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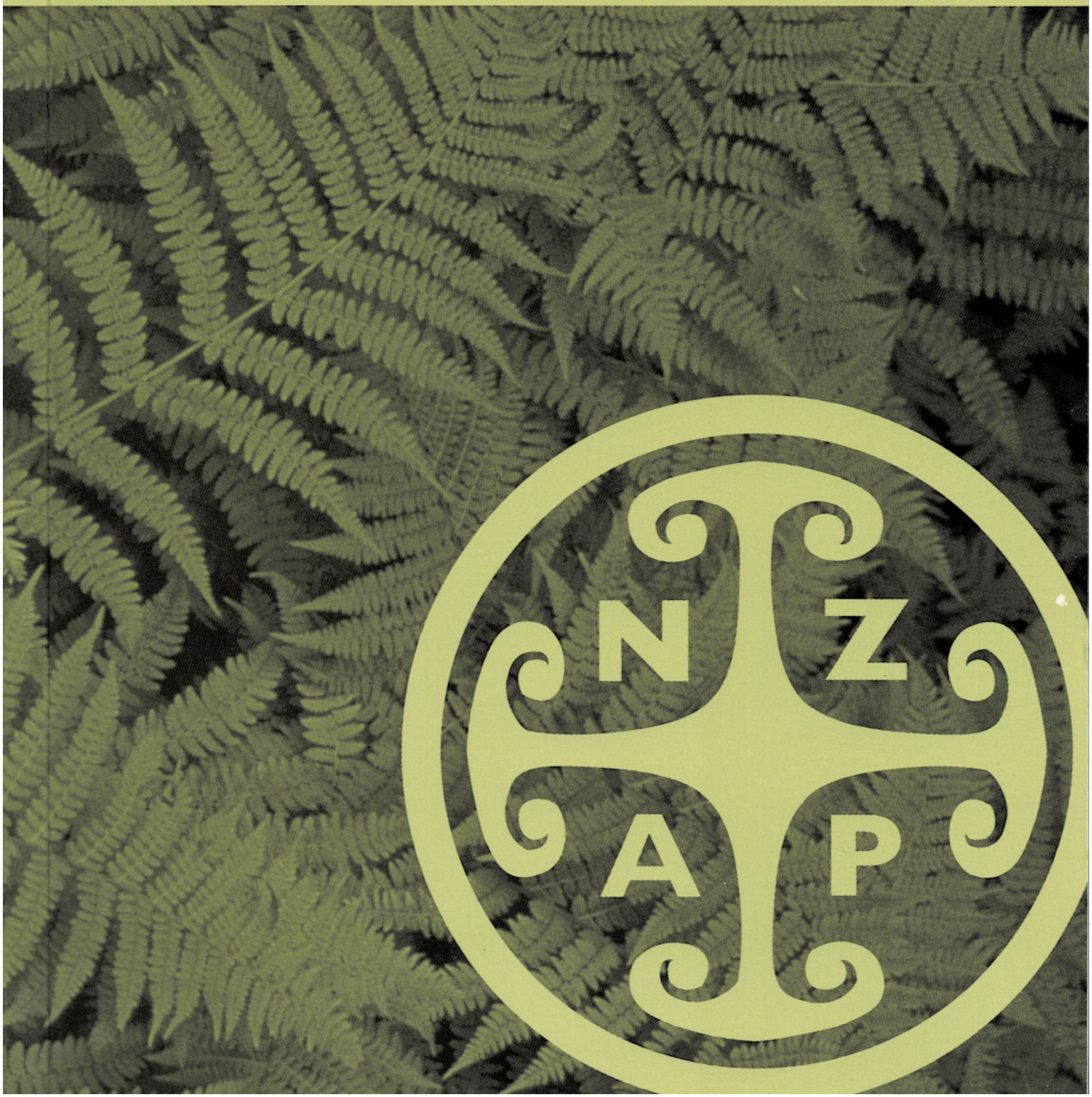

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# Guest editorial: Science and Psychotherapy

## Seán Manning

Five years ago I found myself, more by chance than design, at a conference in London called "The First Neuro-psychoanalytic Congress." I was going to a conference in Halifax, Nova Scotia, and my good friend and colleague, Geraldine Lakeland, who was going to the same conference, found that this event in London fitted perfectly with the schedule. So we went. The name alone is remarkable - it really seemed as if, for the first time in over a hundred years, neurologists and psychoanalysts were having a constructive dialogue. This is of course too extreme a description, but it was certainly a significant event. Chaired by Oliver Sacks, it featured a series of stars on both sides, including Antonio Damasio, whose books (1999; 2003) I immediately began devouring. An analyst gave a presentation, a neurologist replied and there was a discussion. Then it was the other way round - first a neurologist, then an analyst, and another discussion, for three days. I was enthralled, and began a serious round of reading about the brain in relation to psychotherapy.

When I was a child, I remember old people saying the world was going very fast. I thought they just couldn't keep up. Well they were right - it is going fast. In 1985 Daniel Stern's watershed publication, *The Interpersonal World of the Infant*, summarised a body of work that would change the way we saw human development. Previous "ages-and-stages" models needed drastic revision. The Mahler, Pine and Bergman (1975) model of infant development, beloved by therapists and theorists and barely ten years old, was seriously undermined. Infantile autism and the undifferentiated stage both had to go, as the evidence suggested that infants were never normally either undifferentiated or autistic. Bowlby's attachment theory, on the other hand, was vindicated. It appears that we come into this world hard-wired for relationship, and in peremptory fashion we seek it from the first wakeful moment. We act as though we are somebody, and we are aware of the other long before there is anything like a conscious awareness.

In 1999, Daniel Siegel and Allan Schore were both able to publish books setting out in detail what happens in the brain as a consequence of early relationships, and the following year, only fifteen years after Stern's book, we were in London looking at fMRI[1] pictures of what happened in the brain under various

[1] Functional Magnetic Resonance Imaging

conditions. By 2002 Louis Cozolino (2002; 2004) had written *The Neuroscience of Psychotherapy*, telling us in some detail how the brain responds to both trauma and psychotherapy.

This year I have heard Tom Lewis (Lewis, Amini et al., 2000) and Richie Poulton at the NZAP conference in Queenstown, and both Cozolino and Siegel at a seminar in Melbourne. These people - perhaps it is important that they are all men - have in common an interest in what happens in the bodies and brains of people who suffer from psychological distress. They are psychologists, psychotherapists, neurologists, psychiatrists, and they are mostly agreeing with each other, and are mostly confirming the validity of psychotherapy as we know it, with its emphasis on relationship and transference as a therapeutic intervention.

During the twentieth century, my impression is that psychotherapy existed largely on faith. The analytical methods and their successors, the humanistic approaches, the body-focussed methods and the various approaches to the "self", all managed to survive without a lot of evidence for their efficacy. Lots of theory, lots of art perhaps, but little science. Bowlby and Mary Ainsworth changed that to some degree, but on closer examination, experiments replicating the "strange situation" showed attachment patterns in children to be much less stable than was thought (Fonagy 2001) (though adult patterns are actually quite reliable). Truax and others (1967) found evidence for Carl Rogers' general counselling approach in that clinicians with the basic qualities of empathy, positive regard and genuineness tend to get better results, and that was about it. Not much to go on, considering how much psychotherapy was and is practised. In 1966 Paul Halmos published *The Faith of the Counsellors*, arguing that counsellors believed in the power of love. Consumer research consistently showed the relative popularity of counsellors and psychotherapists, albeit with the humanistic disciplines like gestalt and transactional analysis coming out ahead of the analytical methods, especially when compared to medicine. Also I remember a disturbing study or two that showed the less training a therapist had, the better the therapy.

Now the validity of our approach, if not our methods, is being supported by evidence, not from interview or opinion, but from the microscope and the scanner.

We probably need to let go of some things. The unconscious is certainly there, and dreams are indeed a royal road to it, but it is not what we thought it was. The mechanism of implicit memory, the knowledge store for all our automatic behaviour - everything from attachment patterns to occupational preferences to riding a bicycle - takes the place of the unconscious. We can observe it in

ourselves. From an examination of our families and early lives we can understand how it came to be, but we cannot recall learning it. The self, on the other hand, survives very well. If implicit memory is the unconscious aspect, especially in relation to attachment (which also survives), then the episodic variety of explicit, or declarative memory describes the narrative, or script, or schema that defines our repetitive dysfunction and is a reasonable basis for the fragmented self. Its coherent, derivative, autobiographical, declarative memory defines our functional self and our autonomy.

The models for these mechanisms are still relatively crude. As Damasio writes, "There is a functional level of explanation missing between the testosterone molecule and the adolescent behaviour" (2003: 120). We know that certain things happen in the brain and we know what the feeling and the behaviour are like, but we are not so sure how one becomes the other. Feelings turn out, as William James suspected, to be a "perception of the body changed by emotion" (Cited in Damasio, 2003: 112). The areas of the brain that hold information about the state of the body, especially on the right side, provide information to other areas about how the body reacts to the environment (the outer environment, for instance a real time relationship, or the inner, as the memory of a relationship) which somehow becomes a subjectively felt experience, but there are still big gaps in our understanding of the process. The nature and mechanism of consciousness is particularly tricky, and has been the focus of several neurological models (Damasio, 1999; Edelman and Tononi, 2000).

Still, it really seems we are on the verge of the ultimate inner journey - mapping the human brain, and understanding how our subjectivity derives from it. This convergence of theory and evidence from a number of disciplines is generally supportive of what we do, and this poses a new problem. Having survived for a hundred years on theory developed from introspection, clinical experience and intuition with little that could really be called scientific enquiry, psychotherapy has developed an heroically embattled psyche, struggling for credibility against attacks from scientific medicine and behaviourism. The positive qualities of this one-down position include a consistent self-examination, but that is balanced by a tendency to continue to do the same things over and over (though we do not have that quality on our own!) without the need to measure very much. There is pride in martyrdom. We reach out to people, and are secretly smug abut earning less than doctors.

When we designed our conference in Queenstown, several threads came together: love, as an underlying agenda for our work and our lives; science, as a number of us had been reading Thomas Lewis and then the adventurous Sandra Turner

captured him as a principal speaker; and their relationship to psychotherapy. One aim (perhaps this is personal, but I recall it as an agenda of the organisers as a group) was to challenge ourselves by confronting science with the love of the psychotherapists. Can the loving approach survive such a meeting? This unfamiliar validation lends more credibility than we are used to. Credibility is maintained by consistently challenging what we do, and a preparedness to modify it in the light of the outcome. Perhaps the self becomes a narrative fiction, more or less coherent; the therapeutic encounter becomes a face-to-face business, a two-person psychology; the twenty-first century therapist is visible; the unconscious determined by repression morphs into the mechanism of implicit learning. Now we can scan our literature in the light of a scientific examination. Freud's dream is come true, though not exactly as he foresaw.

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# A Glass You Can Drink From

## Thomas Lewis, M.D.

### Abstract

This paper explores a psychobiological model of psychotherapy. An emotion-centered history of the evolution of the brain is followed by a review of the basic psychobiology of emotion, attachment, and memory. Because human beings are social mammals, we regulate each other's physiology and brain development through social contact. This process is likely to be causative not only in the generation of emotional pathology, but also in the therapeutic change that takes place in a successful psychotherapy. As neuroscience elucidates the nature of the brain, insight appears less important to emotional learning than the gradual alteration of intuition through the operation of implicit memory.

The aim of this essay is to review the basis for a secular theory of psychotherapy. By *secular,* I refer to the fact that most existing theories of psychotherapy are indistinguishable, on pragmatic grounds, from religious sects: a charismatic founder lays down axioms, which remain incontrovertible; one or more sacred texts are held to delineate and embody the truth about psychotherapy; and therapeutic mastery within such a framework is held to coincide with the restatement of orthodoxy. You can always spot a psychotherapy paper that emerges from within such a paradigm, because it inevitably begins with a quotation from or a reference to the charismatic founder or the sacred text. This is not one of those papers.

I'd like to see practitioners move away from religious models of psychotherapy, for three reasons. First, such models are unduly limiting. They restrict how we can conceptualise what afflicts patients and what helps them. Second, the proliferation of competing sects, each convinced of the singular truth of its dogma, promotes insularity and false certainty rather than the sharing of knowledge and discovery. And third, religious models of psychotherapy frequently make assertions and predictions that are demonstrably incorrect.

Therapists practise an art that is bounded, as is everything in the natural world, by discoverable but immutable laws. Throughout history, painters have struggled

to learn what they could about the physics of light and colour and perspective, because that is their medium. We therapists must devote ourselves to learning about the neural basis of the self, because that is our medium. Every theory of human nature is, at its heart, a theory about the brain. Consequently, a rational theory of psychotherapy must not run afoul of basic scientific findings about the brain and how it operates. Where neuroscience refutes even our fondest ideas about human nature, we must revise our prior speculation. Within our willingness to do so lies the fundamental difference between science and religion. The former changes (albeit slowly) in response to incoming information; the latter does not.

The notion of an art bounded by scientific limits is not new. Medicine is one such art, and so are physics, and chemistry, and mathematics. Ample room exists in these fields for intuition, discovery, and the gradual acquisition of mastery. Excluded from a scientific domain are dogma, wishful thinking, and a blind insistence on the validity of beliefs that cannot be substantiated, however appealing we may find them. As therapists, we shouldn't feel too bad about relinquishing our hold on this last group. Since we regularly encourage our patients to face reality, no matter how painful and difficult that may be, it's only fair that we ask the same of ourselves and our profession.

If we therapists are to understand how the brain generates the self, we must know a bit about the neuroscience of emotion, relationships, and how the brain learns.

## A brief tour of the evolution of the brain

To understand the emotional parts of the brain, it helps to understand where they came from and why they exist at all.

If we compare our world to the Earth of three hundred million years ago, a number of the same species alive then still thrive: plants and insects, fish, and a host of invertebrate life forms in the ocean. Before three hundred million years ago, no vertebrates existed on land; all of the animals with brains and spinal cords were fish. About that time, some of these fish began to evolve organs that could extract the oxygen from air, and, eventually, they crawled out from the sea. In time, when their transition to a land-dwelling life was more complete, they became the animals that dominated the planet during the Age of the Reptiles.

Reptiles have a particular reproductive strategy: they lay eggs, which are often tough and durable. And then they leave. Reptile progenitors typically perform no parenting duties whatsoever; the young, when hatched, fend for themselves.

The vast majority die before reaching adulthood. No emotional bond between parent and offspring exists: no affiliation, no loyalty, no nurturance, no protection, no monitoring, no feeding, no communication. This method of reproduction, although it strikes us mammals as scandalously neglectful, is nonetheless quite successful, as evidenced by the persistence of the reptilian line today. For two hundred million years, their domination of the land was complete.

A hundred million years ago, the mammals split off from the reptilian line. In school, you may have been taught that mammals differ from reptiles in that they have hair instead of scales, are warm-blooded instead of cold, and give birth instead of lay eggs. From our point of view, the major difference between mammals and reptiles is this: *instead of laying resilient eggs that hatch self-sufficient young, mammals give birth to neurologically immature, largely helpless young, who must be given extensive parental care, or they will die.* Young mammals must be sheltered from extremes of heat and cold. They must be protected from predators. They must be fed. They must be bathed. They must be provided with water. Mammalian young require a number of distinctly different things, and each of the young must be given what it needs when it needs it, or it will die.

Parental mammals must therefore be able to tell what the offspring need, and they must be disposed to provide for those needs – or they will not pass their genes on to the next generation. They must not only care for the young – they must care *about* the young in a way never before seen in evolution. The mammalian way of life thus depends intrinsically upon the existence of emotional traits and behaviours such as loyalty, affiliation, nurturance, and communication between parent and young.

In order for mammals to carry out these behaviours, which reptiles lack, they must have brain structures that reptiles don't. The great French neuroanatomist Paul Broca noted that, above what we would call in humans the brainstem, a mammal's brain demonstrates a great arch of brain tissue not found in reptiles. He called this the *great limbic lobe*, drawing upon the Latin *limn*, meaning *line*, because he felt that this innovation was the fundamental line of division between mammals and lower animals. Inside the *limbic system* we find the neural hardware for just about all of the brain's tasks related to emotion and relationships.

The third and final stage in the evolution of the human brain began several million years ago on the African plains. A few primate species gradually evolved to be smarter and smarter, and as they did evolution witnessed the rise of the neocortex, which in humans is quite massive. The neocortex makes us smart: the ability to use logic and reason, the power to represent ideas symbolically in language

and mathematics, the ability to imagine hypothetical events that have not yet occurred – these are all neocortical innovations. Whatever our shortcomings, human beings possess extremely advanced cognitive hardware. However, the neocortex does not make us any more emotionally skilled than other mammals. Many relatively unintelligent mammals (rats, mice, prairie dogs) are nonetheless fully capable limbic parents, carrying out a variety of complex emotional and relationship-based tasks.

This tripartite evolutionary model of the brain is called the *triune brain* model, devised by neuroscientist and comparative neuroanatomist Paul MacLean. I encourage you to read more about it in his book, *The Triune Brain in Evolution* (1990).

The limbic brain endows mammals with three particular attributes: emotion, attachment, and a particular kind of slow, inefficient learning. It's worth learning a bit about each of them.

## Emotion

The first scientific theory of emotion was proposed by Charles Darwin. Not long after the publication of *On the Origin of Species* (1859) , Darwin wrote *On the Expression of the Emotions in Man and Animals* (1872). That book is still in print, and you can order it from Amazon.com. It's an excellent read.

Darwin's basic thesis was that emotions are a physical attribute of certain organisms, just as beaks and fangs and stingers are physical attributes of certain organisms. He proposed that emotions arose (like any physical attribute) in the course of evolution to serve a specific purpose that advances the reproductive fitness of the animals so equipped. If we studied emotions, he thought, we could discover what particular fitness advantage they confer. Darwin proposed that the eyes widen in fear, for instance, so that a person can take in more of the visual field, which may be advantageous in conditions of danger. He proposed that the mouth opens in surprise to better facilitate the intake of breath, which may be necessary if the surprise should become a reason for flight.

Darwin also proposed that animals that are closely related should display similar emotional expressions, just as related animals (e.g. bats and humans) display close similarities in physical structures like the bony architecture of the hand and wrist. For this reason, he felt that some of the emotional expressions of animals should be similar enough to be recognisable by humans, and vice versa. And, using similar reasoning, he proposed that just as basic human anatomy is identical for

all human beings, basic emotional anatomy must be identical as well. Darwin postulated that the basic conformations of facial expressions would be identical in all human beings, irrespective of culture.

One of Darwin's key ideas is that emotional expressions constitute an *innate and universal language.* To test this hypothesis, researcher Paul Ekman and colleagues journeyed to New Guinea, and they showed the natives (who had never before seen people from another culture) pictures of American emotional expressions, and asked them to match them with a one-line description: the person who has just lost a child, the person who is ready to fight, the person who has just seen a dead pig lying in the road. Ekman found that although they had never seen Americans before, the New Guinea natives had no trouble interpreting American expressions of emotion. We know now that the basic form of emotional expressions is identical, all over the planet. Infants are born with this knowledge encoded in the structure of their nervous systems.

Every normal person possesses, in his or her limbic brain, neural hardware dedicated to the task of analysing the facial expressions, body posture, vocal intonations, and perhaps even the olfactory cues that other mammals produce. This hardware analyses the communicative signals that mammals give off, and it arrives at a conclusion as to the nature of the internal state of the mammals in its environment. This system is quite old and extremely quick.

Just as our visual cortex gives us a rich experience pertaining to electromagnetic radiation in our environment, and our auditory cortex gives an experience derived from changes in air density near our heads, our emotional hardware gives us an experience derived from analysis of signals that other mammals give off: we know what's going on inside them because we can *feel* it, just as we can *see* colours and *hear* music.

The plot thickens a bit when we realize that detecting an emotion is not solely a sensory experience. Detecting an emotion changes the observer's own emotional tone in the direction of the emotion he's observing. For instance, if you show a picture of an angry face to an observer, it's easy to demonstrate that the facial muscles of the observer begin to adopt the conformation of anger: brows knit, lips pursed, and so on. In fact, as more recent brain-imaging data demonstrate, observing someone else *doing* just about anything – moving fingers, picking up a box, exhibiting a sad expression, exhibiting fearful body language – activates the parts of an observer's brain that would be activated if *he himself were doing the thing he is observing.* Mammals, including normal human beings, run an internal modelling programme when they view behaviour. In effect, the mammalian brain

engages in the internal neural simulation of behaviour it observes in others, and the simulation asks this question: "What if *I* were doing that?" This internal modelling of anger is what causes an observer's facial expression to change in the direction of anger when he sees an angry person. In a more general sense, this internal modelling process is the neurobiological basis of empathy. It is how we *know* what another person is feeling – our brains model his behaviour, including his emotional expressions, and so we feel some portion of *his* feeling in our own minds.

## Attachment

Attachment is so intrinsic to the motivation of mammals that it is extremely hard for most people to imagine life without it. Because mammals get so easily attached, we might assume that all animals do, but this is not the case. Take the African tree frog, for instance: if two frogs have spent a good deal of time together, and we remove one of them, the remaining frog will evidence no reaction whatsoever.

In vivid contrast, mammals demonstrate dramatic behavioural and neurophysiologic changes when a relationship bond is severed. As an example, witness the fate of Damini, a 72-year-old elephant. Several years ago, Damini was housed at the Prince of Wales Zoo in Lucknow, India. A pregnant female elephant, Champakali, was housed with her, and the two became close companions. When Champakali died in childbirth, Damini appeared inconsolable. She shed tears, showed no interest in her food and water, and collapsed and died shortly thereafter. *Mammals form complex behavioural bonds with each other, and these bonds have powerful physiologic effects.* This mammalian attribute is dramatically different from anything we see in the reptilian world.

Emotional contact is so necessary for mammals that human infants will die if deprived of it. As a number of deliberate and naturalistic experiments have demonstrated, if human infants are given food, water, and shelter, but are deprived of emotional contact, nearly all of them will die. Why should this be?

The complex neurophysiologic underpinnings of relationship bonds were first studied by Myron Hofer, now director of the Sackler Institute for Developmental Psychobiology at Columbia University. For decades, Hofer studied the nature of the relationship between rat pups and a mother rat. He concluded the mother-pup relationship is a complex web of physiologic regulation, in which an astonishing array of maternal attributes and behaviours regulates the physiology of the rat pups – including cardiovascular parameters like heart rate and blood

pressure, neurophysiologic parameters like levels of neurotransmitters and sleep patterns, metabolic and hormonal parameters like cortisol and growth hormone secretion. If one removes the mother rat, the ordered physiology of the rat pups dissolves into unregulated chaos.

Subsequent research has strongly supported the contention that *relationships regulate physiology* – not only in rats, but in all social mammals. Like the rat pup, when deprived of parental input, a human infant's physiology devolves into chaos, the major difference being that human infants are sufficiently vulnerable that the unregulated state, if allowed to go on for very long, is frequently fatal. Infants are maximally dependent upon relationships for physiologic regulation, but even adult human beings remain embedded in a social web of physiologic regulation, of which they are often minimally aware. We can observe adult relationships regulating physiology in the common phenomenon of *menstrual synchrony*, for instance, wherein the hormonal rhythms in two women who share an emotional bond spontaneously align so that their cycles frequently begin on the same day. We can observe relationships regulating physiology in the many studies that have observed increased morbidity and mortality from a host of diseases in socially isolated people. We can even observe relationships regulating physiology in studies demonstrating that dog ownership has a substantially beneficial effect on blood pressure in those with hypertension, a strongly positive effect on survival in those who have suffered a heart attack, and can vastly reduce seizure frequency in patients with epilepsy.

One important aspect of physiology is brain function, and so if relationships regulate physiology, we should expect to find that *relationships regulate brain function.* And we do. The children of mothers who are depressed exhibit significantly lower levels of neuronal activity in the cerebral cortex, for instance, when compared with children of normal mothers.

In the first few years of life, a child's brain undergoes a tremendous amount of growth and development. At birth, the brain is only about one-quarter of its final size, and in the first 18 months of life, the brain is forming neuronal connections at the rate of 1.8 million per *second.* Because relationships regulate physiology, including brain function, and because the juvenile brain undergoes so much growth and development in childhood, we should expect to find that *relationships regulate brain development in young mammals.* And so we do.

An enormous and fascinating body of research demonstrates that relationships regulate brain development in mammals. Children raised in Romanian orphanages possess measurably smaller brains than normal children, and brain

imaging in the orphanage-raised children reveals large-scale atrophy and neuronal death. Rhesus monkeys raised in social isolation grow to become adults that are highly abnormal, in behaviour as well as in neuroanatomy and neurophysiology. A series of experiments at Emory University in Atlanta has demonstrated that interfering with maternal nurturance by making monkey mothers stressed and slightly neglectful produces permanent brain changes in the *baby* monkeys those mothers are attempting to care for. And an elegant series of experiments by Michael Meaney at McGill University has shown that in rats, altering the kind of parental care young rats get (as by depriving them of the mother rat for 15 minutes a day, for instance) produces long-lasting changes in neuronal gene regulation. This is an experimental result that should really catch our attention: in rats, the juvenile experience of nurturance *turns genes on and off inside the neurons of the baby rat's developing brain* – thereby profoundly altering the long-term behaviour of those neurons, and the brain that houses them.

## Memory

> Canst thou not minister to a mind diseased,
> Pluck from the memory a rooted sorrow,
> Raze out the written troubles of the brain
> And with some sweet oblivious antidote
> Cleanse the stuff'd bosom of that perilous stuff
> Which weighs upon the heart?
>
> *Macbeth*, Act V, Scene 3

Macbeth's plaintive request to his physician has only grown in relevance in the four centuries since Shakespeare wrote these lines. We *do* have some antidotes to emotional dysfunction in our time, in the form of powerful antidepressant and mood-stabilizing medications. Even with these aids, it's *still* not so easy to pluck a rooted sorrow from the memory wherein it dwells, for the very reason that Shakespeare suggests: emotional dysfunction is, in many cases, not a smear on the window of feeling that can be wiped away, but instead it appears to be inextricably intertwined with the same stuff the self is made of. A mind afflicted by certain kinds of emotional dysfunction must, in some sense, be re-written before it can function more normally. Making these revisions is the task of psychotherapy – a task made all the harder by our own ignorance of the mechanisms of memory that underlie the construction of the self. Psychotherapy existed for most of the twentieth century, but an understanding of the workings of memory did not, and that single fact has been responsible for much hardship.

For centuries, people have been aware that human memory is a tricky affair: people often behave as if they have knowledge of which they are unaware; at other times they 'remember' events that never actually happened, and at other times they do not remember other events that clearly did. Devising a model of memory consistent with these phenomena and with the known physiology of the brain proved dead easy at the beginning of the twentieth century, because almost nothing was known about the brain. So extensive was the data vacuum that the early models of memory could include almost any proposition without fear of contradiction. As the century wore on, however, it became increasingly clear that the models of memory forged during that speculative phase, when the brain was a black box, were (and are) fundamentally incompatible with scientific fact.

Our field has inherited a model of memory from those early days of free-wheeling speculation. Let us call that early paradigm *Model A.* Model A goes as follows: information comes in on the mind's bottom floor, through the doors of perception, and from there wafts upward to the level of the *unconscious* (that which we cannot will ourselves to know), and then the *preconscious* (that which we do not currently know, but could, such as the sensation on the bottom of the left foot), and then the *conscious* (that which we know). At any point along this journey, information can be interrupted from progressing upward by the barrier of *repression,* which dictates that things too awful to be aware of must not be known. The difference, in this model, between conscious and unconscious memory is the repression barrier, floating like a glass ceiling between the knowable and the unknowable.

The scientific study of the brain has yielded a radically different model of memory, which we may call *Model B.* Model B posits that the brain possesses two fundamentally different memory mechanisms, each operating continuously and in tandem. The products of one memory mechanism are potentially available to consciousness; the products of the second never are. This model postulates unconscious learning and memory as a normal feature of the mundane operation of the brain. The barrier between what is knowable and not knowable has nothing to do with the emotional impact of the material itself, but instead springs from the brain's basic design, which includes a pair of distinctly different learning mechanisms.

One of these models has a future, and one of them does not. Let us take a closer look at the model - Model B - that has not yet suffered a fatal collision with fact. According to this latter model, two memory mechanisms operate in

tandem – one potentially conscious, one not. The potentially conscious memory is called *explicit* memory, and its shadow is called *implicit*.

## Explicit memory

In the explicit memory system, information comes into the brain, is processed by a circuit involving the hippocampus and the cortex, and some parts of that information may be available for conscious recall later. This is the kind of memory that one utilises to remember a phone number, or to recall the details of a past event: the name of your high school geometry teacher, or the plot of the movie you saw last night. Explicit memory has two properties that concern us here:

1. Explicit memory yields up an account of the past that is extraordinarily inaccurate, unreliable, and changeable, while supplying an utterly false impression of unswervable authenticity to the person doing the remembering.

2. Children are not very good at it.

A huge amount of data has accumulated to indict explicit memory as a wholly unreliable witness of fact. In study after study under controlled conditions, people have demonstrated that, in general, they are remarkably poor at remembering what actually occurred. Instead, their memories slip and stretch like a malleable fabric, including elements that never occurred, excluding ones that did, and incorporating later information, suggestions, and experiences. Explicit memory continues to change slowly over time, like a kaleidoscope that rotates with infinitesimal slowness, presenting a slightly different version of events each time a particular memory is queried. And explicit memory is an extraordinarily gullible recorder – authentic-feeling 'memories' for events that never occurred are remarkably easy to create.

In one study, for instance, investigators met with children once weekly, and asked them this question: "Think real hard, and tell me if this ever happened to you. Can you remember going to the hospital with a mousetrap on your foot?" By the tenth week, 60 per cent of the children reported that they *did* remember this incident, and were more than willing to tell an involved story about it, complete with embellished details, all of them false. In addition, child psychologists and psychiatrists watching these children could not distinguish a child recounting a fabricated memory, from one describing an event that actually occurred. And a substantial fraction of the children in the study could not subsequently be convinced that the mousetrap incident had never happened.

In another study, investigators interviewed a number of 14-year-old boys, and asked them questions about their emotional lives, such as, "What is your mother's best trait?" and "What is the nicest thing about your home life?" When they were 44 years old, the same individuals were asked to recall their earlier lives, and were asked the same questions: "When you were fourteen, what was your mother's best trait?" And so forth. Remarkably enough, the correlation between the attitudes recounted at age fourteen and recalled at age 44 was *no better than chance.* When we ask our patients about what their lives were like as children, how they felt and what they thought, we should keep in mind that we may well be retrieving information that has little or no factual relationship to what actually happened in their pasts. Asking these kinds of questions may tell us something about what is going on in the patient's mind *now*, but it does not necessarily tell us *anything* about what was going on in the patient's mind *then.*

Why is explicit memory so unreliable? The answer is relatively simple, although most people find it difficult to convince themselves that their own minds function according to this principle. If we show an apple to a person, and then later ask him to recall it while we scan his brain, we'll find that the same brain areas light up when we ask someone simply to *imagine* an apple without having seen it. A sensory experience and imagining that sensory experience are extremely similar in the brain, and *the brain does not do a good job of keeping track of the distinction between what it imagined and what it experienced.*

If we invite someone to imagine something, we should expect that a fair amount of the time, the person will come to have a memory of the imagined scenario, a memory that will be indistinguishable (to that person, at least) from a memory of an actual experience. Repeated studies have demonstrated this to be so. In one study, subjects attended a séance supervised by a medium, who was actually a professional magician. During the séance, he told the participants to levitate the table with their minds, and said: "That's good. Lift the table up. That's good. Keep concentrating. Keep the table in the air." When questioned two weeks later, 345 of the participants recalled having actually *seen* the table levitate, although it had done no such thing. In another study, 44 per cent of British television viewers claimed to have seen the footage of Princess Diana's fatal accident in which her chauffeur-driven sedan crashed into a pylon in Paris. No such footage exists, but the viewers had imagined the scenario many times in the course of hearing the event described, and eventually, these imaginings became filed in the brain under the heading 'Memory'.

In therapy, when we ask patients who have normal-feeling memories about their childhood to relate them, it's highly doubtful that we get information that is

wholly accurate about what the past was like. If a patient doesn't remember what happened in the first place, the overwhelming likelihood is that he will never know what happened. If we invite patients to fill in the blanks by imagining one scenario or another, we can easily instil in them a memory that feels genuine and real, and we can imbue it with just about any content we choose. In the 1980s and 1990s (in the United States at least), a good many therapists did just that, and the results were appalling. We can learn the lesson of those years, so we do not have to repeat it. As voiced by Brandon et al. in *TheBritish Journal of Psychiatry* in 1998: "We concluded that when memories are 'recovered' after long periods of amnesia, particularly when extraordinary means were used to secure the recovery of memory, there is a high probability that the memories are false."

The fallibility of explicit memory poses a grave but not insuperable problem for practitioners of psychotherapy. We would like to know what a patient has learned about relationships, because many of our patients have been exposed to emotional adversity and have learned specific and highly disadvantageous lessons from their experience. But if we cannot ask them about their emotional pasts and get anything like a reliable answer, where can we turn for access to this information?

## Implicit memory

The study of individuals who lost their capacity for explicit memory has revealed that they can still learn, in interesting and specific ways. While they cannot recall new facts or new events, they can acquire skills and habits – new motor skills like knitting, and new habits of thought like expectation. The brain has two separate and independent memory systems, one for facts and events (the *explicit* memory system) and one for skills and habits (the *implicit* system.) The first is potentially accessible by the conscious mind, and the second is not.

The *implicit memory system* scans the world for recurring regularities and patterns, and it does this without informing the conscious mind about the content of the patterns it finds. Once implicit memory has detected an underlying pattern within a series of experiences, that pattern then serves as the basis for shortcuts in perception, expectation and action.

