at least, unconscious. The way we experience the world and the other remains limited, skewed.



Many possible ways of being are unnamed, unknown, and we experience a generalised region of feeling for which there is no expression. In the example above, if the mother reacts impatiently, or violently, or with disdain or a lack of involvement, so that the intensity and rhythm of the child's expression is not matched, the result will be a confusion, something experienced that has no name, or is perhaps called 'annoying' or 'bad'—something to be avoided in future, then the child's consciousness of the experience will be impoverished. *Something* will be felt, and *some* name will be found for it, but it will not be adequate. At a later time, when the feeling state is precipitated by a stimulus in the environment, neither stimulus nor response will be recognised. If this event occurs often in early life, in response to a number of different kinds of experience—and this is likely, as what I am describing is a *pattern* of interaction—then distressing emotional arousal will be experienced in response to a common array of stimuli.



Thus, we experience an unnamed emotional arousal that occurs often and has a limited means of expression. This is the nature of a symptom. We can understand how it arises from unconscious processes, but without the need for a mysterious mechanism like repression.

We also know that our differentiated sense of self, its continuity, and our ways of being with others can be disrupted by subsequent events—by extremity, loss or trauma. I do not pretend to understand the wonderfully protective mechanism of dissociation, by which means we lose contact with a continuity of self and a physical experience that have become unbearable, but rather than a repressive mechanism, it seems more a disruption, a separation of things that were previously experienced as contiguous. Memory of events and a sense of being, previously indistinguishable, are now quite apart, though usually neither is lost. As Chernin suggests, the old consciousness is remembered, but not identified with. Memory of events depends on many factors, including age, but we know that adult trauma is much more easily remembered than forgotten.

In this way we can conceptualise a real unconscious process, as opposed to the Freudian myth. And this is the mission, the 'real McCoy' of psychotherapy. For the antidote is the discovery by attunement, the matching, or *re*-matching, the naming, and the learning of a variety of means of expression for a variety of feeling states.

LeDoux writes:

> I conclude with the hypothesis, based on trends in brain evolution, that the struggle between thought and emotion may ultimately be resolved, not simply by the dominance of neocortical cognitions over emotional systems, but by a more harmonious integration of reason and passion in the brain, a development that will allow future humans to better know their true feelings and to use them more effectively in daily life. (1996: 21)

These things are the real stuff, the 'real McCoy' of psychotherapy. *The Unconscious* is, well, actually, it's over.

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The Unconscious: An Integrationist Perspective

Brian Broom

Abstract

I have chosen to look at this subject, *The Unconscious: The Real McCoy of Psychotherapy?* from the vantage point of an integrationist and, inevitably, I speak from my perspectives as a practitioner in medicine, as a practitioner in psychotherapy, and as a person with a long-time interest in spirituality.

Victor White, the Jungian analyst and theologian wrote in his book, *God and the Unconscious:*

> image-breaking is no less part and parcel of human life and history than image-making... For the fixed image evokes the fixed stare, the fixed loyalty which may blind man's vision to the claims of further and wider loyalties, and so paralyse the human spirit and crush its inherent will to advance and to venture. (1969: 27)

The term 'the unconscious' is an image, or a constructed image. It is a label for an aspect, or a group of aspects, of our total functioning, aspects of our functioning which have been known for centuries. As Victor White says:

> Dreams, or automatisms of every sort, the influence of 'forgotten' experience or unacknowledged desires upon conduct, alternating personalities, the phenomena of trance, abnormal and paranormal psychological phenomena of many kinds: none of these was new in human experience. (1969: 48)

What was new from late last century was the systematic study of these aspects, and, commonly, attempts to define them in structural terms, attempts to grasp hold of them as things or 'its', and to delineate their scope and their boundaries.

The term 'the unconscious' is a *signifier* of these aspects of our functioning. But what do or should we include amongst the *signified*? Borrowing Julia Kristeva's words (quoted in Berry, 1998) how should we carve up this "vital psychic space"? As with the word 'resurrection' amongst New Zealand Christians in the 1960s, at the time of the heresy trial of Lloyd Geering, or the word 'soul'

amongst psychotherapists at the 1996 New Zealand Association of Psychotherapists Conference at Nelson, on *The Place of Soul in Psychotherapy*, so in conversing about 'the unconscious' we all use a common term. But, as in these other situations, scratch beneath the surface of the terms and we will find huge differences in assumptions as to what we are really talking about.

What are we talking about? What does our discussion embrace? Is there an implicit Freudian or Jungian or some other dominant discourse defining the parameters of our discussion? I want to open up the discussion to other elements, which are potentially marginalised. More specifically I want to connect the issue of the unconscious to the issues of both body and spirit. In doing that I must raise another related issue. In one way or another it seems that many if not most human beings search for the essence of things, for the real, or, often enough, for that *thing* which is going to make the real difference: if you like, a search for the 'real McCoy'. I have no problem with searching. But I do have a problem with the lamentable tendency in human beings (at least in modernist Western culture) to try and decide what is *fundamental*. An heroic and modernist grasping of the truth in one's hand, achieving some sort of empty reassurance that finally I have got hold of it, leading thereafter to an even more lamentable assertiveness that what I am interested in or good at is fundamental, or *where it is at*.

Thus I have some problems with the title of this year's conference. For me every aspect of life is fundamental. For example, speaking as a psychotherapist, I hold the conscious use of choice to be fundamental, the interpersonal space to be fundamental, the unconscious processes to be fundamental—they all have 'real McCoy' qualities.

Turning to medicine, we are provided with some salutary lessons. The curse of modern medicine is its mechanistic world view, which defines the biological as fundamental, and the psychological as epiphenomenal. This defines much of that which is crucial to us, as persons, as outside the doctor's field of interest. Pataki, an Australian philosopher, said recently:

> Love, friendship, caring for oneself and for others, loss of others and the loss of one's self in madness or death concern us more in daily life, art, literature (though they do not much concern contemporary psychiatry and Anglo-Saxon philosophy) than anything else." (1996: 52–63)

Nor do such things concern modern medicine. The very things which are *at the centre of our concerns* get excluded within a reductionistic mechanistic biological fundamentalism.

We might ask then what sorts of reductionistic fundamentalisms operate for us in psychotherapy? Does our topic draw us both to a healthy focus on unconscious processes, and also to an unhealthy reductionism around the Unconscious?

As a physician I do not believe in *the* Body, though clearly we have physicality as part of our unitary wholeness. As a psychotherapist I do not believe in *the* 'Unconscious' though clearly there is much of our data and history and functioning out of conscious awareness, and unconscious elements have major influence on our existing. I do not believe in these things as entities, certainly not as compartmentalised entities, but as part of that wonderful continuity and unity captured by the word 'person'.

A person is in my view an existent being, an I AM, a unified unbroken continuity. If we *as certain types of observer* choose to take a data slice through this 'I am', this unity, we will see different patterns. The biologist sees physicality and a physical structural pattern, and labels accordingly—the kidney, or DNA (according to the level of the cut). The depth psychologist sees unconscious functioning and labels it 'the Unconscious'. And though it is certainly convenient for us to talk with one another about our focus on either the bodily or unconscious aspects of our functioning in terms of 'the Body' or 'the Unconscious', the reductionism which slips in at this point is ultimately damaging, or at least very limiting to the management of the persons who come to doctors or psychotherapists for healing.

For example the physician, having taken his /her cuts of data in the restricted way I describe, has come to construe and treat the body as a machine, and the result in Western medicine is an expensive, characteristically modernist enterprise, a bloated body-focus, a technology out of control, a system unable to survive its own hypertrophy and now bewildered as it engineers its own (economic) collapse. The doctors have 'McCoyed' the body; wonderful things have come from this, but it has been disastrous in terms of *the devaluation of other aspects of our personhood.* The mind, the social, interpersonal relationship, the unconscious, soul, and spirit hardly figure in the dominant discourse of modern medicine. In my view this constitutes an institutionalised and professionalised disregard for aspects of our patients' personhood, and restrains a range of healing possibilities for our patients. We need to be warned.

Nor is a 'McCoying' of the Unconscious, or any other aspect of our subjective functioning, likely to do justice to the personhood of our clients, unless we know the total embrace of the term (which is impossible), unless we focus upon

its connections rather than on its exact limits. A focus on unconscious processes is extremely helpful, and arguably one of the main foci of the practitioner vantage point we call psychotherapy. But as an integrationist I am strongly against any form of reductionism, reification, or to put it in more understandable terms, 'thingification'—i.e. I am against elevating any aspect of our personhood, against any form of giving priority to one aspect of our reality over another, and definitely against any form of reification which allows the unconscious to become some sort of a 'thing'.

Before I risk being tiresome around a point which some might feel is at the margins of our topic, I want to share a personal anecdote. Some years ago I developed a lesion on my left arm about the size of 50 cent piece. From my medical perspective it looked as if the skin had died, or technically speaking, atrophied. The skin over the lesion became so thin and delicate that I could see tiny vessels beneath the skin, and at times I had to cover it up to avoid damaging it when doing manual work. It neither progressed nor remitted over several years. I had never seen anything quite like it, and didn't consult a medical practitioner because I didn't think anyone would know what it was. I accepted it as one of those small mysteries in life. I had no idea of the significance of the lesion.

Two or three years after the onset of this lesion, and during a period of my own personal psychotherapy, I had two very vivid dreams concerning my father. My father had died of lung cancer at age 59 when I was a young doctor aged 26 years. It was a very difficult time for both of us. He found it extremely difficult to acknowledge that he had a fatal disease, and I was drawn into a painful process of providing (false) reassurance and hope. A few days before his death we had a direct and honest and positively memorable exchange, of which he turned out to be more capable than I.

Though I was left with positive memories of my relationship with him there was one thing, over the years, that seemed to hover around the edges of my consciousness. I sometimes wondered whether I too might die of cancer in my fifties. I had a distant and foggy realisation that I was bound in to him in some way. It seemed that the way he died and the age at which he died could in some way be predictive for me.

Against that background I will return now to the dreams, the second of which seems most relevant to the story I'm telling here. In this dream I walked towards and then into a rest home or hospice on a rise overlooking an Arcadian park-like setting. This mansion had an upper storey with a balcony, upon

which there was a canvas deckchair with wooden framework. I was lying on this chair. The notable thing about the chair was that there were cancerous secondaries, metastatic deposits, in the wooden framework. It was very clear in the dream that the cancerous deposits were in the wooden framework and not in the person lying on the chair.

Following this dream I pondered my relationship with my father, my closeness to him and separation from him, and the sense that I had not grieved adequately. The next Sunday morning I went to his grave and spent some time feeling through some of the past events. After an hour or so I returned home with a feeling that I had done what was right for me at that point.

The next day I noticed that my left arm was itchy, and examination showed that the lesion was becoming reddened. I should say that the lesion itself had not been in my conscious awareness during this period of consideration of the dreams. Over the next ten days the 'dead' skin of the lesion completely regenerated and the skin returned to normal. In addition, the background anxiety that somehow I was tied to my father in respect of cancer and death in the sixth decade also disappeared. Three or four years have elapsed since this event and that old background muted apprehension has not returned. Of course I am not claiming that I have a ticket into my seventh decade, nor that I am now exempt from the exigencies of our common humanity!

I could have used many other patient stories to make the same point which is that *the same 'story' was being told*: in the background apprehension of my consciousness, in the coin-shaped lesion in my physicality, and in the dreams representing my unconscious functioning. Now, which one of these was the 'real McCoy'? Certainly the one I was able to listen to was my dream.

I argue then that I had an awareness in my consciousness of some sort of connectedness, or lack of separation from, or over-identification with my father and his illness. For several years the same thing was represented in the language of the body in the form of the arm lesion. And then in the course of therapy the dreams emerged with a different languaging of the same thing (perhaps because I was in therapy and because dreams are responded to by therapists whereas physical symptoms are not). My point is that the reality of personhood, our 'I Am-ness' gets expressed in the various dimensions of our reality, including the physical, and the conscious, and the unconscious. These are not compartments, these are not fundamentalist realities. They are different cuts through the data of the whole.

It is very appropriate in our roles as psychotherapists to focus upon the unconscious elements. Indeed it might be the approach to the personhood of patients and clients which we are best suited to and trained to utilise. But how many of us allow ourselves to ponder that which we hear in the dreams of patients *and* that which we hear in the physical symptoms of patients? I do not think we should 'McCoy' either of them. They are often the same story in a different language. I suggest that any privileging of *the unconscious* over other aspects of our functioning will in the end lead to compartmentalisations which will leave us blind to other data.

Emphases are of course needed. A non-reductionist focus on our unconscious functioning is something I support. But let us remember or realise that as Westerners and modernists we have privileged objective and scientific knowledge. We idolise measurement, which is an approach to the person which privileges our reality *as objects.* And we end up with a medicine and a psychology which privileges us as objects rather than subjects. But we are subjects, and in my language we are 'I Ams'. We are in urgent need of expansion of our ways of looking at our reality. A focus on the Unconscious is one way of expanding our view of people as persons, as subjects, as is a focus on feelings and suchlike rather than on objective knowledge. Many others are voicing this. I concur with Kristeva, who Phillippa Berry says:

> points to the need to found a new subjectivity upon a discourse around identity which privileges affect and the giving of love, instead of an endless quest for the absolutes of objective knowledge. (1998: 319)

But if, in reaction, we privilege subjectivity over objectivity we will end up with another limiting reductionism. There are perils as we move from one emphasis to another. In the so-called Enlightenment, Western culture moved to privilege thinking. Again Berry summarises Kristeva's suggestion that

> when the *Ego affectus est* of a medieval thinker such as Saint Bernard of Clairvaux was replaced by the Cartesian Ego (as) *cogito*, the resultant definition of identity, which was of course in terms of rational thought, produced a profound narcissistic crisis—a crisis whose consequences we have only really seen in the 20th century. (1998)

Whatever the truth of that, I do believe that we move from one over-emphasis to another at our peril. If we privilege one thing over another we will reap down-line consequences. We must see the unity and the continuity. We must hold conscious, unconscious, interpersonal, intrapsychic, psychodynamic,

behavioural, biological and physical, social, cultural, and spiritual *all in the same space*. That is different from saying we need to be experts from each observer position. And from my observer vantage point(s), and we all have one/some, I want to emphasise this: when we look at unconscious mechanisms let us not be afraid to wonder about and connect with the physical and to wonder about and connect with the spiritual. We must not allow safe and comforting orthodoxy, masquerading under the necessary and convenient defence of Professionalism, and Quality Control, and our own tendencies to *reductionism* around our role as psychotherapists, and our *focus* on the unconscious processes, to imply blinkers to physicality and spirituality.

We *will* have the problem of words and meanings again. Scratch the surface and we will open a can of worms. But that is what the temptation to reductionism is about. It's about knowing for sure; it's about mastery; it's about having friends and keeping controversy out so one can keep friends in; it's about keeping one's equilibrium, and life as safe as possible; it's about keeping the lid on the can of worms.

But as Jung said in respect of the psychological and the spiritual:

> ... the (medical) psychotherapist cannot in the long run afford to overlook the existence of religious systems of healing—if one may so describe religion in a certain respect—any more than the theologian, in so far as he has the *cura animarum* at heart, can afford to ignore the experience of (medical) psychology. (quoted in White, 1996: 22)

So in my view, the medic cannot ignore the psychological and spiritual, the psychotherapist cannot ignore the physical and the spiritual, and the religious cannot ignore the psychological and the physical. We are 'I Ams', we are subjects, and these are all aspects of the whole who is a subject. To focus on one aspect, whilst more manageable and inclined to reinforce our sense of expertise and specialisation, is in reality to collude with a carving up of something which should not be so carved. I cannot agree with the 'McCoying' of any aspect of personhood.

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The Unconscious—The Real McCoy of Psychotherapy

Joan Dallaway

Abstract

What follows may be described as my 'free association' on the subject matter of the NZAP Conference 1999, *The Unconscious - the real McCoy of Psychotherapy?* Since I practise from an integrative and holistic perspective, I scoured many sources that have guided and influenced my being a psychotherapist, seeking in them what may be identified as the 'real McCoy'. My sourcing was not exhaustive. I offer an entree and look forward to the feast we may savour together as we begin to reflect on our individual and collective practice and chosen interpretations of many psychotherapeutic narratives.

Introduction

The letter of invitation to speak at the 1999 Conference came with the brief to 'excite and ignite' discussion. It also came with a comment that the Titanic sized theme had been chosen 'in innocence'. Given that the Titanic has been named in relation to the theme 'the unconscious', could the question mark alongside the theme be a possible measure of the sinkability of its 'McCoy' under certain circumstances?

When I received the registration form for this conference I was somewhat taken aback to see my name written as John Dalloway. The h had been struck through and an a inserted. How could the organisers possibly have known? I pondered. I was born the third of four daughters, I was to have been the son, John, son of John. Clearly I wasn't, so at my birth the *h* was struck out and the *a* put in. Was this an exercise of unconscious process, or coincidence? How do we interpret events and experiences?