Consider language acquisition, for instance. In school, children learn the meanings of certain words in an *explicit* fashion, through effortful memorisation of vocabulary lists. But they learn *how to understand* speech and *how to speak* implicitly, and they learn these skills at a much younger age. No child has to

be taught anything about how to understand or use speech; they have only to be exposed to many instances of speech, and the brain automatically acquires knowledge about the underlying grammatical, syntactical, and phonological rules that lie at the heart of any language. The process happens without any effort on the part of the learner. If a normal child hears (or sees) language, his brain gradually extracts the underlying patterns, and he becomes able to comprehend and produce speech without any effort at all.

Implicit knowledge of those underlying rules informs perception, expectation and action. A child does not have to learn the singular and the plural forms of every noun in the English language, for instance – instead, he learns one underlying *rule*, which serves as a shortcut. In this particular case, the rule can be stated thus: *singular + s = plural.* One cat, two cats. One dog, two dogs. The rule itself is neat, compact and efficient. A few exceptions fall outside the rule (one radius, two radii), and the exceptions can be acquired manually. Children acquire knowledge of what we might call *the plural rule* at a very young age. If we show a four year old a picture of an imaginary creature (for which English lacks a word) and we call it a *blan*, and we then we ask him to describe what he see when we show him a picture of two such creatures, we will obtain a reliable answer: "*Two blans*". This answer cannot occur on the basis of direct experience, because the child cannot have heard the word "blan" before our experiment. He has no *actual* basis upon which to predict the plural form of this word. Implicit knowledge of the appropriate *rule*, however, guides his expectation and his action, and his reply will be unhesitating.

If we ask a child to explicitly *enunciate* the plural rule he is using, (even if his skill level shows us that he has learned it very well), he will be unable to do so. Because the knowledge is implicit, a child can act on the basis of what he knows about the world's regularities and underlying patterns, but he cannot describe the basis for that action. Knowledge of implicit rules guides behaviour, but it does so without informing conscious awareness or comprehension.

A number of studies convincingly demonstrate that if a series of experiences possess an inherent underlying structure or patterning, then the human brain will gradually extract knowledge of those underlying regularities, regardless of the nature of the experiences or the underlying pattern. While they cannot describe implicit knowledge, and typically have no conscious awareness of it, people can act on it. When human beings act on the basis of knowledge acquired through extensive experience with a particular situation but cannot articulate the reason for acting in the way they do, we often say they are *using their intuition.* The

study of implicit memory has uncovered the fact that the acquisition of intuitive knowledge is every bit as legitimate a brain function as vision or hearing. We all possess neural hardware dedicated to the task of forming intuition on the basis of repeated exposure to the world.

Children grow up in a world of relationships. Those relationships have order and regularity to them, just as a language does. The underlying rules regarding relationships vary considerably more from family to family than those regarding language. *If your mother has that tone in her voice, you're going to get slapped. When you tell your father you have done well at something, he gets angry.* And so on. Children acquire implicit knowledge of the rules that underlie relationships in the world they live in – their family. This knowledge, like all implicit knowledge, is acquired automatically, and it gives them a highly specific kind of intuition. It shapes their perception, their expectations, and their actions. Just like a child who says "Two *blans*", a person who has been exposed to a particular relationship environment will, as he lives his daily life, *act* on the basis of rules about which he has no conscious knowledge.

The fact that this kind of unconscious knowledge strongly shapes human behaviour has been recognised for longer than we might suppose. Consider these words, from a prescient observer of human nature:

> The more thoroughly . . . we examine into what may be termed the Mechanism of Thought, the more clear does it become that not only an automatic, but an unconscious action enters largely into all its processes . . . And that these thought patterns can lead to unconscious prejudices which we thus form, [that] are often stronger than the conscious; and they are the more dangerous, because we cannot knowingly guard against them.

The psychologist William Carpenter wrote these lines in 1874.

## Emotional pathology

Psychotherapy is the enterprise wherein one person endeavours to change another for the better. Patients come with emotional dysfunction, and they want to get better. What is the nature of the problem from which they suffer?

In the broadest terms possible, emotional dysfunction is the end result of a particular history of genetic vulnerability and environmental influence, operating in tandem. In some patients, genetic vulnerability predominates. Certain people

inherit a particular set of genes that makes them vulnerable to bipolar disorder, for instance, or depression. In other patients, pathology is primarily the result of experience: they enter the world with the genetic potential to build a normal emotional brain and to have a normal emotional life, but adversity alters the brain in a way that interferes with normality. Perhaps most commonly, genetic vulnerability and life events conspire to impede the construction of a healthy emotional architecture.

Two broad categories of emotional dysfunction exist: we might call them *nonspecific pathology* and *specific pathology.*

Unlucky genetic inheritance, or environment, or both can produce *nonspecific* pathology: an enhanced vulnerability to generic illness states such as depression, anxiety, mood instability, impulsivity, even criminality. Because the development of the juvenile mammalian brain occurs within an environment of social and emotional regulation, and because this regulatory process is a key determinant of the health of the brain that results, *inadequate nurturance alone can and does result in pathology of the nonspecific variety.* Rats, monkeys, and humans all demonstrate significantly increased vulnerability to depression and anxiety if they receive substandard nurturance during their youth. If they are subsequently stressed, many more of the inadequately nurtured group will develop anxious and/or depressive pathology.

*Specific* emotional pathology arises from a different mechanism. Because implicit learning mechanisms are operative in the human brain from before birth, infants and young children *extract implicit knowledge of how relationships work* based on their exposure to them. Because implicit knowledge operates without the intervention of the brain systems involved in consciousness, people extract knowledge of the implicit principles that underlie emotional life in their early environment, but they are not aware of having done so and have no conscious access to the implicit information acquired. In other words, as a normal feature of how the brain works, *people behave in relationships in accordance with implicit principles of which they are not aware.* This implicitly acquired pattern affects not only how they behave, but also what they can perceive and what they are capable of expecting.

Exposure to a specific family environment, and the subsequent encoding of implicit knowledge of the regularities within that environment, traps people within the world of the known. They are best able to see what they have already seen most. Their brains distort incoming information such that on an experiential level, the world does not appear ambiguous and full of new information, but

instead appears to conform to the patterns and fall into the categories they already know. Human beings do not experience direct reality; instead, we experience an internal model of reality that our brain constructs on the fly. This internal model is based *in some fashion* upon actual sensory information coming from reality, but that sensory information is inevitably distorted by a number of factors, including implicit knowledge already encoded in our neuronal networks.

Patients who suffer from *specific pathology* behave as if they have learned idiosyncratic and particular lessons about emotional life that have now trapped them within a very particular, inescapable, and self-confirming reality. One patient may act as if every potential relationship partner wants to stifle him and overrun his autonomy, and in every relationship he has, his expectation materialises. Another patient behaves as if pathological liars are the most attractive relationship partners imaginable. The variety of potential patterns within the domain of *specific pathology* is almost infinite. Just about every patient with *specific pathology* has a different story. That makes ours an interesting job.

Because implicit knowledge is not directly accessible to the brain modules responsible for verbalisation or consciousness, most patients do not *know* that they are trapped in an idiosyncratic world or, indeed, that they have learned anything at all. In order to correctly divine the nature of the world that any single patient lives in, we have to study what he *does* more often than what he *says*.

## Secular psychotherapy

Using the preceding information from neuroscience, we can set out some general secular principles for the operation of psychotherapy.

1. People are emotional animals. Both therapist and patient will broadcast emotional signals, both will read the emotional signals emitted by the other, and the emotionality of each will be slightly altered in the direction of the other. This will take place whether the participants will it to or not, so we might as well take advantage of the process and use it to help the patient.

If I'm attentive, I should be able to get an emotional 'read' on the patient. To the extent that he is attentive and healthy, my patient should be able to get an emotional read on me. He may suffer from pathology that interferes with his ability to do this in a variety of ways, but if he were perfectly healthy, he would be able to read me as accurately as anybody else. I conclude from this that any attempt on my part to make myself difficult to read is, at best, pointless. The

patient is likely to have *enough* trouble reading people correctly without my contributing to his problem by being deliberately obscure. So I make no effort to be obscure.

2. People are social mammals, and so they get attached. Patients get attached to therapists, which may well be helpful to them, both in the domain of *nonspecific* and *specific* pathology.

Several factors help pathology of the *nonspecific* variety. The countermeasures for nonspecific pathology are, unsurprisingly, activities or agents that generally promote neurophysiologic health. Certain medications can reduce vulnerability to anxiety, depression, and emotional instability. Environmental factors like exposure to bright light, regular exercise, or the regular practice of focused relaxation (as in meditation) can reduce these vulnerabilities as well. Perhaps most importantly, because human beings are social mammals, and social mammals rely on social regulation for neurophysiologic stability, *limbic regulation decreases vulnerability to nonspecific pathology.* For this reason, marriage, family, community and other close social affiliations have repeatedly been shown to reduce anxiety and depression, as well as a host of physical illnesses. Pet ownership is similarly helpful.

One aspect of the helpfulness of the therapist derives from the power of social regulation to inhibit pathological vulnerability to depression and anxiety. A therapist, in other words, can serve as a regulator of his patient's neurophysiology. A good therapist, like a good dog, is predictably present, reasonably warm and friendly, and is generally disposed to be nice to the patient. In comparing therapists to dogs I do not derogate therapists; I have a high opinion of dogs and their usefulness. *Companionship makes people feel better.* There is no reason that some portion of the helpfulness intrinsic to a therapeutic relationship cannot or should not come from the regulating aspect of companionship. As long as groundless dogma does not intrude, it's relatively easy to structure the helping environment so that it is friendly to the general requirements of attachment.

Attachment is aided by regular time spent together. This most therapies provide. Attachment is also marked by proximity-seeking when a dependent member is frightened or in pain. Some therapies permit this, and some do not. Attachment is also marked by the strong desire on the part of a dependent member to know the whereabouts of the other while they are separated. Even when the knowledge has little operational value in terms of reestablishing contact, people feel better when they know where their attachment figures are. Some therapies accommodate this, and some do not. I once gave a talk on the psychobiology

of psychotherapy at Lake Tahoe, in northern California, about four hours away from the San Francisco Bay area where I live. I had to miss a couple of days of work to make the trip. After I gave the talk, a psychiatrist came up to me. "Did any of your patients ask you where you were going this week?" she asked. "Yes," I said. "What did you tell them?" she asked. "I told them I was going to Lake Tahoe to give a talk at a conference," I said. This answer surprised her. Her surprise, in turn, surprises me still.

3. People have an unreliable explicit memory system that's available to consciousness, and they have a reliable implicit memory system that is not.

Many of us have been taught in our psychotherapy training that insight changes behaviour patterns, but that hypothesis is astonishingly devoid of empirical support, and considerable evidence suggests it is untrue. Third grade children asked to solve a series of addition problems in the form of **X + Y – Y = ?** (e.g. **17 + 25 – 25 = ?**) show an initial solution time of more than 30 seconds, because they carry out each mathematical operation in sequence. After some experience with this particular problem type, children gradually develop implicit knowledge of the underlying rule (**X + Y – Y = X**) and their solution time abruptly drops to less than 10 seconds. At this point, however, although the child is *acting* on the basis of implicit knowledge (solution time < 10 seconds), he has no *conscious* awareness of it, and if queried will deny having figured out the 'trick' to solving the problems quickly. After several more trials, children typically become consciously aware of their discovery and announce it, although they remain unaware that they demonstrated acquisition of the pertinent rule *before* they had insight into the nature of the problem.

Experience changes implicit knowledge, not insight. Literally hundreds of experimental psychology studies support this assertion, and, as therapists, we ignore such finding at our patients' peril. As a therapist I must confess myself largely uninterested in whether my patients develop insight or not, because I think it irrelevant to their ultimate chance of escaping the confines of their specific pathology. What concerns me is that a patient learns to perceive reality in a way that conforms more closely to the way the world actually is, that he learns to expect from reality what reality generally delivers, and, most importantly, that he finds a way to *take action outside of the unreal paradigm he already knows very well.* "What we must learn to do, we learn by doing," wrote Aristotle. Presumably he did not have therapy in mind, but he might as well have.

The likelihood that therapy proceeds by the gradual acquisition of implicit knowledge, and not the sudden delivery of insight, is strongly suggested anyway by the fact that therapy takes considerable time. Insight learning takes virtually no time at all – if I need to learn a fact that I don't know, your insight can supply me with that piece of information almost instantly. Then I, too, would know it. If I need to learn a skill I don't possess, then that will take time – particularly if I already have pre-existing habits that must be unlearned if they are not to interfere with the acquisition of my new skill. Explicit learning is rapid; implicit learning is slow. "We can be knowledgeable with other men's knowledge, but we cannot be wise with other men's wisdom", wrote Renaissance scholar Michele de Montaigne, highlighting a distinction between explicit and implicit learning that was recognised centuries before our field began.

For some patients, the delivery of insight can serve as a reason to act in a way that their (flawed) intuition tells them is wrong. I concede that insight can be useful in this way, as a tool of persuasion, a means of convincing the patient that the world is other than the way he sees it. But what a pale instrument of persuasion insight is! One good look around the world is enough to tell anyone that much. What in the world motivates patients to act against their own intuition, then, if it is not the cool certainty of reason? Most of the time it's faith, pure and simple – the faith that the patient has in the therapist. A patient finds the courage to move in a direction that is counterintuitive to him because his faith in the therapist's guidance is greater than his faith in himself and his own intuition. Another word that describes this behaviour is *trust.*

I taught a class last year for Buddhists priests at the San Francisco Zen Center, who wished to better understand the process of mentoring and teaching in a one-on-one setting. Many thought that the process they engaged in with their students had little in common with psychotherapy, which they saw as a complex exercise in providing insight to people about their emotional problems. I myself was more convinced that our work and theirs was more fundamentally similar than they supposed. For weeks I struggled to convey what I thought therapy was, and how little intellectual complexity I think is at the heart of it. Finally, I explained it in this way:

"Look," I said, holding up a glass of water and placing it on the table. "The patient wants a drink of water. My job is to get him a drink. Every time he reaches out for the glass where he sees it, his hand closes on nothing, because the glass is *not where he sees it.* I say to the patient, 'The glass isn't over there where you are reaching. Instead, it's over here.' The patient says, 'But I can see the glass right there. I know it's there.' I say, 'Yes, I know you *see* the glass over

there, but that's an illusion, a trick of the mind, a habit of perception. Maybe the water *used* to be over there. Your mind has learned a shortcut that misleads you as to the nature of *this* table before us and what's on it. You keep reaching *there*, and you keep winding up with nothing. Reach *here* instead. You'll get some water.' 'But there's nothing over there,' says the patient. 'Nothing at all.' 'I know it *looks* that way,' I say, 'but it really *isn't* that way. Try reaching over here, where the glass *really* is – what have you got to lose?' And eventually, the patient acts against his intuition, and in the direction of mine. He reaches over where his eyes tell him there's nothing. His fingers close around a glass he cannot see, and at first he can't understand how that's even possible. If he stays with it, and if I'm pointing him in the right direction, he's got hold of a glass he can drink from. And then my job is done. That's all there is to it."

More goes into this process, of course, than the this metaphor portrays. A story is told about the painter James Whistler, in which a man once asked Whistler how long it took him to paint one of his masterpieces. "About two hours," Whistler said. "That doesn't seem like much," said the fellow, unimpressed. "Yes, but it took me forty years to learn how to do it in two hours," Whistler replied.

Similarly obscure layers of skill reside in the expert therapist, who, above all, must be *right*: he must be *right* about how he reads the patient emotionally; *right* about where and how the patient is reaching where there is nothing, and *right* about the direction in which to encourage the patient to reach. It takes most of us a long time to learn to be that right. In the pursuit of such exactitude, a therapist is free to make (as indeed most of us make) a good many errors and missteps along the way, but he must be willing to learn enough from them to serve as a useful guide to anyone. He must be content to be a student of each patient until at long last, he learns enough to become a teacher.

"Science," wrote physicist and Nobel laureate Richard Feynman, "is a long history of learning how not to fool ourselves". As a profession, and as individual practitioners, we need as much help in that department as we can get. And so I finish, more or less as I began, by exhorting us all to immerse ourselves to the greatest extent possible in the process of *learning*: studying neuroscience for what it can teach us about human nature and the brain that creates it; studying the lives and stories of our individual patients, each of whom teaches us about his or her very particular nature. We cannot be maximally helpful if we do not do both. And since the study of human nature is very young, we can be confident that much more waits to be discovered than we have learned so far, if we have but the wit and the patience to keep an eye out for the undiscovered.

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# Relaxing about Cultural Difference: Trusting our Treaty Partners

## Pat Snedden

### Abstract

The theme of this paper is 'relaxing about cultural difference, trusting our treaty partners'. It will try to capture an orientation to the exercise of trust in our cross-cultural treaty relations that might dovetail with reflections on the 2005 conference's theme of 'Love, Science and Psychotherapy'. The paper will suggest that we need a 'big leap forward' in our Maori/Pakeha relations. That leap requires a vital ingredient, trust, which can only come into being on the basis of an understanding of the context, past and present, of our cross-cultural relations.

Let me start with a story.

There is a news report in the *New Zealand Herald* (incorporating *Southern Cross*) of March 1933 of a hui celebrating 92 years since the 1841 landing of Governor Hobson at Okahu Bay. He had been greeted and provided with land by Ngati Whatua on his journey to establish this nation's capital in Auckland. At that 1933 hui were two elderly kaumatua in their 90s, both of whom had been present at the original occasion with Hobson. Also present was a young boy, just six years old, whose birth name was Ian Hugh Paora. At the age of two, exercising their ancient prerogative, his elders had renamed him as Ian Hugh Kawharu after Paora Kawharu, his great grandfather and a 19th century Ngati Whatua chief. Today he chairs the Ngati Whatua o Orakei Maori Trust Board.

This little vignette captures a microcosm of our nation's joint history. So fresh is the writing on the Treaty that there are some alive today who directly knew people who were present (even as young children) circa 1841. And there are customs practised today, such as naming children after ancestors, which date from well before the Treaty. So when some of us talk of the Treaty as 'that was then and this is now', it is worth reflecting on what we are saying. The 'then' and the 'now' are inextricably joined.

The relative immediacy of the Treaty-signing is our great national advantage. In many countries, 160 years is a blip on the radar. Having something of a long view about this will be helpful. Because after 30 years of Tribunal hearings it is now indisputable that the protection of te tino rangatiratanga (chiefly authority exercising trusteeship) as guaranteed under Article 2 has, in historical terms, been adjudged seriously flawed. The evidence abounds. The jury is no longer out.

## Need we fear rangatiratanga?

To understand something of the difference in view than can exist between Maori and Pakeha we need to talk about rangatiratanga. This is a subject that often makes many New Zealanders uncomfortable, even irritable. It need not be so. My view is that if more of us had a reasonably simple Treaty based understanding of the protection of rangatiratanga it would free us up to imagine how we might achieve better social and economic outcomes for all New Zealanders, not just Maori.

So let me explain the relevance of te tino rangatiratanga in the context of our founding document, Te Tiriti o Waitangi/The Treaty of Waitangi. The Treaty has a preamble and three articles. Articles 1 (one law for all) and 3 (common rights of citizenship) are now intuitively understood by all New Zealanders.

It is Article 2 that so vexes both Pakeha and Maori. It was the classic Treaty trade-off article. Maori hapu and iwi rangatira (chiefs) who signed the Treaty did so acknowledging a new legal framework (Article 1) and endorsing the citizenship rights of new migrants (Article 3). But they did so only because they were guaranteed protection of their te tino rangatiratanga (chiefly authority to exercise their trusteeship over their taonga, sacred treasures, meaning resources both material and non-material, both human and non-human). The key word is protection and what was guaranteed protection are the rights of the collective, not individual rights.

Herein lies a central dilemma for Pakeha, indeed all tauiwi.

If those opposed to the Treaty deny the obligation to protect rangatiratanga, we must ask the question; how did we manage to get here? For it was precisely by exercise of this collective rangatiratanga (on behalf of their tribal groups) that the chiefs consented to being a party to the Treaty with the British sovereign. Without explicit recognition of this rangatiratanga in return for a single legal structure (Parliament) and citizenship in common a Treaty could not have been agreed in the way that occurred.

As tauiwi we have an obligation to protect rangatiratanga (Article 2), because it explicitly provided us with the corresponding right of citizenship (Article 3) of this country. Clearly a subsequent denial of this legitimacy is not what any of us want.

Now it is evidentially clear that Maori collective rights under Article 2 protecting the exercise of their rangatiratanga have for over a century prior to 1975 been largely ignored by the Crown, or dealt with remotely, through the Courts. Their presence has not therefore resided in the hearts and minds of our received Pakeha historical consciousness with anywhere the same force as they reside for Maori.

So therefore as a nation, when like last year, we came to pass judgement on the nuances of an issue like the foreshore and seabed debate the Pakeha mind went to the rights, privileges and obligations of individuals and assumed this included Maori as well. Conversely the Maori mind went to the rights, privileges and obligations of collectives, and for Pakeha this counted as an extra, a benefit not available to themselves, a second bite of the cherry.

Perhaps it is not surprising therefore, that Pakeha started to feel that Maori were getting one over them. But are Maori to blame for this sense of imbalance?

When we recognise the evidential truth about the denial of collective rights we become alert to a question that is central to our future national identity. It's a question, some would say, of profound moral dimensions.

Let me put it like this. Having settled claims for past injustices, how and why should we recognise Maori collective rights (and obligations) into the future? In particular, how do we recognise that Maori may see the world in crucial ways that are different from Pakeha and other tauiwi and how might we relax sufficiently to integrate this 'other view' into our national view of ourselves?

We need to be clear-headed about this.

If Maori have been systematically disenfranchised of their Article 2 rights (and therefore unable to fulfil their obligations) then the benefits of that dispossession have, by definition, gone to those who are not Maori. Clearly nobody alive today (either tangata whenua or tauiwi) can be blamed for allowing such historical dispossession to occur, or be held responsible for making good the loss. That is why we have invented the Waitangi Tribunal. It is our way of ensuring that the State bears the responsibility on behalf of us all for both acknowledging and remedying the wrong done. By international terms, this is an unprecedented solution of genius proportions, but it meets only half the challenge.

The other aspect of the moral challenge is precisely to resist the 'that was then and this is now' scenario. Why should we need to do this? Not simply because it is an insular and barren response to creating an informed and inclusive nationhood, but because it won't work. The clear truth is that on the Maori side of our population, the renaissance is underway. Maori are making gains as individual citizens in every aspect of public life and the rate of improvement is accelerating.

## Celebrating manawhenua

Just as crucially, gains in collective or tribal identity are also being established. Herein lies a key understanding for Pakeha and the Crown in this process. This is all about the recovery and affirmation of manawhenua (tribal authority within a region).

When Ngai Tahu began its Treaty negotiations in the mid-1980s, they claimed 6000 identified beneficiaries linked by known whakapapa (ancestral connection). Today they have over 30,000 on their list. Quite possibly these people are simply attracted by potential dividends. But it is more likely that the rising profile of their tribal administration regarding their Treaty claim and pride over their substantial financial success has made it positive once again for Ngai Tahu people to identify with their own iwi roots.

This is not farfetched. In February this year I spoke at a conference in Alexandra in Central Otago. Two speakers thanked me, both eloquent and gracious. One, a Pakeha pensioner, said he had met only one Maori during his school days. The other, a young Maori in his 30s, commented that Maori made up 12 per cent of the population in the Southland district. Such is the gulf in cultural perception across generations of New Zealanders.

Today's reality is that South Island Maori are no longer invisible. Their profile is being transformed through the exercise of rangatiratanga by the newly constituted Ngati Tahu tribal administration. Crucial to this is their identification of their manawhenua status over their traditional tribal areas.

This is where the claim process has been so useful to Maori. No longer are they excluded from resource management issues or without representation on various government agencies. They now have a degree of State and public recognition as a tribal collective (iwi) that they have not experienced for over a century. They are present when decisions are being made and, like it or not, their collective voice is getting a hearing and is being considered. To exclude their collective

voice is no longer politically tenable or legally possible. Their successful Treaty settlements enshrine by Act of Parliament their manawhenua status for future dealings with the Crown. It can't be dismissed.

And this same effect is being felt in every area where tribal groups have resolved their claims with the Crown. Over the next generation as final claims are signed off, this will be true for the whole of New Zealand. For those irritated by the realisation that their old mate Stephen has suddenly become Tipene, consider first the details of the Ngai Tahu story as documented in their claim. Any thoughts of contemporary opportunism need to be carefully weighed with the historical fact of near cultural extinction. A less jaundiced judgement might suggest this is time to celebrate the genuine recovery of cultural identity and to be jointly proud of it, as a nation.

But what's in it for the rest of New Zealand? Quite a bit, actually. The sorry facts are that Maori, notwithstanding their cultural renaissance, are still at the bottom in a whole raft of adverse social statistics. They represent in many Pakeha minds a threatening underclass, capable of destabilising our march toward increasing prosperity. In many areas of our public life, business, crime and politics, Maori appear more often on the radar as a risk to be managed, than as an opportunity to be embraced. The most public exception to this is sport, where precisely the opposite is true.

How do we address and possibly reverse much of this negative reality, and what relevance has Article 2 to this reversal? It is very significant but if all New Zealanders are to experience the benefits of a confident and resurgent Maori population Pakeha need to trust that our Treaty partners can have their own answers to the challenges they face and support the strategies they adopt for this purpose.

## Is kaupapa Maori the way forward?

Looking at the development of kaupapa Maori (Maori for Maori) processes is one of the answers. At crude level many non-Maori New Zealanders find this idea offensive. It suggests separatism, ethnic preference. Or worse, an exclusion of ourselves.

We need to stand back from this gut-level reaction and consider the evidence. Most existing kaupapa Maori services do include non-Maori as part of their client base. Their numbers are often a critical part of their financial viability. They are not ethnic-exclusive.

Further, we need to be careful not to miss a key point. If we continue to do what we do at the moment, and to fail as we currently fail, should it not be obvious to ask for a different approach? The answer is not further welfare penalty, taking away for adoption babies from young mothers and fathers who have been sexually careless, or imposing harsher penalties or longer sentences for crime. For Maori at least, one answer must be to seek solutions within collective Maori frameworks resourced 'to own the problem'.

If today we took a sophisticated view about applying our Treaty understanding of Article 2, we might decide that support for kaupapa Maori approaches is an unfulfilled obligation which we owe our Treaty partners, and that we would be better off resourcing them to get on with it. I am talking here about covering the full range of public interventions: social services, health services, children's services, family services, crime prevention, education and welfare. In short, the whole gamut of activities we describe as support service delivery in New Zealand.

There ought to be options for kaupapa Maori service delivery in all these areas, and they ought to be sustainably resourced.

However, there must be a balance. That balance relates to the quid pro quo of such a deliberate policy departure. There can be no recognition of mana (authority and control) without the requirement for manaakitanga (obligation to provide consideration for others).

Intrinsic to the resourcing of the exercise of rangatiratanga is the requirement for utu: a reciprocity from iwi that involves not only the competent, accountable and efficient delivery of the services, but which exhibits *full and collective* ownership of the problems being addressed. This kind of concept goes beyond the notion that social miscreants are solely the masters of their own destiny, or that risks and rewards are the same for everyone, no matter what their history. The empirical evidence is overwhelming that this is simply not true.

For too many Maori, the historical reality of collective tribal decimation is a profound psychological counter to the idea of a 'level playing field' for all. Recovery of that collective centre, by knowing who you are and where you belong, increases the chances of personal cultural coherence. Thus, providing options that Maori iwi and hapu can deliver for their own people goes to the heart of the personal search for collective belonging.

This is not a short-term exercise but a profound reorientation of the way as a nation we deal with the issues that undermine our national unity and prosperity. This kind of thinking is not foreign to us.

## The parallels with State aid for private schools

In the early 1970s the Catholic population was agitating for state aid for private schools. Their argument was not unlike what I am proposing here. In effect, Catholics were saying that it was not appropriate to insist that the 'special character' of their schools was a matter of personal belief, and therefore outside the requirement for public support. They wanted the power and control to educate their children within their own accepted 'meaning system' and to have that supported by the State. They argued that Catholics paid their taxes like any other people, and were now effectively paying twice for their children's education which, for the best part of a century, was not supported by government money.

Critics attacked the policy as preferential treatment for Catholics. The Catholics responded by saying that it was a century of religious exclusion that had prevented them from being resourced to run their own schools as should always have been their right. In the event, the argument succeeded. The Crown and Catholic education authorities negotiated a settlement that allowed for the 'integration' of their schools so as to have the same funding as State schools, in return for agreed restrictions to the proportion of non-Catholics pupils on the roll. This assuaged in good measure the lobbyists from the public system who were opposed to the new policy, for fear it might undermine the roll numbers at their own schools. Today Catholic school waiting lists are long as people are attracted to the coherent 'meaning system' of that tradition.

One might ask, if this kind of thinking and flexibility in policy is good enough for a religious minority, might it not also be appropriate for a Treaty partner?

Pakeha might fairly be suspicious about such a systematic departure. Many New Zealanders are all too familiar with the media reports of Maori provider failure in many areas, of fraud committed against Trust Boards or individuals acting in their own interests to the detriment of the collective. The face of drug and alcohol abuse and personal violence is often seen as Maori. So too, family dysfunction is perceived as disproportionately a Maori problem.

Many Maori don't trust their own iwi/hapu service delivery because they see incompetence, minimal confidentiality, self-interest for private gain, poor staff relationships, personal aggrandisement or even inter-tribal prejudice. Often there is little confidence in the leadership. So much so, they would rather receive their services from outside the tribal constructs. And they should be able to do just that. This is not about narrowing the choice for Maori but about increasing the possibilities for successful intervention, no matter what the medium.

However, the picture of successful Maori service delivery is far from bleak. There are health and education providers and commercial operations which are among the top in their field. Ngati Porou Hauora runs all health services on the East Coast, inclusive of secondary hospital services, and is accredited nationwide to the highest standards. Mai FM, commercial radio owned by Te Runanga o Ngati Whatua is this country's highest rating music station. It is operating in a fiercely competitive radio market that is dominated by two multinationals. With a fraction of their capital base it has captured the youth market in Auckland. Likewise Ngai Tahu has shown huge financial acumen in its business activities, making it one of the highest performing corporates in New Zealand. Maori incorporations are some of the highest-achieving farming businesses we have.

Te Wananga o Aotearoa, while the subject of much controversy and adverse scrutiny, has had stellar success with the introduction of Maori to tertiary-level education, and its promotion of te reo Maori has been second to none in our educational institutions. No other tertiary institution has achieved such levels of take-up by Maori of tertiary educational options in the whole of our educational history. It would be wrong to ignore its impact on Maori whilst aspects of its financial stewardship are being criticised.

This is not a rosy view. For every first rate success, there are many failures. But the frequency of those failures is not helped by the 'ambiguous climate' in which many organisations operate. I have seen Maori organisations asked to 'tone down' their Maori analysis so as not to frighten the horses, most often the Crown funding agency. I have never seen this happen to Pakeha organisations. It is as if the support for the Maori collective approach is acceptable, provided the funder doesn't become agitated. Thus Article 2 exploration of rights is permissible, provided you whisper. If you shout, the money dries up.

There are also massive Maori skill deficits in all sorts of critical areas. Not least, in tikanga Maori. Consider for a moment the 40 years lost for Ngati Whatua o Orakei in Auckland between the burning of its marae in 1951 and the passing of the 1991 Act which gave Bastion Point back to them. In that period nearly two generations of tikanga practice was relegated to private garages for tangi, and there was almost no public engagement with both the State or other Maori iwi or hapu. The ability to host hui nearly disappeared. Only the resilience of the people retained the vestiges of their cultural taonga (sacred treasures). The fact that they are fully functional in their Ngati Whatuatanga (Ngati Whatua cultural behaviour and custom) is a minor miracle. Yet the recovery of their cultural practices gives vital confidence to their programme of collective revitalisation.

It is the very underpinning of their restoration. They are actively training their own people for the task of self-management ahead of them, and second best is not a concept that will sit easily with this hapu.

The message from this experience is straight-forward. We simply have to get beyond the scandal value of supposed preferential funding for Maori, just as the argument for funding of integrated schools for both Catholic and non-Catholic alike was eventually accepted. Our arrival point must be a mature understanding of the benefits of affirmation of Article 2. We need together, Maori and Pakeha, to determine in our public affairs how support for rangatiratanga can be applied in contemporary terms. And that requires a national leap of faith, a trust in our mutual competence to do what is right.

It is my view that if Maori are appropriately resourced and collectively agree to take ownership of the problem caused by historical social and cultural dislocation, the chances of an enduring solution increase exponentially.

This is a journey. There is no one answer and in some circumstances Maori may say 'we cannot do what you ask of us because the capacity that exists among our tribal collective (iwi) at present to "own the problem" does not exist.'

But I am confident that the overwhelming response from Maori will be to tackle the challenge. Released from the constant burden of having to convince the State of recognition of their rangatiratanga, Maori will mobilise to address the root causes of the social underclass that so vexes us. This will be a long process. My experience with Ngati Whatua o Orakei after the return of Bastion Point suggests that within fifteen years we will be able to identify clear and positive progress. Within a generation we will see transformation.

## Resources for the journey ahead

How difficult is this journey? Fortunately our resources are substantial to meet this challenge. A national inventory of our advantages may be useful.

We have a huge **historical** base to now draw on. This is a great advantage, provided we see it reflected in our school system. The challenge for the 21st century school-age child is to have a grasp of the new history written in the last 30 years, by historians and through the Tribunal process. By not knowing our history, we got ourselves into strife in our race relations. We don't have to repeat the mistake.

We are in the midst of an **economic** boom of sustained proportions at present. The rates of Maori unemployment are at an all-time low since pre-1970. There is more social housing and health care aimed at improving Maori life span than ever before. Maori entry into business, entrepreneurial activity and self-employment is at an all-time high. With surpluses at record levels, the opportunity intentionally to realign the delivery of public intervention for Maori is fundable as never before.

The level of **social awareness** around the issues of Treaty application is rising rapidly. After Dr Brash's 2004 Orewa speech there was an initial outbreak of Pakeha angst that support for Maori had gone too far. Longer reflection on this is changing people's minds. There is, in my experience, a willingness to get to the heart of this matter. The discussion has opened us up and the reflections are promising. We are becoming more informed and better equipped to deal with the wider issues.

There is a **cultural renaissance** of Maori, largely supported and appreciated by non-Maori. We sing our national anthem in Maori and English without reserve. Our Maori artists, filmmakers, commercial and sporting heroes are now representative of 'more of us' than ever before. There are record numbers of Maori members of parliament and a new Maori party is an expression of a self-confidence not seen previously. Our cultural processes are adapting, as the response to last year's hikoi so eloquently demonstrated. We are discovering ways of being a New Zealander that are not solely Maori or Pakeha, but an amalgam of the two.

Similarly there are now **successful working models** of the way things can be done. The kohanga reo movement demonstrates a competently run te reo (Maori language) pre-school service. Where it struggles are in the same areas where the education department struggles with general programmes, where scale is small and expertise is scarce on the ground. There are Maori public health programmes that focus on smoking cessation that are achieving substantial gains with at-risk Maori mothers. Maori language television after a shaky start is well launched. Without question it will need lots of support to sustain vigour, audience reach and programme excellence. It has substantial commercial challenges but in comparison, it requires from the government only a fraction of the resource provided to State run television when it began.

For all our difficulties, there is something approaching **political fairness** in Aotearoa/New Zealand. It is more of an orientation than a fully achieved reality but it is there. The foreshore law may be flawed but it represents a

genuine attempt, albeit incremental, to recognise that there needs to be a way of accommodating the competing aspirations of different parts of our nation. To the extent that the Act represented the fruit of a kind of 'political panic' about race relations it showed how far we have still to go, to be confident and trust each other cross-culturally. But to leave it at that would be to ignore the fact that the legislation did attempt to address customary practices that did not derive from English Anglo-Saxon roots. We can all count that a minor triumph of national self-confidence.

The decision to create the Waitangi Tribunal in 1975 and to extend its brief in 1985 to address grievances dating from 1840 was an act of enormous **courage and insight**. This represents a milestone in our history, comparable to the Treaty signing itself, the right of women to vote and the creation of the welfare state. This is an achievement without parallel in the world. It is incomprehensible that a people with this much good sense, intuitive courage and such insight into the healing of human affairs related to its indigenous people will lose its nerve when confronting new challenges on this path. We now have a legacy of direct dealing even when faced with the painful truth, and we are the stronger for it.

Finally and importantly, we have **time**. Our 160 years since Treaty signing is indeed a blip on the radar of history, including our own. If we understand New Zealand to have been occupied since 1300 CE then our difficulties with the Treaty have been only in the most recent quarter of this occupation. This is not too far gone to remedy.

I began this paper with a call for a big leap forward in our Maori/Pakeha relations. This is underpinned by trust between the parties or undermined if such trust is not present. Let's pick up on the challenge. Indeed, if the generation since 1975 may be described as the 'Treaty truth-telling' generation, let the next be the 'Treaty fulfilment' generation.

Undoubtedly, we will all be better off for it.

## Some Maori terms used in this paper

**hapu** sub-tribe of an iwi

**hikoi** step, journey, can be deputation in support of an issue or for a defined purpose

**iwi** tribal grouping based around common ancestors

**kaumatua** senior Maori elder

**kaupapa Maori** Maori pupose or objective, often described as 'Maori for Maori'

**kohanga reo** full immersion Maori language pre-school

**kura kaupapa** full immersion Maori language primary and secondary school

**mana** honour, dignity, respect deriving from authority and control

**manaakitanga** obligation to offer appropriate hospitality, consideration for others

**manawhenua** tribal authority within a region (**rohe**)

**marae** meeting place, locus of tribal mana

**Ngati Whatuatanga** the practice of Ngati Whatua cultural behaviour and custom

**Pakeha** descendants of settlers from Britain and Europe

**papakainga** tribal homelands

**rangatira** chiefly person

**rangatiratanga** chiefly authority exercising their trusteeship over taonga,
**rohe** tribal region

**taonga** sacred tribal treasures both material and non-material

**Tamaki Makaurau** Auckland isthmus

**tangata whenua** Maori, first people of the land (modern)

**tangi, tangihanga** ritual farewell of the dead, funeral wake

**tauiwi** descendants of all non-Maori, includes Pakeha and new migrants

**te reo** Maori language

**tikanga** cultural manners, beliefs, practices

**tuku rangatira** a chiefly gift

**urupa** burial sites, cemetery

**utu** reciprocity, balancing of debt, benefit and obligations; can also be revenge

**whakapapa** genealogy by ancestral connection

**whenua** land

**whenua rangatira** noble/chiefly land, undisputed ownership and control

# A Benign Psychosis?

## Cilla McQueen

Recently I read in the poetry annual *Fulcrum* the poet Fred d'Aguiar's notes on his work with a poet/patient whose ability to articulate the anguish of her inner world was not sufficient to prevent her suicide. He describes this unhappy outcome as "not a failure of her self, or her artistic abilities, but a failure of utterance itself when deployed in difficult psychological terrain?? writing herself back to health held a limited purchase for her and her troubled psyche." He concludes with regret that "had she lived, she would have continued to write and perhaps written some lasting poems, but not a line of it would have mended her mind."

Poetry is a creative art. All creative writing is not poetry. Unmediated utterance is not poetry. Words can release emotion but mere expression cannot mend. However working on the refinement of that utterance does improve the mind's suppleness and self-discipline.

In contrast to the impulse to write, the art of poetry demands skill and a quiet mind to listen to cadence and metre and all the useful combinatory abilities of words. It is work requiring clarity and alertness and balance. For some people this skill may be impossible to attain. Poetry often deals with fleeing words and brilliant images too rapid and exquisite to catch. A mind needs a certain toughness to engage with language.

D'Aguiar suggests a failing of utterance itself. I would say that in this case language could express but not heal his patient's grief.

It seems to me that language works hardest at the limits of utterance. At an extreme, in contact with a chaotic outside world, language shows the strain and can appear to disintegrate entirely. Early twentieth century European literature responded to the psychological damage of world war with Dada, surrealism and the Absurd. The Orator in Eugene Ionesco's play *The Chairs* is reduced to incomprehensible mumbling; a German artist's wartime self-portrait in the Berlin Museum reveals him freaked out, frozen, his brush lifted off the canvas, staring at himself.

When I draw or write I am aware of a superconducted flow from outer to inner; inner to outer world. Line is a direct and fluent language which bypasses words. Colour also is a language, and music. The expressive languages are

naturally interrelated. In this early 1980's poem I'm not expecting anything from the language beyond that it be fluent and pleasant to use, reminding myself of alternative creative languages at my disposal, such as drawing and music. To express the effect of the outer on the inner world always augments my joy in it.

from **Words Fail Me**
Air's so clear it's tinged with black.
My favourite spot for looking at the
peninsula is on a headland above the road
to Aramoana. Here I sit in the sweet buttery
gorse, a tiny ringing cicada song coming
from many points in space. From the port
comes the logsnatchers' angry growling.
A single black shag on the water which is
pocked pale and darker blue pointilliste
and then the hills limbs gracefully collapsed
relaxing stroked by the shadows of clouds.
It is all a continually moving
picture show. I get out my paper
pencils and ink not to copy nor to
describe but to put into line what
the words are not fluid enough for.

A poem is a satisfying end product but not a reason for writing. Sitting on that hill I was practising, in private, my absorbing art of words and ideas, aware of being both a part of, and apart from, my harmonious surroundings.

The theme of the meniscus runs through my work. Poetry operates at a linguistic interface between subjective and objective experience. To find balance between inner and outer is the thing. I wouldn't recommend poetry as do-it-yourself psychotherapy, but having some command of technique I have at times derived artistic satisfaction, in comfort and recompense, from work which has sprung from difficult terrain in my life. Through making sense and shape of utterance to produce a creative work, it became possible for me to come to terms with the event that produced "The Autoclave," namely the loss of most of my possessions in a house fire. It also served the useful function of storing some precious memories in words before they were forgotten, since their material prompts had disappeared.

from **The Autoclave**

The Flounder Inn is full of holes - I wonder,
can I face another winter here?
The sea laps close to my front window
and seabirds call. Lulled at my wheel
by rhythms of tide and wind
with hand and finger discipline
I spin and ply the yarn
into an endless double helix,
watching the dance of tide and clouds
and seabirds, wind among seagrass, lupins.

Those black swans there
are imports, foreign ships
that empty their ballast on the sand flats
causing a grassy weed to grow
that chokes the cockle beds.
Pale yellow, white, pale green,
olive, taupe, blue-grey.
Low tide, flat calm, nine oystercatchers.
No more than lazy strands of toetoe moving.

A low vibration rattles the windows. I look out -
the calm high tide is blurred by shoals of tiny fish
and a container ship is entering the heads,
tall as an office block and as foreign to the landscape,
the throb of its engines reaching the soles of my feet
through billions of grains of sand.

Fresh water's more important than money in this place.
Rain's always welcome, drumming on the corrugated iron,
trickling along the gutters, pouring into the concrete tank.
There's a sheen on the water,
the tide a stone's throw from the balcony.

Small ripples tickle the shore.
A pulse runs through my days -
tide-pulse, throb of ships' engines in the channel,
my heartbeat, the purring of Lucille,
wing-beats, light and darkness,
the pulsing wheel, endless thread spinning

out of white clouds in my hands.
Beneath the everyday there lie deep happenings,
hidden, sacred -
And then the Flounder Inn burns to the ground,
with everything in it.

The poem goes on to interweave themes of ancestry, polarities, journeys and crossings around the central metaphor of the autoclave and the quarantine station at Point Nepean in Melbourne where the Scottish settlers arrived in the 1850s. An interface of sorts between worlds. Dante provided a useful guide in this poem.

We dream our situations in metaphor so that the waking mind can understand them at a deep level. We tend to put our precepts into poetry, fable, parable, to insert them at a deep level into the psyche.

My idea of the writing process is something like this: The dreams go round like a washing machine in one side of my brain. Through some interface they are drawn across, filter through to the active language side. At the interface sits an entity who deals with the meeting of words and ideas. A grandmother, a Joker, a Janus at the gateway between conscious and

unconscious, looking both out and in, facilitating and shaping the casting of idea in language. In the active language side utterance is made precise, tested and fitted for the outside world. It slides down the arm into the pen and glides out in ink. It has a sense of humour:

**Via Media**

Deep in the brain between right and left
the electromagnetic charge around the corpus callosum
aligns nerve impulses, allowing them to flow
from one hemisphere to the other.

The motto of my grandmother
was "Per via media tutissima."

When she died she was as small as a bird,
but I remember her taller.
Indeed she was a wise interface,
the signal box of her family.

This bundle of nerves is at about ear-level.
I wiggle my ears, locating the via media,
imagining the centre where the impulses align,
a grandmother at the interface wisely regulating.

Daily life flows through her fingers
and passes into dream.
Dream washes out into the daylight
and disappears like foam.

I don't see writing as a means of removing the detritus of my psyche. Poetry is useful because it can hold ideas in words, memorably, lest they slip away. Poetry is as good a way of exercising the mind as any mental activity - such as chess, maths, philosophy, physics. Among other things, poetry is metaphor.

My book *Soundings* begins with a couple of riddles, which look as though they're supposed to be love poems, but they're not, unless they're love poems in a wider sense, love of an isolated population for each other and their island life of cliffs and waves - and seabirds. (The answer to the first riddle is in the second).

**Riddles (i)**

1
my bone
takes my flesh
to your lips
2
my wings
sweep earth
from the earth
3
you walk
on my head -
my neck, your ankle
4
my jaws
hold down
the roof

5
dreaming
I cover you
like cloud
6
I burn,
illuminate your
feast of me

**Riddles (ii)**

"No part of the gannet is ever wasted"

Make a spoon of my breastbone
and of my wings a feather broom.

My head makes a soft shoe laced at the throat,
my beak a stout peg, to anchor the thatch.

Featherdown is your bed in the storm.
I give strength to your body

and brightness to your eyes -
your lamp is my clear oil flame.

Writing poetry can be so intellectually intriguing as to become obsessional. For the poet, creative absorption in poetry is perhaps as intense as a psychotic state. But it isn't channelling the poet's self, it's more of a glass bead game, abstract, of ear and eye, vocabulary and syntax. It seems to produce endorphins.

This poetry is not the psychiatric tool Fred d'Aguiar thought to use. He was encouraging a confessional mode, but the subject pursued his patient into the world and she had no shelter from it. Writing brought no relief. Personal writing can of course be used as a starting point for poetry. When the Flounder Inn burned down, writing an exhaustive list of its contents for the insurance assessor was a gloomy exercise. Then I began writing down memories so that they wouldn't be lost with the objects that evoked them. These enticed me into poetry that went beyond the personal level. When I moved to Bluff, I found poetry a good way

to come to terms with a new house, environment, family, culture, as I looked back as well as forward over my life thus far

Looking back I see the themes of polarity and opposition early in my life, in several crossings of the equator. I was intrigued by the world's hemispheres. Later this awareness of difference increased to include cultural dimensions. At school in England during my father's sabbatical I was made embarrassingly aware of English ignorance about my New Zealand home. At that time, at the age of twelve, I injured my back in a ballet class, and the spinal fusion resulting 26 years later made me very interested in the process of healing, producing the poetry in *Benzina* in 1988.

If poetry's a benign psychosis, do I hear voices? Yes, I hear "voice" suggesting idea or theme and associated words - it's the same as the voice that tells me my PIN number. It's that voice I converse with when I make poetry, the inner voice that articulates ideas and speaks poetic lines. Rarely, it will produce a whole poem. Often the flow of verbal suggestion is so rapid and contradictory that it might be discerned to be many voices. Is this psychotic? I would never be without it. It's the dimension of my mind which speaks in language, in colour, line or music. Following its creative suggestions I draw and paint and have fun with musical scores. It sings, it facilitates synesthesia. I assume it is the voice of intelligence. Poetry is creative writing but all creative writing is not poetry. By poetry I mean the ancient and demanding task of making spoken and written language which is condensed, mellifluous and memorable.

Poetry is an art practised by poets. All patients are not poets, but active participation in creative activity does stimulate healing, as laughter does.

All poets are not patients, but poetry may be akin to psychosis. How else describe the extraordinary lengths to which the mind will go in order to craft an exquisite word-vessel of idiosyncratic tone and form, a thought-experiment, a poem?

Or that intense tenacious worrying among words, obsession with exactitude, with melody, with rhythm, a juggling of possible meanings and short cuts through byways of syntax, that uses to the full the layers of meaning and music arising from elegant verbal combinations.

The poet is both passive channel and active shaper of the flow. I imagine that in real psychosis this balance wouldn't be found. If the shaping side were passive, the active psychosis could predominate. By the "shaping side" I mean the self-engendered disciplines of careful work.

**Museum Attractions, Gore**
The flipside of the Gold Guitar
is perhaps the ancient African figures.

Tough glass encloses
the furious power in their wood bodies.

You may wander in the labyrinth
and stare at them without reprisal -

they have been tranquillised -
examine them until they are not strange,

in the manner of the bald soldier
whose torch probed the mouth of the captured

dictator; ponder your own psyche
through the glass that blocks the tapu.

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The poems quoted are from *Markings* (2000), *Axis* (2001), *Soundings* (2002), *Fire-penny* (2005): all published by University of Otago Press, P.O. Box 56, Dunedin.

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# The Heritage of Disorganised Attachment

## Stephen Appel and Catherine Healy

### Abstract

Clients who characteristically relate in a disorganised way present particular clinical difficulties. A better understanding of what might be going on for the client is helpful to the therapist in the face of the client's erratic responses. To that end we offer this article which provides a description of disorganised attachment and reviews a selection of recent studies in several fields in order to better comprehend the heritage of disorganised/disoriented attachment behaviour, its precursors and outcomes. We include a heuristic framework of the emotional socialization of attachment. The article ends with some thoughts on psychotherapy with disorganised clients attachment and proposes a story-reclaiming framework.

### Introduction

The client does not just speak to the therapist about his or her life, but shows the ways in which he or she creates experience. The client "contributes to an intersubjective construction within the analytic setting that incorporates *in its shape and design* the nature of the psychic space within which the patient lives (or fails to come to life)" (Ogden: 1991: 604, his emphasis). Sometimes this psychic space seems shapeless and without design: now *this* intense emotion, now *that*, now dissociation; now *this* focus of attention, now *that*; now *this* mood, now *that*—simultaneously or in quick succession. Consider Sarah:

> Sarah would enter our office appearing bright and cheery, plop herself down in the chair, and position herself at an angle facing away from me toward the wall. She would sigh, and almost immediately start complaining about someone's (boss, teacher, friend, boyfriend) insensitivity to her or demandingness, telling me how exhausted she was. Then, another shift in her affect would occur. After the initial cheer and then rage, she would move to depression and despair and would blame herself for being disorganised, miserly, ungrateful, and in a word that she often used to describe herself, a malingerer. There were few, if any, pauses in her speech. Sometimes, just as I took a breath to start, she raised her hand much like a traffic director to stop me from saying anything.... When I did have the opportunity to say something, I was usually wrong. When

> Sarah did allow me to recognize her emotional needs, she quickly retreated into a hopeless state....She exhibited contradictory behaviours, e.g. asking to increase the frequency of sessions about a month before she was leaving for a long summer break. (Gubman: 2004: 164)

This is the *hard-to-treat* client. What the clinician faces is the bewildering changeability of the client who has the attachment style known as disorganised. A more famous example: Bobby Fischer, the notoriously difficult chess player, has been called a *mimophant.* Half mimosa, half elephant, a mimophant is extremely sensitive to his or her own hurt feelings and very thick-skinned when it comes to trampling over the feelings of others (Edmonds and Eidinow: 2004).

When working with such a client the therapeutic relationship, Giovanni Liotti says, "may become unbearably dramatic, changeable, and complex for both partners" (2004: 485). Identified only two decades ago, the study of disorganised attachment has become "the most promising current area of attachment research" (Fonagy and Target: 2003: 245). This article is not in the first instance about how to do therapy with the disorganised client. Instead it covers a selection of recent research from a variety of disciplines in an effort to better understand the development and inner world of disorganised attachment. To the extent that this is accomplished, it is our hope that readers who are clinicians may find the article of some help in the difficult process of holding these clients who are both in considerable distress and sorely trying to be with.

## Disorganised attachment and its sequelae

Let us begin with a short introduction to attachment theory and the variant known as disorganised attachment. The theory of attachment founded by John Bowlby derived from concepts of evolution, communication and control systems theory, ethology, and the cognitive sciences. Expanding on Harlow's theory of discrete affectional systems or bonds (those of mother/caregiver-infant; parental complementary caregiving; the sexual pair; sibling/kinship; and friendship) Bowlby elaborated on this to include the behavioural systems underlying these bonds (Cassidy and Shaver: 1999). Attachment theory focuses on the attachment, exploration, and fear/wariness systems. Interacting with the attachment behavioural system are, among others, the feeding, reproduction, caregiving, and sociability systems. These systems function to "control input from the environment in a manner that keeps these essential variables within the limits required for survival" (Cassidy and Shaver: 1999: 46). For example, the attachment behaviour system of fear/wariness protects from danger; the

exploratory and sociable behaviours serve the biological function of learning individual and social group skills, and so on.

Attachment theory proposes "the propensity to make intimate emotional bonds to particular individuals as a basic component of human nature, already present in germinal form in the neonate and continuing through adult life into old age" (Bowlby: 1988: 120-121). The developing infant has the potential to form several attachment bonds and orders them hierarchically, Bowlby said. Primary among these is the mother/caregiver-infant bond: "a relatively long-enduring tie in which the partner is important as a unique, non-interchangeable individual" (Cassidy and Shaver: 1999: 46).

Accompanying the attachment bond are attachment behaviours (crying, sucking, following, clinging, and smiling) designed to monitor proximity to the primary attachment figure to achieve security and safety (Bowlby: 1958). The adult reciprocates the infant's attachment behaviours with his or her own—touching, holding, and soothing—which serve to strengthen the infant-caregiver bond (Bowlby: 1958; Fonagy: 1999a). Attachment behaviours in the first five years are most readily activated by "strangeness, fatigue, anything frightening and unavailability or unresponsiveness of the attachment figure" (Bowlby: 1973: 40). Activation of the infant's attachment behaviour signals the need for a soothing response from the caregiver so that equilibrium, safety, and security are restored. Once terminated, arousal of these behaviours ceases, the secure base is re-established, and the infant can return to exploring the environment (Bowlby: 1988: 11). Containment of the infant's mental state assists the infant to represent itself as an intentional being, as eventually able to think flexibly and make meaning of its own and others' behaviours (Fonagy: 1999b). This reflexive function is fundamental to self organization (Fonagy: 1999a).

In the absence of soothing, especially if chronic, the infant remains hyperaroused. To deal with this overwhelming emotional state the individual may resort to excluding of attachment-related information that in turn thwarts affective development, increasing the risk of later psychopathology. For example, it is thought that individuals with attachment disorganization survive by blocking out their attachment figures' wishes to harm them. This leads to splitting of the representation "primarily into an idealized and persecutory identity" (Fonagy: 1999c: 9) and taking into oneself the caregiver's feelings of fear, rage etc. as well as the caregiver's image of the infant as "frightening or unmanageable" (Fonagy: 1999a: 3). It is these attributions of self-other mental states that become incorporated in another of attachment theory's fundamental tenets,

the Internal Working Model (IWM) which is constructed from the process of repeated activation of attachment behaviours and caregiver interaction. The model created forms the blueprint for future styles of relating.

The infant's attachment construct becomes incorporated—it becomes a *within-child* phenomenon—and it endures; the IWMs are models of expectations of future interpersonal interactions: of self and of attachment figure, their accessibility or inaccessibility (Bowlby: 1982). These early models are remarkably constant over time. There appears to be a biological aspect to the ingraining of attachment style. Alan Schore (1996) and others speculate that, as in animals, the way the caregiver responds to the infant changes the neural structure of the infant brain.

Whenever in life we face traumatic stress we want help and comfort and our attachment system is called upon. If attachment is an enduring affectional bond that one develops with another, one of the hallmarks of secure attachment is that the dyad is effective in the regulation of emotions. Disorganised attachment represents the failure or absence of a strategy of the infant to enlist caregiver support in stressful situations, the infant thus becoming overwhelmed by negative emotions. Identified by Main and Solomon (1986), disorganised attachment is a later addition to the three primary attachment styles classified in Mary Ainsworth's famous Strange Situation experiments designed to test the hypothesis that separation from the attachment figure activates the infant's attachment behavioural system (Ainsworth et al.: 1971).

In this experiment one-year old children were placed in an unfamiliar laboratory setting for a period of twenty minutes, where they were twice briefly separated from their mothers (for up to three minutes). Initially the child stayed with the mother, then with a stranger, and then was left totally alone. Their responses on reunion with the mothers were assessed. Three classifications of infant attachment were discerned: insecure-avoidant, secure, and insecure-resistant/ambivalent. Securely attached children sought their mothers for comfort and were indeed able to be comforted. Avoidant children did not seek comfort from their mothers, instead they were thought to withhold expression of attachment needs. Resistant/ambivalent children became distressed on separation, and angry and clingy on reunion, unable to feel soothed by their mothers.

Subsequent research based on the Adult Attachment Interview devised by George, Kaplan and Main (1985) found that each of these types of childhood responses correlates with a matching style of attachment later in life: dismissing (insecure-avoidant), autonomous (secure), preoccupied (insecure-ambivalent/resistant).

But it was found that there are anomalies in the ways infants attach: "Some infants are not able to organize their attachment behaviour according to any unitary or coherent pattern" (Liotti: 2004: 472). In the Strange Situation such infants show contradictory approach-avoidant behaviour when re-encountering the parent (Main and Solomon; 1990). And these contradictory behaviours occur simultaneously or one after another. Their responses in the strange situation are erratic and confused, e.g. becoming immobile (freezing, stilling behaviour) for thirty seconds or more mid-approach to the parent, not responding to the parent's call, looking dazed/in a trance. They may be frenetically active, or have mistimed or stereotyped movements. The behaviours seem to signify the infant's distress and disorientation: quickly alternating aggressive/affectionate gestures, unusual facial expressions, sobbing, gaze aversion, and falling huddled to the floor (Hesse and Main: 1999). Overtly dissimilar, what the behaviours share is that the infant experiences severe negative emotion which it is unable to regulate through the relationship with the caregiver. And so the category 'disorganised attachment' was devised, although it can be thought of as not a new form of organization, but as an interruption in organized behaviour. Disorganised attachment represents "a fundamental dysregulation of emotion" (DeOliveira, et al.: 2004: 438).

A distinction has been made within the new classification, namely secure/disorganised and insecure/disorganised. Secure-disorganised mothers tended to behave in a more inhibited and fearful way compared to insecure-disorganised mothers who displayed more frequent frightening behaviours (Steele: 2004). But nothing is straightforward in this field; in some people disorganization is so predominant that a secondary category could not be applied. They were designated "cannot classify" (Main: 1993: 220). An example of this is a subject who in the first part of the attachment interview is very dismissing and in the second part is preoccupied, without any obvious conscious awareness of this change.

So, what is going on internally for a client like Sarah, introduced above? The IWM of disorganised attachment is very different from that of stable attachment where there is a sense of the legitimacy of emotions and of the possibility of getting help and comfort during distress. The IWMs of the insecure attachments (avoidant, ambivalent and disorganised) all expect that help will not be available or that requests for help and comfort will be met with negative consequences. In particular, the IWM of disorganised attachment anticipates negative consequences of asking for help and comfort, and it also brings on a non-integrated array of dramatic and contradictory expectations. This is the consequence of a lack of consistency and predictability by the caregiver in

response to attachment behaviour. Subsequently the disorganized person can have two or more simultaneously operating working models both of self and other (Bowlby: 1973) that are segregated from each other (multiple models) (Lyons-Ruth & Jacobitz: 1999). This accounts for the confusing display of behaviour and affect. Bowlby referred to this as "emotional detachment" because of the individual's inability to maintain a stable affectional bond. These individuals, in contrast to those with other insecure attachment styles, have more thoroughly excluded attachment feelings and memories from consciousness so that "there is such a fear of getting close to others that persons in this category act removed and distrustful, and may become severely anxious, depressed, and/or angry if pushed into relating" (Sable; 2000: 64). Clinically, even a therapist's expression of warmth, interest, and care may frighten the client (Cassidy & Mohr: 2001). A simpler way of explicating this is via the drama triangle of persecutor, victim, and rescuer. The disorganised child simultaneously or in quick succession construes both the caretaker and the self according to all three basic positions. So, for instance, the other is seen negatively as the cause of the self's ever-growing fear, but also positively as rescuer; the self is seen as the other's victim and also its caregiver; and so on. This is most useful in coming to terms with the surprising changes experienced when working with a client with whom the establishment of better attachment may be the central goal of therapy (D'Elia: 2001). As Sarah's therapist Nancy Gubman says, having the model of disorganised attachment is "extremely helpful....It places the confusing behaviour in a comprehensible framework" (2004: 168).

## Maltreatment

What are the child's reasons for constructing this IWM amalgam? This article will point to several strands in recent research which taken together give a sense of the aetiology of disorganised attachment.

In the first place, attachment disorganization has been strongly correlated with maltreatment in infancy (as high as 80 per cent in some populations) (van Ijzendoorn, et al.: 1999). Dante Cicchetti argues that maltreatment cannot be reduced to a single risk factor; nor is there a specific lifelong outcome of maltreatment in childhood. His ecological-transactional model suggests that it is the balance among risk factors and processes both determining the likelihood of maltreatment occurring and influencing the course of subsequent development. So, "negative developmental consequences occur when an individual's vulnerabilities outweigh his or her protective factors. In contrast,

resilient outcomes eventuate when protective factors outnumber vulnerability factors" (2004: 732). Indeed, the existence of "one understanding secure relationship can 'save' the child from severe dissociative personality disorders" (Bernardi: 1998: 799).

But maltreatment is hard to pin down because what counts as maltreatment varies, its occurrences are not constant, and the developmental timing of maltreatment matters. Another factor is the existence of multiple attachment relationships. An infant who is disorganised with respect to an unresolved mother, may concurrently be avoidant towards a dismissing father, and secure in relationship to another person. In light of this, attachment disorganization "seems to reflect an intersubjective reality rather than a property of the individual child's mind" (Liotti: 2004: 475).

A recent review on child maltreatment identifies the following: sexual abuse, physical abuse, neglect (emotional, physical, and supervisory), and emotional abuse (rejecting, isolating, terrorizing, ignoring, corrupting, verbally assaulting and over-pressuring) (MacMillan and Munn: 2004). Cicchetti and his colleagues have developed a Maltreatment Classification System which delineates maltreatment by using operational criteria with which independent raters can determine subtypes, severity, frequency, developmental timing, and perpetrators of maltreatment. Following on from this grim work the researchers have been able to establish links between childhood maltreatment and all manner of biological and psychological sequelae.

Cognitive, linguistic, social emótional, and representational development all suffers, and there is an increased risk of developing behaviour problems, major mental disorders, and personality disorders.

> Child maltreatment has consistently been shown to exert negative influences on development over and above the effects of poverty—physiological and affective regulation, the development of a secure attachment relationship with the primary caregiver, the emergence of an autonomous and coherent self-system, the formation of effective peer relations, and successful adaptation to the school environment all pose serious problems for maltreated children. (Cicchetti: 2004: 734-735)

What is the link between early trauma, disorganised attachment, and later emotional disorders? Liotti (2004) makes a subtle point. It is not that trauma leads to disorganised attachment which then in adult life is manifested as emotional disorder, but rather that insecure IWMs increase the vulnerability to trauma-related emotional disorders. The IWM of secure attachment, on the

other hand, is a protective factor. The IWM of early disorganised attachment tends towards disorderly reactions to later trauma. In this way trauma, disorganised attachment, and non-integrated symptoms are "three strands of a single braid".

Let us take this a step further by considering Isla Lonie's argument for an equivalence between borderline disorders and post-traumatic stress disorder. These disorders share many features, but the difference is that in the case of borderline personality disorder, she says, the trauma has either been repressed or, or if it occurred before speech, has not been registered linguistically. Lonie presents the criteria of BPD as "symptoms of failed attachment consistent with early trauma" (1993: 233). From a neurobiological perspective, the link between attachment deficits and emotional regulation is supported by F. Amini and colleagues (1996). The outcome is "disorganized neurobehavioural repertoires and organisms that are incapable of optimal internal self-regulation" (Sable: 2000: 226). In short, childhood abuse greatly increases one's vulnerability to serious emotional disorders in the face of later life trauma.

The link between abusive caregiver and abused child and the consequent disorganised attachment might seem so obvious as to not warrant much further thought here—it is no great mystery why one would be both repelled by and needful of an abusive caregiver. Perhaps so, but not every caregiver of a disorganizedly attached child violently or sexually assaults or neglects or emotionally abuses the child. It is more complex than that. A study of anxiety-disordered mothers, for instance, found that 65 per cent of their infants had disorganised attachment styles (Hesse & Main: 1999). It is also suggested that where an attachment figure has not protected the child from abuse by another family member, the memory of this betrayal of trust may be more wounding that the actual abuse itself (Liotti: 2004: 475). Louise Emanuel (2004) has written about the complex impact of domestic violence on young children. Confronted by a frightening or frightened caregiver the infant is stuck before several closed doors: it cannot approach the caregiver, it cannot shift its attention from the caregiver, nor can it flee (Main: 1995).

## Non-maltreatment (or Maltreatment II)

A meta analysis by van Ijzendoorn et al. (1999) of eighty studies concludes that the rate of disorganised attachment in low risk families is 15 per cent, but much higher in high-risk and clinical groups (as high as 80 per cent in samples with parental maltreatment or drug abuse). How is one to account for that 15 per cent?

This leads us to a consideration of non-abusive parenting which nonetheless predisposes the infant to disorganised attachment. Preliminary research has produced evidence of a link between historical maternal abuse and impaired attachment abilities. Where there was familial sexual abuse, mothers tend to be self-focused rather than child-focused and they use their children for emotional support (Burkett: 1991). While mothers who have been sexually abused are less involved with their child, those who have suffered physical rather than sexual abuse demonstrate more hostile-intrusive behaviours (Lyons-Ruth & Block: 1996).

There is growing understanding that disorganised attachment typically stems from psychological and behavioural problems in the caregiver/s such as "maltreatment, unresolved loss or trauma, depression and marital discord" (van Ijzendoorn et al.: 1999: 227). A longitudinal study correlated such "environmental antecedents" with later dissociation and psychopathology (Carlson: 1998: 1107).

Disorganisation of attachment does not only arise in maltreated infants. Or rather, maltreatment should be seen more widely than as gross abuse or neglect of the child by the caregiver. It is easy, we have suggested, to see how living in a frightening environment might produce a disorganised pattern of attachment; it is as though the child knows not whether to engage in fight, flight, or freezing and so does all three. However, it is less obvious how a frightened environment can have the same effects.