Experiences and Interpretations

If the 'real McCoy' of psychotherapy is 'the unconscious', then of profound significance are our interpretations. I am informed that Winnicott when asked about interpretation replied: "I interpret to show the patient that I am awake, and to show the patient that I might be wrong." As I think in this way I am reminded of the childhood game of whispers and how we laughed at the distortions we created as the message was passed from one to another. Some will remember the classic misinterpretation, as "send reinforcements, we're going to advance" eventually became "send three and fourpence, we're going to a dance."

The processes of postmodern deconstructionism invite us to view again the maps we have used for interpreting our world and the nature of being human. 'The Unconscious - the real McCoy of psychotherapy'? Does the question mark indicate our readiness to deconstruct the pathologically focused maps of our psychotherapeutic past, face the possibility that the interpretations of 100 years may have been incomplete and that another McCoy may be emerging amongst us?

As a consequence of his reflections on the human condition Freud created a map based on the 'pleasure principle', later called the 'reality principle'. But whose reality? The society of which he was part was dualistic, paternalistic, moralistic and reductionist. Dualism split time and space, eros and thanatos, good and evil, knowledge and ignorance, sickness and health, and therefore conscious and unconscious. Truths, religious/moral, medical and educational, were dictated by experts. There was a belief in the supremacy of the mind over the body. Humans were born flawed and sinful, their souls had to be saved and their pathologies identified. What Freud heard, saw and experienced was filtered through these culturally and socially conditioned hierarchical lenses.

Our psychotherapeutic whakapapa is riddled with stories of conflicting interpretations of the nature of human experience. Freud's truth or Jung's, maybe Lacan's? Klein's or Ego Psychologists' interpretations of Oedipal issues? Kernberg and Kohut debated the aetiology of Narcissism, one describing it as "a plant stunted by too little water", the other "a plant mutated into a hybrid". Many others before and since have entered into factious arguments. The jury is still out on definitive conclusions. Whose reality? What reality?

Following the discoveries of quantum physics, Woolfe (1981) stated:

> ...there is no reality until that reality is perceived... reality depends upon our choices of what and how we choose to observe. These choices in turn depend on our minds, or more specifically the contents of our minds. And our thoughts in turn, depend upon our expectations, our desire for continuity.

Could our desires for continuity prompt us to retain our conserved realities as 'the McCoy' rather than excite us into co-creating with others new 'McCoys' for a new generation of the human story?

What are we talking about anyway when we speak of *the unconscious*? Are we agreeing that it is an entity, a process, collective or individual? Whose unconscious? Do we muddle and mix unconscious and unawareness?

A long term client of mine recently completed therapy. We complimented ourselves on the good work we had done; he then undertook to write a book, a novel based on his therapeutic experience. Humbly, I read what I had been unaware of during our work together.

At the time of our alliance I lived in the country and my therapy room was in an outbuilding adjacent to our home. As my client came and went he saw or met my husband. The contacts were brief passings of time. In his novel however, he had woven a story of two parents, my husband supporting me so that I could appropriately care for him. My husband had, unbeknown to me, become as much a therapist as I was. I was unaware of this, but this was no unconscious process. It was rather an intentional and deliberate action of a man creating a *good enough* ending to the current chapter of his story. I/we were there and my client used the relationships he had with us to project his story into existence.

The midrash tradition of Judeo-Christian history tells us that many stories can be told simultaneously, in parallel fashion, one amplifying, complementing and bringing out the significance of the other. These stories are told within a time-space *continuum*, what was *there and then* is *here and now*, holistically present, time is Kairos not Kronos. The midrash tradition also contains the knowing that these stories can have an infinite number of endings and that an ending is being sought in here and now relationships that is *good enough*. The most important issue is how the human story will end today. Belkin confirms that it is only what is happening at the time that is important. The 'real McCoy'?

I recently asked a client on completion of her therapeutic alliance what she believed was the most effective contribution a therapist made, the 'real McCoy' if you like. She pondered only a moment before she replied: "Be there".

A review of psychological and psychotherapeutic literature undertaken by Richard Erskine (1989) revealed that "the single most consistent concept identified is that of relationship". The 'real McCoy'? In 1923 Buber introduced his I-Thou philosophy of relationship; in 1944 Frederick and Laura Perls their theory of contact; in 1950 Fairburn the relationship seeking other; in 1951 Rogers his client centred understandings; in 1953 Sullivan the interpersonal contact. In 1960 Kelly spoke of behaviour as the human question to the world, a person seeking relationship. At the same time the theologian Tillich saw behaviour as a person seeking community. In 1961 Berne introduced his theories of interpersonal transactions. By 1965 and 1971 Winnicott and Guntrip were developing their relationship theories and corresponding clinical implications. In 1971 Kohut introduced us to the processes of sustained empathic enquiry, Surrey (1985), Miller (1986) and Bergman (1991) all focused on relationship theories. Since 1995 Stern and others have spoken of vitality affects and attunement and given us a review of the powerful impact of relationship on therapeutic outcomes.

Erskine (1996) describes *relationship* as "full awareness of sensations, feelings, needs, sensory motor activity, thoughts, memories, internal and full awareness of external events as registered by each of the sensory organs". A subtle but powerful shift from mind focused to total *body to body* relationship. From filters which gave a hierarchical preference to the mind, we come to an holistic understanding, a knowing that through its energy flows, the flutterings of its unique rhythms, breathing, heartbeat, eye movements, varying speeds of thought patterns, a body conveys its story as clearly as any spoken word. The story of our evolutionary journey is being told through the communication means available at that point of a person's life and experience. Through free association, cellular, brain stem, midbrain, limbic cortex, parallel stories are being told within the therapeutic relationship; the new ending is of profound importance. The 'real McCoy'?

Within an holistic perspective body and mind is not split, disciplines are no longer divided, one informs the other. Grotstein's and Schore's research on Projective Identification, Perry and associates' (1998) research on Post Trauma victims, the chiropractic research of Hazelbauer, Morter (1998) and others on cellular communication, the offerings of postmodern theologian Walter

Bruggeman, (1994) all tell parallel stories of a new territory of human relationships and of a new language emerging.

Bruggemann (1994) reflects on the de-structuring of today's society and says that what is before us is 'unknown territory' which we attempt to interpret and negotiate with old maps. We desperately seek to make the old maps fit and end up distressed as we fail. He describes our position as 'in exile'. He goes on to say that when people are in exile they do not know the ways or language of the land they are in. They lament and regress to their 'mother tongue' to communicate their distress and their need. Is what Lacan named "semiotic" and Nancy McWilliams described as "the background music of emotional experience", the 'mother tongues' by which the human story is most profoundly communicated?

It may be said that when we meet with our clients, we do face new territories. We bring to those territories the maps of our known perspectives. We determine the sign posts by what we have heard from other places and other times. We may perceive the phenomenology that is before us, cross reference this with our various culturally shaped theoretical frameworks and still misinterpret what is before us.

So what is the 'real McCoy' of psychotherapy?

As we know, interpretation of unconscious processes requires expert skill; without focus on the nature of the relationship between us and our clients we may well perpetuate the very hierarchies which have perpetrated abuse and distress. Interpretation can be a dangerous pastime, and, as we are reminded, *we might just get it wrong.* A misuse of our power and we have distorted the other's story into our own, cloning the other into our creation.

The Greek word *therapea* translated means the *lowliest servant*, the one who is willing to *be there*, be involved and attuned, *be with* another in a strange land, experience the confusion and terror of *exile*, share 'mother tongues' and be irrevocably changed.

> The life space of clients and therapists intermix in the quantum sense of indeterminacy. No one is ever the same after being emotionally and intellectually 'touched' by another, the change is always reciprocal, so that not only are the two individuals different but the relationship is different as well. (Belkin, 1988)

Could *this* be the 'real McCoy'?

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Into the Cocked Hat: Notes on a Personal Position in the Field of Psychotherapy

Richard O'Neill-Dean

Abstract

A brief resume of three ideas seen as central to the field of psychoanalytic psychotherapy - meaning, mentality and relationship - are presented for the purpose of generating discussion.

Silence and stillness are the canvas of our work. All communication takes place against this background. For me to chart my position, to locate myself in the field of psychotherapy, I think of the 'cocked hat' of marine or land-based navigation (where back bearings are taken from three known landmarks intersecting in a, hopefully, small triangle - the 'cocked hat' that gives one's position).

My first landmark then must be the idea that psychotherapy is a search for hidden meaning, a finding of the words or way to say it, in order to give the symptom speech. The French analyst, Jacques Lacan, is known for his aphorism: "The unconscious is structured as a language". Psychotherapy from this point of view centrally concerns itself with meaning, play, language, speech, symbol, metaphor, metonomy - the whole field of signification and its many 'styles' in the emotional inner-world. The answer to the oft-asked question "What good will talking do?" lies in the recognition that *the symptoms treatable by psychotherapy are "a manner of speaking" and contain both the history and the wishes or desire of the subject. Psychotherapy is the elucidation of this history and desire.*

I met with a man once who both feared and experienced the fact that his skin was unravelling and his body falling to pieces. One day he had a simple but profound insight: "I guess that when I come here (to psychotherapy) I'm speaking my wounds."

A brief presentation to NZAP Conference, Dunedin 1999.

The second landmark that locates me must be the notion that psychotherapy concerns itself with 'states of mind' or 'mentalities'. I believe that we seek to work not with the many and various manifestations of a problematic state of mind but fundamentally with that state of mind itself. I imagine that a person in difficulties might be living his or her life very much under the influence of a single and less than useful state of mind. Examples might include the mentalities of 'make-believe', 'a divided mind', 'severance', 'killing', 'being inside-out' (where the inner world is habitually projected out) and many others.

Here I think of that British seaside holiday treat, a stick of rock-candy where the writing "A Present from Brighton" goes right the way through the stick. It does not make any difference where you break it - that is what is written inside. In the same way a presiding mentality goes right through a person's life and their every relationship and even their every action. As a clinical example you might think of a person with a difficulty around eating. While it could be true to say this person refuses to take in food but prefers to use it as a powerfully destructive expression of his will instead, this may be only one manifestation of the presiding mentality. Perhaps it would also be possible to see the same mentality at work in a refusal to take in prescribed medicines. The person may prefer instead to store up medicines in order to destructively overdose. The mentality might be visible again in a refusal to take in and think about the therapist's thoughts and words, preferring to store them up ready to hurl them back as missiles rather than digesting them as potentially useful to emotional growth. This idea of a presiding constant in the psyche is in my understanding close to Wilfred Bion's conception of 'the Infinite', which he uses in place of the idea of the Unconscious.

For another illustration of this idea of a mentality at work you might think of an alcoholic wondering if he should drink or not. From a certain point of view it makes no difference that he does not drink if his state of mind does not change. This state is familiar to all and even carries a name – the 'Dry Drunk'.

Simply saying someone is narcissistic, if it is only to diagnose or categorise, has no significant therapeutic action in itself. But *to delineate and illuminate a person's inner state of mind and its activity, so that a person can see it in action inside himself, is the path to cure.* The narcissist must actually see, working within himself, his destructive anti-life cutting off, his envious contempt, his terrified and terrifying arrogance. It is important to note in this connection that an

interpretation is not something a therapist says, it is something that takes place in the mind of the person in therapy. We try to bring about interpretations, we do not make them.

There are three further elaborations to this idea of mentalities being of importance in therapy. The first is that therapy may need initially to help a person to 'mentalise', that is to bring something into the field of mental contents. This may be true for example in somatic conditions where the meaning is not in the mind, or 'mentalised', at the outset of therapy. The second is that the concept of a presiding state of mind is as useful and instructive to understanding in the case of a couple, or even a group, as it is in the case of an individual. The third would explore the idea that, perhaps most fundamentally, all states of mind reduce either to a need for love or to a capacity to love.

What of the final landmark? It is Relationship. There is a story from the East of a pupil who asks his teacher, while they are in a boat together, "Master, who discovered the water?" The teacher replies, "I know who didn't discover the water: The fish didn't discover it!" We, as therapists, constantly talk about transference and counter-transference but we are so constantly *in it* that we are like the fish trying to discover the water. *The foundation of therapeutic action is the mutual understanding of what is actually happening in the relationship with the therapist in vivo.* A while ago in therapy someone became distressed and enraged with me in what I thought was a most blameful and unfair way. The attack was so wounding to me that I could not contain myself and became angry in response. The force of this unprofessionality shook me and I realised that I had failed the person. Then I became curious about what had happened. Here was a mind (my own mind) that could not contain the distress of the other - like a parent who cannot contain and detoxify the projections of the infant. I spoke to the person about how awful it must have been for them when I could not contain their distress without retaliation. This was a turning point in the therapy.

Here then is the 'cocked hat'. But anyone who is familiar with navigation will know that it is possible to draw a fourth line and that this may not confirm the other three! All of us have stories that seem to indicate the existence in the field of psychotherapy of other territories altogether. When my first analyst was dying of cancer I was unable to say goodbye. I could not visit him in his last months of life. The analysis had been broken by his illness. One night I dreamt

that I saw him gathering his things at his upstairs bedroom window. In the dream I said to myself, "Ah, that's because he's getting ready to go on a journey". In the morning when I talked with my wife about my dream and my difficulty, she said, "Well, then you must go and say goodbye". There and then, at first light, I drove to his house. As I entered the garden gate I met his daughter coming down the stairs and out of the front door. I explained that I had come to say goodbye to her father. She looked shaken and asked "How did you know?" He had died about an hour earlier that morning.

Here is another example of this other angle on the field of therapy. I recently had an odd experience. I had been working with someone who had suffered from a psychotic-like break (a psychiatrist might easily have called it a psychotic breakdown). At the end of a session and apropos of nothing that had passed between us at any time beforehand that I could see, he told me that he had a good cure for mouth ulcers which he would like to pass on to me. I asked him why he mentioned this and he said he did not know, but that it was hard for people to find a good remedy and he had a recommendation that really worked. In fact *I was* suffering from a mouth ulcer at the time, a relatively rare occurrence for me. I was all the more surprised as in this work he was using the couch and would not have had much opportunity to observe me directly.

Wherever these further wonderings take us, certainly at the best of moments in therapeutic work, I often have the feeling that perhaps I have been like a journalist who happens to find himself at the crossroads of some great moment in history, a bystander, a witness. The word 'therapist' derives from that of 'attendant'.

In navigation we must move from 'location' to 'direction'. For me the direction of therapy must be towards emotional growth, perhaps particularly towards the reduction of narcissism: that is to say a move from 'the need for love' towards 'a capacity to love', and a move or at least a striving towards the articulation of truth. And no doubt this last raises as many questions as it answers...

Some Aspects of Projective Identification: Three Clinical Observations

Carol Worthington

Abstract

After a brief review of the literature, the paper takes a somewhat light-hearted look at projective identification as it reveals itself in the interactions between the therapist and three patients. Three slightly different examples of this mechanism are given, the final one illustrating the difficulty in drawing firm distinctions between projective identification and countertransference.

Theory has been under-emphasised in favour of clinical observations.

Without necessarily subscribing to the concept of 'the' unconscious one can readily illustrate unconscious mechanisms at work, and projective identification is one such. This paper takes a somewhat light-hearted look at this mechanism as it reveals itself in the unconscious interactions of the therapy couple. The mechanism sheds light on interactions that might otherwise be uninstructive or downright destructive.

The term originated with Melanie Klein (1952), who used it to describe an infant's unconscious phantasy of projecting itself into the mother in order to control her or to evacuate dangerous parts of the self into her. Because the self is projected into the object, the object becomes identified with the self. Bion (1959, 1961) agreed, but included a second alternative: to introduce into the mother (or others) a state of mind, as a means of communicating with her about this mental state.

Ogden (1982) describes it as a psychological mechanism in which one person has the unconscious phantasy of getting rid of an unwanted or endangered part of himself and putting it into another person in such a way that the recipient is pressured to think, feel and behave in a manner congruent with the ejected part of the self. There is pressure on the therapist to experience himself in terms of the patient's unconscious phantasy. The patient can induce feelings in the therapist that correspond to significant early interactions with caregivers, and

because of this the boundary between projective identification and countertransference is somewhat blurred. Ogden has clearly extended Klein's original description in such a way that projective identification can become a useful tool enabling the therapist to understand the patient's psychological processes as they pressure the therapist into phantasy or activity. Powell (1997), who prefers a Self Psychology explanation (Kohut, 1977), presents examples that took place within one session rather than over a period of time, which differs from the examples I shall present. (He also includes a useful review of the literature). My own feeling is that the peculiar pressure these patients exert over one, over a lengthy period, in that one finds oneself behaving uncharacteristically and sometimes uncontrollably, suggests that some process is at work other than mutual frustrations of self-esteem.

I am going to present three examples, using fictitious names, in which I think projective identification in Ogden's sense was at work. In the case of Chris, reliance on her verbal recollections proved quite misleading, and discerning the projective identification involved enabled a correct reconstruction of her history in such a way that it made sense to her and also allowed her to access her own rage.

With Joe, allowing myself to be drawn into his well-rationalised aggressive attacks on me enabled us to get in touch with his deeply buried hostility. Had I viewed his attacks on my ideas as purely resistance, neither of us would have experienced the full intensity of the murderous hatred that underlay his delusion of having killed his father.