A vicious cycle results from a fundamental misalignment between caregiver and infant. When the caregiver's attachment system is activated while attending to the infant's attachment needs, it is thought that early traumatic memories emerge disrupting soothing, containing care of the infant, and thus "frightening or frightened" caregiver behaviour results (Main and Hesse: 1990). Such mothers would seem to be helpless to control their own feelings and to respond to those of their children. Themes of inadequacy, helplessness and losing control are present in their self-reports about their ability to handle caregiving situations (George and Solomon: 1999). The traumatized adult's state of fear manifests itself both in her facial expressions and in her frightened and/or frightening interactions with the infant. The child, wanting closeness and comfort from the caregiver, experiences instead either further threat or sees frightened preoccupation and unavailability. The caregiver's unresolved trauma can manifest as dissociation, leading to dissociative responses in the infant due to the caregiver's frightened appearance, or to behaviours inducing intense fear. For instance, the caregiver may freeze with a dead unblinking stare in the face of the infant's attachment cues, or may simultaneously attempt to soothe then grab the infant in an abrupt

and frightening manner. "Even in the absence of abuse, then, this strange, unpredictable, and potentially threatening behaviour stands to frighten the infant, creating the approach/avoidance conflict in stressful situations" (DeOliveira et al.: 2004: 440).

This dysfunctional attachment relationship is characterized by a noxious combination of fear, sadness, and anger, together with a sense of helplessness. As a consequence the infant experiences a paradox: "fear without solution" (Cassidy & Mohr: 2001: 15). Suffering from chronic activation of the attachment system and/because of the mother's inability to stop this activation through providing security and reduction of arousal, the infant is unable to find a consistent and coherent behavioural strategy "to interrupt the loop of increasing fear and contradictory intentions (approach and avoidance)" (Liotti: 2004: 478). This thwarts the infant's development of a coherent attachment style (Carlson: 1998) and increases the risk of non-abused infants developing disorganised attachment. In the absence of abuse or neglect, but where the infant's attachment system is highly affected by affective dysynchrony as described above, Schore (2001) ascribes the term *early relational trauma.* This, he contends, affects brain development and, says Liotti (2004), may be the basis for susceptibility to dissociative responses when faced with future trauma.

Perhaps matters can be clarified somewhat. If trauma was absolutely consistent it makes more sense that the child would become, say, avoidantly attached: a stable solution to a consistent problem. What it is about frightened/frightening caregiver behaviour which produces disorganization may indeed not simply be the presence or severity of such behaviours, but their inconsistency (Schuengel et al.: 1999); an unstable solution to an inconsistent problem. As security is the goal of the attachment system which is essentially the regulator of emotional experience, optimal receptivity to the infant's attachment behaviour serves to augment positive affect, and modulate negative affect providing security (Siegel: 1999).

Lyons-Ruth and colleagues (1999) observed that the level of breakdown in affective caregiver communication, independent of the influence of discrete observations of frightened or frightening behaviour, does predict disorganised attachment. Maladaptive behaviour must be chronic and/or severe for the child to be left with disorganised attachment as its only option. Not only that, there is a *dosage effect*: seriously hostile and frightening parenting is associated with disorganised/*insecure* attachment, and more subtly abnormal parenting is associated with with disorganised/secure attachment (van Ijzendoorn et al.; 1999). So, while the severity of the symptoms of the affective mal-communication certainly push matters past the tipping point, it not the severity per se but the

breakdown which is the active ingredient. As Jeremy Holmes (1993) puts it, it is the quality of the reciprocal infant-caregiver interaction more than the quantity that is decisive. He says that although many infants frequently spend less time with their fathers, they are strongly attached to them.

Consider the study conducted by Mladen Kneževič and Milivoj Jovančevič (2004) of the maternal attachment of 185 Croatian women in refugee camps who had had several traumatic war-time experiences. (The sample excluded mothers whose babies had serious diseases or malformations, or who were born prematurely, there being evidence that such mothers interpret the children's emotions differently.) The IFEEL instrument for interpreting emotions developed by Emde and colleagues (1993) was used. The test has thirty photographs of the everyday facial expressions one-year-old children. The subject looks at an album of the photographs which have been arranged in particular order and then writes one word that expresses the strongest and most distinct feeling of the child in each photograph. These answers are categorised as passivity, interest, joy, surprise, pain, anger, sadness, fear, shame, shyness, disgust, guilt, or other. The results of this study were compared with other studies including a study of Croatian women conducted in 1993, in other words before the war.

Here are just some of the findings. The mothers who assess anger and interest on a lower level and were more likely to interpret the child's expression as fear were also those mothers who had been wounded or had serious war-related illness. The mothers who tend to assess passivity less than other mothers are those who experienced imprisonment or who witnessed violence towards other people. Mothers who recognised pain, surprise and pleasure are those who did not experience direct enemy attacks, separations from husbands and other family members. The mothers who assess the child's emotion as surprise and pain were those mothers who had been separated from their children and at the same time exposed to extreme hunger for a long time. There is a striking correlation between personal endangerment of the mother and her perception of fear in the child. This link, the authors note, presents a serious developmental difficulty as it puts mother and child in heavy dependence. Further, there is a correlation of maternal psychotic behaviour and PTSD with the recognition of fear as the dominant emotion on a baby's face. As in studies done of high-risk populations, the mothers tended to choose the *energetic emotions* (joy, sadness, anger, fear) and notice to a lesser degree the emotions with *intellectual* contents (interest, caution, shyness). All in all, "the situation after a dramatic, traumatizing experience leads mothers to the state in which they notice and interpret their children's facial expressions in a different way" (144).

Interestingly, studies using the IFEEL pictures with physically abused children as the subjects showed a significant investment by the child in deciphering facial displays of anger, compared to happiness, fear, and sadness (Pollak et.al.: 1998). Survival of course is highly dependent on the child's heightened ability to detect anger and so avoid abuse.

Such affective misattunements predict attachment problems for mother and child. For example, Lynn Murray (1988, 1992) has shown the deleterious effects of post-natal depression on mother-infant interaction and then on infant development. She and Trevarthen (1986) have demonstrated the infant's immediate awareness of when the mother is not attuned with its affects. They devised an experiment where mother and two-month-old infant were placed in different rooms but able to communicate via television screens. Then the screens were set to run recordings of previous positive interactions rather than the current live displays. As a consequence of this contrived misattunement both mother and infant altered their behaviour, thereby demonstrating how keenly susceptible they were to the other's responses. The infants looked away, became distressed, cried; the mothers saw the infants as not paying attention and instead of their normal baby-talk took to giving directives. As Lonie reminds us, these infant behaviours were very much like those of the infants in Main and Solomon's (1986) study of disorganised attachment. In the post-natal depression study Murray found an immediate worsening of the baby's mental state when what appeared on the screen was the mother's blank face. "What is missing in this blank faced image that can lead to such rapid deterioration in a baby's emotional state?" asks Emanuel (2004: 50). What is missing is whatever it is that is present in that process of accurate attunement and matched interaction Winnicott called *the primary maternal preoccupation* of the *ordinary devoted* or *good-enough mother* where baby is not traumatized by mother's infrequent failures. "Trauma means the breaking of continuity of the line of an individual's existence. It is only on a continuity of existing that the sense of self, of feeling real, and of being, can eventually be established as a feature of the individual personality" (Winnicott: 1967: 22).

Affect attunement is of great importance for attachment and later development and psychic health, or to put it conversely, affect misattunement is of great importance for attachment difficulties and later developmental problems and psychopathology. Might caregiver misattunement not profitably be considered a form of the child maltreatment? This not to attach blame, but rather to understand the nature of the attachment. The prefix mal- has two meanings: bad and faulty. While the intention to harm may or may not be present in child maltreatment, the interactions can be seen as faulty and the consequences

are often bad. So, one might think of frank abuse or neglect as Maltreatment I. And rather than talk about "non-maltreating parents" as do Hesse and Main (1999), dissociated, frightened and threatening parental behaviour—the second-generation effects of unresolved trauma—might be better referred to as Maltreatment II.

Can one be even more specific about the precise nature of caregiver-child misalignment which predisposes the infant to disorganised attachment and all its attendant problems? Disorganised attachment, as we are beginning to see, is not straightforwardly a consequence of maltreatment. It seems as though there is something about the nature of the caregiver-infant attunement that goes awry. In a study by Jacobovitz and colleagues mothers of disorganised infants did not differ from other mothers in the sample in terms of other parenting measures like sensitivity and warmth (cited in Fonagy and Target; 2003: 245). Rather, attachment disorganisation is the product of specific forms of distorted parenting associated with unresolved loss or trauma in the caregiver. We have had the latter painfully demonstrated by Kneževič and Jovančevič 's study with Croatian mothers traumatised by war. Jonathon Green and Ruth Goldwyn outline with some specificity what it might be about the caregivers which contributes to disorganisation, and so the "frightening or frightened" caregiver model proposed by Main and Hesse must, it seems, be refined. Stronger associations are found with a broader definition of abnormal parental behaviour which includes severely disrupted affective communication, hostile/intrusive parental behaviours, and the parent's "role confusions" with the infant (Lyons-Ruth et al.: 1999a).

The point that Green and Goldwyn make is that these correlations are specific. To repeat, it is not simply a matter of general parental insensitivity. Take the matter of mothers with unresolved loss and trauma. It has been shown that they show high frequencies of unusual voice patterns, grimaces (like teeth-baring), intrusive invasions of the child's space (like the sudden placing a hand on the infant's throat), or long periods of dissociation. But this seems only to be the case with mothers who themselves were insecurely attached. Securely attached mothers with unresolved trauma and loss show little of these behaviours (Schuengel et al: 1999). Attachment disorganisation has a correlation with high parental expressed emotion (Jacobsen et al.: 2000). As the intensity and inconsistency of this malparenting become chronic, so does the likelihood of disorganised attachment grow.

## The infant's part

But disorganised attachment is not simply the imposition on the infant of these specific forms of distorted parenting. Green and Goldwyn (2002) show that the infant also introduces something into the mix; in particular, there are correlations with neurodevelopmental vulnerability in the child. There has been evidence of a genetic link. Lakatos and colleagues (2000, 2002) have found a strong association between attachment disorganisation and a polymorphism on the DRD4 gene. Having noticed that a genetic factor is at play in disorganised attachment, it is necessary to emphasise that biological heredity does not determine attachment. Fewer than 40 per cent of people carrying this polymorphism develop disorganised attachment; "this genetic factor is, therefore, insufficient to yield attachment disorganization by itself" (Liotti: 2004: 476). The genetic factor is neither necessary nor sufficient, and yet it is beginning to appear that the infant can have a biological propensity with regard to developing disorganised attachment. Green and Goldberg put the matter judiciously: there is no *gene for attachment,* but rather a variation in temperament and arousal modulation which, in association with specific forms of distorted parenting, is a risk factor.

To throw a corrective light on the matter the case of adopted children and their biologically unrelated parents is instructive. A longitudinal study of internationally adopted children by Geert-Jan Stams and colleagues (2002) followed children from infancy to age seven. It was found that even without genetic relatedness, cultural or ethnic similarity, the characteristics of the early child-caregiver relationships and attachment security played a significant role in shaping children's adjustment in middle childhood. Contra ideas that genes drive experience, we see here that parenting is decisive even when genetic commonalities do not exist. The parent-infant relationship predicts socioemotional and cognitive adjustment in middle childhood even beyond biological, cultural, and ethnic identity, infant temperament and gender, and parents' socioeconomic status.

The interaction between parenting and the infant's biology is also shown by Spangler and Grossman (1999) who demonstrate that low parent-infant interaction produces high autonomic arousal and adrenocortical response, and disorganised attachment. *Relational and developmental* factors may combine in an *additive interactional* way whereby intrinsic developmental vulnerability increases susceptibility to disorganisation by lowering the infant's resilience to distortions in parenting (Barnett et al.: 1999). One can extrapolate this unhappy cycle by suggesting that a mother whose child demonstrates the behaviours associated with this intrinsic vulnerability would find it even harder to empathise with and relate to the child, thereby exacerbating the situation, and so on.

A particularly potent negative combination was children with difficult temperaments whose attachment to their mothers was disorganised. One is faced, though, with a chicken-and-egg dilemma: which comes first? Regardless, it is not difficult to imagine that they will reinforce each other: the mother is out of sync with the child, the child reacts adversely to lack of attunement, the mother finds the child more difficult, the child feels even further away from the mother, and so on in a spiral of increasing mutual alienation.

So, where have we come to? Disorganised attachment is a strong predictor of later developmental and relational problems and psychopathology. The principal origins of disorganised attachment are instability of caregiving—1. actual abuse, and/or 2. maternal factors—in the context of which there may be 3. infant genetic predisposition. As for the nature of the parent-infant relationship, we have seen that it is specific forms of distorted parenting and not just general parental insensitivity that matters. There are many variables at work. Whether the child has other positive (secure) relational experiences, whether the caregivers' disorganization stems from a base of secure or insecure attachment, the severity of the inconsistency, and the level of affective caregiver breakdown, other hereditary factors contributing to disorganization of attachment such as a family history of mental illness; these are all factors worthy of ongoing and further study.

## The socialization of emotion

We said earlier that attachment becomes a within-child phenomenon. This presupposes a prior stage when the attachment is not yet an incorporated style, a stage when these interactions are still in formation. This is the interpersonal or social phase of caregiver-infant interaction. A further part that the infant plays is its effects on the caregiver. Much of human emotion is social in nature, and the development of emotion develops in its social context (Sroufe: 1996). A relationship, after all, develops through feedback loops.

Now, what more can be said about the actual working of the emotion-based mechanism at work? We consider here a heuristic device which captures well the essence of what is at stake in the caregiver-infant interactions which produce disorganised attachment and its devastating sequelae. Carey DeOliveira and colleagues (2004) have come up with a promising model in an attempt to conceptualise the processes at work in the development of disorganised attachment. The authors base their idea on the understanding that what we are talking about when we talk about attachment is the socialization of the emotions. This seems like an obvious but neglected point to make; caregiver-child social

interactions mediate the infant's *biological* predispositions and *psychological* formation. "Emotional communication is at the heart of attachment" (Siegel: 2001: 80) and "many of the most intense emotions arise during the formation, the maintenance, the disruption and the renewal of attachment relationships" (Bowlby: 1980; 40).

In Figure 1 we present a simplified version of their model. The heavier the arrows, the stronger the effect. Arrows running both ways indicate that the factors interact in a two-way and cumulative way.

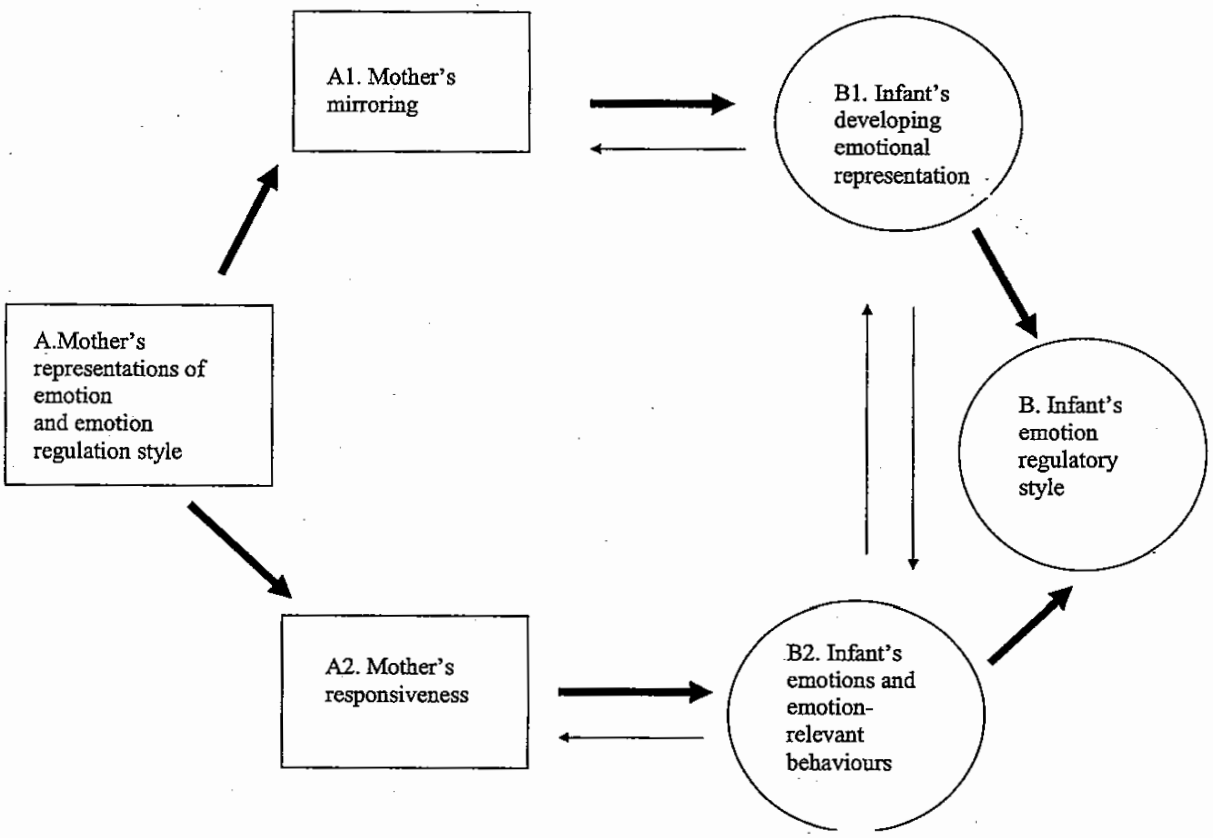


Figure 1. Emotional socialisation (adapted from DeOliveira, et al: 2004:452

The mother's own representations of emotion together with her style of emotional regulation (A) have a strong bearing on both her ways of mirroring (A1) and her responses (A2) to the infant. The infant with its own temperament and biological factors, meanwhile, attempts to receive security and comfort from the mother. Mother's mirroring strongly influences the infant's developing internal emotional representations (B1), and her responsiveness strongly influences the infant's emotions and emotion-relevant behaviours (B2) as displayed in the interaction. These two processes (B1 and B2) occur simultaneously and dialectically. Not only that, they have a reciprocal and reinforcing effect on the mother's socialization practices (A1 and A2). Occurring regularly over the first year the emotions of the infant are likely to be socialized in a particular emotion regulatory or attachment style (B).

In the case of disorganised attachment it is easy to see how chronic emotional mismatching can, through a process of feedback, become exacerbated as increasing emotional distress and mutual emotional alienation. This constant looking for, looking away, and shying away then become entrenched for the infant as a set, though disorganised, style of attachment.

One particular virtue in this model is that it captures the fact that attachment occurs via complementary, overlapping processes of emotional socialization. Readers who are clinicians will immediately grasp that an additional benefit of this heuristic is the thought that perhaps therapeutic interventions can be made at any of Figure 1's sites.

## Some thoughts on treatment

Many issues for client treatment suggest themselves. For one, therapist constancy is clearly vital as the disorganised client is easily thrown into disorganization, extreme distress, or acting out by any perceived misattunement suggested by the therapist's conduct. Having said that, these clients, because they are so needy and also because they routinely push the edges, tend to produce very strong countertransference responses to act, to do something. In Sandler's (1976) terms, in response to unconscious pressure from the client the therapist easily finds him/herself in the role of rescuer (or persecutor or, indeed, victim). The impulse to give the client more (or less) time, telephone-calls, advice, etc. must be resisted and the therapeutic frame maintained (Luca: 2004). This conundrum—how to satisfy this insatiable need enough and maintain boundaries—needs to be contained by the therapist. Perhaps the dimensions of the frame can be adapted for the particular client, but then that frame should be adhered to as much as is possible.

Another difficult issue in the countertransference is the issue of distrust and anger. Through their hostile reactivity disorganised clients notoriously provoke angry interchanges with their therapists and the question is how to work with this. On the one hand trying to hold it within oneself and not to show anger is likely to be futile as these clients are hyper-sensitive to the responses of others. On the other hand, to show anger is likely to be traumatizing for these sensitive clients. In both cases anything from the full range of disorganised client response may result—impasse, rage, devastation, suicidality, breaking off treatment, etc. If one is neither to show anger nor to hide it, what is one to do? Constance Dalenberg (2004) asked clients what they thought on this matter and, while client feedback should not be taken as gospel, their responses are worth noting. Clients preferred therapists who disclosed their emotions after angry episodes

and who took some responsibility for disagreements; this as opposed to therapists whom the clients experienced as blank-screening anger.

In the treatment of disorganised clients it does seem obvious that, certainly at first, insight-oriented psychotherapy is contra-indicated. In a review of the literature on working with disorganised clients Catherine Healy (2003) found that an attachment-based treatment model specific to the disorganised client is lacking. She found instead that treatment suggestions for the disorganised client were often gleaned from interrelated disorders and their treatment models, e.g. PTSD, trauma, dissociation. The question of safety arises when this kind of haphazard choosing of ideas occurs. For instance, Liotti makes the point that trauma-based therapies which work well for simple PTSD "can exacerbate rather than resolve the patients' difficulties" in complex PTSD (2004: 484).

Holmes devised a Brief-Attachment-Based-Intervention (BABI) which, while it is not aimed at disorganised attachment, is of note in that he recommended "post-BABI therapy" for the disorganized client and referred to Linehan's emotional regulation therapy (Holmes: 2001). Healy has accepted this invitation and added to an extended metaphor in the work of Holmes which highlights how the client's manner of speaking about their difficulties provides vital clues about their internal working model and attachment style. Holmes (1999: 2004b) who has written extensively on narrative, attachment, and psychotherapy purports that the way we tell our stories reflects our view of the world. Narrative "is the raw material of therapy and provides clues to the interactional matrix out of which it emerged" (Holmes: 1994: 70). When, in the initial encounter, the therapist asks the client about how it all began (history taking), the process of the client claiming authorship of their story begins, i.e. thinking and talking about what has happened, one's feelings and reactions. Difficulties begin to get placed into a more meaningful context (Holmes: 2000b). (Psychoanalysis can be seen as being about narrative; telling a story is referred to by Winnicott as "an extended form of history-taking", Holmes: 2000b: 97).

Holmes coined the terms *story breaking* and *story making*. Story breaking refers to "those clients who have little to say and speak dismissively of experiences and events, i.e. avoidantly attached clients" (Healy: 2003; 48)—hence the need to assist them to break open their story. As children of avoidant caregivers they frequently experienced rejecting or overly intrusive responses resulting in misattunement. These clients learned to withhold expression of attachment needs that is reflected in their often limited and dismissive story telling. "Conversely, the ambivalent/preoccupied client, who is overwhelmed and often flooded with emotion, needs help to give form and containment to their story" (Healy: 2003:

48). This is story making. Inconsistent, unreliable and insensitive responses to attachment needs as an infant lead to an overdevelopment of affect due to its incomplete reinforcement. Stories lack coherence, are preoccupied by past attachment experiences, and are associated with angry, fearful and passive affect (Holmes: 2001).

Even despite a traumatic childhood, Holmes believes thinking and talking about the pain is a protective factor leading to secure attachment (2000a). He thinks it is possible that this acts as a kind of surrogate relationship that helps to build an internal secure base (Holmes: 2000b: 98). Secure attachment denotes the ability to coherently articulate feelings, to separate self and other experiences, and to deconstruct and reconstruct stories according to new experiences. That is, to fluently negotiate the dialectic between story making and story breaking (Holmes: 2001).

Conversely the disorganized client's story is broken and incoherent, remembering is disorganized and is characterized by "incomplete, idealized, and/or inconsistent descriptions of their past experiences" (Sable: 2000: 44). This is indicative of gaps in the early holding environment, the secure base.

With the disorganized client the therapist responds to inconsistencies, gaps, and discontinuities by exploring with the client when a story does not seem to hang together. As the therapist expands and reflects, the client considers if this fits, learns to put words to feelings, and a narrative and mental representation is forged. Eventually a more fluent, coherent, affectively charged and meaningful narrative emerges (Healy: 2003). Healy contends that the disorganized client needs help with both story making (to access split off memories/emotions) and story breaking (to contain and shape their story). She proposes a third narrative task to capture the unstoried nature of the disorganised client, namely *story reclaiming*, which she incorporates in a treatment guide: a beginning *foundation* phase, a middle *re-creation* phase, and a late *integration* phase. These clients, frequently traumatized and dissociative, need help to unearth and reclaim their story as gradually split off memories and emotions emerge.

> At the core of the client with disorganized attachment is an almost entirely obliterated self. The fundamental lack of a trusting relationship, of the ability to understand one's own mind and that of others results in relationships fraught with mistrust, fear, terror, projection, pain, illusion, despair, and a lack of intimacy and autonomy, i.e. core sense of self. To unearth and reclaim this split-off self/selves is at the heart of the therapist-client work (2003: 53).

## Conclusion

The study of disorganised attachment behaviour is undoubtedly already both rich and large. Typing *disorgani$ AND attach$* in the PsychINFO database produces 392 references. In the face of being overwhelmed by information it is helpful now and then to attempt to be frugal in one's thinking. To synthesise, then, abuse, maternal dissociation, or frightened/frightening behaviour all predict *some form of attachment disorder.* But what is particular with regards to *disorganised attachment* is when mother strongly and chronically misinterprets baby's attachment cues, and when mother gives conflicting messages that both elicit and reject attachment. Reading the recent literature we come to the following: chronic caretaker-infant affective misattunement is likely to produce disorganised attachment. Infant abuse or neglect, unresolved maternal trauma, loss, or depression, and infant genetic predisposition all act as risk-factors. It is the predictability of the unpredictability of response rather than trauma per se which, it seems, tips the scales towards infant disorganisation. Conceiving of the development of attachment as emotional socialization is, we suggest, a useful heuristic framework, as is thinking of treatment in terms of story-reclaiming.

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# My Closest Friend: Love and the Search for the Lost Maternal Object

## Susan Alldred-Lugton

### Abstract

This paper discusses our fundamental need to have an intimate ally, a close friend in the form of an internalised, loving and loveable object. It will explore the origins of loving feelings as they relate to the infant's first love affair with mother and how this translates into relationships in later life. It will be argued that many patients in therapy will be needing to get in touch with the preverbal. It will be suggested that training in an infant observation is useful in gaining the skills to treat the infantile aspects of such patients. Projective identification and countertransference will be discussed, as well as the process of breaking through the false self to recognise the deep suffering that the baby and the small child faced as a result of being raised by a narcissistic parent. It will be suggested that psychotherapists may unconsciously be searching for their lost maternal objects in their patients, hence the need for the therapist to have had sufficient therapy in order to be attuned, but separate.

### Introduction

**Dream on little one, dream on.**
Dream on little one,
dream on,
That's all there are, just dreams.
It isn't't what they promised you,
when you were only one.

Dream on little one,
dream on.
Where's the partner and the kids?
It isn't what they promised you,
when you were twenty one.

Dream on little one,
dream on.
Where's all the joy and love?
It isn't what they promised you,
when you were thirty one.

Dream on little one,
dream on.
Unfold those angel wings,
and fly up to the soft white clouds,
So high above the sun.

Dream on little one,
dream on.
Now you are free from pain.
It's just what Nanna promised you,
When you were only one. (Lugton: 2005)

The poem, with its sad and lost tones, reminds me of how I came to write this paper. I was sitting on some steps in a market in Provence sipping an iced drink in the searing heat, and thinking about an argument I had just had with someone I had imagined was a close friend. I noticed a group of young travellers, about twenty-five of them, mainly men. Some would describe them as gypsies.

They were poor, shabbily dressed, a little dirty and had a desperate edge to them, but they had one thing in common. They all appeared to have a dog, and their dogs were so healthy, seemingly better cared for than their owners were. Somehow these dogs seemed to make their owners complete. Each time the dogs got into a spat, their owners were very protective, as if their dogs were their closest ally, their closest friend, important for their survival. Were their dogs the gypsies' closest friends? Where had the gypsies come from? Where were their families? Did anyone other than their dogs care about them? Had they ever been loved? Looking at them that afternoon made me wonder about the meaning of friendship and love.

## What is friendship and what is love?

I have always thought that one's 'closest friend' was the person one would sit on the cliff edge with, if one knew that the end of the world was coming. In other

words, a friend who may or may not be a lover. One's closest friend, often a partner, maybe the person you imagine having a baby with. It could for many, perhaps the gypsies, be a pet. When a cat snuggles up to a person on the bed at night the words "Sweetheart, I love you so much" are uttered as the cat gazes adoringly at its owner, whiskers quivering. The feeling towards her is so gentle, so pleasurable, so safe, so easy. But really, a cat is just like a baby, no words, just unconditional love, dependent attachment.

There is also the idea of God's love: what is that? Unconditional love, what is that? I think any type of love invokes a strong imaginary component, perhaps based on a type of faith. Barrie's most highly successful play *Peter Pan* demonstrates the powerful fantasy element involved in love and childhood friendship (Chaney: 2005: 330-331). Robert Burns (1759 -1796) said "For if the truth were known, love cannot speak, but only thinks and does".

Our first, close friendship or love affair, as we all know, begins with an idealised, symbiotic union with mother, where mother knows everything about the baby and the baby imagines he knows everything about mother. This is truly projective identification and most would agree, love.

Perhaps the best way I can describe unspoken human love and that first experience of idealised love, is to quote something I wrote during an infant observation. I called the particular observation 'Reverie/Maternal Preoccupation'.

> As soon as Matthew was at her shoulder his lips opened and he smiled and looked very pleased. He then nestled under her chin and his lips opened and he laughed, and his eyes rolled up into his head. It reminded me of an orgasm. There was so much pleasure. I laughed and I said, "He looks very happy, he's smiling," and Sarah laughed, and said "Is he? You little devil, you gorgeous one. I'm in love with him." He snuggled in even further and I thought, he'll never go down now, but down he went. "I think I'll put him on his tummy this time," said Sarah, and he lay there eyes wide open with his fingers in a different position over the thumbs. He turned his head and gazed at her. I knew it must be hard for him to know that they would soon be separate (Lugton: 1993).

I feel very touched, moved each time I remember this scene. It is so heartfelt, mostly unspoken as Burns observed.

But close friendship and love in adult life is different from that between a mother and her baby. It is no longer idealised with the friendly, loving feelings far more complex. Adult friendship involves a degree of separateness and the subtle

negotiation and balancing of love and hate. Even though one may imagine that one's partner knows everything about one, it is not the case, nor is it necessary. One should be able to retain something for oneself, to be one's own closest friend, in order to negotiate one's travel into, and throughout, adulthood. The ability to have become somewhat separate by adulthood is crucial to healthy relating as my discussion about development a little later will illustrate.

I think the concept of respect is also relevant to friendship and love. Respect is a type of empathy, an ability to genuinely value another, and there is also more agreement on what respect is, hence it is more quantifiable. Many people who have not received empathic attunement early in their lives, are very sensitive to disrespect (Winnicott: 1996: 3-13) .

Being in love is something different again, and too big a subject for this paper. However, I recall Julianne Moore the actress as saying, "to be in love is to be in a permanent state of anxiety", possibly because as D. H. Lawrence said, "the great emotions like love are unspoken" (Steele: 2004: 158). However, the unspoken can lead to misassumptions often involving phantasy, hence anxiety.

In the end love is more likely to be an idiosyncratic concept, particular to each person and each situation. Oscar Wilde in particular is a great illustrator of this point. I think the words that have made most sense to me lately as to why loving, adult friendships are important, were beautifully scripted in the film *Shall We Dance.* Susan Sarandon, playing the role of the wife at risk of losing her husband, talks to a private detective about marriage and adult love. She says:

> We marry because we need a witness to our lives. You need to know that your life will not go unnoticed, because your partner will notice it. Your life will not go unwitnessed because your partner will say "I will witness it. I will be your witness."

This is not idealised love, but something much more realistic and sustainable. The psychoanalytic literature is in general agreement that the infant who experiences his mother as his closest ally, a person who would love him and protect him, witness his life unconditionally, has a greater chance of moving to the point of mature relating which involves the capacity to form friendships and to love and be loved.

## When Mother is not good enough

It is frightening, and I think disturbing, to realise that there are many infants being raised by parents who cannot empathise with their children, who cannot truly

acknowledge the existence of the other, and therefore, are unable to love them in a way that allows for healthy psychological development. I would describe them as superficial, perhaps "false self" parents who, for reasons of their own, cannot be a loving and loveable witness to the development of their children. The repercussions of this may be many (Anthony: 1983; Hopkins: 1987; Brown: 2002).

In very general terms, the child may go on to being a compliant child, more often than not empathising with mother, not empathising with himself, often accommodating to the environment, rather than being part of it and finding himself in it. Winnicott's "false self" may emerge, with the child forever on the look out for other people's feelings, rather than exploring his own. This is when feelings may be converted into symptoms such as psoriasis or something akin to that, the bleeding burning skin (Bick: 1968).

The Winnicottian concepts of "true and false self" are useful. They invoke the concept of a split at the very heart of being. Winnicott says:

> The true self is the theoretical position from which the spontaneous gesture and the personal idea emerge. The spontaneous gesture is the true self in action. Only the true self can be creative and only the true self can be real . . . . The true self comes from the aliveness of body tissues and the working of body functions including the heart's action and breathing. It is closely linked with the idea of Primary Process and is, at the beginning, essentially not reactive to external stimuli but primary (Winnicott: 1962; Winnicott, 1990:148).

Christopher Bollas has extended this concept by stating: "We use the structure of the mother's imagining and handling of our self to objectify and manage our true self" (1987:51).

Winnicott explains how the the "false self" at one extreme sets up as real a defensive structure whose function is to hide and protect the true self. Where the mother repeatedly fails to meet her infant's gesture, the true self doesn't become integrated in subsequent development but, in a sense, must never be found, for that would mean a total sense of annihilation of being. She substitutes her own gesture, which is to be given sense by compliance of the infant. This compliance on the part of the infant is the earliest stage of the false self (1990:145).

Michael Fordham, a Jungian analyst, describes things differently, probably because he calls the early self the "primary" self, and sees the infant from the beginning as a person, separate from mother. He says:

> At times the fear of the meeting between expectation and object is not satisfactory. The infant becomes distressed, consequently tries to defend himself

> against his distress, and ego development is impaired. At times the rage and fear are so great that the infant erects defences of the self which protect him from disintegration (1947:169).