With Tony, the degree to which he felt inferior and defended himself against this, thereby causing catastrophes in his interpersonal relationships because of his compensatory grandiosity, would not have been so readily suspected if he had not gone into defence mode so swiftly, and powerfully aroused a set of identical anxieties and defensive grandiosity in me.

The first example is of Tony, aged 43, who has a narcissistic personality disorder. In this case feelings were induced in me that were too painful for Tony to acknowledge as his. Tony complained that people said he couldn't communicate with them and he was to lose his job if this didn't improve. He felt he was superior to others and couldn't understand their reactions to him.

Early on I started feeling not quite my usual self. I felt ill at ease and my voice would sound strained, as if I thought my ideas were silly. I had trouble recalling what he said, which led me to make comments that were sometimes the

opposite of what he'd said; he would correct me, slightly irritably. He was the first patient on Mondays and sometimes, after a silence or an awkward comment from me, he would sigh, "Oh well, it is the first session of the week!" which implied that only later would I start functioning adequately. Thinking in his presence became very difficult, though in my own defence I have to say that his conveying of material was confusing, to say the least. For example, he spoke of the expense of sending his two sons to private schools; only later did I realise that one of these sons had died at birth but Tony liked to think of him as part of the family.

Within the first two weeks I began having ideas of smartening up my image. When I bought clothes I would think, "Will Tony think these are okay?" The next urge was to paint my consulting-room—"Tony has noticed how drab it is"—and when choosing the paint, "Will Tony approve of this colour?" I felt anxious that he would not. When the inevitable happened and I spilt paint on the carpet, I was already formulating a story for Tony's benefit that totally exonerated me from such a stupid act.

My feelings of inferiority and incompetence escalated and a series of defensively grandiose phantasies started that would prove I wasn't senile. It seemed vital that Tony should learn of one of my stranger hobbies, which is to fly overseas and climb volcanoes. This was okay as a phantasy, but to my dismay I heard myself giving him a lecture on the basalt content of volcanoes and how this affects lava viscosity which in turn determines the dangerousness of a volcano! I had no conscious intention of telling him this; it was as if I were blathering on foolishly, which somehow he compelled me to do. Another set of phantasies involved resuming my musical career and playing a fiendishly difficult Liszt Hungarian Rhapsody on a 12 foot concert grand as Tony fortuitously walked past. I even found myself scanning 'For Sale' columns for 12-foot concert grands! In sessions I could not get a grip on the dynamics, and concluded I was clearly the most inferior and foolish therapist this poor man could have chosen. Significantly, during this same period Tony himself was boasting of his own high IQ and his superior ability at work, and it gradually dawned on me that I had become as grandiose and narcissistic as my patient, presumably as a defence against feelings of intense inferiority, coupled with an inability to actually deliver the therapeutic goods.

Having at the time of writing seen him for only five months, I have no solid confirmation of any hypotheses; but when I became able to reflect on his saying he hoped he would never have to tell me about his fears, and I thought of his

anxiety dreams in which *he* never seems to get things right, I concluded that starting therapy was a huge narcissistic threat to this very fragile man. He was confronted with someone who knew more than he did, was more integrated than he was, and who expected him to talk of his inadequacies. It was understandable that he projected into me this part of him that felt an intolerable failure—feelings he could not bear to have about himself, and had defended himself against with similar grandiose phantasies to those he had induced in me. Feeling judged by him as a failure, I was too anxious to function as a therapist and instead sought refuge in being the Edmund Hillary of volcanoes, just as he did. Although we are still having difficulties, at least my phantasies and acting out have stopped, and he has started talking about his fears.

The next example concerns Chris, aged 37, with a schizoid personality disorder, and deals with trauma occurring before the infant was fully verbal. By projective identification she made me feel the truth of an infant–mother interaction which differed considerably from the way she wanted consciously to recall the events in which she saw herself as non-hostile victim.

Chris had been left in the care of her aunts when she was roughly one year old, and some time during her second year her mother returned to collect her. Chris's version was that there was anticipation of a joyful reunion but that her mother totally rejected her. In turn Chris had gradually cut off all contact, choosing to live with her aunts.

The early years of therapy were occupied with phantasies of what an ideal mother I was, accompanied by diatribes against the wicked mother who had so cruelly deserted and then rejected her. She would go over and over the events, unable to explain to herself why she had been so ill-treated, since her mother was loving and caring with subsequent children. I too experienced the whole thing as inexplicable. Gradually, however, Chris's behaviour in the waiting-room started to change. We had both always looked forward to her sessions, so it was a shock when I collected her for the session with the usual greeting and friendly smile and was met by silence and a stony stare, though the session itself would be friendly enough. Although at first I was simply puzzled, and Chris explained it as trying to hide her love for me, I gradually started feeling rejected by her and very angry. I began to dread opening the waiting-room door, because the silence and stony stare were so hostile that I was afraid I might say something retaliatory and nasty to her. It finally dawned on me what was happening when one day I had to clench my teeth to avoid

blurting out, "You nasty little thing, when I've been such a good mother to you!" As these words came into my mind, I realised Chris had been showing me what she could not tell me since it was unconscious: her true reaction when mother came to collect her and take her home. She had made me feel how her mother had felt when she tried to get close to her enraged and traumatised infant and was rejected. In turn her mother had rejected Chris, unable to cope with the stony hostility. I fed this interpretation to Chris in small doses over a year or so, and she was finally able to resolve a little of the split between ideal mother and wicked mother, and to send her mother a card last Christmas, to which her mother joyfully responded—the first contact they've had in thirty years.

The final example is of Joe, a brilliantly intelligent man of 40, with an obsessional and depressive personality disorder, in which he projected an extremely aggressive and controlling part of himself into me with such force that we both came to believe and act as if I were really as he saw me. It was a terribly destructive part which could sweep aside anything in his way, and he both cherished this part and was dreadfully afraid of it.

Instead of using the waiting-room Joe usually knocked on the consulting-room door half a minute or so after due time. We had done a lot of work on his obsessions, and had survived a psychotic episode in which he had developed the delusion of having murdered his father, when his behaviour changed and he started knocking on my door just a few seconds before due time. This started to worry me, and over a few weeks I became enraged at what felt like an invasion of my space—that I *had* to open my door when he wanted instead of when I wanted. I told myself I was unreasonable, but rage and frustration grew because I felt so totally under his control. It so happens that my watch beeps on the hour, and I started to feel that if I let him in even one second early he would hear the beep and know he'd triumphed over me. I was shocked to feel like this and thought I was becoming very aggressive and controlling, to want everything my way. Finally I apologetically and deferentially asked if he would mind using the waiting-room in future as I allowed only 5–10 minutes between patients and it was sometimes awkward for me to let him in early. There were howls of protest, and accusations of the very feelings I was anxious about: that I was aggressive and controlling and engaged in a power struggle to humiliate him and make myself the more powerful of the two, and if I were really upset by a half-a-second early arrival then I needed more analysis! He conceded that he himself could be controlling but only as a reaction to a control freak like me.

This aspect of himself was so firmly lodged in me that I took it for granted that I must really be like that, but this was just a prelude to the really destructive part of him which made a full appearance, via arguing. Now all therapists know never to argue with a patient, so it was with dismay that I found myself arguing with Joe. It was subtly done at first: he would query a trivial utterance and I would clarify; he'd dispute it, I'd again clarify, and so on. He started disputing his own utterances, saying he could not have really meant what he'd just said but must in fact mean so and so, or even such and such. I knew he hated and envied my therapeutic potency, and I *felt* I had become very controlling, so I tried to shut up and restrict myself to empathic noises, and before every session I resolved not to argue—and ended up doing just that! I felt completely taken over. Eventually he would scarcely let an idea escape from me before he attacked it. I felt defeated and helpless.

When I finally managed to stand back from all this, I realised that I felt he was trying to destroy me as a therapist and that by in turn destroying his arguments I was fighting for my life. I had become exactly what he wanted me to be: trying to stay in control yet defeated and impotent, like a father defeated by his clever adolescent prick of a son. I hated him, and I was sure he hated me. But the worst feeling of all was that he was forcing my words back inside me and forcing his own ideas down my throat and this led me to feel in a panicky way that I was choking and suffocating. This sensation was so intensely physically real that at times I felt like running from the room. When I further considered that the main idea he was trying to force down my throat was that he'd murdered his father five years ago and had only just remembered it, and that the 'murder' had involved stuffing a pillow over father's mouth till *he* suffocated, what was happening inside me started to make sense. It then became possible to interpret, instead of arguing, that his fear that he had killed his father was based on the same phantasy he was acting out with me in trying to destroy me as a therapist. With father in phantasy, and with me in reality, he had tried to suffocate us both.

He very gradually ceased to attack my every utterance and became able to look at the whole area of rivalry with father, which previously had been denied. I felt that he'd needed to put this intolerably destructive part of himself into me to contain it until we were both ready to look at it. It's an interesting reflection that if I had obeyed good therapy rules and not let him force me to argue, neither of us would have felt the full force of his murderous rage and the situation would never have come alive for this unemotional obsessional, so one

could think that he unconsciously influenced me to give him what he needed. In retrospect it was vital that my arguing kept me alive and not destroyed by him, as his image of the murder was of father lying helpless in hospital as Joe suffocated him. He has since said that if he'd ever managed to convince me of the murder—which was tantamount to destroying my credibility as a therapist—he would have suicided.

In conclusion, what characterises projective identification for this particular therapist is that one gets caught up in a process, almost unnoticed at first and seemingly outside one's conscious control, caused by the patient's pressure 'forcing' one to feel and behave uncharacteristically. It creeps up on one insidiously, and slowly builds to a climax of unacceptability—and is quickly dissolved, almost miraculously, when one becomes suddenly freed and aware and able to think about what has been happening.

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Attachment with Children with Special Needs

Betty Robb

Abstract

The paper, initiated by personal experience, looks at the fear of attachment to children with conditions which put them at risk, the experiencing of grief at the loss of the 'fantasy baby' and the acceptance by the parents which enables the attachment to proceed.

Reference is made to attachment issues in the case of adoption, styles of attachment, and some notions of reconstruction in therapy with 'special needs' survivors where attachment has been insecure or the process attenuated by length of risk.

'Of all the obstacles that confront a new mother, learning that her child is not completely healthy can be the most staggering.' (Stern, 1998: 182)

Thus begins the chapter on children with special needs in Daniel Stern's new book *The Birth of a Mother.* He comments that the normal, imaginative playing out and reworking of the future and its place in the landscape of the mind of an expectant mother, is brought to an end with the severe shock at the recognition that a handicap of some kind does exist—an 'end to the future' as it was going to be. Some time after the successful operation to close the palate of my baby granddaughter, Ailsa, I gave my daughter Julie Stern's chapter to read. After some minutes she looked up and said "Mum, how does he know me?"

In June 1997 we were all caught in the present, and unable to go on elaborating the future. With the words "She's a lovely, lusty girl, just a little hole in the roof of her mouth" the house surgeon handed me the little blue bundle I was anxiously waiting to hold and as I took her, the busy sounds of the theatre staff finishing off the necessary Caesarian operation faded into the background. The rush of my eagerness suddenly tripped and shuddered to a halt. Inside my mind a voice said "Damn it, why ... ?" as I felt all the readiness to love, adore and attach to the little person suddenly gather up inside almost physically and twist into a tenseness that would not recede for many months, and still can return to haunt me. Immediately the absolute thrill of being able to phone my husband was tempered

with a stabbing consciousness that by this phone call I was about to wound a lot of dear relations and friends as well as relieve them with the news. Not knowing the extent of the cleft at the time was possibly a good thing as they, like me, could be let in on the gravity of the situation piece by piece–as happened in the next few hours. Foggy from lack of sleep over the last two days, and sitting with my drug-fuddled daughter, Ailsa's father Stewart and I heard the paediatrician explain her condition at length. The timing of this was inopportune—he left a bemused family behind.

Joan Cornwell (1983) says:

> The birth of her first baby precipitates the mother into a sudden and massive loss of identity. She is no longer the woman she was before the birth. She does not know who she is, having not yet acquired her new identity as mother. Her bewilderment and aching sense of loss are joined to a realisation of her total responsibility for this live, helpless baby despite feeling utterly incompetent for the task. She herself feels like a newborn baby, suddenly vulnerable, exposed, unheld. The father too experiences this same loss of adult identity. He may feel like a lost little boy, faced with a situation beyond his competence.

How much more so when something like this adds confusion.

A summary of the doctor's information is as follows: Pierre Robin Sequence is the condition where in development the palate has failed to close due to a failure of the tongue's descent from posterior positioning and micrognathia or short jaw is the result. Much variation of opinion about causes exists from hereditary and genetic factors, to growth disturbance affecting maxilla and mandible, uterine position, and lack of amniotic fluid so that the jaw does not float free. It was also suggested to us that sprays inhaled or ingested by the mother at a certain time in pregnancy could be implicated. The operation to close the palate could not be done until nine months – and an operation to splint her jaw and bring it forward might be needed. It would be necessary to have her on an apnoea monitor until she had matured enough for the tongue not to block her airway and risk choking.

After the doctor had gone, little one was bathed and the naso-gastric tube replaced and a small feed was given. When mother and baby had settled for the night, Stewart and I went home and listlessly ate scrambled egg while having a slightly acerbic exchange: he objected to the doctor naming it as a 'condition' and I, who had not said it was, tried to say that I had heard what the doctor had to say as if indeed it was one, but fortunately eminently curable at nine to ten months. I now see that I was trying to overcome his necessary defence in the circumstances by using one of mine. He needed to survive by denial at that time; I have been trained that understanding is the key to surviving crises.

The days of hospital visiting and staying overnight to support my daughter melted into one: helping Julie learn to bath baby (a politically correct and tooth grinding experience, watching Julie's terror and the reluctance of staff trained to 'let the mother find her own way' to tell her what to do – which eventually I could not stand

and interfered as the shivering baby waited to be wrapped up); changing the tube; trying to express; trying to feed and giving up; many visits by medical people with various opinions and information. My daughter was becoming bewildered and angry and was struggling to assimilate it all.

As a developmentalist, my overriding thought was — what does it do to attachment if the handicap is so much to the fore that she can't see the real baby? How will she discover who baby is and how will baby discover her? How will I? Will I be given the opportunity? In my fear I was uncomfortably reminded of the time 35 years ago when my son choked at two days with unaspirated phlegm, and I thought for an agonising eternity that he had died as he was not returned to me for what seemed like hours. How was I going to live with a threat so similar for many months when I would be three hours' drive away? The little heart monitor winking its messages was our constant companion. With all the fear, empathy was a struggle and huge unspoken questions hung over me about my daughter. Would she neglect the baby? Would she go and try to leave the baby at the hospital? No-one said anything of this at the time, although I discovered later how worried the midwife, social workers and nurses were, not to mention my son-in-law who was pulled into fatherhood full time by the amount of attention the little scrap needed.

The special kind of a bottle and teat needed for a cleft palate baby requires strong rhythmic squeezing which squirts milk to reward the biting, which was all that she could do, and, of all things, both my daughter's hands were disabled by pregnancy-related carpal tunnel syndrome—a sort of double-whammy in the circumstances. Thus the baby's arrival and subsequent needs caused physical pain as well as emotional maelstrom, and for many months both parents argued over when to give up the slow intake (of perhaps forty mls of mixture from the bottle) and revert to siphoning the rest of the feed by tube. (A constant overfeeding may have been in progress, Ailsa's only defence being the forcible ejection through mouth and nose of the just ingested milk, which could happen three to four times a day.)

After many sleep-fractured nights I had to return to my 'babies' in Auckland and as the young couple had established something of a co-operative routine, I had to be content with that. They had the support of the midwife, social worker and Karitane nurse, (for which, thank goodness) as these were all visiting Julie and observing her behaviour as well as Ailsa's, as they were as concerned as I was. I visited as I could, driving to Rotorua and back, watching the agonised removal and replacement of the naso-gastric tube—tricky if parents have no experience and have a dislike of things medical; watching the feeding which seemed only just over when it started again; listening to their frustrations and bitter comments to each other as the baby slowly pulled them into parenting; knowing how wounded in self identity they were both feeling but not saying; and listening to the self-recrimination as the discussion of possible causes went on. Two other babies were born at that hospital in the same month with this 'sequence'. One novel notion was that agricultural sprays may have caused it, as all three babies were in utero on farms during the Christmas thistle spraying. (There is no way to prove this, of course.) Genetics, mutations and developmental accident (big father,

short mother with large baby), all sorts went on –'somehow someone must be responsible'.

The worst of that was the feeling of defectiveness which led to deep despair and anger in the 'white nights' when my daughter, tortured, sleepless and angry, sat watching the monitor blink, terrified in case it stopped or the alarm went off. Only later did she tell me that even the baby's father, exhausted as he was, did not know that her nights were so spent. But in that time 'attachment' worked its magic too; 'the two way street' (Stern: 193) was in action. Despite the pain and the unnecessary guilt, the process of making the 'stranger more familiar' which having a handicapped baby accelerates (out of the extra physical needs and procedures as well as the psychological) was growing and burgeoning. At the same time, their marriage was having to be 're-invented', their caretaking roles defined and the acquisition of other support systems took up a lot of time and shortened patience.