Whichever language you are comfortable with, these are powerful words. Winnicott and Fordham have clearly described something that I am familiar with in many transferences. For a patient to be so disconnected from himself is a personal tragedy.

So what happens next? Do we all need a safe internal maternal object? The answer is, of course we do!

## The lost maternal object and loneliness

I believe that everyone, in these very narcissistic times, needs more than ever, a safe, reliable, and emotionally attuned, maternal figure. If it has not been internalised in infancy, I think there can be a lifelong search to fill the void. People who have an insecure attachment style may not be able to adapt to change, especially separation, as well as those with a more secure attachment style (Ainsworth: 1989).

Divorce, for example, may evoke powerful feelings. Dells and Phillips in *The Passion Paradox* state:

> Romantic loss reawakens the primal fear of abandonment. Babies instinctively feel abandonment because their physical survival depends on having a constant caretaker. In a sense, we are all like babies when we feel abandoned, only our fears centre on emotional survival needs. The anguish of romantic rejection tells us something about the strength of these needs (1990:97).

The principal message that many patients convey, both verbally and non-verbally, is being lonely: not something easily described, but just a sense of a deep inner aloneness. We can be naive about the inevitability of loneliness: the fact that unlike when one is a baby, as an adult it is normal to sometimes feel, or be, lonely.

David Schnarch, in *A Passionate Marriage,* says:

> Eventually we must grapple with the immutable separateness of being human. Loneliness is a basic condition of our existence. It is part of understanding and appreciating intimacy and, when correctly handled deepens and extends our humanity (1997:402).

Clark Moustakas, in his book *Loneliness*, writes "To love is to be lonely". He says:

> We confuse existential loneliness and loneliness anxiety. Loneliness anxiety is our common but necessary fear of being alone, our normal neurosis, our alienation from ourselves. It surfaces in the pervasive 'never be lonely' themes in modern society and what we now call 'fears of abandonment' (1961:101).

The psychologist Eric Fromm (1941) says that intimacy is the way that we escape from "the prison of our separateness" (quoted in Schnarch: 1997: 403). Fromm presumed an acceptance of existential loneliness, rather than a denial of it. His understanding is that the healthy person acquires the ability to manage the feelings of being alone. A person who has not been able to find their true self in life, who has not internalised a comforting maternal object, can actually feel traumatised if they do not have a partner.

I am reminded of a patient; I shall call him John. John came to see me after spending four years in bed. He called his condition "chronic fatigue syndrome". Others might call his state of mind adult, anaclitic depression. During the initial stages of John's therapy he would text me confirming an appointment or to let me know something about his life. I replied once or twice, although reluctantly, and then I began to wonder why he did this. Finally, about two months into the therapy, I plucked up the courage to say that I was wondering what the text messaging was about. He smiled and said he didn't really know. He needed to do it for some reason, but he couldn't find the words to explain it. I said that the text messages were held in my phone and I wondered whether it was his way of always being with me, reminding me that he existed so I would not forget him. Perhaps it was something to do with his Dad.

He thought about this and said "Yes, I think you might be right". His eyes were very moist, but he was not able to let the tears flow. My eyes were moist as well. I felt connected with him.

John then talked more openly about his childhood. When he was one, his father, who was a postman, was gaoled for taking cash out of envelopes, ostensibly to feed his family. He went to gaol for nine months. John, again, could not find the words to explain his loss. When he was four his father had tried to kill himself with a shotgun. He succeeded in damaging his chest and shoulder, and made two large holes in the living room and dining room walls. All John can remember is coming home and finding his grandfather plastering up the holes. Shortly after that, his mother left the house with the children. John reconnected with his father much later and they are now friends. After that session the therapy took a

leap forward. I think prior to that, John had been frightened that I would not be able hold him in my mind, remember him, especially when I did not speak.

## Repercussions at various developmental stages

The DSM-IV is relevant to this discussion. It states that the Dependent Personality Disorder is among the most frequently reported personality disorders encountered in mental health clinics. Two of the symptoms are

> 6) Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself.
>
> (7) Urgently seeks another relationship as a source of care and support when a close relationship ends (DSM-IV: 669).

It is not surprising that a person might develop these symptoms, if he or she has been in a fused, dependent position with a mother who, consciously or unconsciously, wants her child to remain a child rather than mature.

So at which points are those who have had an experience like John, for example, at risk of not being able to contain a lonely or alone state of mind, not able to feel that someone is alongside them, and in adulthood, urgently need a real life partner? In other words, at risk of developing dependent traits, or worse still, a personality disorder.

*Oral Phase*: For the developing infant, object constancy is generally reached at eight months, when, if mother goes out of the room, the infant has the capacity to hold onto an image of her in his mind: the depressive position, holding the good and the bad breast alongside one another (Klein: 1940: 347).

How must it be for an infant who has not had the empathic, loyal, trusting experience? How do they manage this? Probably not well. If he has not been allowed to be a little separate, does he get thrown again and again into the "paranoid-schizoid" position, not having the internalised mother-infant couple to contain his anxiety? The false self may by this time be emerging (Winnicott: 1990: 145).

*Anal Phase*: For the anal infant control is the central issue. For the first time, the young child may be able to do a poo in the potty, a very real gift to mummy. What happens if mother is not attuned to the toddler's struggle and delight at finally being able to control this part of his body? He will need to sense the congratulatory empathy of the mother, a shared joy. I suggest that the mother who feels that her child belongs to her or in phantasy, is part of her, may enviously

attack anything which does not involve her and belongs to her toddler. Often patients who are stuck at this stage may be quite withholding, secretive, for fear that they will be intruded on, have things stolen from them.

*Oedipal Phase*: For the oedipal child, a myriad of sexual issues are beginning to surface where parental attunement and empathy are again critical. The process of falling in love with his mother, and in fantasy, killing of his father, finds the little boy desperate to find his own identity with much confusion and conflict about "Is this OK?". If the parents cannot tolerate his outbursts of rage, again he may be left floundering, reverting back to only pleasing his parents, rather than having his own little identity, with the false self further developing.

These oedipally fixated patients can become enraged, particularly in groups, when for example, a woman fancies someone else. They may also develop fetishes, for example, with the little boy identifying too much with his mother and cross dressing. I suggest that gender difficulties may also emerge where the child may not be able to tolerate difference and will prefer to be with someone who is the same. This can be revisited in the genital phase.

*Genital Phase*: During the genital phase, when oedipal issues arise again, the adolescent begins to slowly participate in small acts of sexual behaviour. The adolescent girl may be in a constant, exhausting battle with her mother. Some say the task of adolescents is to murder both the parent of the opposite sex and the marriage, but of course, if they do, it is disastrous. There is a lot of pushing and pulling and the parent with low self esteem can find the process close to annihilating.

Hormonal adolescents face head on the task of finding their own identity, struggling to separate from their parents. The narcissistic parent may need, wittingly or unwittingly, to inhibit their child's need and rightful destiny to become a sexual being. They don't know how to handle the young person who is becoming sexual. The child who has previously been so accepted and so loved and loveable, feels unable to repress the sexual aspects of themselves and at the same time feels a pressure to remain a child. The adolescent can feel a type of stuckness, a pull from the parents to be a child, an impulse from himself to become an adult. This feeling of impasse may generate an unbearable sense of being alone and lonely. Suicidal ideation or actual suicide may follow.

*Adulthood and Marriage*: The marriage of an adult child is a time where it is sometimes hard for narcissistic parents to set aside their own phantasies about who their child should be with, and to respond positively to their child's choice of a partner.

Unwittingly, the child may make an unconscious choice to be with a partner who is similar to the parent who is most problematic. After which there may be a struggle, often for many years, to convert their partner into what they think they need. This is an unconscious attempt to change the internalised object they remember from childhood. Again, a search for the lost maternal object.

*Becoming a parent*: As I have discussed previously (1994), the main danger lies in the parent overcompensating for what she believes she did not have as a child (Clulow: 1982). Alternatively, a mother may feel great anger towards her baby if she is expected to idealise her baby. If this is not understood, her repressed rage and murderous phantasies may contribute to a post-natal depression. In either case, she may enviously attack her relationship with her baby to avoid the baby having more than she had herself. This is often a time that mothers or couples present for help, as intuitively they fear that they may not do a good enough job. With support, however, they often are good enough mothers and parents (Clulow: 1982).

*Menopause/Retirement*: Unfortunately, this period often comes alongside the couple's parents dying, or friends developing terminal illnesses and becoming vulnerable. It can be a threatening constellation of events when one or both partners may develop a depression and neither can contain the other as they formerly did. It is not surprising that without a solid, internalised, comforting, maternal object, fifty-year-olds can develop a very serious, almost psychotic depression, especially if they have a tendency to be melancholy. I think this is also the stage where there is the danger of an affair, a desperate need to feel love or be in love, as time is running out: mid life crisis time. In many instances an affair could be described as an erotomaniac defence against retapped early anxiety and depression, even anaclitic depression (Spitz: 1965). The experience of the loved object turning away, or being experienced as lost, leaves the other vulnerable to seeking love, touch and warmth elsewhere. Again, an example of a search for the lost maternal object (Lugton: 2004).

Whatever its origins, the wish to be in an idealised "in love" state of mind, similar to that with mother, can lead to sexual acting out and serious consequences. So often the fifty-year-old, menopausal woman may get entangled with a dark, smouldering charismatic, Darcy type, the narcissist who may turn out to be a rigid, controlling and dominating nightmare - a baby in adult clothing. This baby in adult clothing has a powerful, familiar pull, as he represents the narcissistic parent (Reich: 1986).

It is clear from the preceding discussion that many of the transferences that present themselves in the consulting room are not only difficult to understand but difficult to tolerate and manage (Joseph: 1985); hence the requirement that therapists are appropriately trained and suitable for engagement with infantile aspects of their patients.

## Training

Psychotherapy is a co-operate, conciliatory relationship where the therapist, ideally, needs to be in a state of mind where he or she can suspend critical judgement, at the same time being aware of what is at play in their own superego. This attitude creates a space in which the therapist has more chance of creatively engaging with the conflicts and suffering that patients bravely bring. Most clients feel critical of themselves, feel guilty and ashamed and may have difficulty putting the issues into words.

So many of our patents have been traumatised during the first year and so often are in that early traumatised state of mind in our presence (Hopkins: 1987). As such, we have nothing to go on except our experience of being in the room with them. Often this is a silent time, when much is being communicated and needs to be held, digested and understood. Sometimes it will be the first time in his life that the patient will have felt listened to and understood.

One of the most useful training experiences to prepare oneself for working with infantile transferences is to undertake an infant observation based on the Esther Bick method (Bick: 1964; Tuters: 1988).

## Learning through infant observation

The merit of using aspects of the method of infant observation in the therapy setting with adults has been discussed widely (Bick: 1964; Covington: 1991; Dowling & Rothstein: 1989; Freud: 1975; Harris: 1987; Henry: 1984; Miller,Rustin & Shuttleworth,:1989; Tuters: 1988).

The experience of completing a five-year infant/child observation was critical to the development of my skills as a therapist. It both fascinated and frightened me. It also taught me just how sensitive an infant is to his mother's engagement with him, and how important this is in one's start to life. Fortunately, the mother I worked with was mature and used to babies, Matthew being her third.

I emphasise that the infant observation training experience is very different from bringing up one's own children. The observer needs to be separate, and aware of that separateness (Coulter: 1991). Critical is the fact that because the first year of an infant observation is without language, it is usually only the mother who is attuned to her baby's communications. As such, it teaches the observer a great deal. This is when the mother is truly a witness to her infant's life and the observer is a witness to the mother's and infant's lives.

The "infant observation" method is simply the way observers are taught to watch and listen. As therapists we are also observers. Rather than observing a mother and her infant the therapist is observing the therapy dyad: the therapy/mother and the patient. Not an easy task. I think if this can be achieved there may be more of a chance of the patient internalising the therapist as a "good enough mother" (Winnicott: 1986:13n). The goal is to try to develop the capacity to look inward and outward simultaneously. This state of mind is described by Bion as "binocular vision".(Grindberg: 1971: 35) It is a way of seeing the struggles to prevent the session from being clouded and distorted through preconception. We must try to listen as Freud suggested, with "an evenly suspended or poised attention" (Laplanche: 1988: 43) so that we are optimally available to respond to both conscious and unconscious communications from our patients, at the same time being aware both of our own and the patient's state of mind. Similar descriptions of this process include "quasi telepathic" and "coenesthetic", "receptive" or "empathic listening" (Nathanson: 1988).

## Projective identification

Many of the unconscious communications of infant and mother proceed via the processes of "projective identification" and "projection". Klein (1932, 1957) first introduced the term "projective identification", describing it as an unconscious defensive process by which human beings, in phantasy, can rid themselves of unwanted painful feelings. Bion (1967) extended Klein's usage, describing "projective identification" as a communicative process by which the infant (patient) can project all of his feelings, bad and good, into the mother (therapist), to help her make sense of his needs. The mother (therapist) unconsciously identifies with what is being projected and may be induced to think, feel or behave differently.

Bion and Winnicott viewed projective identification as an essential form of two-way communication which can induce identification both of infant with mother and mother with infant. Bion describes this complementary state of mind as

the infant being contained by the container/mother and believes that it is the precursor to the infant being able to think, another goal of therapy (Grindberg: 1971: 52-53). As such, it is critical for normal development.

In the therapy setting, when the infant/patient is anxious, he may project the anxious part of himself into the therapist/mother, who may identify with the anxiety. The next stage of projective identification involves the sensitive therapist/mother processing the projections for the patient. She can then respond in her own way, her own creativity at play, so that the patient's projections can, in time, be converted into a more acceptable form, the last stage of "projective identification" (Ogden: 1979, 1982). Gordon (1965) and Jureidini (1990), both Australians, provide useful discussions of projective identification.

## Countertransference

The process of projective identification is linked with countertransference. Racker (1968) provides a comprehensive discussion on the subtleties of countertransference including the terms "complementary" and "concordant".

Countertransference is composed of the feelings that appear to come from nowhere and may well be what the client is unconsciously communicating to the therapist. Part of one's response will also be due to one's own personality, defence mechanisms, psychopathology; and all psychotherapists have that, whether they want to admit it or not (Guntrip: 1986).

Countertransference is one of those terms about which there is much disagreement (Laplanche and Pontalis: 1988; Rycroft: 1985; Hinshelwood: 1991). Perhaps that is why David Malan in his text *Individual Psychotherapy and the Science of Psychodynamics* refers to countertransference only once (Malan: 1982: 85). My understanding of countertransference is again influenced by Melanie Klein (1932, 1957, 1991). I prefer to think of it as almost all of the unconscious reactions, including thoughts and feelings, that one has when one is with a patient. As such, the therapist is like a "tabula rasa" or empty plate, whose major function is to be the container (Bion: 1967, 1970) for the unconscious projected feelings and parts of the patient's self and object world. The process that then occurs is a resonance from unconscious to unconscious.

Countertransference is similar to an internal reflective mirror that can help the therapist make working hypotheses about the unconscious relationship between therapist and patient and what may have occurred between the patient and his primary care-giver, often mother. For example, if the patient's experience

as an infant was that when he or she cried, mother would leave the room, the patient may imagine that will happen if he cries in front of the therapist: that the therapist will not be able to bear any difficult feelings and leave the room, at least emotionally. A therapist who can stay in the room, rather than be propelled by the patient's projections of a deserting mother, will represent a mother who can tolerate the infant's cry. The therapist who uses countertransference to inform her of the patient's internal object-relations may be able think about her countertransference and thereby contain a patient's projections. She will then will be able to process what the patient is communicating to her and feed it back to the patient in the form of an interpretation. I emphasise the 'may', because sometimes therapists are unable to think, especially in the presence of borderline or psychotic aspects of their patients. Hence the importance of supervision.

Crudely, you could say that what the therapist is feeling is a guide to what the patient is feeling. Those who object to this interpretation of countertransference are, I think quite rightly concerned about those parts of the countertransference which are made up of reactions of the therapist which, as I mentioned above, come, for example, from his own psychopathology. Freud stressed that no therapist can go further than his own complexes or resistances permit. Consequently to enable the countertransference to be a more valid guide to what is going on with the client one does need to have submitted to a personal analysis, to assess one's own ego defences (Freud: 1968; McGuire: 1974).

## Empathy

Perhaps within all of this, as Nathanson (1988) suggests, useful terms are empathy or empathic listening. Many therapists believe that they are empathic, and it is often only after years of working in this field that they come to recognise how, unconsciously, they themselves defend against authentic empathy, possibly to avoid being retraumatised themselves. It is only in a genuinely empathic, respectful, loving space that patients can slowly begin to digest interpretations perhaps about their inability to describe their feelings and their own capacity for empathy.

Over time, as patients learn that perhaps their mothers were not good enough, they can allow themselves to become more separate and empathise with themselves, at the same time slowly beginning to internalise the therapist. As the true self is accessed they begin to have a feeling of being less alone. They may even believe that they have found a friend. It is at this point in the therapy and in the transference that the patient may begin to have many

phantasies or dreams about the therapist being a real friend. With appropriate boundaries the grief involved in knowing that this can never be so can be worked with. Their capacity to grieve and to sob sometimes uncontrollably, often becomes evident when they cry for themselves rather than others. Whilst this can be extremely painful, it can also feel like a great relief and they may say things like "I don't feel myself" or "I feel strange, suspended". This is the "me, not me" idea that Winnicott talks about, transitionally and often perilously balanced between false self and true self (1986:130). This often the time when patients get in touch with the psychotic aspects of themselves, where breakdown may occur and good containment is critical. On the more positive side, by understanding why they nearly went mad as babies, patients become more compassionate and less blaming of themselves. Many patients are beset by guilt and shame, perhaps the most destructive of feelings, because their mothers could not empathise with them. They were left in the dark with the only explanation being that it was their fault, often carrying their mothers' shame as well.

## Case study and assessment

I had been seeing a patient for some time twice a week. I shall call her Janet. She, like John, was depressed, with a sense of not knowing whether she really existed for anyone. She repeatedly said that she had never existed for her mother and was always sensitive to not existing in her relationships. Janet often talked about killing herself. She would then have truly ceased to exist. It was hard for me to hold her through these times and the transference was terrifying for both of us. After a session when my patient was trying to recover from her husband's premature death from cancer and four years later, her twenty-five-year-old son's murder in Africa, I found myself writing the poem "Dream on little one, dream on". Adult life for her was far removed from her childhood dreams.

A month later I received an email from her which had a kindly sense to it. She asked for a change of time which I was able to do, and she said "Thank you" in the most genuine way. I told her of my experience of her gratitude and she cried and said "Yes". In that moment, she felt as if we were really close and she did feel grateful. This had occurred two weeks after she had shouted at me "Why do I always get blamed? You are attacking me". I was able to tolerate her murderous feelings, her attempt to murder my existence. I think my being able to withstand the intensity of Janet's murderous and self-murderous attacks may have been what Bion would have called surviving "catastrophic change" (Grindberg et al.: 1971: 17-18) and the turning point that effected the change

in her. She said later "I was never able to scream at my mother and I have never been able to do it to anyone". Whilst it was horrible when she was doing it, it had led her to realise that you can be very angry with someone, but they may still care and not disappear. I was very moved and reassured because I had hated her shouting at me and I had a nightmare afterwards. Reading 'Hate in the Countertransference', Winnicott's seminal paper (1987:194-204), helped me to contain my own raging countertransference. A day later I came upon a poem by Mary Elizabeth Coleridge (1861-1907):

**Affection**

The earth that made the rose,
She also is thy mother, and not I.
The flame wherewith thy maiden spirit glows
Was lighted at no hearth that I sit by.
I am as far below as heaven above thee.
Were I thine angel, more I could not love thee.

Bid me defend thee!
Thy danger over-human strength shall lend me,
A hand of iron and a heart of steel,
To strike, to wound, to slay, and not to feel.
But if you chide me,
I am a weak, defenceless child beside thee.

Janet and John highlighted some of the things to look for during assessment. Amongst other things, I look out for the capacity for empathy. A useful idea to play with is, "Could I imagine this person being my mother or father?" I think the clearest sign of a person who has not received empathic attunement is one who cannot empathise as mother couldn't and may find parenthood difficult. Early in Janet's therapy I worked for three months with a broken ankle encased in a huge cast. Little was ever said about it. Denial, or lack of empathy, but worth wondering about.

Listen to your body. It may pick up something often preverbal. In the first session with John the hair stood up on the back of my neck. I think my physical response reflected his fear as a small boy, his lack of containment, even a feeling of going mad (Wiener: 1994). In general, the psychotic patient tends to be more concerned with the authenticity of the heart not the words, particularly during a first meeting with the therapist Look out for discrepancies even lies.

The narcissistic personality, on the face of it, is constructed to suit the needs of others but in fact they often have to keep secrets in an effort to maintain their power. John lied consistently throughout the initial stages of therapy, laughing as he did so. Perhaps he was enjoying teasing me, shades of contempt? My feelings of disquiet were palpable.

## The therapist's search for the lost maternal object

And now for perhaps the most challenging part of my paper. We know a great deal about what we, as psychotherapists, are to our patients. We have compassion for our patients. We enter their worlds and share their suffering. Some would say that we love them. We believe that we respect them.

We are, as we know, never in reality our patients' closest friends, but I think we are pivotal, transitional friends. We provide a space in which they may feel less alone, in an effort to help them find themselves in their struggle, to help them grieve for their lost maternal and paternal objects.

But what are they to us? Someone once said "Scratch the back of any therapist and you will find a depressed mother". I reframe that to say that a therapist/ mother who has suffered so much herself may have little left for her patient, and may not, temporarily, have the capacity for empathy. Sad for both her and her patient, as mutual attunement is critical at this time. So what about the neglected symbolic infants in us?

Much has been written about the way we can project our infantile needs into our patients and have them cared for vicariously through the process of that contact. Alternatively, we may in part want our patients to be our babies. I have noticed how many therapists begin their training just after their children have left home.

As I mentioned above, an addictive aspect of this work is the fact that one of the things we get from patients, even when they are in the negative transference, is respect and a type of love. It is often at times when clients do not treat us with respect by not paying an account, for example, that we may feel abused, used, perhaps a revisiting of the early trauma, when attunement by our mothers or fahers was not present. A bit like not getting a drug hit.

I would like to suggest that many patients have difficulty finding words for something, perhaps an early, powerful and pre-verbal trauma. I think this is sometimes matched by the difficulty the therapist has in being able to

genuinely empathise with the deep suffering of the patient, preferring to fall back on theoretical interpretations, however well-intentioned. How to be able to understand this preverbal period is an important task for us all and I think it promotes a loving transference. I am not certain that we can create this unless we have completed an infant observation.

Fairbairn once said, "I can't think what would motivate any of us to become psychotherapists if we did not have any problems of our own" (Guntrip: 1986: 448). Kernberg (1980) and more recently, Neville Symington (1993) also emphasise the need for therapists to have the deepest parts of themselves looked at, empathised with, and thus potentially able to be managed. If the lost and long-suffering babies in us are not attended to, surely it makes sense that we may search for that in those closest to us, and that may be our patients. I think there are times when our patients reassure us, feed us, providing sustenance for our hungry narcissistic selves. If this is more than temporary, an ongoing need, then we may be repeating the experience they had with their own mothers, hence the danger of therapy "interminable" (Freud: 1937).

All I am suggesting is that we need to be aware of our own vulnerability, respect it, and find our own authentic true selves in the myriad of projective processes. We also need to be attended to by getting mothering, love and friendship from other parts of our lives, rather than relying on our patients for sustenance, relying on them to be our mothers. Otherwise, every time we connect with something in the patient that resonates with our early lives we may be retraumatised and be at risk of exhaustion and inevitable burnout.

One of my supervisors once said to me "To be a therapist you need a very passionate partner". Not all of us are in that position, so we have to make do. We will sometimes make narcissistic object choices when choosing partners and that will certainly not feed us (Reich: 1942). I have been fascinated by how many therapists choose partners (patients) who resonate with the long-suffering infant in the therapist, the partner often being pitied rather than the therapist pitying herself. As a result we have two adults with deeply denied suffering parts of themselves trying to have an adult relationship. Twins without parental objects present and internally available: potential catastrophe.

Our lives, like those of our patients, are never ideal, but we have our supervisors, we have intimate friendships and we have or own therapists. It is important for our survival to make the best use of them.

## Conclusion

What I have argued is that, in the end, we are alone with our experiences of life, our knowledge of life, and our insights about ourselves. Some of us are surrounded by many people, some prefer to be more solitary, the extrovert influenced more by the external world, the introvert more persuaded by his or her internal world.

The patient, more often than not, comes to therapy with an unconscious need for someone else to make his or her life complete: the "witness to their life" idea. By the end of the therapy there may be much more of a sense of living alongside oneself, in the knowledge that intimacy with another is a choice rather than a need, sometimes a desperate need. In today's world with the couple state seemingly so much "under fire", many people will find themselves single, if only towards the end of their lives. Those that seem content are those who have a sense of an accessible inner optimism with good internal objects guiding them along the way.

Whatever we choose to do, to rely on our own inner world or on the environment, the only truly close friend is our own authentic self. The self-love or self-respect we manage to develop is something which cannot be taken away. It belongs to us. Ideally it is real, it is palpable, it is alive and creative.

When a patient can honestly say "My closest friend is me", I think we are getting somewhere. Rather than being depressed they could be better described as unhappy, a state of mind that can be comforted. In my experience it is hard to comfort a depressed person.

I am reminded of a verse from a poem, "The Love Song of J. Alfred Prufrock" by T. S. Eliot. For me, his words capture the most fundamental element inherent in any psychotherapy session: courage.

> And indeed there will be time
> To wonder, "Do I dare?" and, "Do I dare?"
> Time to turn back and descend the stair. . . .
> Do I dare
> Disturb the universe?
> In a minute there is time
> For decisions and revisions which a minute will reverse (Eliot: 1930).

As a psychotherapist you will not only descend the stairs with your patients through their various stages of development, you will invariably disturb their

universe and also your own. Through this process, as with T. S. Eliot, we often unwittingly expose much of ourselves, both consciously and unconsciously. Without a capacity to be vulnerable ourselves, I think there is less potential for creativity in the therapeutic relationship, more of a risk that it will be a vicarious experience for the therapist.

You may, as I have said, be experienced as your patient's closest friend during this process and you will dare to love them, hate them, fight with them and make up. Most of all you will stay with them, explore, tolerate not knowing where each moment may take you, allowing yourself to oscillate between yes, no, yes, no. The people who ask, often so desperately, for our assistance, need to know that we have the capacity to survive all of this, often because their mothers could not. Their mothers were their lost maternal objects, the often blank register. Patients need us, albeit temporarily, to be a witness to their lives. Often they will reclaim hope, find their true selves and leave us. They may want us then to be a friend in the outside world but we need to be able to say goodbye: they will be sad and so will we. As my poem suggests, our work will indeed be done.

**Little one**
I sit beside you little one
To hear your memories good and bad.
They often can't be told in words
But simply felt and heard
I sit beside you little one
Until our work is done (Lugton: 2005)

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# The Feminine

## Felisa Roldan

## Abstract

This paper attempts to introduce a concept very rarely, if at all, mentioned in psychotherapy: "the feminine". It proposes that psychotherapy would benefit from better understanding masculine and feminine principles, particularly the latter one, in view of the neglect they have suffered over the years. Finally, it also suggests that psychotherapists could collude with an over-masculine culture if not careful. Awareness comes primarily from a personal encounter with the feminine. Jungian and Post-Jungian psychoanalysts add some light to this issue.

### Historical framework

Whenever I refer to the masculine or the feminine principles, I am not implying gender. I am not exploring differences between men and women. In this article, I focus on the feminine and I mention the masculine only in passing when it seems necessary.

The slow change from polytheism to monotheism contributed to the loss of the goddesses which kept alive the feminine principle. The original pagan Germanic and Celtic religions had many cults of Mother Earth and other nature goddesses. Ancient cultures, ruled by feminine archetypes, lasted about 25,000 years as compared with 3,000-4,000 years of later masculine sovereignty (Meador: 1992). Many other events in the history of humanity added to the progressive suppression of the feminine:

Widespread hopelessness and alienation marked the onset of the witch persecution in a Europe decimated by the Black Death and disappointed by the failure of its Crusades in the Holy Land. As a result women were cut off from their own spiritual experience. Barbara G. Walker (1985) says that about nine million persons were executed after 1484 by the Inquisition, and uncounted numbers before that date, mostly women.

The birth of Science in Western culture emphasised the predominance of masculine thought processes. Science set out to look at the world in terms of 'cause' and 'effect' to gain some mastery over our surroundings. It appeared to

make the world safer and at the same time it turned away from the complexities of life and other forms of thinking.

As psychotherapists, we need to be very aware of the value system in the culture we live in and reflect on the subtle ways we might collude with the predominant value system.

## Defining the feminine

Masculine and feminine principles are two different ways of being. This is reflected in a different way of thinking, feeling and behaving. Jung referred to animus and anima to make a differentiation. Post-Jungian analysts developed his ideas further. Unfortunately, Freudian Psychoanalysis has not added any depth to this subject. Marie-Louise Von Franz points this out by saying that "Freud had very little recognition of the feminine element and therefore always explained it as sex" (1996:85).

The progressive burial of the feminine and its intrinsic nature have left us with few words to express this principle. As a consequence there is a gap, a missing link in our psyche. This is why I believe it is important to make the effort to find the words that might come close to defining the feminine even at the risk of not getting it totally right.

In Chinese tradition the parity and complementarity of female and male concepts are clearly expressed by the *yin-yang* symbols. *Yin,* being the feminine, was associated with the qualities of darkness and coolness. *Yin* was also described as hidden, recondite and unseen. The moonlight (in contrast to the sunlight) was one of the images to represent it. The light of the sun strikes in a cutting and direct way, the moonlight blurs the outlines and collects all in a tenuous and diffuse way. Therefore *yin* came to represent secrecy, mystery and abstraction. In psychological terms it is used to symbolize docility, humility, openness, receptivity, detachment, restraint and self-mastery (Cleary & Aziz :2002:65). Jung understands the anima as the personification of all feminine psychological tendencies in a man's psyche, such as vague feelings and moods, prophetic hunches, receptiveness to the irrational, capacity for personal love, feeling for nature, and his relation to the unconscious. Talking about anima he says:

> . . . I have noticed that people usually have not much difficulty in picturing to themselves what is meant by the shadow...But it costs them enormous difficulties to understand what the anima is. They accept her easily enough when she appears in novels or as a film star, but she is not understood at all

> when it comes to seeing the role it plays in their own lives, because she sums up everything that a man can never get the better of and never finishes coping with. Therefore it remains in a perpetual state of emotionality which must not be touched. The degree of consciousness one meets with this connection is, to put it mildly, astounding. (Jung:1953:para 485)

Post-Jungians have developed the term further. Marina Valcarenghi (1997) talks about the masculine and feminine principles as two different and complementary ways of expressing the activity of instinct, feeling, and thought.

## Feminine thought

Feminine thought does not start with the examination of a detail, but with contemplation of the whole, and it is not oriented toward penetrating, but toward absorbing the object of knowledge: thus it is a process which tends to develop toward the inside, at times seeming covered with sand, not existing, like an underground river, until it springs all of a sudden, with its conclusions, after having followed an invisible course. (Valcarenghi: 1997:3) It makes connections in a symbolic and inductive manner. Unlike the masculine which is more interested in analyzing and classifying in a more logical and deductive fashion, feminine thought creates connections that are not so clear to the logical mind. For this reason it has often been judged too close to the magical realm and dismissed.

Logos and gnosis are two concepts that help us see the difference between masculine and feminine thought. Logos is rational, objective, logical, expressible in words or numbers - while gnosis is subjective, non-rational , nonverbal, feeling-tinged, expressible through poetry, images, metaphor, and music, and is often unprovable by its very nature. Paradox as a way of encompassing two aspects with an apparently opposing nature sits well with this attitude. Metaphor and images also get closer to the feminine ways i.e. the realm of the symbolic. When thought becomes too masculine the balance is lost and thinking turns too rigid with a lot of "shoulds" and "oughts" and a lack of flexibility.

## Feminine feeling

The feminine remains centred and still around feelings. It witnesses them and tries to reveal its deepest meaning. Unlike the masculine which orients itself toward feeling to reach an end, to make plans, feminine psychic disposition is contemplative. It concentrates more in being than in doing, and it involves

relationships between things and people more than the actions of things and people (Valcarenghi:1997:22).

Sometimes as a consequence of the feminine's freer attitude towards feelings, it has been regarded in a sentimental way. Sentimentality does not acknowledge the depth of the feminine. This attitude once more ignores the true validity of this principle.

## Feminine instinct

There is an active, dynamic aspect of feminine nature, that which promotes change and transformation, counterbalancing the static and maternal, which, although providing for growth, is essentially conservative and protective. Feminine instinct presents two aspects: the maternal sphere and the feminine sexual sphere.

The *maternal sphere* has a desire to protect, nourish, and nurture. Like other female animals, genetically prepared to be responsible for lives other than their own, women are quick learners and keen observers and can achieve high levels of understanding of the human condition. This is sometimes called "feminine intuition". Suffering is also part of the feminine. In the not so distant past childbirth was followed by death. Aztec women who died in childbirth were equated with warriors who died in battle. Suffering is also necessary for increased awareness and development of personality. The feminine knows how much effort goes into the creation of a life and is therefore less easily persuaded by the we /they dichotomy, and more prone to sympathize with the basic humanness and vulnerability of other human beings.

Finally,the feminine is closer to the natural cycles which are alive in a woman's body on a regular basis.

The other aspect is the *feminine sexual sphere* which has suffered repression over the years.