There is a good case for saying that this whole event is a lengthy set of traumas resulting in post traumatic stress syndrome, complete with flashbacks, recurring dreams, distress and reactivity on exposure to these, guilt, avoidance, detachment from others, restricted range of affect, irritability, hyper-vigilance and exaggerated startle response. Fortunately those who cared for the family over the next few months were able to integrate diverse opinions, encourage, support and nurture so that the circumstances were calmer and more conducive to the growth of love and attachment, until finally Julie was able to say that although Ailsa was not the daughter she wanted, she was "the one she wanted now".

Understanding Attachment

Turning to attachment concepts, I would now like to say something about a way we used to look at bonding and attachment. It was said that 'bonding' (whatever that was), was a process that happened soon, if not immediately, after birth. The inference was that within hours or at least a few days, a 'bond' would have occurred between caretaker and baby. In his earlier work *The nature of the child's tie to his mother* Bowlby (1958) had explained the notion of attachment to a discriminated chief attachment figure, using the analogy of the phenomenon of imprinting in which young birds will attach to any mobile figure to which they are exposed at a sensitive period in their development. (This analogy was later revised as not so applicable to humans.) However attachment, unlike imprinting, was a process which was much slower, requiring several months. It gave adopted, premature and ill babies some kind of 'second chance' — the infant remained ready to 'attach' if some inappropriate 'bond' may or may not have taken place, for example, to nursing staff, to an object, or to the birth mother rather than the adoptive mother.

I think we now have a much clearer way of seeing this process, largely due to the influences of John Bowlby, whose monumental work *Attachment* (1983)

stemmed from his earlier paper, and of those who followed him in attachment research and writing, which of course continues presently. Attachment theory accepts the customary primacy of the mother as the main caregiver but nothing in the theory suggests that fathers are not equally likely to become principal attachment figures if they are the carers (Holmes, 1993). Recently Alessandra Piontelli (1992) discovered through studying the scans of pregnant mothers while they were in progress that a huge amount of attachment is already taking place under possibly less than ideal conditions. The fantasy which used to be elaborated by about four to seven months and was modified towards the full term of most average pregnant women so that the sex, appearance etc., would not be too far at variance in truth as in fantasy, is now elaborated by being actually 'seen' in action as it were. It is now possible that many opinions and interpretations are often made thoughtlessly and projectively by theatre staff and patients alike. Previously a 'kicking' baby was thought of as being a 'footballer' or 'ballerina', now there is evidence visible to support this, albeit distorted, projection.

Patterns of Attachment

These distortions add rich fuel to the fantasies of mothers who already unconsciously have representations of several types of attachment pattern according to their own mothering. Three common types according to Mary Main's research are the dismissing, enmeshed and autonomous patterns. [1]

> A *dismissing* attachment pattern (described by Stern, 1998: 42) comes into effect with a mother to be who is not particularly interested or involved in reflection about her own past. It may be accompanied by personality traits which are congruent with that, such as avoidance of issues expressed or unexpressed. This mother keeps her distance from feelings and appears to be less absorbed by the thought of a coming baby, at least on the surface.
>
> An *enmeshed* attachment pattern is that which is present in women who become so involved that a clear perspective on what is happening may be impossible. They may be women for whom separation and individuation have not fully occurred from their own mothers and are normally deeply involved in actively maintaining the enmeshment.
>
> *Autonomous* attachment is that occurring between mother and baby when mother has the ability to reflect on processes between herself and

1. See account of Berkeley Adult Attachment Interview in Karen, 1994: 365–379).

> her baby, as well as those between herself and her mother, in a balanced way where neither process dominates.

Already in the uterus, with connection to feeding and elimination processes through the umbilical cord and placenta, much is happening. The chemical compositions of bodily fluid in which the baby is bathed are familiar, the interchange processes are an unthought given, and the dim external world with its repetitious happenings is familiar also. The shocks of the unexpected may make a baby 'leap in the womb', but the procedures like the body of his mother becoming vertical each day, the bumpy vertebrae that push at his space when she lies down, the sound of her voice and others, the even beat of her heart above his head, are all commonplace to him. He is born, whatever way, ready to increase and proceed with the attachment process.

Attachment Issues in Adoption

Something important may be said here about adoption. From Nancy Verrier's book *The Primal Wound* (1993) there is important awareness to be gained from the recorded feelings about babies separated from the already familiar at birth or just after: a procedure that was rife thirty years ago, but fortunately much less in force now, except in much more unusual circumstances and hopefully with more informed adoptive parents. Those of our patients who have been adopted children and have lost that sense of self already formed and connected with their birth mother are sometimes in grave need for us to understand the small 'psychic death' which has occurred in them as a result.

Hofer's paper (1983) proposed a unified theory in which attachment behaviour develops with the biological regulatory processes hidden within the mother-infant interactions. In this the loss of mother not only evokes psychological responses but it also has a direct impact on the body due to the withdrawal of the previous biological regulations supplied by the mother, and this modification of systems may influence later susceptibility to disease.

This relationship has been beautifully expressed in the *Autobiography of a Baby* by Pat Hunter:

> I have moved through panic to desolation. I need to be with my mother. She needs to be with me. She does not allow me. In this desolation I know this which I didn't know before. She needs my love. Without it she cannot love and feed me. I need to love her. I cannot love her from my emptiness. I want no-one else. I do not cry out. My desolation is better than the pain of their

> touch. I speak to my mother soul to soul. But my words smash against the iron door — shut against them. I cannot enter. (1989: 15)

We need to work with this as imaginatively and sensitively as possible so that the grieving of that 'self' who died and reformed as another may be completed, rather than haunt their lives producing difficulty in behaviour and relationships.

Attachment and Self-Regulation

Metcalf and Spitz (quoted in Taylor, 1987: 122) suggest that the 'psychic precursors of dreaming commence during this switch-over period (the first month of extra-uterine life) and the beginnings of recognition memory indicate the rudimentary psychic structures are being formed'. Research has since confirmed that the infant is 'a highly organised creature who seeks out and regulates incoming stimulation and engages actively with the mother, who he can discriminate as a recognizable, specific object by two weeks'. (Stern, Emde & Robinson, 1979, quoted in Taylor, 1987: 15). Stern cites the experimental situation where adequately fed infants will continue to suck on an electronically bugged pacifier in order to make the carousel on a projector change slides after scanning. He thinks that infants have 'optimal levels of stimulation below which more stimulation is sought and above which stimulation is avoided' (1983: 10). This indicates that self-regulation is an inborn capacity which is met by the mother in an interactional system, thus organising self-regulation from birth, shifting gradually from physical to psychological levels as the infant becomes increasingly aware of being separate.

Condon and Sander (1974, quoted in Taylor, 1987: 125) found that neonates synchronise their movements exactly to the rhythm and structure of speech. The intuitive repeating rhythms of rhymes and word games which parents use with babies attract this response, and there are many different patterns of attention, action, and affectivity present at two weeks (Brazelton et al., 1975, quoted in Taylor: 125). Modification and adaptation continues between the two over time, in increasingly complex and diverse ways, and self-regulation, due to the influence of both, will ensue as the two enter into and emerge from states of separation and attachment.

Hidden processes as a biological as well as a behavioural modifier include the mother's role as outside homeostatic regulator for nutrition, warmth, holding and handling. Animal studies have proved that heart rate in baby rats is regulated by the amount of milk the mother supplies (Hofer & Weiner, 1975). This regulation is moderated by autonomic and central nervous systems and

not by circulation. It may not be possible to extrapolate a similar influence for human babies yet, but it is well known that the baby's suckling stimulates the mother's oxytocin flows which influence the production of milk. In experiments with sleep-wake rhythms and the regulation of growth hormone with baby rats, their mother's separation caused a fall in blood levels which was raised by reunion. Separated infants also become apathetic and depressed after the initial 'protest' response described by Bowlby (1969). Rocking, patting and other movements normally provided by the mother may well appear in a stereotyped automatic way when human and monkey infants are deprived of this.

The transitional object described by Winnicott (1953) may go some way toward the continuation of regulation in the face of anxiety evoked in mother's absence. The infant's own creation of emotional dependency on a specific chosen object like a toy or soft blanket provides an illusion of 'oneness' at the same time as awareness of separation. Winnicott suggested projected feelings and meanings of the infant imbue the object with representations of mother and infant, through smell, touch and taste.

In his overview of the more recent research on psychology and neurobiology of the mind, Allan Schore (1994) proposes a model of the ontogeny of emotional self-regulation. His thesis is that:

> the early social environment, mediated by the primary caregiver, directly influences the evolution of structures in the brain that are responsible for the future socio-emotional development of the child... The resulting variety of dyadic affective interactions between the caregiver and the infant is imprinted onto the child's developing nervous system. Different types of stimulation are embedded in these 'hidden' socio-affective interactions, and they elicit distinctive psychobiological patterns in the child. In response to such socio-environmental experiences, hormonal and neuro-hormonal responses are triggered, and these physiological alterations are registered within specific areas of the infant's brain, undergoing a structural maturation during a sensitive period. (Schore, 1994: 62-63)

He further proposes that

> despite the changes in object relations over the stages of infancy, the mother's constant self-object role as an external regulator of the child's internal affective state is essential in providing the infant's limited nervous system with the modulated stimulation that optimally enhances the growth of its own affect regulating structure... These experiences are stored and can

> be accessed and regenerated to regulate the emotions, even in the mother's absence. (Schore, 1994: 62–63)

This experience has been named by Stern (1995) as the 'evoked companion' or, 'the recalled memory of being-with-another', which has been constructed by the infant forming a representation of how he feels within himself while being with the other in that way.

Holmes (1994) reminds us that Klein and Bion discussed the modification of phantasies resulting from rage by the soothing presence of a parent. In the past Bowlby himself had said the restoration of proximity to the discriminated figure is central to the Attachment theory. An aggressive or retaliatory mother who is unable to accept the child's anger may leave it harbouring phantasies of revenge, and with a self-protection which may appear as indifference or avoidance of these. Bowlby saw loss as central to disturbance and the importance of mother in neutralising the destructive effects of rage in response to loss. He also saw the use of affective withdrawal as a defence against unmet longing or anger faced alone.

The insecure attachment resulting from these unmodified states was named in two groups in Mary Ainsworth's research into the Strange Situation (1978) which can be summarised as follows:

> *Insecure avoidant* – children who show few overt signs of distress on separation, and ignore mother on reunion; they are however watchful of her and limited in play.
>
> *Insecure ambivalent* – children who are distressed and not easily soothed by mother's return, seek contact but resist it, pushing away or refusing comfort, angry and clinging.
>
> (*Insecure disorganised* is a third category more recently described and is a confusion of the previous behaviours, with stereotyped movements and 'freezing' behaviours).

The Centrality of Empathy

What would be the outcomes for my granddaughter? Would the anger Julie felt make her unable at times to receive (as a container) and modify the projections Ailsa would be making? I had to remember that Ailsa did not know any other way to be in the world with her parents – knew no reason for her tube rather than breast or bottle, or the terminals for the monitor that were pasted to her body. She was not left alone except when asleep and she was ready to go on attaching. What she was up against was the fear and frustration and grief of her parents instead of the relaxed confidence they both expected to grow into. For her the soothing

presence was not available while one or other was worried or angry (or they both were, with each other).

There was however an obvious empathic quality which showed that they knew how she felt when in pain and discomfort, and the requirement of her lengthy feeding and attention meant that these times were compensated by many cuddles, smiles and just the determined gentleness that both tried to show as much as possible. It was not uncommon to find Julie sitting up asleep with Ailsa's sleeping head on her shoulder for hours at a time. The soothing presence was there and as time passed in those first few months her trust in being able to use both their bodies for comfortable sleep grew. Both were distressed most of all at the tube changes as they had huge fear of hurting her (grappling the unconscious wish to retaliate). Yet it seemed there was ability to act as 'auxiliary egos' for her, 'feel into' her experience at times and respond sensitively enough despite their exhaustion and despair.

During those months I was with them enough to observe and hear plenty about the professional help which was available. It seemed that there is now a good level of understanding and teaching going on with the professional bodies represented in this help, but the quality of the individual's ability to offer and act on the understanding was often questionable. The best help Julie experienced came from a young Karitane-trained Plunket nurse who visited and sat quietly and listened to Julie while holding Ailsa for an hour a week. I watched her carefully observing Ailsa's and Julie's interactions. She couched requests for information on how things were in the context of conversation, so that Julie was reasonably unaware of supplying it. She was attuned to them both in an unusually mature way not often seen in those from other disciplines.

Many of the other helpers were preoccupied with external issues, whereas the young Plunket nurse seemed able to acknowledge for Julie how difficult the balance was between her doing her best and feeling so guilty and angry.

Cornwell (1983) says:

> The pattern of feeling inadequate as a mother when the baby is suffering, and then dealing with this by the baby's ability to feel, or trying to be reassured by obtaining the knowledge of the baby's satisfactory development in weight gain or increasing motor skills, is seen repeatedly by observations of mothers with young babies. It is very difficult both to acknowledge and tolerate the feelings of persecutory guilt and yet continue to struggle to do one's best. (p. 30–31)

In a case which began two years before this personal experience, I encountered M who was having relationship difficulties. She told me how when D, her son, was born he was given six months to live. With a double cleft palate and multiple heart defects it was thought better if his mother didn't visit him. Her husband handled the whole thing with flippancy as a defence which made her feel dreadful. Despite the hospital's discouragements she did however visit D

to feed him but felt afraid of getting close because he might die. He didn't and M lived in hospital with him for three months. The danger of his operation was very real, with two resuscitations necessary in the course of the operation and for eleven months after it he was fed through veins. At eighteen months although undernourished he was able to learn to sit with the aid of a physiotherapist. The repair of his palate went well but persistent pneumonias threatened his recovery. M stayed in hospital with him—recalls that by his third year he was admitted only three times. Because of his condition he went to a special school and was given speech and occupational therapy. Mainstreaming was tried but he became depressed therefore needing the care of a special unit. With the strains ongoing his parents parted when D was six. At seventeen he still has the aorta in the wrong place and three holes in his heart. His attachment to M is strong. Recently he had quite an Oedipal challenge when M started to see a new partner, but has survived that and while dependent has achieved much.

Insecure Attachment

> Access to the emotionally responsive mother engenders a secure attachment, an expectation that homeostatic disruptions will be set right. On the other hand the mother's incapacity to act as the infant's psychobiological regulator specifically defines a growth inhibiting environment. Securely and insecurely attached infants express different patterns and capacities for affect regulation during proximal separations and reunions with mother. The mother of the insecure 'avoidant' infant experiences contact with the infant to be aversive, and the child reacts to this by avoiding the painful and vacillating emotions aroused by her. The mother of the insecure 'resistant' toddler *inconsistently* allows contact at reunion, that is, she *partially* participates as an affect regulator. This is experienced by the child as an unpredictability, and interferes with leaving her in order to explore the surrounding environment. (Schore, 1994: 384)

The insecure avoidant child then avoids the misattuned disorganising stimulation it expects to emanate from mother's face. What follows is a limited capacity to experience intense positive or negative affect, and conservation withdrawal. The insecure resistant infant is in a mixture of approach and avoidance (ambivalence) in response to mother's facial expressions and cannot resist the unpredictable eye contact. Winnicott (1971) expressed this saying that such a baby quickly learns to make a forecast: "just now it is safe to forget mother's mood and be spontaneous, but any minute mother's face will become

fixed or her mood will dominate and my own personal needs must then be withdrawn otherwise my central self may suffer insult". (p. 113) For the insecure avoidant the development has occurred in the parasympathetic system strengthening the withdrawal. For the insecure resistant the sympathetic system dominates, causing the personality to manifest intense emotionality and susceptibility to under-regulation, just as the avoidant is susceptible to over-regulation disturbance, being disabled in regulating sympathetic arousal. Grotstein (1990) has explained the role of the right hemisphere in mediating the processing of more primitive emotion, and considers that a limitation in one attachment pattern or over-stimulation in the other, may be inefficient in modifying, adjusting and monitoring the more 'primitive mental states'.

In reunions after attachment ruptures, psychobiologically attuned mothers of securely attached infants act to re-regulate the child's arousal level back to a moderate range, for example, through distress-relief sequences or 'interactive repair' (Tronick et al., 1989, 1990, cited in Schore, 1994). Adler and Buie (1979) proposed that this representation is able to be evoked from memory as an image of comforting object and function in the mother's absence. This image is a multimodal or averaged image of the mother's face during interactive repair interactions. The mother of an insecure infant does not engage in interactive repair in distress relief. This may mean the infant is stuck in unmodulated negative affect and therefore inhibited, perhaps permanently, in the development of the very systems of hormone production which enable motivational and cognitive processes.

Developmental deficits, previously thought of as arising from traumatic activity suffered by the child, are now able to be conceptualised as traumatic 'absence' (or unrelieved negative affect) resulting in deficits (Lansky, 1992) arising from deprivation of empathic care creating a growth inhibiting environment, and thus immature and vulnerable regulatory systems, in which narcissistic rage and humiliated fury are unable to be modulated.

The reparative value of therapy in adulthood is that the therapist is prepared to attune empathically and carefully reconstruct the past with the patient. Not only is the verbal narrative taken into account but the pre-verbal which is always there waiting to be 'interactively repaired' or modulated, so that internalised negative affect may be transmuted at last.