> The harlot archetypal image, a feminine ancient Goddess, was reduced in its entirety by collective Judeo-Christian morality. It was considered an exclusively negative, lowly, and inferior matrix, devoid of spirituality. The Goddess represented by the harlot archetypal image was identified solely with the prostitute polarity. The denial of the Goddess' divinity brought about an annihilation of the sacred priestess polarity( Hillel:1997:112)

Analyst, Dr. Rachel Hillel, expresses this very well: 'The feminine's essential meaning to the human psyche is reduced when the sacredness of the vulva is unacknowledged and denied" (1997:120).

Nancy Qualls-Corbett similarly expresses the same sentiment:

> No matter what her name, the love goddess is related to the earth, the body, to passion, sexuality and fertility. She is the moving, transforming, mystical power of love which unites the human element with the divine (1988:16).

Consciousness of feminine nature begins in deep appreciation of, and caring devotion to, the body. Women are closer to the natural rhythms by the fact of their physiological cycles. The attack on the body that we see in the rise of anorexia nervosa in adolescents gives room for thought as to the metaphorical attack of the feminine given that this illness comes so close to the time when a woman has her menstruation. Generally, however, the attack tends to be more subtle and yet not less damaging.

## The malaise of our days

Jung writes that "the loss of an archetype gives rise to that frightful discontent in our culture" (1953). This is the case I believe with the feminine. With the burial of the feminine, important values and psychic experiences have been suppressed, leaving unsatisfaction and lack of balance in our lives.

> When the divine feminine, the goddess, is no longer revered, social and psychic structures become overmechanized, overpoliticized, overmilitarized. Thinking, judgement and rationality become the ruling factors. The needs of relatedness, feeling, caring or attending to nature go unheeded. There is no balance, no harmony, neither within oneself nor in the external world. With the disregard of the archetypal image so related to passionate love, a splitting off of values, a onesidedness, occurs in the psyche. As a result,we are sadly crippled in our search for wholeness and health. (Qualls-Corbett:1988:16).

Dr Hillel has found in her work with women analysands that repression of the feminine is a central theme they generally need to explore during their work. She says:

> Women's introjected masculine values prevent their true liberation. Women's psychological work entails becoming aware of this internal possession so that they can free themselves from the identification with the role of the father's daughter. This is made harder in a culture that promotes masculine principles. (1997:65)

Jung, when talking about the anima,suggested that this kind of work needs to be done by men and women if a development is to be wished for:

> After the middle of life, however, permanent loss of the anima means a diminution of vitality, of flexibility, and of human kindness. The result, as a rule, is premature rigidity, crustiness, stereotypy, fanatical one-sidedness, obstinacy, pedantry, or else resignation, weariness, sloppiness, irresponsibility, and finally a childish *ramollissement* with a tendency to alcohol (Jung:1953:para.147).

## Psychotherapy and the feminine

I believe that psychotherapy could do with questioning and talking about the masculine and feminine principles. For these principles to be an integral part of the therapy, the psychotherapist needs to experience them in him/herself . Some forms of therapy are by nature less in balance, i.e. cognitive-behavioural therapies would align closer to the masculine.

If the therapy that we practise overvalues the masculine, we need to be aware of the unspoken message that we give to our clients. Lack of the feminine in our work makes us too attached to our theories and too little in contact with "what is". The feminine helps us receive our clients. In this act of receiving, one needs to be open and have some space to allow the person to show themselves. The feminine principle also helps us walk in darkness and bear the unknown territories which are part and parcel of the journey in therapy.

Practising psychotherapy that gives the same value to masculine and feminine principles in our culture can feel in many instances like being "out of synch". Whatever type of psychotherapy we practise and whatever our personal style is, the psychotherapist's values will have an important influence over the therapy even if this effect is hard to measure. If we as psychotherapists are too attached to the masculine principle in our lives, our therapy will be coloured by this. For example we might value "outward achievements" in our clients much more than insights or personal reflections. We might not appreciate small but significant internal experiences and gains in our clients. It is hard indeed to perceive what we do not regard as valuable.

In education, our culture has encouraged science over and above the study of humanities i.e. art, philosophy, mythology, religion, poetry etc. Humanities bring us closer to a person's internal experiences and closer to the feminine. Why aren't these subjects part of the training in psychotherapy? James Hillman says that " consciousness arising from anima would therefore look to myth, as it manifests

in the mythologems of dreams and fantasies and the pattern of lives" (1996:95). Marie-Louise Von Franz in a similar vein stresses like Jung did the importance of dreams:" By attending to one's dreams for a long time and by really taking them into consideration, the unconscious of modern man can rebuild a symbolic life"( 1996:96). It is not just a question of attending to dreams, images, subtle moods or paradoxes, of course. It is a certain attitude and a particular value system which is in the present day not the predominant one.

A psychotherapist will do well to keep these questions in mind:

> How does one integrate the feminine principle?
>
> How do we make a synthesis of what appear to be opposite principles, the feminine and masculine?

The tension that will surely occur between the two principles can also be a creative, dynamic force.

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# The Self and Janet Frame: Creativity and Selfobject Experience

## Sue Griffiths

### Abstract

The theory that psychological trauma restricts or inhibits the development of 'self', or the stream of consciousness, sparked my thinking about how these ideas link to creativity. Evidence of a flourishing stream of consciousness is apparent in many literary greats who have experienced emotional difficulties. Among them is Janet Frame, who writes poetically about the landscape of the mind. Within the framework of the psychoanalytic structure of self psychology this paper examines Frame's life, her 'self' development, and the healing function of her writing.

### Introduction

I was absorbed, amused, saddened, and at times tearful during the hour and a half ceremony. There could be little doubt that the entire gathering attending Janet Frame's public Memorial Service was fully engaged. The 'spirit' of Frame was very present.

This was a tribute to the woman who has been acclaimed as New Zealand's most eminent writer: a woman who escaped having a pre-frontal leucotomy by a matter of hours, while she was a patient in a psychiatric hospital in the 1950s. A person who was reputed to shun the company of others and was apparently uncomfortable in situations where relating was expected. Her essence was perhaps most accurately described by her nephew, who said that if she were still alive one would never be sure if she would turn up to such a gathering in her honour.

Behind Frame's poetic use of language, described by many as genius, lived a retiring woman whose story is known to most New Zealanders: a story of a disadvantaged but highly imaginative child, who grew into an agonisingly shy young adult. Her creative life was shadowed by depression, fragmentation, ongoing social isolation, and difficult interpersonal relationships. This paper will explore the nature of the emotional difficulties Frame experienced, examining what is written in her autobiography, and by her biographer Michael King.

Central to her problems in childhood and adolescence were the experiences of loss and social isolation. It is reasonable to assume that Frame's grief was not adequately addressed, and was an aspect of her early depression and collapse. A diagnosis of schizophrenia made when she was 21 was many years later revoked by a Maudsley Hospital psychiatrist, who instead diagnosed a schizoid personality disorder. In her fictional writing Frame represented those who are misunderstood, traumatised, and rejected by society, often drawing from her own life experiences.

Frame's creative ability led to considerable literary achievement. The possible selfobject function her writing provided will be explored. Anna Ornstein (cited in Meares: 2000:165) suggests that a mental activity resembling the creative or poetic process is necessary to the piecing together and integration of the traumatic story. Did Frame achieve such integration and was her self restored through her creativity?

After beginning treatment at the Maudsley hospital in 1957 Frame found in her psychiatrist and the therapeutic milieu "support, safety and understanding" (King: 2002). Consequently improved self-understanding was gained and her writing flourished. Did this self-understanding enable Frame to develop her own mind to the point where she could maintain her equilibrium enough to remain out of hospital? How much self-restoration occurred, and how much did Frame's writing provide a selfobject function necessary for self-regulation, self-cohesion and self-reflection?

## Background

Janet Patterson Frame was born in Dunedin, New Zealand, on 28 August 1924, the third of George and Lottie Frame's five children. She was the survivor of a pair of twins. (Her twin did not develop beyond a few weeks). Her mother also suffered a miscarriage the year of Frame's birth. The second child, 'Geordie', developed epilepsy and was constantly at loggerheads with his father: a source of ongoing tension in the Frame household.

George Frame worked for the Railways, eventually becoming an engine driver. Working-class life at that time meant he worked long hours and most of the child-rearing was left to his wife. The world-wide depression of the late 1920s and early 1930s affected all working people with no exception in New Zealand. Although never out of work George Frame had his wages reduced by a cut in working hours and overtime.

At one time the Frames lived in two railway huts, cut off from each other during the night by the snow and freezing temperatures of a southern winter. The four children slept in a separate hut. Frame (1989) writes that it was then, at four years of age, that she knew unhappiness for the first time, feeling miserable and cold locked away from her parents each night and unable to reach them except by going through the snow.

Some solace was sought by Sunday readings of the family Bible when Lottie Frame attempted to teach her children her fundamental Christadelphian beliefs. Lottie also wrote poetry, which may have helped ignite the flame of Frame's early literary imagination. It perhaps also suggests that Lottie needed an escape from the harsh realities of her life, and thus constructed a more idealised and romantic world view; unlike her husband who carried within his war experiences.

King writes that it was here in Southland at age three or four that "Janet began to accumulate what she would refer to later as her 'remembered life' " (King: 2002: 23). In this 'life', Frame (1989) describes an early play with words and a delight in her discoveries of both her inner and her outer world. This pleasure is interspersed with memories of experiences of humiliation and shame which overshadowed Frame's childhood and early adulthood.

The family's final move to Oamaru, north of Dunedin, initially held some hope for Frame and in her writing she described this town as "her kingdom" (Frame: 1989: 52). Here she enjoyed school and achieved academic success. Socially she did not feel at ease however and it was mostly with her sisters that she appears to have been able to relax and play. With her sisters she enjoyed a rich and imaginative life. They created plays and games in a family where impoverishment had its bounds in the material necessities of daily living.

In standard four, when Frame began to write poetry, she found herself the "teacher's pet" and blossomed as both an athlete and scholar under her teacher's guidance. Frame writes of this time "How proud I was of myself" (1989:65).

Unlike Frame, her older sister Myrtle was described as "loud, assertive and unmistakably present" (King: 2002: 68). She was important to Janet. Her sudden and accidental death by drowning early in 1937, at the beginning of Frame's first year of High School, "was the great shock and the defining event of Janet's adolescent years" (King: 2002: 33). In her grief Frame sought comfort in poetry and was amazed to find in her study of literature, poems that seemed to express exactly what she was feeling (King: 2002).

Not surprisingly, Frame described her years at secondary school as mostly unhappy (King: 2002). She wrote prolifically during this time, becoming a regular contributor to a local newspaper and having her poetry published. A prize winning poem was read on national radio. Her two remaining sisters shared her love of writing and together they discovered the world of the Brontë sisters and made it their own (King: 2002).

Despite being top of her class in English and runner-up Dux of the school Frame slid into a "pit of depression in that final year at school" (King: 2002: 41). Her exam results were her weakest ever and she writes in her diary "I am convinced I shall commit suicide soon. There is no bodily pain. I just want to cry and cry at the slightest sadness. I will die. I will commit suicide. Why should I live? I hate myself" (King: 2002: 41).

King (2002) records that her cycle of depression was interrupted by a dramatic change in her circumstances, brought about by her leaving home and beginning her teacher training and university study. Although free of the tension at home – the unresolved grief of her sister's death, and increasing animosity between her father and her brother – the following years were difficult for Frame. The chasm between herself and her family gradually deepened (ibid). Discovering the writings of Sigmund Freud and T.S. Eliot. Eliot she would return home and expound her new understandings to her bewildered parents. Through her absences and new experiences, Frame also came to feel excluded from the lives of her two younger sisters (King: 2002). When her family moved to their own home in Oamaru, finally buying a house, Frame felt that this would never be her home, feeling uncomfortable in this cramped living environment.

Boarding arrangements in Dunedin were also less than satisfactory for Frame. Her extreme shyness often rendered her unable to deal with matters both personal and social. She was more 'at home' in her imaginative world than managing the practicalities of everyday life. Frame developed a 'crush' on a handsome psychology lecturer, John Money. It was to him that she confessed, in a written assignment, her suicide attempt, made during her year as a probationary teacher (King: 2002).

A period of increasing tension preceded Frame's decision to take her life. Although she managed her classroom teaching she avoided contact with her fellow teachers and would dread the visit to her classroom by the headmaster. She stayed in her classroom during her break and lunch hour under the pretext of working. The psychology lectures she enjoyed on Saturday morning had been taken over by another lecturer and she missed her contact with John Money. This had been

her only source of pleasure and replenishment and Frame's unrequited 'pash' on Money caused her further distress (King: 2002). Following a particularly unhappy week at school she decided to take her own life and attempted suicide. Shortly after this Frame gave up teaching, literally fleeing from her classroom, and after she told Money of a further suicide plan, he arranged to have her committed to Seacliff Mental Asylum on the outskirts of Dunedin (ibid).

A series of hospitalisations between the years of 1945 and 1953 followed. During this time Frame had her work published and was the recipient of a prestigious literary award. (The Medical Superintendent at the time, hearing of this, took her off the waiting- list for a leucotomy.) Further tragedy had descended on her life in 1947, however, when Isobel, Frame's younger sister, drowned whilst holidaying. Six months later, John Money, who had provided supportive counselling for Janet after her first hospitalisation, departed for America. In her grief she sought help from a Christchurch psychotherapist John Money had recommended. This led to another hospital admission, and Frame receiving further electro-convulsive treatment.

It was not until 1955 that Frame found a niche in society when her remaining sister June introduced her to writer Frank Sargeson. Frame eventually came to feel accepted and valued by Sargeson and fellow writers of the time and under his mentorship her success as a novelist was launched and celebrated (King: 2002). Frame received a grant to travel and live abroad, and in 1956 she left for England, where her career as an internationally acclaimed writer was to develop.

A rich and significant period in Frame's life occurred later in 1956 when she spent time writing and living on the Mediterranean island of Ibiza. This was the place Frame would come to remember literally and metaphorically as "mirror city" (King: 2002). Here Janet experienced an inner transformation – an experience referred to symbolically in her autobiographical writing (Frame: 1989). She also felt 'at home' in her external world where she fell in love and became pregnant. Eventually realising her love was not reciprocated Frame fled to Andorra where she suffered a miscarriage. During her time there she became engaged to an Italian fellow-lodger but, becoming overwhelmed by the thought of marriage, left her fiancé and returned to England.

Following these experiences Frame, at John Money's recommendation, sought psychiatric assistance at the Maudsley hospital in London (King: 2002). During the next six years she received intermittent inpatient care and ongoing therapy from two different psychiatrists who appeared to attune to her inner world and

the vitality of her writing. Her significant and lasting relationship with John Money was life long, as were her other major friendships.

Frame returned to New Zealand as a celebrated writer in 1963. She initially lived with her sister June and her family and maintained a close relationship with them until her death. Later Frame lived independently in New Zealand; she travelled, continued to write and have her work published. She was a contender for the Nobel Prize for literature in 2003.

## The development of Self

"There is a vast literature on the usage of the word 'self' in psychology and psychotherapy" (Hobson: 1985:148). Hobson says that this "puzzling notion of self" has been discussed in many different ways since the time of William James in 1910 (ibid). For the purpose of this paper the theories of Kohut, Meares, Hobson and Wolf will be discussed.

In looking at circumstances for the development of self in Frame's life there is portrayed an early environment that was far from ideal. The beginning of her relationship with her mother is not recorded in precise detail. However in what is written by Frame there is warmth of feeling, and evidence of an early flow of inner life.

Outlining the Conversational Model of psychotherapy Russell Meares expands on earlier developmental theories, and the concept of William James in which self is considered to be a flow "of inner life - the stream of consciousness" (cited in Meares: 2002: 1) Frame writes that her mother passed on intimate minutiae of her own family stories (Frame: 1989). She engaged her children in her own imaginative world – her stream of consciousness.

Unlike Frame's father, with whom there was a lack of intimacy. "Father, known to us as 'Dad' was inclined to dourness with a strong sense of formal behaviour that did not allow him the luxury of reminiscence" (Frame: 1989: 9).

Frame's earliest "fragmentary" memories were set outside – in the cow byre, under the walnut tree and in the neighbour's orchard. While her mother was busy with the new baby born when Frame was 20 months old, Grandma Frame became her companion and friend (Frame: 1989). When her grandmother burst into song Frame was filled with a feeling she claims that she identified later as "sadness". Memories and feelings before her third birthday are described by Frame as "isolated" (ibid).

Describing the work of Endel Tulving, Meares (2000:35) proposes a memory system that may be interrupted by trauma. This memory system consists of personal memories containing affect, referred to as 'autobiographical' or 'episodic', as compared with a memory of external events, not containing affect, called semantic. In this structure, Frame's 'fragmentary' and 'isolated' memories are both episodic or autobiographical and semantic. From the age of four she recalls ongoing personal memories of both her inner and outer world. In those who suffer early trauma the personal memory system is impaired or lost. This does not appear to have happened to Frame. As previously quoted Frame refers to her life from the age of four years old as her "remembered" life. A significant "isolated" memory is recorded from when Frame was three years of age:

> I remember a grey day when I stood by the gate and listened to the wind in the telegraph wires. I had my first conscious feeling of an outside sadness, or it seemed to come from outside, from the sound of the wind moaning in the wires. I looked up and down the white dusty road and saw no one. The wind was blowing from place to place past us, and I was there, in between, listening. I felt a burden of sadness and loneliness as if something had happened or begun and I knew about it. I don't think I had yet thought of myself as a person looking out at the world: until then, I felt I was the world. In listening to the wind and its sad song, I knew I was listening to a sadness that had no relation to me, which belonged to the world (Frame: 1989: 12).

Having a sense of inner and outer at three years of age shows the beginning development of a sense of 'self' (Meares:2000). And a beginning of a 'play' with words, fired by her imagination, that was Frame's undeniable talent.

Another important marker described by Meares (2000) in relation to developing a self is the discovery of a secret. Frame reflected on an experience when she moved to her third home at four years of age:

> On our first week in our Glenham house on the hill, I discovered a place, my place. Exploring by myself, I found a secret place among old, fallen trees by a tiny creek with a moss-covered log to sit on while the new-leaved branches of the silver birch tree formed a roof shutting out the sky except for the patterned holes of sunlight. The ground was covered with masses of old, used leaves, squelchy, slippery, wet. I sat on the log and looked around myself. I was overcome by a delicious feeling of discovery, of gratitude, of possession. I knew that this place was entirely mine; mine the moss, the creek, the log, the secrecy. It was a new kind of possession quite different from my beastie dress or from the new baby Isabel (1989:14).

In this passage not only does Frame reflect on the delight of her discovery of a secret place, she also reveals an embryonic sense of agency and a sense of ownership (Meares:2002). Using William James' description of a 'stream of consciousness' Meares identifies at least ten additional characteristics of self. These characteristics, additional to agency and ownership, are duality (i.e. reflective awareness), movement (sense of vitality), positive feeling (warmth and intimacy), non-linearity, coherence, continuity, temporality, spatiality, content beyond immediate present (i.e. of the possible, the imagined, the remembered) and boundedness (Meares:2002). Most of these characteristics are illustrated above.

There can also be little question that in all three passages Janet Frame as an adult writes poetically about the movements of her early inner life. She portrays a sense of aliveness and of vitality, and a 'doubleness' created by the reflective awareness of inner events (Meares:2004). From this evidence we might assume that Frame also experienced an early social environment and "particular form of relatedness" (Meares: 2004: 15) that, despite popular thinking about Frame's background of privation, was in Winnicott's language 'good enough'. Early idealising, mirroring, and twinship needs may have been met, at least in part, by her grandmother as well as her mother.

A further flowing of consciousness is demonstrated as Frame reflects on her life as a six-year-old.

> Life at Oamaru with all its variety of new experiences was a wonderful adventure. I was now vividly aware of myself as a person on earth, feeling a kinship with other creatures and full of joy at the sights and sounds about me and drunk with the anticipation of play, where playing seemed endless, and on and on after school until dark, when even then there were games to play in bed – physical games like 'trolley works' and 'fitting in' where each body curled into the other and all turned on command, or guessing games or imagining games, interpreting the shape and colour in the bedroom curtains, or codes, hiding messages in the brass bed knobs. There were arguments and fights and plans for the future and impossible dreams of fame as dancers, violinists, pianists, artists (1983:32).

Besides the clear flow of conscious thought in this passage Frame is also illustrating some of Kohut's thinking about the definitive qualities of self:

> Our sense of being an independent centre of initiative and perception,
> Of being integrated with our most central ambitions and ideals,
> And with our experience that our body and mind form a unit in space and a continuum in time (Kohut, quoted in Suesske: 1997: 9).

And, as an eight year old, in her singing class that she loved Frame writes of further movement of her inner life and her ability to connect thoughts and feelings as they occur. "We sang the Maori words too; 'E pare ra....' As we were singing, I felt suddenly that I was crying because something terrible had happened, although I could not say what it was: it was inside the song yet outside it, with me" (Frame: 1989: 41). When Frame arrived home that afternoon she was to find that her sister Myrtle's cat that the children shared had died. She reflects on the significance of this experience: "That sad afternoon of the singing of 'E pare ra' became part of my memories like the telegraph wires and the discovery of My Place" (Frame: 1989: 41).

Frame's autobiographical writing thus demonstrates a rich quality of inner and outer life, illustrating that in spite of the disruptions endured in early childhood, a "dynamism of self" as formulated by Meares (2002) was achieved. This particular form of consciousness described by Meares arises out of the brain's interplay with the sensory and social environment; it arises in the context of relatedness, is mediated by conversation and has to be achieved with the Other (2002). On self, Meares also writes:

> The domain of self, which depends upon intimate relating, is more fragile than that of adaption. It must come into being through the child's developing secure attachments to his or her caregivers, who have provided appropriate responsiveness. He or she develops the feeling of trust. This feeling allows the child eventually to use symbols and exercise the narrative function, as Jeremy Holmes has pointed out (2000:29).

Frame's use of symbols is abundantly evident in her narrative – in her autobiography, her poetry and her novels. Symbolic play is most obvious in her use of metaphor in her written work.

Having observed a rich and flowing early inner life we now look at whether Frame's developing self-structure provided strong enough scaffolds to withstand the many storms of her following years. It is in the sphere of intimate relating that Frame's world toppled. The constant feature of a healthy self in any theoretical model is that it develops in relationship with the Other and is expressed in language (Meares: 1993, 2000; Kohut: 1984; Hobson: 1985).

## Self-disruption and the impact of loss

Leaving the cocoon of her family and starting school heralded a negative change in Frame's social world signified by her grandmother's death. She writes:

> And Wyndham was the time of the dentist and starting school and Grandma Frame's dying: all three memorably unhappy, although Grandma Frame's death was different in being world-sad with everyone sharing – the cows, the hens, the pet rabbit, even the stinky ferret as well the family and relations – while going to the dentist and starting school were miseries that belonged only to me.
>
> The visit to the dentist marked the end of my infancy and my introduction to a threatening world of contradictions where spoken and written words assumed a special power (Frame: 1989: 22).

Frame reflected on how she had to somehow bear her miseries of school and the dentist alone. She described a trip to the dentist where, terrified, she was lured into smelling a "pretty towel" which had been immersed in chloroform and rendered her unconscious. Understandably, "fury and total distrust" followed (Frame: 1989: 45). Frame also recalled crying in her bed at night because of her toothache. Her father "tanned her backside" when she was unable to stop crying because of her pain (ibid: 46). His literal spanking of her bare bottom was witnessed by her siblings who teased her the next day. Her response was to pretend that she was warmed by her "hiding" – an attempt to hide her shame. (Frame's teeth were to become an insurmountable problem of her later life. Self-conscious of their decay she was unable to seek dental care and her teeth were eventually removed when she was a patient in Seacliff Hospital.)

Other situations, where Frame's spontaneity was ridiculed by her family, could be described as disjunctive experiences and led to what Frame described as "a certain wariness, a cynicism about the ways of people and of my family, and an ability to deceive" (1989:24). Her ability to deceive with words became, perhaps, a needed way of managing her disjunctive experiences. Words appear to have been of particular importance especially at this stage in her life, when Frame does not appear to have had the "joyful response of her caregivers giving her sources of idealised strength and calmness, being silently present and in essence like her" (Kohut: 1984: 52).

This "threatening world of contradictions" became more dominant for Frame, as death and sickness became more prevalent in her life. She writes: "From being a horizontal thread or path that one followed or traversed, time in that year suddenly became vertical, to be ascended like a ladder into the sky with each step or happening following quickly on the other. I was not yet eight" (Frame: 1989: 36).

Frame goes on to describe how their lives were suddenly changed (1989). Her mother's time was taken up with the care of her sick brother, whose frequent seizures caused enormous upheaval in an already burdened family. The shadow of loss began to loom constantly during her childhood. Her discovery of the world of literature and poetry was an immense comfort to her and served a selfobject need as the distress of her brother's epilepsy prevailed in the family. Frame perceived her own inner states reflected in the world of poetry and withdrew further into her inner world, as the reality of her life became more complex. Frame found it harder to maintain her internal equilibrium as empathic responses from others diminished.

In describing the beginning of her adult life Frame entitles her first chapter "The Stone":

> The future accumulates like a weight upon the past. The weight upon the earliest years is easier to remove to let that time spring up like grass that has been crushed. The years following childhood become welded to their future, massed like stone, and often the time beneath cannot spring back into growth like new grass: it lies bled of its green in a new shape with those frail bloodless sprouts of another, unfamiliar time, entangled one with the other beneath the stone (1989:49).

The richness of Frame's childhood - "the green" - was now hard to see as the weight of the "stone" accumulated in her life. Frame's affect-regulation or self-regulation failed when she was finally visited in her classroom, during her probationary year as a teacher, by the school inspector and her headmaster.

> I waited. Then I said to the inspector,"Will you excuse me a moment please?"
> "Certainly Miss Frame."
> I walked out of the room and out of the school, knowing I would never return.
> (Frame: 1989: 187).

Following this event Frame obtained a doctor's certificate giving her time off school. As her return date loomed she decided that the only way out was suicide, and attempted this one weekend by swallowing a bottle of aspirin when her landlady was away. Thus began her intermittent hospitalisations where, as was the psychiatric practice of the time, Frame's symptoms appear to have been barely examined and she was misdiagnosed as suffering from schizophrenia. With no one to attune to her inner world except John Money who left the country shortly after her first admission, Frame was to suffer periods of fragmentation during the following years.

Fonagy et al. (2002) suggest that for attachment theorists and psychoanalysts, the regulation of affect is linked to the regulation of self, and that affect-regulation entails the capacity to control and moderate our own affective responses. Meares (2000) traces the beginning of self development in the proto-conversation between infant and caregiver described by Trevarthen. Within this dyadic orbit an embryonic innerness develops through play. Meares says it is necessary for the child to experience the caregiver as an extension of his or her self. This experience of the other as an extension of oneself is what Kohut called a selfobject experience. It is these selfobject experiences that sustain a developing sense of self, which we might also presume assists the process of affect-regulation.

Frame appears to have been unable to maintain affect-regulation or self-regulation at times of extreme distress when there was clearly no sustaining experience of another. Her "powerful use of words" and her ability to "deceive" as noted by her literary critics was perhaps a much needed self-sustaining and self-protective activity. Frame's reaction to disjunctions appears to have been that noted by Meares: "crippling shame, which was in extreme cases devastation, associated with the loss of a sense of personal worth" (1993:81).

After eight years of intermittent hospitalizations, Frame worked as a waitress, pursuing her writing in her spare time. She was keen to meet other known New Zealand authors and poets of the time, and constantly visited a book store in Dunedin which some of these writers frequented (Frame: 1989). Eventually she is recognised, and receives an invitation from Charles Brasch, poet and editor of the literary magazine *Landfall* (King: 2002). The described conversation during a visit to Brasch's home for tea is characteristic of Frame's social interactions as a young adult. She attempted conversation with Brasch by commenting that her mother at one time worked for his grandmother:

> Mr Brasch looked stern. I felt he disliked personal reminiscences and references, but what else could I say? I knew so little. He began to talk of New Zealand literature. I remained silent. I thought, he must know where I have been for the past eight years. I suddenly felt like crying. I was awkward and there were crumbs of seed cake all over my plate and on the white carpet at my feet. Then, remembering the introduction to 'Speaking for Ourselves' I murmured one or two opinions on the stories, quoting directly from the text.
>
> 'I agree with you' Mr Brasch said. Our conversation died away. Mr Brasch poured more tea from an attractive pot with a wicker handle arched above it.
> 'I'm fond of this teapot' he said noticing my glance at it.
> 'I'd better be going' I said (Frame: 1989: 237).

Mr Brasch's stern look was felt as disjunctive, Frame lost her sense of personal worth, attempted to maintain social discourse, was unable to, and eventually fled. In this instance there was a common interest, but experiencing shame and a constricted sense of herself, Frame was unable to converse about their shared understanding of literature.

Frame's life story however indicates that when alone she was not always afflicted with the pain of isolation and alienation. This pain was alleviated by the language of her writing – a vehicle for the communication of her rich inner world. It is in relationship with others that Frame appears to have struggled. Unlike those who suffer a severe self- disorder Frame was not caught in the zone of adaptation. In fact it could be said that it was with the language of social speech, described by Meares as language that is linear and outer-directed, that Frame struggled (Meares:2000).

Meares, in describing the two human languages of inner speech and social speech, observes that for most of the day the child uses the language of ordinary communication (social speech) and for most of the day the adult is not lost in thought (2002). We see from Frame's writing that her 'inner speech' is, as described by Meares, associative, inner-directed, intimate and self-related, unlike 'social speech' which is linear, grammatical, logical, communicative, outer-directed, non-intimate and identity-related (ibid). It would seem that from an early age, Frame discovered the "power of words" and came to feel more comfortable in her inner world and with the language of her inner speech. It is the view of Meares that the "two language forms become co-ordinated and mingled" (Meares:2002). To be effective in the world both languages are needed.

The concept of two playrooms is another associated idea of Meares (1993) relevant to Janet Frame. Meares writes of the child of three or four years inhabiting two playrooms – one real and the other partly illusory – from which the child oscillates between two states of being with the Other (ibid). The child, Meares asserts, needs both experiences, i.e. parents who are attuned to his reality and also experiences when the Other is not felt as part of this reality. "These experiences establish the concept of self boundary, since they bring into the child's awareness an 'outside' world which contrasts with that which is inner" (Meares: 1993: 79). It could be said that it is in the "real playroom" that Frame lacked sufficient attunement.

This lack of sufficient attunement in her social world was an ongoing difficulty for Frame who as an adult struggled with identity-related issues, especially after her admission to psychiatric institutions. She wrote of how the world and even her

family saw her as a 'mad person'. Her sense of her inner self, however, survived long enough for her to know in her own mind that she was not 'mad'.

In response to an invitation from Charles Brasch to write for *Landfall* Frame offered a poem about her experience of electro-convulsive therapy. The poem was not considered suitable for publication. The poem is entitled 'The Slaughter-House':

> The mind entering the slaughter-house must remain
> calm, never calmer,
> must be washed clean, showered on where the corned hide
> holds fast to bits of bacterial thought, must await the
> stunning hammer
> in silence, knowing nothing of any future load (Frame: 1989: 238).

This poem, like Frame's interpersonal experience, did not always engage the other. Following the rejection for publication of this poem Frame lapsed into empty despair, feeling her "life raft" – her writing – would no longer save her (ibid: 238). She recovered, however, shortly afterwards when her poems were accepted for another publication, *The Listener*. The much-needed mirroring was provided.

## Creativity and other selfobject experiences

"Frequently the selfobject function is performed by a person, but it is important to remember that the selfobject is the function not the person" (Wolf: 1988: 52). Wolf also says that any experience that functions to evoke the structured self and manifests as an experience of selfhood, or maintains the continuity of selfhood, is known as a selfobject experience. It is not the relationship with the other or an object that provides this experience, but the subjective aspect of a function performed by a relationship (Wolf: 1988). In this sense it is intrapsychic and does not describe the interpersonal relationship (ibid).

In her thirtieth year, Frame moved to Auckland and met the writer Frank Sargeson, eventually living and writing in a hut on his property. Of this offer from Sargeson she wrote "it might save my life" (Frame: 1989: 245). Sargeson arranged for Janet to obtain a medical certificate enabling her to receive a welfare benefit which would provide the means to continue her writing. Hospital authorities had previously refused this request, insisting that a job would be more beneficial. Although Frame was working she wrote: "My only freedom was

within, in my thoughts and language, most of which I kept carefully concealed, except in writing. For conversation I reserved harmless chatter which - surely - no one would label as 'peculiar or 'mad' " (Frame: 1989: 246).

It was therefore by Sargeson that Frame felt understood and validated. His role in providing important mirroring, idealising and twinning selfobject experiences was crucial at this time in Frame's life that could be viewed as a 'transitional' stage: a stage when she was still struggling to adapt to her social world. From this time there is described gradual freedom also in her outer world where former constraints seemed far away. What was most important to Frame was that Sargeson "actually believed" she was a good writer (Frame: 1989: 246). This validation, and the space to write unencumbered by unattuned demands for adaptation, allowed Frame to explore more fully her inner and outer world. Her writing flourished and she gradually joined the social milieu of a small group of fellow writers.

As noted by Bragan (1989) Sargeson was interested in the breeding of silk worms and demonstrated to Frame the life cycle of the silk worm – how the silk worm appears to die and comes to life again. This provided an important metaphor for her that had a personal significance as she had also experienced and come through a living death (Bragan: 1989). She took up the golden thread of life again and wrote an autobiographical novel, *Owls Do Cry*, with a chapter heading "Finding the Silk" (ibid).

Sargeson's belief in her writing was reinforced by Dr Robert Cawley whom Janet was to see over a number of years whilst both an inpatient and outpatient at the Maudsley Hospital in London. As Bragan (1989) points out, we do not know the nature of her therapy with Cawley but we do know that she experienced him as empathic; that he saw her over a long period of time, did not desert her, was interested in her writing and provided important selfobject experience crucial to her recovery. He gave her confirmation in two important ways: that she genuinely needed to write and particularly write about her long hospitalisation in New Zealand and that she was a solitary sort of person and should not try to be sociable against her nature (Bragan: 1989). This was an essential validation of Frame's core self. She did write and publish a novel based on her hospitalisations, entitled *Faces in the Water*. Frame records that she left the Maudsley Hospital ". . . no longer dependent on my schizophrenia for comfort, attention and help but with myself as myself" (cited in Bragan: 1989: 141). The ongoing discovery of herself found in her writing is represented by the illuminating title of the last volume of her autobiography: *Envoy From Mirror City*.

Along with selfobject experience, attunement, and validation there is another important marker of Frame's recovery that is recognised in our work within the framework of Psychology of Self and Meares' Conversational Model. In a recent literary review of Frame, Patrick Evans (2004) relates a story he learned from a psychiatrist, Craigie Macfie, who worked at the Maudsley Hospital when Frame was a patient of Robert Cawley. Macfie told Evans (2004) that while Frame was an inpatient she would each night engage Cawley in a game of her devising. She would give him a baffling sentence to unscramble. Presumably, Evans says, something like the cryptic crossword clues she helped her father with. Cawley was expected to have 'solved' this each morning and he did. Although this is interpreted differently by Evans, who parallels it to the deliberately concealed aspects of Frame's writing, it could also be seen as a delightful example of the co-creation of a play-space.

In writing of the necessity of the play-space in early development Meares (1993) stresses the importance of the Other's presence as a selfobject in the developing sense of innerness. Frame's sense of innerness is not in question here; rather it is the question of her maintaining a cohesive sense of self in both her internal and external world and her relationship with others in her world. Meares (1993) suggests that responses from others that 'fit' an evolving personal reality have the effect of evoking a positive emotional tone, and if repeated, influence the acquisition of self esteem. It is possible therefore that Cawley joining Frame in her world of words - her play-space - was a pivotal step in what was clearly for Frame a lengthy and sustaining selfobject experience. And it is, as Wolf (1988) writes, how these experiences assist appropriate structuring into an organisation we call 'self' that is important.

The notion that creativity has a restorative function is supported by Kohut (1978), Hagman (2002) and Kligerman (1980). Kohut puts forward the idea that there is a certain childlike quality in the psychological make-up of the paradigms of creative imagination, and that this provides some form of tension mastery (1978). He says it is the special intensity of all the varieties of experience that forces such a personality to create because as adults they have less reliable neutralizing and buffering structures and are, therefore, less protected from traumatisation (ibid). The more protective structures that might exist in the average adult, Kohut argues, also give them less access to creativeness and discovery. This is an interesting suggestion regarding Janet Frame and the more creative clients I see. It might also shed some light on the different responses that exist amongst siblings, as seen with the Frames, who experience similar childhood experiences.

Kligerman (1980) elaborates further by suggesting that a sense of engagement is made possible by one's creative productions. This idea makes sense when one thinks about our subjective responses to art, music and literature. Like me, many attending Janet Frame's Memorial Service did not have a personal relationship with Frame. We were, however, intensely engaged, with heightened affect which was beyond sadness evoked by her loss.

The creative medium of writing for Frame provided an externalisation of subjective experience. It was healing, restorative and ultimately achieved the mirroring approval of the world and saved her from a long incarceration in a psychiatric institution. Her writing was the formal embodiment of her deepest experience of being in the world (Hagman: 2000): a representation of her inner state, providing a sense of vitality and self-cohesion. When, as was often, Frame did not receive resonance from others, she found it in the world of literature and the experience was soothing, perhaps providing as Wolf suggests an intimate personal selfobject responsiveness (1988). However, at vital times – times of loss and adversity – Frame's creativity was only partially sustaining. It was not until the time of her therapy with Robert Cawley that Frame wrote: "(T)he wastage of being other than myself could lead to the nothingness I had formerly experienced" (1989:383). Ultimately, it was the therapeutic relationship with Cawley and her creative self-expression that validated her personal experience and was restorative.

**When The Sun Shines More Years Than Fear**

When the sun shines more years than fear
When birds fly more miles than anger
When sky holds more bird
Sails more cloud
Shines more sun
Than the palm of love carries hate,

Even then shall I in this weary
Seventy-year banquet say, Sunwaiter,
Birdwaiter, Skywaiter,
I have no hunger,
Remove my plate.
*Janet Frame*

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# Dilemmas and Dialogue in Organisational Settings

## Teresa von Sommaruga Howard

### Abstract

Dialogue is invariably thought of as a conversation between two people. But as it is much more than that. This article shows how providing a space for dialogue encourages collaborative enquiry in groups of all sizes with beneficial consequences for organisational effectiveness as well as personal wellbeing.

Key words: Dialogue, Culture, Large Group dynamics

### Organisations do strange things to people

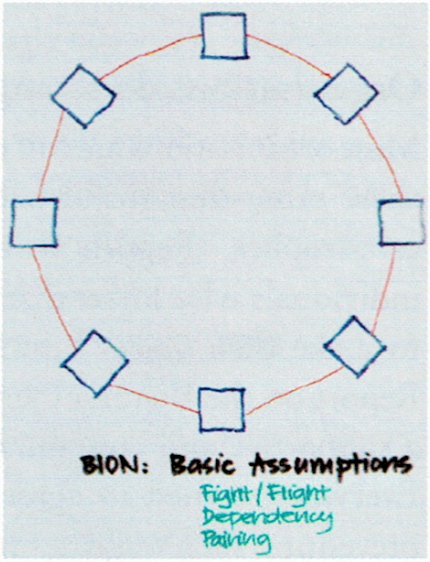
Most organisations are full of thoughtful people yet despite their best intentions these same thoughtful people may find themselves responsible for terrible catastrophes. Reports written after the Challenger accident describe the way individuals who knew that such a calamity was almost inevitable were unable to make their voices heard (Morgan: 1989: 112). Reactions to the Laming Report on the Victoria Climbié case demonstrate how easily the importance of a supportive and communicative atmosphere in the workplace is overlooked. Everyone seemed to agree that individuals should be made responsible for preventing such tragedies from ever happening again, but the evident repeated failures in communication that led to the tragedy of her death did not figure (*The Guardian* 2003). When individuals join large organisational contexts, something strange seems to happen. They appear to stop talking and thinking together. "Why is it that intelligent people perpetuate cultures that are so self-destructive?" (de Maré: 1991:87).

Although there is a wish to make people accountable for their actions, there is an accompanying tendency to treat them as little more than counters on a board game. Every time there is organisational reshaping people are moved about with little time given to mourning the loss of colleagues or familiar places. With no formal structures to assimilate and make sense of such new realities, staff and managers will instead 'mutter in corridors'. Many people I meet are in a state of despair. They feel unvalued and replaceable as if they were just another disposable commodity. Although initiatives to improve 'synergy', 'empowerment'

and 'attunement' abound, staff tend to feel that these are often little more than window dressing leaving them feeling even more discouraged. It is difficult to know what to do about unhappy staff but in this state they are unlikely to give of their best.

## Trying to understand what is happening

When failed relationship processes are described in organisations psychoanalytic theories are often employed. Although psychoanalysis does shed light on the behaviour of individuals, it does not adequately explain the complexity of group process. Describing the group as if it were one merged individual leaves out how individuals are able to influence each other. By taking a group perspective, the origins of what many of us experience in our working lives but find difficult to describe or make sense of can be explained.

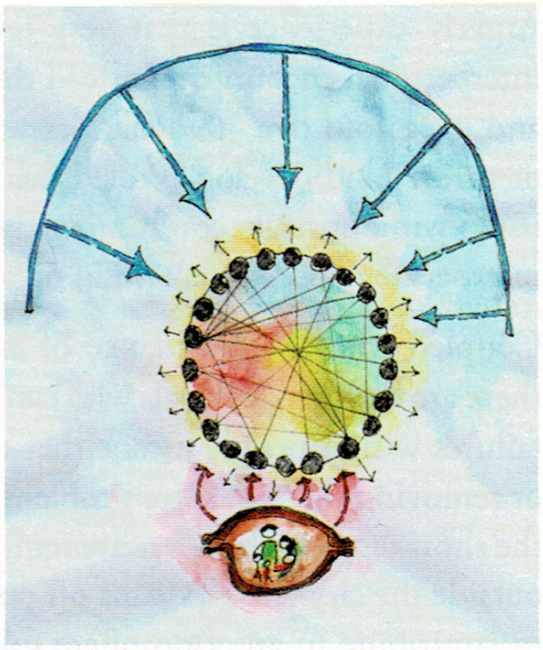



Bion's descriptions of group process are most often referred to. He drew attention to the innate anxieties that individuals inevitably suffer in groups and described three universal 'basic assumptions'. 'Fight/flight', 'dependency' and 'pairing' that are employed to defend against the fear of just being in the group. These give rise to two simultaneous processes: the 'work group' and the 'basic assumption group'. If left unattended these basic assumption forces will undermine the 'work group' (Bion: 1961: 98) preventing it from completing its 'primary task' (Rice: 1963 cited in Trist and Murray: 1990:172). It is in this fuzzy area of unseen feelings that managers' best intentions are most often undermined.

## More ways to understand

Foulkes (1964: 292) developed a more multidimensional view of groups. He believed that human beings have more autonomous possibilities to form relationships and developed the concept of the 'matrix' (ibid: 118) to describe the complex network of relationships that exist in any group. As each individual brings unconscious assumptions and expectations, based on their past experiences, to their work situation they contribute to the formation of a 'foundation matrix' (Foulkes: 1974:131). By seeking to understand how this matrix interacts with

the organisation's 'dynamic matrix' (ibid:132), it is possible to understand how and why there might be difficulties in messages being heard and understood. Not only are organisations groups but they are essentially large groups. Small and large groups have very different dynamics and it is in these differences that many organisational difficulties exist.



Most people find large groups so difficult to navigate that they avoid them. de Maré (1991: 18), on whom Bohm's (1985) work is predicated, drew attention to the difficulty that almost everybody has just thinking clearly and speaking articulately in large group settings. Although some people can make prepared speeches, speaking personally is mostly out of the question. Just calming one's nerves sufficiently to take the risk of saying something can take an almost superhuman effort. This temporary autism applies to almost anybody irrespective of their intelligence or ability. Consequently open communication in organisations is problematical just because they are large groups.

In contrast, most people feel comfortable in a small group. They are accustomed to it. When pressures become too great in the large group of the organisational community, many people retreat into the small group of the team. Just when they need to confront the social situation of the large group they revert to defensive behaviours learnt early in life. Although helping them survive childhood, these behaviours do not usually serve them well in adult working life. When faced with conflict, many people find themselves stuck in self-destructive and group destructive behaviours just because their repertoire of possibilities is limited.

For most of us our first experience of larger groups occurred when we went to school. The classroom and morning assembly, usually set in a hierarchical framework, provided little opportunity for learning to speak one's mind. Apart from answering adults' questions, most were trained to rely on being told what to do often by teachers who were terrifying. This history is not good preparation for taking on autonomous responsibilities required for organisational life.

Recent research describes the way leaders in some of Europe's best known companies feel pressured to remain detached from their staff tending to behave

like school masters [or mistresses] handing out tasks and 'marking' work" (Binney, Wilke and Williams 2004: 29) mirroring the very history that was so humiliating for so many. As "thinking itself is born out of interpersonal relationships" (Hobson 2003: 5) the ubiquitous model of the distant manager is not encouraging.

Argyris' experience is that very few managers are prepared to deal with the interpersonal encounter. Instead they employ behaviours that are "anti-learning and overprotective" to avoid "experiencing negative surprises, embarrassment, or threat" and develop "skilled incompetence" to apparently attend to difficult issues without really confronting them. The tendency is to retreat to a place of interpersonal disengagement in organisational structures (Argyris 1987: 5).

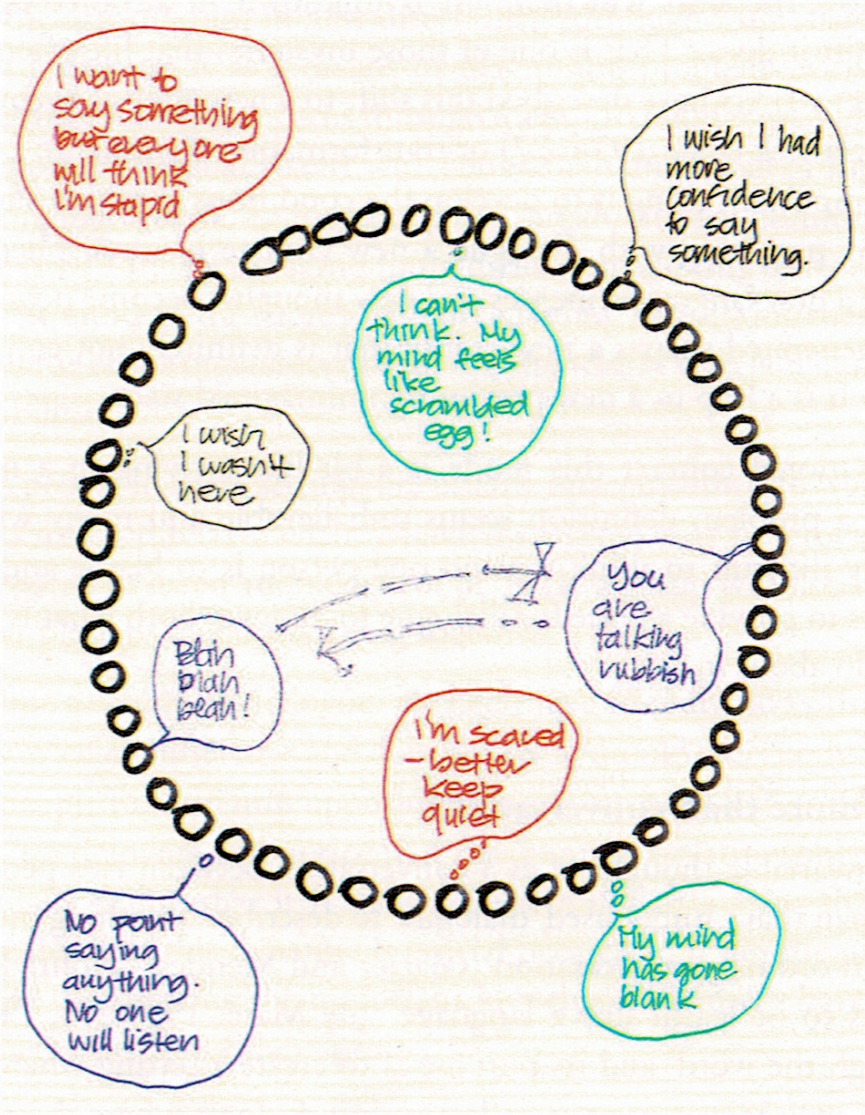
Coupled with this avoidance of engaging in relationships is the notion that there are faulty individuals who can be blamed when things go wrong. Locating failures within people means that the focus can go on disciplining, punishing or removing them to solve problems. Although appearing to improve things in the short term, such moves are reminiscent of the old idea of leaving a scapegoat outside the city walls to ward off possible danger. 'Letting staff go' is also likely to contribute to an atmosphere full of unnecessary anxiety as those left begin to wonder 'Will I be next?' Placing staff in such situations creates a fertile soil for conflict. When conflict does arise, as it inevitably will, the focus will be on two people, with resolution sought through mediation, physical separation, limited interaction and so on (Morgan: 102). Others in the team either distance themselves or take sides and are rarely if ever asked to contribute to working through the conflict.

## Another perspective on conflict

When I am invited to work with conflict in organisations, there is nearly always an expectation that I will adjudicate, find a consensus or compromise and at worst, instigate a sacking. This adversarial approach is expected and reinforced in many of our civic institutions such as industrial relations, the law and parliament. There is an assumption that by two sides arguing a case while a third listens and decides whose view is correct, a just solution will be found.

When working with a large group experientially it is possible to see that an overt conflict between two people is an expression of a hidden anxiety that cannot be directly articulated by the group. Likewise in organisations when conflict emerges 'out of the blue', it is quite usual to discover that something

catastrophic has happened that cannot be consciously registered. The conflict acts as a diversion by absorbing everybody away from feeling the consequences of the unacknowledged catastrophe.




Conflict often arises after a period when what feels most important cannot be expressed. In a large group as a conflict takes hold, a mesmerised audience tends to form that sits and watches silently. If allowed to continue, the atmosphere will become more and more frightening. Resolution only emerges when this mutually reinforcing cycle is interrupted by a meta-level intervention that invites those who are silent and watching to talk about what they are feeling and thinking. Such an intervention acknowledges that the fundamental dispute is about whose view of reality will take precedence. It moves the focus away from the battling pair to an on-the-level multifaceted state of enquiry. Individuals are encouraged to step out of their autistic silence and to relate to others in the group. Even when their thinking and feeling is apparently quite unconnected, the contribution of the silent majority is what makes the difference.

When each person begins to speak from their own unique experience something shifts. As the context around the disagreement changes, the battling pair with an audience becomes a group of individuals working together about a shared difficulty. How the shift will manifest is unknown in advance but in my experience, shift it does. That is one of those mysteries that life often gives us as a gift. Other writers have described this shift to a new state as Second Order Change (Watzlawick et al.: 1974: 77) or transformation (Gutmann: 2003: 133 - 140). The important thing is to develop the conditions in which such a shift can occur. By persisting with dialogue a new climate or atmosphere can be created where a new language emerges and new thoughts become possible. The new culture generated shapes a new reality that is definitely not consensus or compromise! It is a leap to a new previously unimagined state.

In an organisational context this mode is a bit like arriving in a new land. Initially such a problem definition seems unbelievable and many will find it extraordinarily difficult to think that no one person is to blame and that the way forward is to provide a place for dialogue to discover both what is going on and what to do about it.

## Is dialogue more than conversation?

Dialogue is invariably thought of as a conversation between two people. It is much more than that. Buber used 'dialogue' to describe something much more profound than ordinary conversation (Glatzer and Mendes - Flohr: 1991:41). "Dialogue has to be learnt like a language" (de Maré: 1991:17). 'Dialogue' means 'through the word' and its purpose is to create a setting where a group of people can maintain conscious collective mindfulness where thoughts flow like water in a stream. This multifaceted atmosphere cannot emerge in a pair relationship. To be effective, a large group of everybody remotely involved will need to gather. Most people will feel anxious but attending to this anxiety will contribute to a helpful outcome.

Isaacs in describing his work with dialogue groups emphasises the importance of learning to listen to oneself. "Some of the most powerful contributions come from people who have begun to listen to themselves in the new context of the group" (Senge: 1994:375).

Open Space Technology is another mode of working in large group settings where 'ordinary people work together to create extraordinary results with regularity' (Herman: 2004:1). In Open Space events, participants create and manage their

own agenda of parallel working sessions around a central theme of strategic importance but do not necessarily work in one large group together.

Both these models use dialogue groups to gather people as a creative resource to move the organisation in new directions. Although I use dialogue with this intention I also use it as a means of diagnosing problems while providing a forum for discovering new paths through them. To build trust and a safe enough place to work in, I usually start with individuals and small groups as a way of slowly bringing everybody together in an organisational community that can recognise itself. By encouraging individuals to make this shift from the 'small group in the mind' to the 'large group in the mind' I am asking them to engage as a citizen of the entire organisation with the attendant expansion of responsibilities and possibilities.

Although people in these settings are usually unaccustomed to working without an agenda and a directive chair, I have discovered that by providing aids and being prepared to listen and take a lot of 'flack' a group will slowly move to the unfamiliar place of openly working together.

It takes time to establish dialogue. Generating a friendly, accepting atmosphere that acknowledges difference and does not try to mould everybody into one mind or allow people to form into opposing factions can be a slow grind. As dialogue develops, participants will notice that the 'climate' or 'atmosphere' is changing and gradually realise that it is their collective understanding that is changing it. Recognition of this dynamic is crucial because in it lies the ultimate power of dialogue transmitting the important idea that individuals have the power to change their situation if they speak.

## Is it conflict or something else?

Much of my work involves moving individuals or teams out of destructive patterns that are either upsetting them or someone else. My task is to encourage them to see a bigger picture than they are accustomed to and to find new and perhaps more flexible ways of relating. The key is to establish a safe enough space to begin to explore what is going on and to give it words by building a narrative together. To illustrate is an example that describes a situation where a conflict was the reason for the commission but what emerged through the work was an imminent catastrophe that was only recognised by one person.

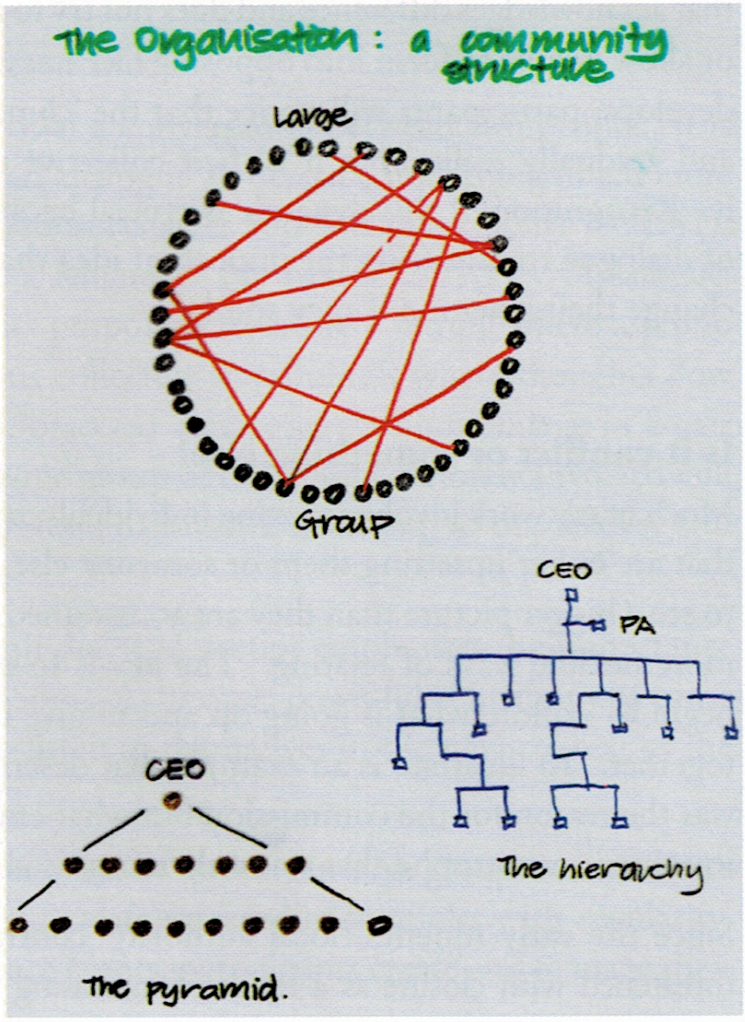
Since the early nineties, local authority 'contracting' departments have been threatened with closure as a result of increasing competition from private sector

commercialisation. The usual response has been one of rushing to greater financial efficiency generating anxiety that often goes unacknowledged leaving managers, often with the best of intentions, struggling against a powerful negative backwash.

I was called in with a colleague to one such department to help with a difficult situation that the managers feared would 'cause bloodshed'. They didn't understand what had happened but were every preoccupied with the consequences of a destructive atmosphere that had developed.

Apparently the women had divided into two warring factions that were refusing to speak to each other. The personal assistant to the director, whom I'll call Sue, had built a wall around herself with filing cabinets. Another woman whom I'll call Jo, we were told unofficially was said to be having an 'affair' with her team leader. Believing that this relationship gave her special advantages, the remaining women had made an official complaint about the way she had been recruited. Managers told us that they thought these women were making a 'big fuss' but had no explanations for their behaviour.

My colleague and I divided the team workshops between us but worked together with the managers and on the whole department workshop. We met first with the management team. They suggested that we meet with the women or even with each woman alone to 'sort them out'. We asked about the history and future of the department but interestingly the 'affair' did not emerge.




We then devised a series of workshops with each of the four teams to explore their thoughts about what was contributing to the poor atmosphere. We asked each group what they thought were the most pressing issues facing them at work. Each was organised as informally as possible: chairs in a semi circle, no table and a flip

chart to record what was said. 'Post-it' notes were used so that individuals could record their responses free from the agony of initially having to voice them out loud. The notes were then stuck to the wall for everybody to view together. As they discovered the commonality of the themes they began to talk to each other about their experiences.

The first team I worked with included the pair who were said to be having an 'affair'. I arrived to find that the room had not been prepared for the days work: no flip chart, no chairs to sit on and tables scattered about. The team was standing around smoking, chatting. Something in this welcome told me that they did not want to meet with me. The team leader whom I had already met with the management team collared me and said "I don't think we should do this. When I said that the day had been arranged with his previous agreement he continued with, "'Jo' is very vulnerable. I don't want her involved". I told them both that it was very important that she stayed and found a way of talking about what it was that was upsetting her and that I would do my best to support her. We found chairs, the flip chart stand, paper and pens and prepared to start.

In the event 'Jo' did talk about her experience of feeling pushed out and excluded by the other women. It also became clear that she had been constructively dismissed from her previous job and as a single Mum felt particularly vulnerable. As I was packing up afterwards other members of the team who were all men informed me 'confidentially' that the real issues had not emerged but they acknowledged they had begun to see another perspective. Afterwards I wondered why this clearly vulnerable woman was evoking so much jealous rage in the other women. Even if she were having an affair, why was it causing them so much distress? What was it that they felt she had that they were not getting? It took until the whole department workshop before the answer became clear.

In the meantime, I worked with another team. In this team there were several women who were also in distress. One theme that emerged was that women on the whole felt unvalued, unseen and unheard. Afterwards one of the women told me, "You are the first person who has really listened to me" and later another, "I felt as though a big load had been lifted off me. I felt so much better."

My colleague and I planned the whole departmental workshop to clarify what had been learnt in each of the team sessions and to help them learn from each other as a way of preparing the ground for a large group dialogue where we hoped they could talk to each other and come to their own conclusions about what had been happening and what they wanted to do about it.

To prepare for the whole departmental workshop we created an exhibition using all the 'Post-it' notes from the team workshops to give everybody the 'whole picture'. We asked each person to think about what had surprised them. In the group dialogue that followed, a new story emerged as we pieced together the previously hidden history and unknown future.

We learnt how innovative many people had been in creating the funding for the department in the beginning but that it was likely to run out within two years. Most importantly we learnt that the director was preparing to leave imminently. We also discovered that although he had brought Sue with him he was not taking her this time. Unlike Jo's team leader he did not appear to care about her future. This information was the crucial clue to understanding what had contributed to the situation we were brought in to resolve. Sue felt a deep sadness and feeling of abandonment that could not be acknowledged. Instead she became difficult to work with and a mutual pattern of retaliatory relating that kept reinforcing itself developed. It turned out that everybody felt anxious about the future without this director but the conflict between the women had distracted them from a deep, shared anxiety. Recognition of what had been happening brought with it enormous relief, thoughts about how to manage the future and not a drop of blood had been split!

## Conclusion

In the current environment of constant but unsupported change, conflict and lack of trust are likely to abound. Without a place to make sense of their experiences poor levels of communication are likely to become chronic resulting in inadequate shared information. By providing a space for dialogue, people tend to relax and a climate of collaborative enquiry encouraged. Previously inaccessible information is retrieved so that authentic decisions can be made that are coherent and appropriate.

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# Silence in the Conversation

## Anna Moore

### Abstract

This paper explores the difficulties of working with clients who struggle to use words in the therapeutic context. How do we work with these difficult clients? I focus particularly on those clients whose organizing principles predispose them to using silence as a means of holding themselves together or who persist in using silence in dissociated ways, often when traumatic memory gets triggered. I present a clinical example, a "silent" client, as a way of developing the sense and feeling of silence in therapy and I explore how we can understand such "silent" clients. Concepts such as dissociation (our clients' and our own), intersubjective and interpersonal listening, and poetic and nonlinear conversation will be considered. Drawing particularly on Bromberg's and Meares' work I will then look at what the therapeutic task is with these clients.

> What is the source of our first suffering?
> It lies in the fact that we hesitated to speak.
> It was born when we accumulated silent things in us.
> Gaston Bachelar

This quotation captures something of the essence to which we, as therapists, orientate ourselves in the therapeutic conversation, particularly with those clients who struggle to speak in the sessions. Understanding why some clients are unable to speak, how we listen to 'silence', use it, orientate ourselves towards it, what it means, and how we might have a conversation with 'silence' are the questions I will explore.

I will focus on those clients who struggle to use words in the therapeutic context, particularly those clients whose organizing principles predispose them to using silence as a means of holding themselves together or who persist in using silence in dissociated ways, often when traumatic memory gets triggered. Such clients can be in considerable psychic distress and pose special challenges to the therapeutic endeavour.

Difficulties that arose with one such client of mine have inspired me to explore this topic. I have formulated specific questions around my 'silent' client in the hope of expanding my knowledge of how better to enter into a conversation with her and thus with clients of this nature in general.

For many of our clients there is bewilderment and significant distress at their inability to speak. It does not seem reasonable. What they don't understand is that due to the way our brain is designed, emotional life defeats reason. We are not usually speaking to the logical reasoned part of the brain but rather to its emotional life; therefore some creative way needs to be found in order to speak to this 'silence'.

Robert Hobson says: "The skill of a psychotherapist lies in his ability to learn the language of his patient and to help in creating a mutual language – a personal conversation" (1985:46). What does this language of silence mean? With no words to help us, how do we learn and understand this silent language? He also notes: "A therapist in action needs to draw upon a large repertoire of different ways of 'speaking' verbally and non-verbally" (1985:47). What repertoire do we need for the non-verbal encounters? How can we help our clients elaborate and transform their conversation?

When our clients are mostly silent, how can we establish what Meares believes to be the first aim of therapy, which is to "establish a form of relatedness in which the experience of self emerges"? (2004:7). Korner puts it this way: "The sense of self is only possible through processes of mutual recognition through a system of self and others" (2003:18). What is it that our clients are expressing and needing us to recognize in their silence? Although at times we may be able to identify intrusion of traumatic memory, it is more difficult to achieve what Meares believes to be the second aim of therapy, which is to "integrate them into the ordinary ongoing dualistic consciousness" (2004:1). We need to find a way of helping our clients 'know' and express their thoughts so that they enter into the world proper.

## Helen: a clinical example

Helen is an extremely thin, married, fifty-four year old mother of two adult children, who was referred for psychotherapy by her General Practitioner. At the time of writing, she had been seeing me twice weekly for almost four years. Helen suffered from a serious disorder of the self. Her history was one of agitation, depression, anorexia, somatisation and self harm. She had several long admissions to hospital. On presentation she told me rather angrily that her doctor had

instructed her to come but she was there under sufferance and although I sensed she was in considerable distress, both mentally and physically (she suffered severe headaches), it was difficult for her to tell me what was wrong.

It was in those early sessions that I found that one way I could help her to say a little was by asking some direct questions about her history. I rather naively inquired as to whether there had been other times in her life when she had found it impossible to speak - a question I thought might have been asked by others when she was treated in hospital. But she reported people working with her becoming angry with her silence, demanding that she speak and accusing her of not helping herself.

My timing must have been right for she was able to let me know that at the age of twelve she had been raped by her uncle. She felt deeply shamed and blamed herself, for she believed that if she had not frozen but had instead told him to leave her alone she might have been able to stop him. Much later in the therapy, after months of sessions where she spoke very few words, she was also able to tell me of being raped again, this time as a married woman, by a family "friend". Again she was deeply distressed at having been frozen, without words to ward him off. Unable to speak, she once more blamed herself. I wondered if, in part, her response to this trauma was dissociated. Bromberg states that to "freeze" is "one of the hallmarks of a dissociated response to trauma" (2003:690).

This inability to speak was re-enacted many times in the course of our therapy as was the way she came to think about it. Helen's inability to "act" and her sense of lack of agency influenced the way in which she viewed traumatic events in her life and in therapy. This further diminished her sense of value and worthiness. "Why couldn't I speak?" "Why can't I speak?" were constant sources of distress for Helen.

Helen lived with the trauma of growing up in an emotionally unresponsive environment. Her developmental history was one of neglect in which she lacked an attuned caretaker who could provide appropriate responsiveness to her own subjectivity. The second oldest of a large family, Helen's early memories were of having to keep everything to herself. Her early life experience meant that she had a self-organising and self-regulating system that predisposed her to being silent. Symington (1985) suggests that if a baby has the experience of a mother who is absent, or present but emotionally unable to contain the baby's distress, then the baby has to resort to ways of holding herself together. Perhaps silence was a system that held Helen together and helped her manage her anxieties. Her inner life was undeveloped and as a result she was stimulus entrapped.

At twelve, after the rape by her uncle, she began to exercise obsessively - this became a lifelong habit as did staying silent about her distressing feelings.

This information was hard won. In most of our sessions, Helen experienced herself as being hopelessly silent. I too could feel hopeless as week after week, month after month, year after year, a significant part of each session was taken up with us grappling with Helen's difficulty in giving voice to the distress she was feeling inside. To make matters worse, not only did traumatic memories return in the silence, but our silence in the sessions resembled the original traumatic experience and so further triggered her traumatic memory system. My own silence was not experienced as a sanctuary by Helen, rather it brought a constant tension. If the silence continued for too long Helen would cry out "Leave me alone", as if I was her silent abuser. There were times when I too feared I might be an abuser as we sat in this unbearable silence. When her defences did break down and she was able to speak she was left feeling exposed, confused, depressed, anxious and at risk of fragmentation.