After many months, finally Ailsa reached the required weight, and on a windy February afternoon I met the little family when they arrived at Waikato Hospital.

Ailsa and mother were to be admitted for her operation and Stewart and I were to be 'support staff' and stay at the nearby hostel.

The tension that night was palpable and despite all our efforts we could not sleep. In the morning we all accompanied the little cot through the rabbit warren of corridors to the theatre floor. Julie carried Ailsa to the prep room for the first anaesthetic, returning in tears, devastated at watching her go limp. We waited and walked and returned and waited some more till nearly three hours later the doors opened and the high pitched noisy crowing breathing of the little one emanated from the cot as it was wheeled to the intensive care unit. With her learning to breathe with an unfamiliar obstruction in her mouth the next six hours were terrifying; watching the heart and breathing recorded in winking lights, cuddling her when she cried (very awkward with about eight leads attached to her body in a tangle). However the amazing skill of the surgeon working in such a tiny space was underpinned when he came to check her and announced that the second operation would not be necessary. The tissue had been sufficient to close the hole. (Daughter nearly fainted at the news: for a moment they nearly had a second patient!)

The next week went by in a haze of walking up and down the corridor with Ailsa in pushchair or in arms, speculating what to try to spoon or syringe in when she wasn't looking, wondering if she would ever go to sleep (she was suspicious of letting herself because of the nasty things that had happened before), dozing in the armchair or watching while both mother and baby slept, exhausted.

However with the surgeon's blessing, and protesting about the cones tied on her arms to keep her from putting her fingers in her mouth, Ailsa and the rest of us then travelled back to Rotorua. Days and nights were extremely unsettled. We took turns to be up while the others slept, and watched videos of Barney the purple dinosaur many times in the night with Ailsa when nothing else would calm her. She was soon able to consume increasing amounts of food again, however, and after a couple of nights where she slept five or six hours at a stretch, I left them to it and came back to Auckland, as they were well resourced with Plunket and social workers for help. Since then Ailsa has gone from strength to strength and we are very thankful.

When I look back to the many months of travel back and forth and with the level of fear and anger I was holding, I often wonder how I was with my clients. In some ways having a heavy case load was a blessing in which I could submerge myself in responding to them in the work we did together. I do wonder however about some who were deeply in their own fears and griefs at the time and were particularly responsive to me and may in fact have spared me more than I knew. Certainly I am aware that for some of my long term clients, their own work has moved quite quickly this year compared with last, and their state of 'interactive repair' is now fully evident as I have been able to relax much more.

In Kestenberg's paper (1972), discussed by Theodore Jacobs in his book *The use of the self*, she states that it is between the ages of three and five that memory fragments are organised and gain meaning, although in later phases they

become more elaborated by the then prevailing ideational content. As the young child organises his nonverbal memories under the guidance of his parents who supply the words and structure, he is bound to delete or distort what his parents themselves deny or repress.

Despite Piaget's' position that no evocative memory of early childhood exists, some researchers since have suggested quite differently. Piaget thought that sensorimotor function was built by physical action and not available to 'internal manipulation by the infant'.

Lichtenberg (1983) had made a case for function as perceptual-affective-action mode in the first year, without use of symbols within mentation and therefore unavailable to interpretation in analysis.

Later research by LeDoux in rats, found that the thalamo-amygdala circuitry in the brain processes simple sensory cues, and it may be in these that the memory traces are stored prior to cognition. This may help substantiate the view that 'emotional memories' are stored very early in a raw form, unintegrated. Share (1994) speculates that there may be a parallel with Bion's (1962) beta elements here or Freud's (1923) 'perceptual image'. Terr (1988) in her work on trauma stemming from the memories of the victims of the Chowchilla kidnappings, found that the significant age for registering and later retrieving a verbal memory of their trauma was two and a half to three years. But strikingly in post-traumatic play the children often played or re-enacted parts of the whole experience. The "mirroring of traumatic events by behavioural memory can be established at any age, including infancy". (Terr, 1988: 96)

Share (1994) cites the research of Stern and Nachman (1984) where 75 six month old infants were subjects of an experiment to show a capacity for evocative memory of affective experience with two puppets. One which evoked a laugh initially, evoked a smile one week later. The other which was neutrally responded to at first evoked neutral response one week later. They conclude that:

> Our finding suggests the presence of a memory storage system, including affects, that are recallable by cue very early in infancy, long before the emergence of a language or symbol based semantic recall memory system. (Share, 1994: 136)

The well known case of Monica, who George Engel studied for 30 years, born with oesophageal atresia which necessitated feeding with a tube directly into her stomach till she was 21 months, is a case in point. Although Monica never

saw the films made of this, when she was a mother she fed her baby girls as she had been, lying flat on their backs across her knees—as two hands had been necessary to hold the tube for her—there was no attempt to contour her babies to the more comfortable position on her arm. She had fed her dolls this way and it is a matter of record that her own daughter in fact started to feed her own baby in this way, later shifting to a more normal position. Presently Julie is in touch with two mothers who feed their children in this way because of oesophageal disabilities and it will be interesting to observe these and Ailsa as they grow.

Two more examples:-

> A child was encased in plaster at nine months for a broken femur which made it difficult to change nappies etc. Later in the play room this child was excessively concerned with 'dirt and smells'. Another child was bandaged and hospitalised at nine months when treated for recurring eczema for some months. The separation from insecurely attached parents was traumatic and he recalled in therapy the feelings of intense sadness associated with cream coloured shadowy walls like hospital corridor walls. In therapy he described alternating impulsive relationships with several women in which need overcame caution, somewhat replicating those with the nurses when in hospital. He was also stuck, immobilised in therapy for some time before a new capable self emerged.

Share (1994) records many instances of adult clients whom analysts have described with dream fragments and behaviours which later exactly parallel recovered memories or corroborated information about their lives. She says "the presence of another who is willing to consider the whole of a person's life and to understand it at its very depth seems to help the patient to 'mentalise' the terrible pain – to bring it to a form in which it can be thought about, and mentally borne. Once it is borne, a turning point seems to occur in the treatment – symptoms are alleviated, and real life begins" (p. 167).

In conclusion, it seems that a secure supported mother-infant attachment may help diminish the effects of shock and strain trauma eventually, while insecure attachment due to inadequate or enmeshed processing may increase the effects with anxiety, inability to self-regulate, and withdrawal. My observation of Ailsa is that the former has occurred. We also feel hopeful for evidence of this in the future.

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Play, the Therapist and Associative Thought

Gill Caradoc-Davies

Abstract

If we do not totally cast out the concept of left brain / right brain with the bath-water of New Ageism, we can examine what may be useful in the concept that different parts of the brain are used for different ways of thinking. I want to show that the right brain processes are essential for associative thought, which in turn is essential for play, and play, of course is the way we are able to transform ourselves.

"*Psychotherapy is done in the overlap of the two play areas, that of the patient and that of the therapist.* If the therapist cannot play, then he is not suitable for the work. If the patient cannot play, then something needs to be done to enable the patient to become able to play, after which psychotherapy may begin." (Donald Winnicott, 1971: 54)

"*The client writes themself on the fertile ground of the therapist.*"
(Joseph Zinker, personal communication, 1997)

A Little Science – And Myself

Neurology recognises that a bleed into the left hemisphere of the brain usually results in the loss of speech, writing, and what is considered rational linear thinking. A bleed into the right hemisphere results in visuo-spacial agnosia, constructional apraxia (or inability to order the world in three dimensions), loss of musical ability, and loss of prosody in the voice (emotional expression and lilt). A sculptor with a right-sided bleed would not be able to sculpt, a painter could not paint, and a musician could only play mechanically. Whether a musician could play at all depends on whether she is a professional or not. When a professional musician is played a piece of music and their brain is

examined under positron emission tomography (PET) the *left* side of the brain is activated, but when another person is played a piece of music the *right* side of the brain shows activity. A musician friend of mine laments that for years after leaving the orchestra, she could not enjoy music, because she was too busy analysing it.

When I play on my harp music learned by ear, my learning is swift and seemingly effortless. I can add accompaniments and variations with panache. When I am given a sheet of music, yes, I can play it. It takes me seeming ages to learn it, and it is always correct and a little wooden.

For many years, I believed the difficulty I had in making myself understood was because I now needed to express myself solely in English. I overcompensated by talking too much, paraphrasing myself again and again, hoping to obtain understanding in the bewildered hearer. My Gestalt colleagues put me right. They told me that they now understood that my seeming obtuseness arose out of my associative thinking. They thus gave me a key to myself and to the many difficulties I experienced in my own journey.

I do have some mastery of left-brain, linear thought, or else I could not have passed my medical exams. I remember, however, as a registrar attempting to present a case to the Professor of Psychiatry, being told that "you will fail your clinicals, not because you don't know what you are doing, but because of how you present the material". Thought provoking, indeed. I went away and tried to understand this. I did not have the words to say it then but I realised I was trying to present associative thought to a linear thinker. I was assessing the patient as a topographical map, with mountains, waterfalls, forests and villages. What was required was a two-dimensional AA map of the main highway. I could do this. I passed my clinicals on my first attempt.

All of us doing psychotherapy are capable of in-depth associative thinking. This is part of the job description. It is evident in Freud's use of free association and in Jung's 'active imagination'. It is not, however, a skill that is necessarily rewarded highly in this culture.

Other cultures seem to conceptualise more associatively. Consider Chinese characters, particularly in the banner "Chinese Splendour" hanging all over the city, the radicals that make up the last character.

Wang: 'King' 王

Put a small 'stone' with it 丶

We have yu: 'jade' (royal stone) 玉

Place it under a 'roof' safely 宀

We have bao: 'treasure' 宝

From this one is tempted to hypothesise that, with such associational language in its symbolic form, the Chinese have developed a different integration between left and right brain hemispheres.

Introduction To Play

The complete working through of therapy is not possible without play. By play I do not mean "to occupy oneself in a game or other recreational activity; to act light-heartedly or flippantly". That is a current dictionary definition which is not adequate for us. Play is not just kids' stuff. It is the key to what makes humans human.

Play is the ability to tangle with existence both manifest and sublimely transcendent, concrete and intangible, logical and fantastic. This ability to play in the broadest sense is the mother of invention, the passion of Shakespeare, the emotive capture of Picasso, the exultation of Beethoven. It is also, in its darker aspects, the lusts of Auschwitz, the threat of nuclear capability, and the killing fields of Cambodia. These latter are definitely not 'child's play'. But they can be thought of as the same energy, before perversion.

Empathy is essential for therapy, and on its own is not enough. Insight occurs with therapy, but can also occur with experiential understanding alone or where very little cognitive integration appears to have taken place. I however believe, with Winnicott, that therapy cannot be completely *worked through* without play.

Consider a new concept of play in the therapeutic sense. Here play is really a state of mind, a state of being where everything is fresh and new and everything potential. Nothing is analysed, labelled or set out in a logical left brain fashion. Instead, right-angled, right-brained associative thinking is encouraged, and thoughts, words and objects in both the real and imaginary world can at any moment take on new meaning, grow and metamorphose. In this state of being, there is often excitement, liveliness, creativity and spirituality, and feelings of delight, anticipation and novelty. Sometimes there may be a more savage side. A cat 'plays' with a mouse. One must never forget the darker side of play.

The state of mind that goes with play can be quickly recognised.

Experiment 1

> Close your eyes. Put your hand out in front of you. Imagine that I am placing some fairy dust in your palm.
>
> Now open your eyes and 'look' at it.
>
> Are you open to a momentary feeling of delight at these brightly coloured stars that are part of 'fairy'?
>
> Now experience that space inside you where you are open to this, where there are little sparks of colour.

This feels for me similar to being in touch with my life force. Although I remember this as part of my childhood, it is also part of my adult self. I can listen to a sparrow chirp and suddenly 'hear' it. I can pass a very small and simple daisy in the grass with as much delight as I would look at an orchid. It is in this space.

Experiment 2

> To explore the extent of this space in yourself.
>
> Take a tissue, and simply 'go with your energy'.
>
> After 5 or 10 minutes, stop and consider your experience.

Did you become preoccupied in your own space in making something with the tissue? Did you become angry or irritated, feeling that this was foolish or silly and a waste of time? Did you become competitive, aggressive, or physical? Rude or 'unseemly'?

What did you discover about yourself with this very simple stimulation and freedom to explore?

This is often our clients' experience when they are ready to start exploring their world and being themselves in the world. This has the feeling of something new and untried. This is also a place where there is no 'right' way to be. Winnicott (1971: 41) says that this experience has place that is "neither inside nor outside", and makes the point that playing is doing and doing things takes time.

> The essential feature of communication is this; that playing is an experience, a creative experience, an experience in a space-time continuum and a basic form of living. (1971: 50)

When he was talking about a mother and a baby, he called this 'potential space'. I suggest that there is also such a space between you as therapist and your adult clients. This is not the early stage of therapy where the potential space is sacred and where, some therapists would have us believe, the therapist must not intrude. This is a space into which the client will often *invite* you. This is the kind of playing that leads into relationships and is a form of communication.

Winnicott says that unless the therapist can play then he or she is not suitable for the work. I understand this to mean that unless the therapist can engage with the client in this state of mind for the working through of therapy, therapy will not reach a conclusion which is life giving. Winnicott acknowledges that the client must be enabled to play. The earlier part of therapy is devoted to engendering some sense of self in the client. The client now feels relatively secure with the therapist, and engaged. Some of the insights have taken place and patterns are starting to emerge. This is when play is important. Now the client starts to spring themselves from the prison of their past into the potential of their life for the future. Here the therapist who may have been shadowy or in the background needs to be available as a potential playmate for the client, both to maintain safety and to provide the boundaries, as well as being a sounding board and mirror for the client. This therapist provides timing and containment. It is essential that the therapist enjoy this stage and not be frightened by it, and be able to enter this space where there are really no rules, where everything is potential, in flux, where the outcome is uncertain and apart from safety and overall containment, the therapist is not necessarily in charge of what emerges. This is where it is possible for the unconscious of the client and the unconscious of the therapist to work together. All of you will have had experiences where you may have an image, tune, bit of poetry, or a story that is very similar to your client's and triggered at the same moment. I take this to be when I am in tune with the client's unconscious. We have now a reciprocal feeling of understanding at the associative rather than the logical level.

Anxiety

Experiment 3

> Imagine, at the end of your working day, taking some body glitter and putting some on your face.
>
> Imagine leaving your place of work, travelling, entering your home, being seen by your nearest and dearest, hearing what they say as they comment on it.

Depending on your experience of exposure, and boundaries, you will probably have felt, to a greater or lesser extent, some anxiety. In Gestalt, we think of anxiety as excitement arising but with blocks to following through.

Winnicott reminds us that "playing is inherently exciting and arousing and precarious". Playing, while essentially satisfying, is therefore often anxiety provoking because it is new. There are no rules. Even though it is satisfying and life giving it also involves the body and therefore in clients who have had traumatic body experiences (such as in sexual abuse) playing may be particularly anxiety provoking. In order to play, the client must then trust the therapist to keep the play space safe.

As therapists, we must be very careful while playing not to interpret, lest the client become confluent and go along with the therapist, therefore losing the essence of unique creativity that is part of play. Interpretation certainly takes the anxiety away but it may take away the vitality as well. The client needs to learn to tolerate the anxiety of chaos as they may have good reason to be anxious

The Dark Side of Play

Terry Pratchett (1997) says "It was nice to hear the voices of little children at play, provided you took care to be far enough away at play not to hear what they were actually saying."

All playing has a shadow side, just as human beings and indeed the whole world have both light and shadow. To enter into play without being aware of the possibility of shadow in oneself, in the client, and in the potential space between, is to take an unacceptable risk.

To listen to the words of children at play is to quickly discover that there is a very dark side to play. It involves emotions and behaviour which society identifies as less acceptable. Yet it may be important to "mine the shadow for gold" in Jungian terms.

These are energies which may need to be recognised and expressed, lest they become perverted in the client's life. The therapist really needs to know themself in this as well.

(a) *Competition*

This hardly needs explanation. Anyone who does not enjoy winning in a competition with others really needs to see a psychotherapist! This is a biological given, that we strive with each other to be better than the other. If we do this playfully it does not become aggressive or destructive to the other. Rather it is a pitting of one against the other, a refinement of the life-giving skills of both. This is the transcendence of what could become a perversion—envy, spoiling and destruction of the other in order to triumph.

(b) *Tricking, lying, cheating*

The Nordic God of play is Loki, the trickster. Recall the film *The Mask* for its reminder about the dark side of play.

Remember the card game called liar poker. You take cards from a deck and in turn declare your hand in poker terms. You can declare anything you like. If you are challenged and you have declared falsely, you forfeit. If you have declared accurately and are challenged, the challenger forfeits. There is great tension and glee in the playing. Who is tricking or lying? Should you challenge or not? What should you declare your hand to be? Because it is contained in the ritual of a game, there is safety in exploring your responses to the feelings you are having.

We are most at risk in play when we cannot recognise these sorts of aspects in ourselves. When we recognise them, it brings them into our awareness and makes it possible for us to modify our actions if we choose.

Creativity

When we have the anchor of awareness we can be free to explore. How well do you know yourself? Do you know whether you are mainly visual, or kinaesthetic, or do you hear things? Do you sing, paint, make up poetry on the spur of the moment, tell stories? Do you know how to find out which of these is important for your client? I believe that when Freud was asking for free association, he was actually inviting the client to enter into a play space with him and was responding to the words in a playful fashion, albeit very seriously. I sometimes ask the client what their favourite fairy story is and explore that

with them. When a client brings a dream to work on they are bringing me into that area where there is the associational quality of playing. Sometimes, when I am working with a client, I will sing a song or play a game. When I feel they are challenging me, I will lie on the floor and ask them to arm wrestle with me.

Whatever I do in this state, I loosen myself up and make myself multi-potentially responsive to the client. If a situation of reasonable trust with adequate boundaries has been built up with my client, I can risk being my non-logical and playful self with them.

A Client

A professional man in his late twenties presented with crippling depression and loss of motivation. He is highly successful, but the success is like ashes in his mouth. His mother was not a 'good enough' mother, she was a 'too-good' mother who gave her all to this son to "enable him to achieve his great potential", or at least, her version of what she thought it should be. As we have worked, especially with the transference, he has been facing what Gestalt therapists call the Creative Void: namely, what fills this seeming emptiness if my mother (or my therapist) won't fill it for me?

One day, he arrived full of energy and ideas and talk. My inner psychiatrist had her button pressed—was he manic? Then I realised that the grandiosity he seemed to be expressing was the grandiosity of the omnipotent two-year-old. We talked for some sessions about his delight in this, and his fear that he would get out of control. He also started to play with me as a playmate. Previously, he had been unable to use the sand-tray, or metaphors, without cognitive deflections.

Recently he bounced in, giving me a leaf that had been caught in the grill of his car, with the injunction "Brace yourself". [Both: "Do not let me destroy you by your getting caught in my grill" and "I fear I/you cannot control me".] He told me of his uncharacteristic acting out the previous weekend. He had become drunk at a pub, and had 'enjoyed' himself. What made him curious was his wife remarking that he would front up to people with his right hand extended, fore-finger and little finger straight, and the others bent, like a bull's horns. He had no idea what it meant. I invited him to play with me; to do this in my face. I had no idea what would emerge. My only thoughts were of the Italian sign for the cuckold. I was wrong, as it turned out. After a minute he said it was about control—he remembered the movie *Crocodile Dundee,* where wild animals and dogs were controlled by the gesture. With laughter and

excitement we explored this. I shared my image of the hero in *Dune* riding the huge worm, after he made reference to messianic feelings. We talked of the discipline ['control' becoming 'discipline'] of the Benegesserit [female priests] in the book. At the end he was clear that instead, he was aspiring to the sureness of an Indian chief, 'sureness' replacing 'control'.

I believe he is playfully on his way.

Conclusion

Terry Pratchett (1997) writes: "Humans need fantasy to be human, to be the place where the Falling Angel meets the Rising Ape." With play we rise to meet ourselves.

I am sure I have not presented anything new. My hope is that I have reminded you that psychological work is not just anguish and pain, but can also be play that is full of humour, creativity and challenge as well.

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Listening Differently with Maori and Polynesian Clients

Philip Culbertson

Abstract

Changing demographics, both nationally and internationally, strongly suggest that the traditionally Caucasian client-base of psychotherapy is dwindling in size. More and more of us will be asked to work cross-culturally in the future, yet few of us are adequately trained for such work. This article addresses some of the cultural information that psychotherapists need to know about Maori and Polynesian clients, in order to work more effectively with them. Particular emphasis is placed on the rule of culture in defining identity and the sense of self, the way decisions are made, proper methods of joining therapeutically, and the role of metaphor. Therapists are recommended to take a stance of 'informed not-knowing' when working cross-culturally, and to address the insights of Critical White Theory in order to make themselves 'culturally safe'.

Introduction

> No one goes anywhere alone, least of all into exile—not even those who arrive physically alone, unaccompanied by family, spouse, children, parents, or siblings. No one leaves his or her world without having been transfixed by its roots, or with a vacuum for a soul. We carry with us the memory of many fabrics, a self soaked in our history, our culture; a memory, sometimes scatrered, sometimes sharp and clear, of the streets of our childhood. (Freire, 1994: 32)

For most of psychotherapy's history, both practitioners and clients have been drawn from the white middle or upper-middle class. Certainly in New Zealand, psychotherapy has been an approach to emotional and mental health of which Pakeha were almost exclusively the only consumers. Yet demographics are changing rapidly across the whole world, so that today descendants of white Europeans count for less than one third of the world's population. Similarly, it is predicted that by the year 2025, the Maori, Polynesian and Asian

populations of Auckland will outnumber the Pakeha population. In keeping with such changing demographics, a decade ago the American Psychological Association (1987) issued the following challenge for the future: "psychological services must be planned and implemented so that they are sensitive to factors related to life in a pluralistic society such as age, gender, affectional orientation, culture, and ethnicity" (p. 13).

Expanded training programs in New Zealand in counselling, pastoral counselling, and psychotherapy mean that an increasing number of new practitioners are being trained, at the same time that the traditional Pakeha clientele-base of psychotherapy is dwindling. Perhaps the time has come for us as professionals to consider whether certain modifications need to be made and sensitivities developed that will better equip us in the future to deal with what will surely be a growing non-Pakeha client base for most of us.

Before I proceed, I must address the question of by what authority I, as a white male, write on this subject. The best authority for this sort of discussion would be indigenous writers. Overseas, there is a growing Afro-American voice in psychotherapy, as well as an Hispanic voice. Here in Aotearoa New Zealand, we have yet to produce a significant pool of indigenous writers on the contextualization of psychotherapy. Very few members of NZAP are Maori, Polynesian, Indian, or Asian: in fact nationally, they number fewer than ten, and the statistics in training programmes are not yet more promising. There is an urgency to this topic that suggests it cannot wait, unless we are willing to become a profession relevant to only a privileged minority of the future. Those of us with some cross-cultural experience must begin to speak now, and hope that in the future, psychotherapist authors indigenous to this country will step forward to help us.

On a personal level, I have taught pastoral counselling theory for seven years now to Maori, Polynesian, and Melanesian students. I have learned much from this classroom experience about the impact of culture on emotional and mental health and on the definitions of the self. As well, I have seen a few non-Pakeha clients in my private psychotherapy practice. What I offer here, then, is a combination of classroom learning, therapy room experience, and the translation of overseas theory into the context of Aotearoa New Zealand, where I believe it to be applicable.

Definitions of Normalcy and the Self

An increasing number of feminist psychotherapists, gay and lesbian psychotherapists, and therapists of colour have pointed out how influenced the definitions of normalcy in any culture are by the dominant males within that culture. The foundational theories of developmental psychology, for example, such as those of Erik Erikson, were developed using an almost exclusively male research base. Because of these basic assumptions, any individual or group whose characteristic response to illness or stress is different from the dominant culture is likely to be labelled 'abnormal'. More current research (McGoldrick, Giordano & John Pearce, 1996) argues that people differ in the following:

1. Their experience of pain.
2. What they label as symptom.
3. How they communicate about their pain or symptoms.
4. Their beliefs about its cause.
5. Their attitudes toward helpers (doctors and therapists).
6. The treatment they desire or expect.

These fundamental variations are further influenced by the emotions that the client's culture will tolerate, their acceptable forms of expression, culturally-approved aspirations and hopes for the future, tolerance for self-expression and individuation, comprehensible dream thematics, their accepted symbolism, and the culturally-normative interpretation of those symbols, and above all by the culturally-constructed sense of self to which the client may aspire.

Highly individualistic cultures such as the North American Eurocentric one assume the self to be a boundaried entity consisting of a number of internal attributes including needs, abilities, motives, and rights. Each individual carries and uses these internal attributes in navigating thought and action in different social situations. By contrast, a different construal of self is more common in many non-Western cultures, including the Polynesian and Asian. According to this latter construal (Matsumoto, 1994), the person is viewed as inherently connected or interdependent with others and inseparable from a social context.

David Matsumoto (1994: 21) charts the distinction between these two cultural constructions of the self as follows:

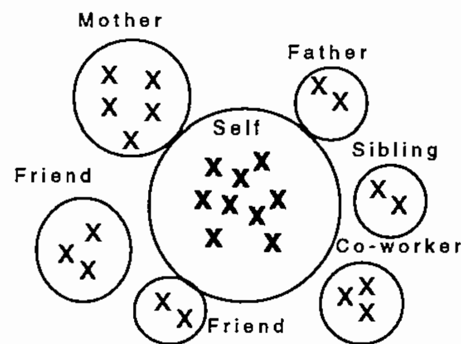

Figure 1.

Here, self is a boundaried entity, clearly separated from relevant others. Note that there is no overlap between self and the others. Furthermore, the most salient self-relevant information (indicated by bold Xs) consists of the attributes that are thought to be stable, constant, and intrinsic to the self, such as abilities, goals, rights, and the like. As such, these intrinsic attributes are bound to be quite general and abstract.

By contrast, many non-Western cultures neither assume nor value this overt separateness. Instead, these cultures emphasise what may be called the "fundamental connectedness of human beings" (Matsumoto, 1994: 21).

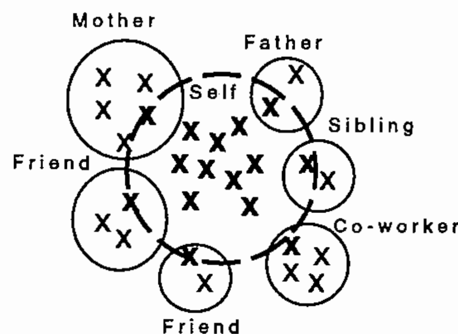

Figure 2

The primary normative task is to adjust oneself so as to fit in and maintain the interdependence among individuals. Thus, many individuals in these cultures are socialised to 'adjust oneself to an attendant relationship or a group to which they belong', 'read others' minds', 'be sympathetic', 'occupy and play one's assigned role', 'engage in appropriate actions', and the like. These are the cultural tasks that have been designed and selected through the history of a

given cultural group to encourage the interdependence of the self with others (Matsumoto, 1994: 20–21). For example, it may be very difficult for a Samoan to claim a boundaried identity, such as "I am shy." The Samoan's definition will more likely be quite contextual: "I am shy when I am with white people," or "I am vulnerable when my mother shames me." From an ethical point of view, psychotherapists must question, when working with clients from communal cultures, how far it is appropriate to encourage them to stand alone, or break ties, or individuate in the manner that is considered normative among Europeans. To encourage these traits of independence may instead be a form of violence against the client's culture, and may eventually make the client unfit to live comfortably in his or her culture of origin. [1] A simplistic but memorable note of caution is that Westerners value High Performance, while Maori and Polynesians value High Conformance.

Defining Culture

"Culture is contextual," writes Joan Laird (quoted in McGoldrick, 1998: 24). "Thus, because no two contexts are ever quite the same, it is always more or less changing and it is always emerging. Who we are changes from moment to moment in shifting settings. We are all multiple cultural selves." The term 'culture', then, can be applied to ethnicity, race, the choices dictated by sexual orientation, and the vicissitudes of life experience. In each instance the client is affected by influences, assumptions, and perceptions very different from those held by the therapist. Of course, when 'culture' is defined so broadly, it can even include the many differing 'cultural narratives' that co-exist in the same family—stories which are also gendered, raced, classed, aged, etc. This wide-ranging specificity should not encourage us, however, to duck the responsibilities for being sensitive to the increasingly diverse ethnic needs of Aotearoa New Zealand. Ultimately, it is in the test of ethnic sensitivity that our over-all cultural sensitivity is most seriously tested.

1. In working cross-culturally at psychotherapy, it may often be the case that a new set of ethics applies. For example, at a major conference on the future of professional psychology, Korman (1973: 105) stated: "The provision of professional services to persons of culturally diverse backgrounds by persons not competent in understanding the providing professional services to such group shall be considered unethical... it shall be equally unethical to deny such persons professional services because the present staff is inadequately prepared... it shall be the obligation of all service agencies to employ competent persons or to provide continuing education for the present staff to meet the service needs of the culturally diverse population it serves." See Allen Ivey, Mary Bradford Ivey, and Lynn Simek-Morgan. *Counseling and Psychotherapy: A Multicultural Perspective.* Third edition. Boston: Allyn and Bacon, 1993: 11-12.

Aotearoa New Zealand is officially a bi-cultural nation which honours the values of the Treaty of Waitangi. Unfortunately, for many Pakeha therapists, the values of Maori culture remain largely mysterious, and therefore the impact of culture upon our Maori clients is not always easily recognised in the therapy room. Maori Marsden has summarised the basic values of Maori culture as follows: "We must teach our children that the Treaty of Waitangi is a covenant whose roots are rangatiratanga, tohungatanga, whanaungatanga, manaakitanga, and ukaipo. However, beyond these is the root of the vine, kotahitanga." Student therapist Sam Mansfield (a.k.a. Mihiteria Kingi) has interpreted Marsden's words in a manner that emphasises the communal character of their values. Rangatiratanga is the role of weaving together a band of travellers. Tohungatanga is the art of reading and interpreting signs and symbols, including the symbol system known as whakapapa (loosely, genealogy). Whanaungatanga concerns the sense of belonging to an identifiable group of people, helping one identify a specific past and present, and projecting into the future. Manaakitanga is to enhance the mana of someone else. Ukaipo is the space, place and symbol system that nourishes the individual within community. Kotahitanga is the transcendent sense of unity, both internally in the sense of congruence, and externally in the sense of belonging to each other.[2] As is obvious, these basic Maori values are dependent upon one's staying in close touch with one's extended family and ethnic community in order to find their fullest expression. In this sense, the individualism typical of Eurocentric cultures must be understood as destructive of traditional Maori identity.

Culture, like gender and sexuality, is performed, rather than being a static 'given'.[3] Ethnicity and culture can be difficult issues for displaced populations, including many of those Polynesians living in New Zealand, for 'in exile' the question of how to perform culture becomes fraught with anxiety. Physically separated from the geographic source of their living culture, some Polynesians in their displacement rigidify their culture, fearing that even the smallest change will bring about the destruction of all they have been taught to value. As well, authority in Polynesian culture works 'from the top down', and questioning the advice or instructions which elders have given is considered culturally inappropriate. Sources of wisdom in Polynesian cultures concentrate heavily on tradition, custom, and personal experience, all three of which are generally mediated through the recognised elders of the community or senior

2. Sam Mansfield, Maori Awareness Workshop, in the "Social and Cultural Context of Psychotherapy," Auckland Institute of Technology, Akoranga campus, 29 March 1999.

3. The idea is adapted from Judith Butler's seminal work on sexuality as performance.

members of an extended family, and all three of which tend to discourage critical thinking. Leo Foliaki (1981) points out that too often, advice from the elders is based on societal expectations 'back in the islands' rather than on the reality of life in Aotearoa New Zealand. Community elders often fail, or even refuse, to recognise the difference, thereby creating enormous stress for those who have sought their counsel. As well, Pacific Islanders tend to wait so long to get help with their problems that it is often too late. In the island, an extended family is aware of problems a lot earlier; here people are away from their extended families, and so the social controls relied upon in the islands are not operational or effective here.

Edward Taub-Bynum (1984) identifies three interrelated levels of unconscious functioning, at work in us all, but demanding particular therapist sensitivity when working with non-Pakeha clients. The individual unconscious is similar to that characteristic of most individualistic, Eurocentric approaches to psychodynamic thought. The family unconscious is composed of extremely powerful affective energies from the earliest life of the individual.[4] The cultural (or collective) unconscious is first learned and experienced in the family. The family unit is the culture bearer—and we need to recall that the nature of the family and its functions vary widely among cultures. The interplay between individual and family affective experience is the formative dialectic of culture. It is not really possible to separate individuals, families and culture, their interplay is so powerful and persistent.

Drawing on Taub-Bynum's theories, Ivey, Ivey, and Simek-Morgan (1993) argue that though counselling and psychotherapy have usually been thought of as a two-person relationship, in working with non-Pakeha clients there is reason to conceive of four 'participants' in a counselling session. Figure 3 provides a schematic of this four-factor relationship. The individual or family brings their specific cultural and historical backgrounds that may affect the session powerfully, and the therapist also brings his or her own unique cultural background to the session. As the figure shows, the client and therapist are what one sees and hears communicating in the interview. But neither can escape the cultural and family heritage from which they come. Further, each individual who comes for therapy is likely to be some mixture of cultural frames of reference, for we all live in a (con)fusion of many cultures (e.g., Samoan culture, the Ponsonby coffee culture, the gym culture, the X generation, etc.).

4. See also R. D. Laing, "The Family and the 'Family'," in *The Politics of the Family and Other Essays.* New York: Vintage Good, 1971: 3-19.

It is important that we not expect our clients to construe the individual, the family, or a culture in the same fashion we do. What is pathological in the therapist's frame of reference may be highly functional and normal for the culturally-different client.

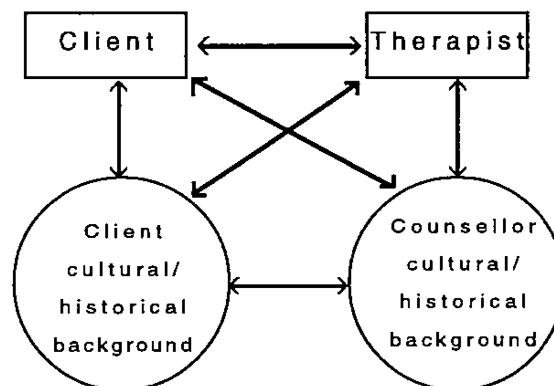

Figure 3 The Influence of Cultural/Historical Background on the Interview

Auckland therapist Cabrini Makasiale suggests that culture be brought directly into the counselling room as a part of the therapeutic process. Maori and Polynesian cultures are full of traditional sayings (whakatauki) which function as metaphors for therapeutic exploration. For example, recently my Masters student Tavita Maliko cited a traditional Samoan parable:

> Samoans believe in curses from parents and village elders, as well as in blessings from the same people. Samoans really believe and treasure these blessings, a value held in a similar magnitude to Isaac's blessings of his sons Jacob and Esau. A son naturally is expected to serve his father. There is a famous legend of a blind old man Fe'epo, and his son Leatiogie. The son was going on a week-long war game (a traditional one, rather like kick-boxing but also using a spear), so before he left he went and dug up seven ufi (a kind of Polynesian sweet potato) and prepared them for his father to eat each of the seven days he would be away. The son left home with his father's blessing and he won all his fights. Upon hearing of his son's victory, the old man just clapped his hands while lying down. From this legend comes the saying *Ua pati ta-oto le Fe'epo,* a saying often quoted on ceremonial occasions to promote the authority of powerful elders and the submissiveness of younger men, especially sons.

Maliko was able to identify nine possible meanings for this parable. Most of the interpretations implied quite negative messages for younger men who are trying to find their own identity in a highly patriarchal and traditionalist society. Here are four of the possible interpretations which Tavita identified, and which would have particular use in the therapy room:

1. The son was unable to succeed on his own, but could succeed only because his father blessed him. This would imply that sons who have not been blessed cannot succeed.
2. The father only blessed the son after the son was obedient enough to bring food which would sustain the father during the son's absence. Reading Tavita's analysis, I was reminded of the manner in which Lord Acton signed a letter to his son, "Adieu, and be assured that I will always love you, as long as you deserve it".
3. The father clapped his hands in joy while his son was still at the battlefront. But by the time the son got home, the father's pride was no longer apparent.
4. The blind father is symbolic of the lack of nurturance and the father's inability to be present physically, emotionally, and spiritually to his son. To prove his masculinity, the son has to go it alone.

The analytical work of Tavita Maliko illustrates one of Cabrini's insights into working with Polynesian clients. Culture must be honoured and respected in the therapy room, yet the packaging of that culture often suggests that cultural expression is malleable. Cabrini illustrates her point via the history of the lei. Traditionally Polynesian leis were made out of flowers, and offered for welcoming and other ceremonial cultures. Polynesians in New Zealand find that they don't have access to flowers year round, and that they are expensive, and so here leis have evolved into strings of lollies. This modification keeps the meaning and values of the traditional custom, but modifies their expression to suit new circumstances. Narrative therapists will immediately recognise this as a form of reframing.

What works for Pakeha clients may not work for Maori and Polynesian clients. For example, the transferential level toward older therapists will be higher for Maori and Polynesians, due to the cultural respect for the wisdom of age, than it might be with Pakeha clients. Maori and Polynesian clients will be quite sensitive to the geography of the counselling room, for in such cultures, seating arrangements are used to signal who in the room is empowered and who is dis-empowered. Some therapists who work with Polynesian clients sit on the

floor together with them. Direct eye contact in these cultures is often considered rude, and the language of body postures needs to be read differently. Maori and Polynesian cultures often value symbolic thinking and poetic expression, as opposed to linear thinking and concrete expression. Many Maori and Polynesian names have an identifiable meaning behind them. It is important to learn to pronounce those names absolutely correctly, and hearing the story behind a client's name may serve as a convenient entry point to the therapy process.

In the initial stages of therapy with Maori and Polynesian clients, and certainly in the joining process, it is not culturally appropriate for the therapist to appear as a blank screen. That sort of anonymity, while ultimately necessary for the management of the unconscious process, is usually offensive to Maori and Polynesian clients. Maori clients may expect to know what river and mountain the therapist claims as his or her own (Ko wai koe? No hea hoe?). Polynesian clients may expect to know who the therapist's father and mother were, and where he or she was born. These are the culturally accepted ways of joining with which Maori and Polynesian clients are familiar, and which they find respectful. In general, they may expect the therapist to meet them where they are first, before calling the client forth into a new and unfamiliar place. This concept will place demands on the therapist to re-think the more traditional positions on therapist self-disclosure.

As well, Sue and Sue (1990) point to two difficulties in the traditional therapeutic orientation toward self-disclosure by the client. One of these is cultural, and the other is sociopolitical. "First, intimate revelations of personal and social problems may not be acceptable, since such difficulties reflect not only on the individual, but also on the whole family... [Secondly], few Blacks initially perceive a White counsellor as a person of goodwill, but rather as an agent of society who may use the information against them. From the Black perspective, uncritical self-disclosure to others is not healthy" (p. 40). Native American therapist J. Good Tracks makes a similar point: Indians may perceive the therapist as "an authority figure representing a coercive institution and an alien dominating and undesirable culture."[5] The therapist can counter this by joining with the client, following the client's directive, and being willing to admit to confusion and misunderstanding (Sutton and Broken Nose, 1996).

5. The reader may be reminded here of Selma Fraiberg's "Ghosts in the Nursery," in that present perceptions are affected by the tragic events of the past. These same "ghosts" can haunt issues of power and authority in the therapy room.

Of course, ultimately culture may also serve as a mask behind which the client may well hide. Some clinicians have argued that culture is 'camouflage'— that is, it is used in families in manipulative or controlling ways as a red herring in order to preserve the status quo, bind children to their parents, keep family boundaries closed, and so on. Others, like Montalvo and Gutierrez (1998) have seen culture or ethnicity as a potential mask that can obscure people's problem-solving modes:

> By using cultural constraints selectively... the family can pull the therapist away from reality. The therapist is made to deal instead with a cultural image of the ethnic group. In the process the family—as simply people having difficulties in solving problems—is lost (p. 21).

These authors have believed that if one is simply a good listener, or, as in the case of various family therapies, able to surface the family structure, rules, and other patterns, what is important about culture will emerge. One needs no special knowledge. Monica McGoldrick, perhaps the most articulate and dedicated spokesperson in the clinical arena for the importance of the cultural dimension in family life, has taken a very different position. She points out that ethnicity patterns our thinking, feeling and behaviour in both obvious and subtle ways, playing a major role in determining what we eat, how we work, how we relate, how we celebrate holidays and ritual, and how we feel about life, death, and illness. Joan Laird (1998: 22) takes a middle road, arguing that whatever our therapeutic models, listening and questioning in and of themselves are not quite good enough, and that special 'knowledges' are helpful as long as we hold them tentatively. For if we do not learn about our own cultural selves and the culture of the other it will be difficult to move beyond our own cultural lenses and biases when we encounter practices that we do not understand or find distasteful; we will not be able to ask the questions that help surface subtle ethnic, gender or sexuality meanings; and we may not see or hear such meanings when they are right there in front of us. Laird thus argues that a therapist's work cross-culturally must hold together just the right balance of knowing and not-knowing.

Knowing and Not Knowing

The client's world is made up of so many different cultures that no single therapist can be expected to be competent in them all. For example, as an American, I cannot comprehend fully the culture of cricket, much less the culture of kilikiti (the Samoan version of cricket). As a male, I cannot comprehend fully the culture of women, much less the culture of feminism or

of sexually abused women. As a Caucasian male, I cannot understand the culture of racial or ethnic oppression and marginalisation. But none of these should keep me from working with those who come from a culture other than my own. Instead, they should caution me to learn more, in order to equip myself to be a more apt therapist to a larger variety of clients.

Sue and Sue (1990: 168–169) suggest four basic policies in working with clients who come from cultures other than the therapist's own:

1. The culturally skilled counsellor must possess specific knowledge and information about the particular group he or she is working with. He or she must be aware of the history, experiences, cultural values, and lifestyle of various racial ethnic groups.
2. The culturally skilled counsellor will have a good understanding of the sociopolitical system's operation in [his or her country of residence] with respect to its treatment of minorities.
3. The culturally skilled counsellor must have a clear and explicit knowledge and understanding of the generic characteristics of counselling and therapy. These encompass language factors, culture-bound values, and class-bound values. In some cases, theories or models may limit the potential of persons from different cultures. Likewise, being able to determine those that may have usefulness to culturally different clients is important.
4. The culturally skilled counsellor is aware of institutional barriers that prevent minorities from using mental health services. Such factors as the location of a mental health agency, the formality or informality of the decor, the language(s) used to advertise the services, the availability of minorities among the different levels, the organisational climate, the hours and days of operation, the offering of the services needed by the community, and so forth, are important.

The same authors (Sue & Sue, 1990: 166–168) add a further five points which describe the therapist's working awareness of his or her own assumptions, values, and biases:

1. The culturally skilled counselling psychologist is one who has moved from being culturally unaware to being aware and sensitive to his or her own cultural heritage and to valuing and respecting difference. It is clear that a counsellor who is culturally unaware is most likely to impose his or her values and standards onto a minority client. As a result, an

unenlightened counsellor may be engaging in an act of cultural oppression.

2. The culturally skilled counsellor is aware of his or her own values and biases, and how they may affect minority clients. Culturally skilled counsellors try not to hold preconceived limitations/notions about their minority clients.
3. Culturally skilled counsellors are comfortable with differences that exist between themselves and their clients in terms of race and beliefs. The culturally skilled counsellor does not profess 'colour blindness' or negate the existence of differences that exist in attitudes and beliefs.
4. The culturally skilled counsellor is sensitive to circumstances (personal biases, stage of ethnic identity, sociopolitical influences, etc.) that may dictate referral of the minority client to a member of his or her own race or culture or to another counsellor, in general.
5. The culturally skilled counsellor acknowledges and is aware of his or her own racist attitudes, beliefs, and feelings. A culturally skilled counsellor does not deny the fact that he or she has directly or indirectly benefited from individual, institutional, and cultural racism and that he or she has been socialised in a racist society. Addressing one's Whiteness as in the models of White identity development is crucial for effective cross-cultural counselling.

Having thought through these various suggestions from Sue and Sue, I would claim that they are just that: suggestions which are worthy of serious consideration. They may be admirable as training goals for all psychotherapists in Aotearoa New Zealand, but most of us are not quite 'there' yet, and in the meantime have a variety of clients who increasingly demand our best cross-cultural skills.

I find myself fascinated and somewhat comforted, therefore, by Joan Laird's (1998) theory of "Informed Not-Knowing". She defines "Informed Not-Knowing" as meaning that "we are never 'expert', 'right', or in full possession of 'the truth'. On the other hand, I believe that only if we become as informed as possible—about ourselves and those whom we perceive as different—will we be able to listen in a way that has the potential for surfacing our own cultural biases and recognizing the cultural narratives of the others" (p. 23). She continues:

> Borrowing from the anthropologists and congruent with the notion of culture as metaphor, several writers in the family field, myself included,

> have argued for assuming the ethnographic metaphor in practice. What this stance most fundamentally is about is figuring out how, when entering the experience of another individual or group of individuals, to be as unfettered as possible with one's own cultural luggage—how to leave at home one's powerful cultural assumptions and to create the conversational spaces wherein the voices of the 'other' can emerge. Anderson and Goolishian (1992) in their effort to deconstruct the ethnographic stance, have argued that it is the client who is the expert; as therapists, we do (or should) enter the experience of the other as "not-knowing." Dyche and Zayas (1995) suggest that 'cultural naivete', and 'respectful curiosity' are as important as knowledge and skill. Knowledge, or what they call 'cultural literacy,' they believe, can obscure our views and privilege our own representations over those of our clients.

With my supervisees I often suggest that in dealing with culturally-different clients, they adopt the sauce of 'cultural tourist', leaving it in the hands of the client to teach the therapist which cultural values and practices are necessary to understand for the therapist to work effectively. Such a stance empowers the client, and goes far to make the therapist 'culturally safe'. At the same time, the therapist must be alert to instances in which the client manipulates the therapist's 'not-knowing' as a form of resistance.

Critical White Theory and Therapist Introspection

Given the overwhelmingly European makeup of the NZAP membership, it would surely behoove us all to pay serious attention to a developing new field of knowledge called 'Critical White Theory'. Of course, self-examination and self-scrutiny have always been part of the professional requirements to be a good therapist, but such introspection has not usually included asking hard questions about how we as therapists are blinded and deafened by our own culture-of-origin.

In teaching issues of cultural awareness and cultural safety at St. John's College, we nominate six areas of identity which need intentional address by almost all Pakeha residents of Aotearoa New Zealand. Just as these are appropriate topics of address for ministry formation, so they are also appropriate topics of address for ongoing formation as professional therapists. The six are:

> **Racism.** This includes our attitudes to the cultural practices of anyone who lives, thinks, or behaves differently than we do, particularly, but not limited to, those with a different skin colour. Robert Jay Green (quoted in McGoldrick, 1998) observes:

Regardless of their other characteristics as individuals, skin color constitutes a fundamental organising characteristic of their lives and tends to structure their interactions with other racial groups in the society. And the same is true for Whites, although it involves racial privilege rather than racial discrimination. White skin color is a fundamental organizing characteristic of persons' lives, contributes to much of Whites' relative economic privilege, and structures much of their interaction with other races, including Whites' lack of interaction with other races (p. 103).

Sexism. The privileging of males over females, the devaluation of femininity or things 'feminine', or more recently, the putting down of males in stereotypical ways (emotionally illiterate, victimisers, resistant and unreachable).[6]

Cultural Imperialism. When Europeans came to Aotearoa New Zealand, they presumed their culture to be superior. Maori were presented with written literature (Bibles, books), 'modern' medicines, and firearms. To this day, many argue that Maori and Polynesians are culturally inferior to Pakeha, granting little or no credence to non-European systems of medicine, beliefs in the inbreaking of the supernatural, oral knowledge and wisdom, and communal values.

Classism. Schofield has noted that therapists tend to prefer clients who exhibit the YAVIS syndrome: young, attractive, verbal, intelligent, and successful. This preference tends to discriminate against people from different minority groups or those from lower socioeconomic classes. This has led Sundberg sarcastically to point out that therapy is not for QUOID people (quiet, ugly, old, indigent, and dissimilar culturally). (Sue & Sue, 1990: 33).

Heterosexism. This is the hallmark of patriarchal societies and cultures, and its effects are pandemic. Heterosexism means that 'normalcy' is defined by the values, assumptions, and behaviour typical to white middle-class heterosexual males. Heterosexism makes no room for the voice of women, non-Europeans, or non-heterosexuals.[7]

Ignorance of Social Justice Issues. The middle-class bias of psychotherapy may make the therapist blind to the social and cultural realities within which Maori and Polynesian clients live. Without a

6. Donna Awatere (1981) argues that unless counselling address the three great 'isms'—sexism, capitalism, and racism—it only maintains the status quo of social inequality.

7. The literature on the effects of heterosexism is expanding. One of the earliest, and still excellent, is Jung and Smith.

> working knowledge of our clients' individual contexts, we cannot intervene with or respond to them in the most effective manner.

By what approach can we best begin to address these issues, as Pakeha psychotherapists, primarily immersed in a Pakeha culture, practising a profession whose origins are exclusively Caucasian, and treating a client base which is also largely Pakeha? Peggy McIntosh spent the first part of her writing career addressing issues of feminist concern within psychotherapy. At some point, it occurred to her that even through all the tension between white men and white women, they had something critical in common: power and privilege. McIntosh (quoted in McGoldrick, 1998) writes:

> I think whites are carefully taught not to recognize white privilege, as males are taught not to recognize male privilege. So I have begun in an untutored way to ask what it is like to have white privilege. I have come to see white privilege as an invisible package of unearned assets which I can count on cashing in each day, but about which I was 'meant' to remain oblivious. White privilege is like an invisible weightless knapsack of special provisions, maps, passports, codebooks, visas, clothes, tools and blank checks. (p 148)

Whites are taught to think of their lives as morally neutral, normative, and average, and also ideal, so that when we work to benefit others, this is seen as work which will allow 'them' to be more like 'us'. It is only by "unpacking the invisible knapsack" that we Pakeha therapists all wear, that we can be appropriately sensitive to what our non-Pakeha clients are telling us. We cannot see the knapsack, but those who don't have one can. (McGoldrick, 1998: 220)

Conclusion

There are many psychotherapeutic issues which this brief article has not explored. To the best of my knowledge so far, little or nothing has been written on the way that transference, projection, and imitation work cross culturally. However, we can be sure that the countertransference of Pakeha therapists will always contain within it White assumptions and values about what is healthy and normal, and what sorts of interventions, treatment plans, and outcomes are appropriate for clients, be they Pakeha or not.

Today there exists a growing body of knowledge and innovative techniques to respond to cultural diversity. McGoldrick, Giordano, and Pearce offer the following guidelines as useful in working cross-culturally, particularly across ethnic lines:

- *Assess the importance of ethnicity to patients and families.* To what extent does the patient identify with an ethnic group and/or religion? Is his or her behaviour pathological or a cultural norm? Is the patient manifesting 'resistance' or is his or her value system different from that of the therapist?
- *Validate and strengthen ethnic identity.* Under great stress an individual's identity can easily become diffuse. It is important that the therapist foster the client's connection to his or her cultural heritage.
- *Be aware of and use the client's support systems.* Often support systems—extended family and friends; fraternal, social and religious groups—are strained or unavailable. Learn to strengthen the client's connections to family and community resources.
- *Serve as a 'culture broker'.* Help the family identify and resolve value conflicts. For example, a person may feel pride about some aspects of his or her ethnic background and shame about others, or there may be an immobilizing 'tug of war' between personal aspirations and family loyalty.
- *Be aware of 'cultural camouflage'.* Clients sometimes use ethnic, racial or religious identity (and stereotypes about it) as a defence against change or pain, or as a justification for half-hearted involvement in therapy.
- *Know that there are advantages and disadvantages in being of the same ethnic group as your client.* There may be a 'natural' rapport from belonging to the same 'tribe' as your client. Yet, you may also unconsciously over-identify with the client and 'collude' with his or her resistance. Unresolved issues about your own ethnicity may be 'mirrored' by client families, exacerbating your own value conflicts.
- *Don't feel you have to 'know everything' about other ethnic groups.* Ethnically-sensitive practice begins with an awareness of how cultural beliefs influence all our interactions. Knowing your own limitations and ignorance and being open-heartedly curious will help set up a context within which you will have a mutual learning with your clients.
- *To avoid polarisation, always try to think in categories that allow for at least three possibilities.* Consider, if you are exploring Black and White differences, how a Latina might view it. Consider, if you are thinking of how African Americans are dealing with male-female relationships, how a Black lesbian might view it.

These introductory observations barely scratch the surface of the complexities

of doing therapy cross-culturally. My hope in writing this piece was simply to challenge us all to look closely at the biases in what we do as psychotherapists, and how our biases actually prevent us from serving well a growing segment of the national population. In the end, the wisest words will have to come from indigenous therapists, as more and more of them enter the ranks. This new pool of therapists will not emerge, however, until we commit ourselves to a two-pronged recruitment approach: doing therapy effectively enough cross-culturally that Maori and Polynesian clients can experience the benefits first-hand and experientially, and then encouraging these same clients to consider training to themselves become therapists. Until this recruitment plan proves itself successful, we who can ever only see 'through a glass darkly' will have to play out our Treaty commitments and our concerns for the health of this whole society by intentionally embarking on the journey toward becoming bicultural. [8]

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8. While not specifically geared toward therapists, James Ritchie's *Becoming Bicultural* (Wellington: Hula Press, 1992) is a useful guide on the journey, as are the works of Michael King, especially his recent *Becoming Pakeha Again.*

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Book Review

Tony Coates

Adam Phillips. (1995). *Terrors and experts.* London and Boston: Faber and Faber. ISBN 0-571-17584-8. Pb

At a time when psychoanalysis and 'analysis' in general is attracting increasing attention within the association, I was intrigued and stimulated by this slim book by British child psychoanalyst Adam Phillips.

The book is about the search for expert knowledge, and the impossibility of the analyst as expert. For Phillips, a psychoanalyst is anyone who uses what were originally Freud's concepts of transference, the unconscious, and dream work, in paid conversations with people about how they want to live, and here he raises issues that are both challenging and engaging for our profession. I found his comments succinct and pertinent.

Phillips begins with a stimulating introduction in which he looks at how human terror drives us into the arms of the 'experts'. Here, in the psychoanalytic interview, the repressed unconscious is the uninvited guest. ["The unconscious", he states, "does not have a professional life, except that is, in psychoanalysis." (p. 24)]. The analyst is the expert on how and why people turn themselves into strangers, and also the expert from whom the patient learns 'inner hospitality'. He continues with a chapter on authorities, in which he discusses the nature of the relationship between Ferenczi and Freud. I found this a little off the point, without the sharpness of the other chapters, and it does not follow the thrust of the rest of the book, but then the past is our analytic obsession.

The rest of the book is filled with intriguing material. The chapter on symptoms begins: "People come to psychoanalysis—or choose someone to have a conversation with—when they find they can no longer keep a secret" (p 33). He continues with a delightful vignette about Tom, aged seven, who has eczema, and he explores what the eczema means, suggesting that one of the aims of analysis is to increase the repertoire of possibilities for exchange. In other words to enable the patient to forget himself, to freely associate. The aim of analysis, he suggests, is not to cure people of their conflicts but to find ways of living them more keenly. The risk of psychoanalytic theories, of psychoanalytic expertise, he says, is that it won't even meet the patient half way.

Phillips outlines how psychoanalysis can show us that fear, far from exclusively being a reflex, a natural reaction, is also constructed through the way we protect ourselves from it. "Fear is a state of mind in which the object of knowledge is the future, but is of course a knowledge that can only be derived from the past" (p 53). The meaning analysts give to dreams is a particular example of this, a meaning that is created in the psychoanalytic context. It is easy, he says, for therapists embroiled in our trainings or larger professional worlds to forget or disregard context. A Freudian slip made in a group of analysts has quite a different significance from a slip made when ordering something on the phone. He reminds us that when patients accept the use of dreams in therapy they have accepted the context in which the dreams are interpreted as well. He questions expert authority on dreams. The dream, he says, can make a mockery of its interpreters.

Whilst he pays tribute to postmodern deconstruction by analysing psychoanalysis itself he remains true to its basic tenets and at the same time re-establishes its territory.

Adam Phillips is both a critic and proponent of his craft, which he likens more to poetry than science. He sees its use as a particular way of interpreting human experience, and implies that psychoanalysis has no more expertise in the field of interpreting human experience than any other model. Yet it does have a viewpoint, one, he says, that the patient accepts in the course of being a patient.

> The psychoanalyst and her so called patient share a project. The psychoanalyst must ask herself not, Am I being a good analyst (am I wild enough, am I orthodox enough, have I said the right thing)? But, what kind of person do I want to be? There are plenty of people who will answer the first question for her. Faced with the second question, there may be terrors, but there are no experts (p xvii).

I found this book to contain an incisive and revealing account of psychoanalysis in the 1990s, largely free from the reified theoretical abstractions which to my mind have cluttered and obscured the field over the past few decades. However, like so many psychoanalytic commentators, he illustrates his points with Freud's all too familiar case histories and peer relationships. Yet another account of Little Hans I could do without. Surely his own work, I thought, would be authority enough. Nonetheless Adam Phillips comes across as a highly original and articulate thinker. The material is dense, stimulating and demands to be further discussed.

Book Review

Jerri Bassi

Anne Ancelin Schützenberger. (1998). *The Ancestor Syndrome: Transgenerational psychotherapy and the hidden links in the family tree.* London: Routledge.

Anne Schützenberger is Professor Emeritus of Psychology at the University of Nice, France, co-founder of the International Association of Group Psychotherapy, and is internationally renowned as a trainer in group psychotherapy and psychodrama. In *The ancestor syndrome*, she has brought together an invaluable legacy: stories of past generations gathered during 40 years of clinical experience in psychoanalysis and psychodrama. In this book Professor Schützenberger weaves together histories of Freud, Moreno, Jung, Rogers and many others, acknowledging an inspiring professional lineage. She links the psychological developments of the century to psychoanalysis, psychotherapy, anthropology, family therapy and history. Special tribute is made to the founder of psychodrama and sociometry, Dr J L. Moreno. Of Moreno she says "he transmitted to me and allowed me to develop the creative imagination, the sense of the encounter, the desire to meet the other and the stubbornness to help those who are suffering".

In her work Professor Schützenberger extends the notion of genogram to the 'genosociogram' which she defines as "an annotated representation of the family tree", and describes how detailing the quality of relationships and family traits and events assist therapy. She emphasises the 'uncanny' elements in history taking and quotes Freud as saying "the uncanny is that class of the frightening which leads back to what is known of the old and long familiar".

The author regards extensive knowledge of family history as assisting in unravelling psychosis in schizophrenic patients. She describes the development of strategic systems therapy, structural family therapy and analytical family therapy with reference to many researchers in family therapy.

Exploring "invisible loyalties" in family systems, Professor Schützenberger refers particularly to the work of the Hungarian psychoanalyst Boszormenyi-Nagy whose focus on relational bonds reconstructs past family ethics and values. She constantly returns to Morenian notions such as the "social atom",

which she describes as "a womb from which an individual builds his or her identity". The original social atom is the family.

With historical references to Napoleon, Schützenberger unearths ideas of "transitional terror" and "the trauma of the wind of the cannonball". She discusses how past traumatic events become transgenerational experiences for those who were close to death and war. She explores transgenerational debts and merits handed down through the generations of families. She writes about "gifts with teeth", obligatory family traits and our common need to receive something with the proviso that we can pay back later.

In the section of the book in which she attempts to make links with somatic manifestations of the mind we would benefit from some clarification of her thinking. Another criticism might be that the author attempts too much linking with other theorists, yet after a while the reader takes the point that the history of psychology is extremely complex.

Cultural stories, myths and historical truth are woven into an insightful and painful picture of a European past. Professor Schützenberger's references to fourteenth century Kosovo shed new light on the experience of war in 1999. We are encouraged to consider J. Hilgard's "anniversary syndrome", and to recall connections between historical periods and events when working with trauma victims, refugees and the transient.

While Professor Schützenberger restates the importance of intrapsychic dynamics she also encourages us to take into account interpersonal loyalties between family and other group members. In detailed genosociograms, patterns of behaviour are recorded that will assist therapy when mapped out carefully.

This work refers to many analytic researchers and includes very interesting case material. References are made to phantoms and ghosts who speak through the generations. With reference to classical one-to-one therapy Professor Schützenberger makes clear her view that not all people are able to make symbolic representations of their past and that some may benefit from a different therapeutic approach such as psychodrama or group analytic psychotherapy.

Anne Schützenberger generously details her method of building a genosociogram with significant clinical examples and guides us in practical applications. Her transgenerational approach to psychotherapy reflects her wide capacity as psychoanalyst, psychodramatist and holder of knowledge.

This book is a tribute to the memories and value of our creative forebears in the evolving fields of psychology. The linking of many important theorists follows the theme of valuing history and its development. These links offer clarity and weight to practical techniques of history taking and assisting those who are suffering.

Contributors

Jerri Bassi is an applicant member of NZAP and a member of the Australia New Zealand Psychodrama Association. In private practice he provides psychotherapy, individual counselling and group therapy. He is also employed as a student counsellor with the Dunedin College of Education. Jerri lives in Dunedin, enjoys the play of nature and loves to tell stories.

Tony Coates is an Auckland psychotherapist. He works in Community Mental Health, in Occupational Heath and in private practice. He is interested in the work of Maturana and Varela (The Biology of Cognition) and its application to psychodynamic and cognitive theory and practice.

Philip Culbertson is a US-born Anglican priest on the faculty of St John's Theological College in Meadowbank, and a lecturer in pastoral counselling in the Theology Department of Auckland University. There he teaches a masters level paper entitled "Spirituality and Counselling". He is also an occasional lecturer in the psychotherapy programme at AIT Akoranga, and on the Continuing Education faculty of the University of Waikato. He is the author of seven books, six of which are on counselling theory, and over 100 scholarly articles. He practises psychotherapy part-time in Ponsonby

Joan Dallaway began her professional life as a teacher, during which time she developed her interest in the study of human behaviours and relationships. She left teaching in 1971 and worked as a Pastoral Assistant for three and a half years. Joan then trained as an Anglican priest and Psychotherapist at the same time, finding the integration of the two disciplines that reflect on the nature of being human a fascinating study. Her passion for integrative psychotherapy has developed from this time.

Joan teaches Psychotherapy at the Auckland institute of Technology and has a private practice of psychotherapy and supervision in South Auckland. Joan became a member of NZAP in 1985 and a member of the Auckland Supervisors' group in 1992.

Seán Manning (BSc(Hons), DipSW, DipGrad, ITAA(PTM), MNZAP) is a psychotherapist in private practice in Dunedin. He has worked as a social worker, therapist, supervisor, lecturer and trainer over a 25-year period in psychiatric hospitals, addiction and employment programmes, social work and counselling agencies, therapeutic communities and tertiary institutions in Ireland, Scotland and Aotearoa New Zealand. Having emigrated to this country from Belfast, Ireland at the age of 30, he maintains contact with his

cultural origins, mostly through music, and has complemented this over his 23 years here by becoming familiar with Maori language and custom, leading to a keen interest in cross-cultural communication and the culturally bound nature of psychotherapy.

Richard O'Neill-Dean trained in Psychoanalytic Psychotherapy on the MMedSc course at the Irish School of Psychotherapy in conjunction with University College Dublin and St. Vincent's Training Hospital. He holds a DipClinPsychTh and is a Member of the Irish Psychoanalytic Association (which is an organisation member of the European Association for Psychotherapy) where he worked before emigrating to New Zealand. MNZAP.

Betty Robb is a psychotherapist in Auckland with an abiding interest in attachment issues and child development, which she teaches about in the Foundation of Psychodynamic Psychotherapy course at AFCPC and uses in conjunction with object relations theory when holding groups for mothers and babies at the Centre.

Carol Worthington, MA, PhD, MNZAP, MNZPsS, is in private practice in Wellington, with a particular interest in obsessional, phobic and borderline personality disorders. She practises an eclectic psychoanalytically-oriented approach in individual psychotherapy and is also a supervisor for the Psychologists' Registration Board.

Guidelines for Contributors

The notes that follow are intended to guide contributors in preparing manuscripts for submission to *Forum*. These guidelines have been chosen to conform with those used by most international journals in the fields of psychology and psychotherapy.

Submission of manuscripts

The editors welcome the submission of papers, commentaries, research notes, letters and book reviews from the association's members and applicants and from others outside the association with an interest in the field of psychotherapy. Contributors are asked to include an abstract (100 words approximately) and a brief biographical note.

The closing date for the submission of manuscripts is **30 April**. Changes following the editing process need to be completed by **1 July**, when both a revised hard copy, and the disk that contains it, should be returned to the coordinating editor.

Preparing manuscripts for publication

Layout: Manuscripts should be double line-spaced throughout on one side of A4 paper, with margins of at least 20mm all round. Preferred font size is 12 point.

Endnotes: These should be typed on a separate sheet following the text, and numbered consecutively throughout the text, with numbers positioned as superscripts.

Tables and drawings should be in black ink or laser-printed, and clearly labelled to indicate their place in the text.

Copyright: Authors alone are responsible for securing, when necessary, permission to use quotations or other illustrations from copyrighted materials.

Acknowledgements: Acknowledgements should be typed on a separate sheet of paper.

Quotations: These must always be acknowledged, and full references - i.e. author, date of publication and page number - provided to identify their

source. For quotations of three lines or less, the quoted passage is enclosed in quotation marks without a change in line spacing e.g.

This client's state of mind might be summed up by Phillips' conclusion that "adulthood . . . is when it begins to occur to you that you may not be leading a charmed life" (1993:82).

Longer quotations should be set out, without quotation marks, as a separate paragraph, with single spacing and indented five spaces from the margin e.g.

> The seduction theory had to do with the effect of manifest environmental evils on people's mental balance; the theories of infantile sexuality and the Oedipus complex were elements in a radical and quite fantastical conception of human nature which says we are ruled (and sometimes unhinged) by events that we only imagined as small children . . . (Malcolm:1984 :77).

Omissions: When part of the passage quoted has been omitted (as in the quotations from Phillips and Malcolm above) this is indicated by . . .

Citations: The source of ideas from the work of other writers should be acknowledged in the text, and all such sources should be included in the list of references e.g.

Malcolm (1984) set out to chart the complex and sometimes explosive responses of Masson and Swales to Freud's archival legacy.

References: A full list of texts referred to, arranged with authors' names in alphabetical order, should be supplied. (A bibliography listing texts not cited in the paper is not required). All references should include the name of author, date of publication, title, place of publication and name of publisher. Their format should be as follows:

A chapter in a book

Flannery, R. B. (1987). From victim to survivor: a stress management approach to the treatment of learned helplessness. In van der Kolk, B. (Ed.) *Psychological Trauma.* Washington: American Psychiatric Press Inc.

A journal article

Hofer, M. A. (1975). Studies on how maternal deprivation produces behavioural changes in young rats. *Psychosom. Med.* 37:245-264.

Books

Malcolm, J. (1984). *In the Freud Archives*. London: Flamingo.

Phillips, A. (1993). *On Kissing, Tickling and Being Bored.* London and Boston: Faber and Faber.

van der Kolk, B. (1987). *Psychological Trauma.* Washington: American Psychiatric Press Inc.

For further guidelines, authors should consult the *Publication Manual of the American Psychological Association* (4th edition,1994).

Manuscript Review

Where appropriate, manuscripts will be sent for peer review to a reviewer with expertise in the relevant subject area.

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