The trauma memories, when described, were "script-like", stunted, without the progressive, sequencing quality of a true narrative. Her traumatic memory system was organized around negative self attributes. It was repetitive and invariant. It was a difficult place for her (and often me) to be. She was ashamed of her difficulty in speaking. Before she came to the session she would tell herself that she would speak this time, but when she was there the overwhelming feeling tended to be that it was better to say nothing or worse still, she simply had no words to describe what was happening inside. It was terrifying for she feared "losing control". In those moments it was as if her reflective capacity was wiped out. She suffered terribly. When she was able to speak she told of her desperate feelings of agitation, shame and acute physical pain. She also spoke of her suicidal thoughts.

There were times when I felt at a loss as to how to convey my understanding of her and yet other times where we became out of reach of each other and I could not even guess at what was in her mind. I could only use my own countertransference feelings and imagine how out of touch, isolated and ineffectual Helen might feel. At these times I would feel responsible for not grasping what was going on and worried that I was cruel to put her through this therapy.

## Discussion

In order to have a conversation with Helen's silence and to understand what her silence actually meant I had to confront several problematical issues. Clients such

as Helen seem to have evolved the powerful organizing principle that it is not safe to speak. This traps them in their silence. We often (initially at least) have to guess at the reasons why this has occurred. They do not have an adequate self-structure or 'psychic headquarters' with which to symbolise experiences. To complicate matters further the silence often occurs when these clients are dissociated. Hersch asserts "that dissociation is a very specific alteration in consciousness – one that involves at its core a loss of experience of self" (2202:94). How then do we create a sense of relatedness with such clients? How do we have a conversation with experience that is not yet symbolized? When our conversation is with silence, how can a self structure begin to develop and organizing principles be modified? If we understand that Helen's silence was often an enacted dissociated experience then what is it that she was enacting and how might we best have conversations with clients such as Helen whilst in these dissociated states?

## Dissociation

It is important and useful to have a clear understanding of what dissociation means in this context. Freud made a considerable contribution to our understanding of dissociation with his "conviction that we have mental content outside of conscious awareness, which paradoxically affects our experience of ourselves, others and the world" (1998:17). Pulman (1992) has described the mechanism of dissociation which helps us cope with trauma as "the escape when there is no escape" (1998:104). Bromberg says:

> When ordinary adaptional adjustment to the task at hand is not possible, dissociation comes into play. The experience that is causing the incompatible perception and the emotion is "unhooked" from the cognitive processing system and remains raw data that is cognitively unsymbolised within the particular self-other representation, except as survival reaction." (1998:269).

Meares explains how this "unhooking" happens. He sees "dissociation, at its first appearance, as the manifestation of a subtle disorganisation of cerebral function brought about by the overpowering effect of the emotions associated with the traumatic event" (2000:44). Explained in this way, dissociation is not seen as a defence. The explanation that the prior experience of trauma creates a vulnerability which may lead to its recurrence gives insight into Helen's silence. It also involves changes in attention which Janet describes as a "contraction of the field of consciousness" (2000:45). We might understand Helen's retreat into a wordless 'self' as a process that Jackson calls "dissolution" (2000:48), whereby when environmental circumstances are unfavorable the self becomes stunted

and there is a retreat down the developmental and evolutionary pathway of the brain-mind system, leaving only the earliest, most primitive, preverbal memory systems functional. Meares (2000) describes this perceptual representational memory system as pre-reflective, highly accurate and specific, but automised and inflexible as was the case with Helen.

In order to stay empathically immersed so as to establish some form of relatedness with these clients we need to at least have some idea of the complexity of what is going on. This is a difficult task without the usual assistance of speech. Equally challenging is Helen's struggle to integrate her traumatic intrusions into her stream of consciousness without the aid of words.

Bromberg is helpful here. He reminds us that Helen's dissociated state, in particular her silence, is not fragmentation. Rather, in speaking, she feared fragmenting. Her silence was what held her together. Helen's dissociated traumatic system seemed so firmly established that there were times when it felt that change was impossible. This makes more sense when we understand that clients such as Helen have a personality organised more around a dissociative mental structure rather than around conflict which, according to Bromberg, means that there is a greater resistance to losing their depressive reality.

## Intersubjective and interpersonal listening

All that we have to go with when these clients are silent is the feeling that arises between us - what Anthony Korner (2003) calls the language of "primary intersubjectivity". Meares says that "privilege must be given to feeling-tone and how it arises in particular forms of relatedness" (2000:75). Bromberg (1994) suggests that what we need is "an interpersonal and intersubjective listening stance". Laub and Auerhahn (1989) stress the need for us to be receptive and authentic.

When I listened to Helen she certainly conveyed something. Her facial expressions, her breathing and her body posture gave me some clues. Her deep despair and distress were palpable. Sometimes there were no words. At other times I sensed she was remembering the trauma and at yet other times I felt as though I was doing something cruel to her. There were periods when it felt as though Helen was controlling me and forcing me to speak. Bromberg (1994) describes eloquently what was happening during such times.

He says:

> In the interplay of silence and words, a patient can, at least potentially, force the analyst to give up his attempts to 'understand' his patient and allow himself to 'know' his patient – to know him in the only way possible – through the ongoing intersubjective field they are sharing at that moment (1998:523).

Often in these moments my sense of her despair and my genuine compassion for her distress was communicated without words but 'felt' between us.

For Helen there were often times when her attempts to convey in words how she was feeling felt futile. It was not till some time into the therapy that I realised it was also futile for me to try to put words to what I supposed were her experiences. My anxiety to translate recognition of this state into understanding and to give her my own words was not always helpful. It was as if I was trying to catch not a fact but a feeling, but this feeling had no words. I was to come to understand that this was not an empathic stance.

Laub's and Auerhahn's article "Failed Empathy" (1989) speaks to this. They explain that when memories of the traumatic past break through they can be neither absorbed nor organized. Discussing the past can feel like reliving it again. They emphasise, like others, the importance of our client's ability to sense some form of relatedness with a 'good other' who can hold things together. No wonder it takes time to work with clients such as Helen, for the capacity to trust has to be rebuilt in the therapeutic relationship.

Laub and Auerhahn also describe how survivors of trauma "remember their experiences through a prism of fragmentation and usually recount them only in fragments" (1989:386). It makes perfect sense that these clients who have suffered severe trauma have a diminished sense of self given that, as Meares explains, "memory, at least a certain kind of memory, unifies the multitudinous atoms of experienced data, past and present, that make up the flow of inner life" (2000:32). Little wonder that, with a depleted inner life, there are times when there is nothing to say. As Helen put it, "there is nothing there".

Symington believes that babies can develop primitive survival mechanisms that hold them together. These mechanisms develop in the absence of a reliable good object and so a belief (or organizing principle) "in having to do it [hold oneself together] oneself becomes so ingrained that it is difficult for anyone to get through to the fragility underneath" (1985:133). Helen, when silent, was frequently overcome with a feeling that it was better to keep things to herself and that I could not help her for she "needed to do it on her own".

Being able to turn such fragments of memory into a cohesive story or narrative is one of the aims of therapy. It requires the capacity to be alone so that clients can become attuned to what is happening inside but for clients such as Helen, and Helen states this, being alone is terrifying. The therapeutic relationship is perhaps the first time Helen has had the experience of a reliable "good object", or selfobject, to enable her to tolerate being alone with her experience. Winnicott states "that the capacity to be alone is based on the experience of being alone in the presence of someone and that without a sufficiency of this experience the capacity to be alone cannot develop" (1985:33). Meares (1992) notes that this is a prerequisite for exploration and play. To have a sufficiency of such experience will take time, which perhaps explains why therapy with these clients progresses slowly.

As Helen became able to feel held by silence rather than feel isolated, these silent pauses in our sessions would be of a quite different quality. They would be more like pregnant pauses before the birth of something new, the awakenings of an inner life and growing sense of self. Knowing this helped me hold on to myself when progress seemed so slow. It gave me some understanding about what it was we were aiming for as well as hope that if I could stay with her for long enough we would get somewhere.

Despite this knowledge there continued to be moments when I felt that I failed Helen dismally by being unable to stay with her. The intersubjective space was at times unbearable for me and Helen's great fear that I would not be able to tolerate her silences became real. What she needed to know was that even in this silence I hadn't given up trying. It was when I could stay with her that something important seemed to be happening. Bromberg remarks that "through the forced involvement with what the patient needs to call attention to without communicative speech, the dissociated self can start to exist" (1998:526). Meares' concept of helping our clients integrate the traumatic memory systems into "self as the stream of consciousness" (2000:4) has its beginnings in these moments.

## Where there are no words

Psychic structure, in part, is organised by trauma. Meares explains that the more severe traumata will be represented in the perceptual representation and procedural systems of memory where no words exist. It is not then surprising that some trauma can be wordless. When our clients move into these silent dissociated spaces they often return to the "trauma zone" (Meares) where the intensity of their anxiety wipes out all sense of their inner life and they experience

what both Meares and Bromberg describe as "not-me" states of mind. Bromberg says these states of mind, in order "to be taken as objects of self-reflection ... must first become 'thinkable' while becoming linguistically communicable through enactment in the analytic relationship" (1985:539). Until this happens, this traumatic dissociated state continues to be repeated. Freud first noticed this when he spoke of repetition compulsion. Chu (1991) states that trauma that is dissociated gets repeated.

Silent enactment is a state of consciousness that has its own relational context. It brings with it particular difficulties when in a dissociated form because without the language, thought or spoken, it is not possible to move into the "play-space", for neither client nor therapist can know what this enactment symbolises. All Helen and I had to work with was what was going on between us in the silence and sometimes the only thing I had to go on was what it felt like was being done to me. There were often times when this was gruelling as I sat and experienced the excruciating depth of her psychic pain and despair. How were we to move to something that was known and that could be symbolized so that we could work with it together in the play-space?

Although Helen continued to be constrained by the powerful organizing principle that it was dangerous for her to speak she was eventually able to spend the first few minutes of each session talking of quite ordinary things. It could be about the traffic on the way to the session. She was delighted to discover that we both took the same route. At other times it could be the weather. As her sense of connectedness to me strengthened these conversations lengthened, were more affect laden and contained some personal details – for example she might tell of a problem she had with her demanding mother or what she had done with her beloved granddaughter, though she appeared secretive about such things.

Eventually, whether it was two minutes or ten minutes into the session Helen would plummet into silence and the Helen who had been with me just a second before would effectively disappear. It was as if this affective shift signaled the presence of a self state that was not only disjunctive with the one preceding it, but also relatively inaccessible to it. Because of the discontinuous realities that trauma and dissociation breed they are not amenable to interpretation.

At times Helen was able to say that whilst in these states she was often unable to think - there were no words. She might begin a session with something she wished to speak about, even longed to give voice to, but when the time came the words could disappear or there could be an over-riding thought, "don't tell anyone" – a warning both perpetrators had given her. At other times she would

be overcome with the thought that it would make no difference to her distress if she spoke, even though in other moments when not dissociated she knew it to be helpful. There were yet other times when she felt I would not be interested or that she was a burden and I would find her "too much" or that she could harm me. All this made sense in the context of Helen's early traumatic, unattuned environment. I understood this also in the context of Helen's personality which was organized by dissociative protection against trauma so that she was prone to these shifts in states of consciousness.

Occasionally an unattuned response from me might cause this shift but mostly it was her internal narrative that was the trigger. What was difficult was that while in this state Helen's ability to reflect – what Meares (2002) calls doubleness – was wiped out. There were many things that Helen felt shamed by and she feared fragmenting if she spoke them out loud – the sexual abuse, the hatred towards her mother, her inability to cope, her suicidal thoughts, her agitation, her resentments to name but a few. There were times when Helen was able to articulate a thought, feeling or memory but the fear of being shamed could trigger these dissociated states.

## Poetic, nonlinear conversation

How was I to speak to such states? Apart from attempting to stay empathically attuned I recognised that using metaphor, elaborating and noticing the multi-layered meanings and feeling tone within words seemed important. Lewis, Armini, Lannon suggest that poetry, with its nonlinear, associational form, is one of the few languages that 'speaks' to the emotional mind. "Poetry transpires at the juncture between feeling and understanding – and so does the bulk of emotional life" (2000:4). Bromberg suggests that one of the goals as an analyst is "to enable our patients to experience a spontaneous overflow of powerful feelings [Wordsworth's definition of poetry] as safe rather than shame ridden" (2003:708). He adds that to help our clients "transmute traumatic affect into a potential for poetry" is one of the aims of therapy.

My listening stance, too, needed to be nonlinear so that I could recognize and then begin tentatively to explore these shifts within a relational context using Helen's transference and my own countertransference responses. I looked for subtle shifts in bodily movements and facial expressions. It was not always easy as several dissociated states seem to occur almost simultaneously and I needed to remain mindful of them all. But when I was able to notice and give voice to what was happening in the immediacy of the moment the therapy came alive.

It has been a slow process, but there are now moments when we are able to work together like this. In this relational context my willingness to explore, value and understand her feelings has been a new experience for Helen. Unlike the traumatic process, with what Meares describes as "shifting, oscillating and discontinuous forms of relatedness" (2000:92) what Helen needs to experience is a stable form of relatedness to me. It allows us to put some tentative language around what is happening out of which a new kind of story, a 'narrative', can evolve. Moments when Helen gets a glimpse of a cognitive insight are precious, as they are when she understands and experiences herself in a new way and experiences a new form of relatedness with me. At these times a small step forward enables Helen to move from a dissociated state to a more integrated one.

In Bromberg's words, "Dissociated domains of self can achieve symbolization only through enactment in a relational context because experience becomes symbolized not by words themselves but by the new relational context that the words come to represent" (1998:534). I would add that this process needs to happen time and time again. Bromberg also notes that the process of moving from dissociation to conflict and integration requires "the use of language in the act of constructing cognitive meaning from experience" (1998:535).

Laub and Auerhahn (1989) explain the difficulty of putting words to the recurring traumatic memories. When clients enter this zone it is as though they are in a "black hole" causing an effective blackout of the present. It is desolate and lonely. The sense of self is wiped out with little possibility for connectedness or creativity. Meares believes that in those who have suffered severe trauma "the state of self is diminished or almost lost" (2000:92).

## Therapeutic task

What then is the therapeutic task with such clients? Laub and Auerhahn believe that "the therapist must take the integrative step and lead the reconstructive process more actively than he or she would normally" (1989:389). This helped me articulate my own questions. For example, when Helen called out in the silence "leave me alone", could I have helped her integrate this into something more coherent by putting into words what was happening and tentatively verbalizing my thoughts that as she relived the trauma she was trying to tell me that she wished she could have told her attackers to leave her alone? Or could I have suggested that she was saying to me what she wished she had been able to say to her abusers? Rather than waiting for her to come to this herself as I ordinarily would with other clients it seemed that at the right moment it might

be useful to speak these things with Helen. It does not seem to contradict an empathic stance but rather to strengthen it by giving Helen a way of putting words to what might be happening when she was not yet able to symbolize through language. Feeling deeply understood by me would simultaneously strengthen our relatedness.

Wolf (1993) states that it is not whether a verbal statement reaches the client's unconscious that is most important but rather the experience evoked by the statement. It appeared helpful and soothing for Helen when she moved out of her dissociated state at the end of the session to occasionally provide her with an explanation particularly around her guilty feelings – for example, my explaining that being raped at twelve would make her especially vulnerable to freezing again as an adult. As Nolan eloquently says, this facilitated "a disentanglement from a traumatic system as well as a reconnection to others [me], self and life" (2002:9). As Helen was unable to reflect or think about this it was as if I undertook to do this task for her, modeling how to 'double 'so that, little by little, this would be taken in and assimilated by her. In addition it would leave her with the experience that I did not judge her. There is general agreement in the literature that it is the relationship with our clients which is all important. Laub and Auerhahn write of these clients' need to know we are involved with them and of how harmful analytic neutrality can be. They go on to say that "The task of the therapist working with a traumatized individual is to re-establish relations which would result in the reinstatement of symbolization and wishing" (1989:391).

How we do this with our silent clients is more complex, although the Conversational Model gives us some clues as to our analytic stance. Meares suggests that the client's experience of resonance when we converse in a style rather like the "proto-conversation" can have a transformational effect. If we are to think of the early conversation with our babies there may be no words, only the expression of face and eyes, the movement of our body, the tone of our voice, abbreviated or incomplete sentences. We are somehow 'right in there'. Using our imagination and flow of feelings, our conversation and listening stance is not unlike poetry. We are involved with our child's experience in an ongoing way. Not only what we do but how we 'are' is perhaps the process that Bromberg describes as "the 'knowing' one's patient through direct relatedness ...so that those aspects of self that can not 'speak' will find a voice" (1998:536). In this way we can be the selfobject our clients need.

Remaining involved in our client's world can be an exhausting and demanding task. There were times when I would feel frustrated and impatient with Helen's

silence. It could feel as though I was trying to force feed a baby who was stubbornly shutting her mouth. What Helen required was an authentic and receptive response to her distress. It was my understanding that it was more about not knowing how to open her mouth or trust that she could swallow something life-giving that helped me to take a more empathic stance. This matched more accurately and helped create "a feeling of fit" that would ultimately give value to Helen's experience and out of which meaning would emerge. Meares writes that "the feeling that gives value also gives meaning" (2000:68). Without meaning there can be no words. My own words, inadequate as they may have been, were necessary, for as with the child, these first words needed to be provided by another.

Before these first words can be spoken, even by the therapist, the client needs to feel as if the dissociated self-state holding the experience of the trauma is 'known' by them both. It is with the felt experience of being in the silence with our clients that we get to live through their inevitable enactment of the original trauma. This provides the best chance of having this unprocessed experience become a real memory. There were times when I was so immersed in Helen's world that my breathing or body posture replicated hers. We were in this preverbal state together. There were yet other moments when I consciously thought of this and was reminded of Meares' stance, which is that to mirror our clients' affective state, we need to attend to the minute particulars of their 'conversation'.

Bromberg explains why these clients experience often unbearable psychic distress. Because the mind experiences and retains these dissociated states of consciousness as a dread of what can happen or is happening, rather than as memories of what has happened, their world then becomes (through continual enactment of this experiential memory) a miniature version of the original trauma. For Helen this meant that she was in a constant state of tension and experienced a nameless dread (Bion:1967). There was no respite; she slept badly, remaining tense and vigilant, even in her sleep, on the outlook for attackers. She would hear noises that would paralyze her with fear, imagine men in her room and dream of being attacked by groups of men.

In the first few years of therapy she suffered from an unbearable sense of internal pressure, as if she could explode, trying to push the memories to the back of her mind. She did not always have words to describe what it was she was avoiding or if she did they could disappear once she entered into the memories. Whilst in such states contemplating speaking to me was terrifying as she feared the memories would become even more real or that she would fragment. There

could be weeks of silent sessions where she held something in her mind before she would be able to give voice to it. Each time it was as if I was forced into becoming involved in her excruciating psychic reality so that I could 'know' it. I would search for words to describe what I was feeling but could find none and so became speechless myself. We would share this intersubjective space together. It seemed that what Helen needed of me was my willingness to stay with this process so that she could have the experience of a "good enough" other creating a safe and consistent environment that she could rely on. It was the way we approached these dissociated traumatic memories rather than what was actually said that enabled change to slowly take place.

Bromberg further challenges us when he suggests that we need to think not only about our client's dissociative states but our own. He writes "therapeutic action depends on the freedom of the analyst to make optimal use of dissociation as an interpersonal process (the analyst's dissociative experience as well as the patient's) and, in so doing to maximize a patient's capacity to self-regulate affect in these areas where trauma has left its mark" (2003:707).

This stretched my thinking around Helen. My own supervisor often pointed out that there was something angry and resistant in Helen's silence but I seemed unable to 'know' this. Could I not bear to know about her anger? What of my own anger and frustration? Is this a dissociated aspect of myself? There had been an occasion when out of frustration I had said rather crossly to Helen that I wasn't a mind reader. On reflection, that was a time when Helen was able to respond with some words. Perhaps more of this co-constructed interaction of our various shifting self states, both mine and Helen's, was needed? Bromberg believes that in order for traumatic experience to be cognitively symbolized what is needed is "a 'safe-enough' interpersonal environment – one that has room for both analyst's affective authenticity and an enacted replaying and symbolization of the early traumatic experience that does not blindly reproduce the original outcome" (2003:708).

Change can occur, says Bromberg, when:

> an enactment is serving its proper function and the patient's dissociated experience that the analyst has been holding as part of himself is sufficiently processed between them for the patient to begin to take back into his own self-experience little by little (1988:544).

## A way forward

As this process slowly moved forward there were significant changes for Helen as she moved from a place of dissociation to one of conflict. In this new place she has had to deal with her own difficult feelings. Her experiences in the therapeutic relationship with me in which neither of us fell apart when she spoke, gave her the opportunity to modify her old organizing principle. Her repertoire of affects and ability to communicate them has expanded. There have been moments when Helen has been able to truly speak to me about herself. Bromberg states that such moments "mark a point of true structural growth in personality. . . signaling steps in the organization of mental structure from dissociation to internal conflict" (1998:22). In a recent session Helen was able, with some embarrassment and difficulty, to express her yearnings for connection by saying, "I keep feeling this wish that someone would hold me and tell me everything will be alright". There have been the beginnings of mourning for what has been lost; resentment for what wasn't provided. In our current sessions she suffers less from flashbacks and has some relief from her debilitating feelings of tension and pressure. Our conversation is transforming. Helen is able to make some links between her past and present. It is still tentative but there are precious moments of warmth and intimacy between us. Most recently, at the end of the session, Helen showed me a photo of her granddaughter. There was shared pleasure in our interaction that was communicated both in silence and with words.

When our clients are able to 'know' their pain and their pleasure our conversation with 'silence' will feel and be quite different. This silence will be one of nourishment and safety as well as a signal that our clients are in touch with their inner world. A new kind of language will emerge which is full of silence and words, a fine balance of intrapsychic and intersubjective experiencing. This new language, instead of being a substitute for experience, will allow something new to emerge and enable a new self narrative to be created so that, as Meares puts it, "the therapeutic aim [which] is to reverse this hierarchical descent and to foster the emergence of a larger dualistic form of consciousness and a growing sense of spontaneity, or freedom of movement in psychic life" (2002:223) will be achieved.

> If you do not bring forth what is within you what is within you will destroy you.
>
> If you do bring forth what is within you what you bring forth will save you.
>
> Gnostic Gospel

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# The Wounded-Healer in Psychotherapy

## Shizuka Torii

### Abstract

This paper argues that the therapist's woundedness can be useful and indeed has wonderful potential for therapeutic effectiveness on condition that the therapist has integrated his/her woundedness. It discusses the ethos, the paradigm and the beauty of the wounded-healer by reviewing relevant literature, followed by clinical vignettes from the author's very beginning practice to illustrate some aspects of wounded-healing.

### Introduction

It is said that many of us who choose the professions that involve helping others do so because we are damaged ourselves. In my experience, this is true. Reflecting on how I came to train as a psychotherapist, I remember that I was motivated at least partly by my desire to heal my own wounds. While my vision for the possible (or impossible) future career as a psychotherapist gradually emerged as a result of working through my 'midlife crisis', the devastating effect of the crisis was still haunting me. Very simplistically, I had a successful and supportive husband, who was also a good father to our son. I did very well in my academic pursuits and eventually received a PhD (in linguistics). On the surface, I did everything I wanted to do and had everything I wanted to have. However, I painfully experienced that the fulfilment of the ego (by accomplishing the goals of the identity project) does not suffice to bring fulfilment to life. My marriage came to a dead end. So did my linguistic career. I was thrown down from "I had everything" to "I had nothing". I was shattered.

I desperately searched for who I really was. A faint light I started to see at the end of the long tunnel was the possibility of somehow utilising the brokenness or woundedness I experienced and identified with. I naively thought that if I could heal myself, I should be able to help others heal as well. While I was in search of my own healing, my brokenness or woundedness paradoxically gave me a kind of confidence in my potential to become a psychotherapist. Perhaps I had a vague image of wounded-healer, though I did not know the specific term and concept until later.

> Bugental (1964) states that psychotherapists are regarded as the latest descendants of a long line of healers which can be traced back to prehistoric times. These are the archetypal wounded healers who are thought to be best suited for their professions because of the extent of their own personal wounds (Goldberg, 1986; Guy, 1987). Their own pain is thought to give them empathy and insight into the distress of others, and their transcendence over their pain is believed to give them authority and power to effect "cures" in others (Guy, 1987). (Todaro, 1995: 2-3)

The motif of the wounded-healer is so ancient that its original source is lost in the mists of prehistory (Miller & Baldwin, 1987), and "so universal as to be represented variously across the millennia, as well as cross-culturally" (Todaro, 1995: 21). The character of Chiron in Greek mythology is one of the early representations of the image of wounded healer. While it may seem rather trite to begin by recounting the myth of Chiron, as most authors who employ the concept of the wounded-healer do so (e.g., Grosbeck, 1975; Holmes, 1991; Kirmayer, 2003; Whan, 1987), I think after all that it is an effective way to introduce the basic idea. I avoid a lengthy recount of the story and simply quote the most succinct summary.[1]

> Abandoned by his father, Saturn, and rejected by his mother, Philyra, who preferred to be transformed into a tree rather than raise a creature who was half human and half animal, Chiron was emotionally wounded from the outset. As he matured, he became skilled in the healing arts and mentored Asclepius, the founder of medicine, as well as Hercules, who subsequently injured Chiron accidentally with an arrow. Chiron's suffering was so extreme that he asked to trade places with a mortal, Prometheus, so that Chiron might die and Prometheus be granted eternal life (Hayes, 2002: 97).

The tragic aspect was that Chiron's wound was incurable. He was eternally wounded. However, his ability to heal was not detracted from, but was paradoxically magnified by his wounds. "His cure was not to be" (Grosbeck, 1975: 127). This paradox, that he who cures over and over yet remains eternally ill or wounded himself, appears at the heart of the mystery of healing. The underlying principle of this mystery is "nothing other than knowledge of a wound in which the healer forever partakes" (Kerenyi, 1959: 99).

[1] Chiron is a centaur (a mythological beast) with the body and legs of a horse and the torso and arms of a man.

The ambiguity of the wounded-healer contrasts with the clarity of a god of healing such as Apollo. Unlike the wounded-healer, who is "infected" and affected in his very being by the healing work, Apollo is a "mortally clean" god (Kerenyi, 1976: 39). He works his medical art by means of catharsis, purification and sublimation. In Apollonic forms of medicine there is a definitive split between healer and "contaminated" patient.

Mahoney makes a similar distinction by comparing the wounded healer with the guru model of therapeutic practice:

> The wounded healer has not only experienced historical wounds and subsequent healing, but is able to maintain a current status of continuing vulnerability . . . . The guru, on the other hand, is at great pains to be a perfect rather than a wounded practitioner. This model encourages psychologists to represent themselves as "paragons of socially defined adjustment". (1991: 354)

While this distinction between wounded-healing and Apollonic healing or that between the wounded healer and the guru is conceptually clear and important, it does not clarify the ambiguity of the wounded healer. The ambiguity is rather essential to the notion of wounded-healing.

However, what should not be overlooked is a possibility of a healer being too wounded to heal. This paper is concerned with the woundedness (rather than the cleanness) of the therapist and focuses on its potential value and possible uses in the service of healing others, primarily due to the author's interest. It is important to acknowledge that such a stance is taken not to discount the value of the therapist's healthiness or cleanness. In fact, it is the therapist's vulnerability (the Latin word "vulnus" means "wound"), which I take to essentially mean the therapist's wholeness, that I am interested in. Wholeness, by definition, embraces all parts and polarities. Wholeness requires both *yin* and *yang*, light and shadow. Cleanness is a part, or a polarity. The other polarity, that is woundedness, is needed to make a whole. In other words, it is not *either* woundedness *or* cleanness but *both* woundedness *and* cleanness that I believe to be vital for the therapist to do therapeutic work.

This point is beautifully captured in the following quote on the wisdom underlying the ancient practice of shamanism (which also embodies the concept of the wounded-healer).

> in older healing practices such as shamanism, woundedness is seen not as evidence of vulnerability but as the mark of knowledge. . . The wound validates the healer's ability to move "between the worlds" - the world of the well and

> the world of the ill, for it is in the bridging of these worlds that the healing power lies (Halifax, 1982: 82).

It is such an ability to move between the two poles, the woundedness and the healedness, that interests and inspires me. An important implication in this is that the wounded-healer polarity needs to be balanced in order for one to be able to move between the two poles.

Let me also note here that I purposely hyphenate the words "wounded" and "healer" (hence "wounded-healer"), following Miller & Baldwin Jr. (2000). This hyphenated approach aims to clarify that I am *not* discussing a professional having personal problems, such as the "impaired physician". When hyphenated, the word "wounded" is not subordinate. For example, the "wounded-healer" can be qualified with adjectives such as "effective" and "respected". Indeed, it is my wish and ultimate goal to become an effective wounded-healer.

## The Wounded-Healer

It is remarkable that interest in the wounded-healer paradigm has experienced a revival not only among therapists with Jungian orientation (e.g., Kirkmayer, 2003; Sedgwick, 1994; Whan, 1987) but also among therapists with various approaches (e.g., Hayes, 2002; Miller & Baldwin Jr., 2000; Holmes, 1991). In this section, I discuss the ethos, the paradigm and the beauty of the wounded-healer.

### The ethos

I believe that it is only fair to start the discussion of the ethos of the wounded-healer by referring to Jung. The following quote points to what I consider the basic assumption underlying the whole idea of the wounded-therapist.[2]

> No analysis is capable of banishing all unconsciousness forever. The analyst must go on learning endlessly, and never forget that each new case brings new problems to light and thus gives rise to unconscious assumptions that have never before been constellated. (Jung, 1951: 116)

[2] I take 'analyst' in the quote as parallel to 'therapist' (or 'psychotherapist') in that both refer to the helper. These terms are used interchangeably throughout the article according to the original usage by different authors. The same applies to 'patient' and 'client', and 'analysis' and 'therapy' (or 'psychotherapy'). However, I set 'therapist' (or 'psychotherapist'), 'client', and 'therapy' (or 'psychotherapy') as default terms, in favour of their less pathological and more democratic connotation.

While it is important that the therapist's pathological or volatile complexes should be tamed and worked through, it is also important to acknowledge that they are never totally worked through, and can sometimes be reconstellated under the impact of the client's unconscious. In other words, there are always "inevitable residues of one's own wounds" (L. Harvey quoted by Sedgwick, 1994: 108), which can be stirred up by the client's wounds and conflicts. In addition, "the exigencies of his or her daily existence press on the analyst" (Wolf, 1988: 138) and shape other conscious and unconscious dynamics inside him/her. Kirmayer says "with each new patient we are brought down again into fresh regions of darkness. Complacency is a sure sign that we have ceased to grow and our link with the depths is broken" (2003: 271).

Jung went on to state that:[3]

> a good half of every treatment that probes at all deeply consists in the doctor's examining himself, for only what he can put right in himself can he hope to put right in the patient. It is no less either, if he feels that the patient is hitting him, or even scoring off him: it is his own hurt that gives the measure of his power to heal. (1951: 116)

Returning to the story of Chiron discussed above, Chiron's "ability to help others was increased by his continual search for relief from his own unhealable wound" (Reinhart 1989: 24). This "metaphorically supports the need for continual acknowledgement of our own woundedness as a prerequisite for our ability to heal others" (Holmes, 1991: 34).

> To be wounded means also to have the healing power activated in us; or might we possibly say that without being wounded, one would never meet just this healing power? Might we even go as far as to say that the very purpose of the wound is to make us aware of the healing power in us? (Adler, 1956: 18-19)

## The paradigm

The paradigm of the wounded-healer is based on the recognition that just as the healer has a hidden inner patient, the patient has a hidden inner healer. This is supposedly a response to much of the tradition of clinical psychiatry and psychoanalysis which "has been that the clinician sees himself or herself as

[3] I take 'doctor' in the quote to essentially refer to the helper like 'analyst' and 'therapist' (or 'psychotherapist'). See endtnote ii above.

healthy and mature and looks down, subtly or blatantly, on the patient as sick and immature" (Aron, 1992: 182). Racker captured this tradition and critiqued it best in stating that "the first distortion of truth in 'the myth of the analytic situation' is that analysis is an interaction between a sick person and a healthy one" (1968: 132).

Guggenbuhl-Craig (1968, 1971) is the first one who applied the notion of bipolarity inherent in the image of the wounded-healer to the practice of analysis and more widely in the helping professions. Samuels summarises Guggenbuhl-Craig's theory as follows:

> the image of the wounded healer, with its inherent contradiction, is an archetypal image, and therefore, the *bipolarity* of the archetype is constellated. But we tend to split the image so that the analyst figure in the therapeutic relationship becomes all-powerful; strong, healthy and able. The patient remains nothing but a patient; passive, dependent and prone to suffer from excessive dependency. (1985: 187)

Whan (1987) has pointed out that such a split in roles also negates possibilities of intimacy between the two parties who assume separate roles since intimacy would lead to a blurring of roles. Essentially, if the therapist only identifies with the healer, he or she may distance him/herself from the patient, keeping the patient in the role of the ill.

Along similar lines, Searles (1975) complained, from his own experience of being in therapy, that "the analyst, like each of my parents long before, maintained a high degree of unacknowledgement of my genuine desire to be helpful to him" (Searles, 1975). He "argued that patients suffer from guilt that they were unable to cure their parent's suffering and that only as they are genuinely able to aid their analyst can they enhance their own worth and feel more deeply a fully human individual" (Aron, 1992: 184).

Many decades previously, Ferenczi also recognised that the patient's therapeutic value to the analyst was an important aspect of the analytic process. He developed mutual analysis in which "the analyst encourages the analysand to say what he or she may think or feel the analyst's problem is in the relationship or in his or her ability to respond" (Rachman, 1997: 278). Rachman points out that embedded in the concept of mutual analysis is "a humanistic assumption - that is, a belief in the capacity of the individual to use empowerment to grow, to trust the perception, thoughts, and feelings of an analysand as containing basic truths, and the healing and curative aspects of an emotionally vulnerable and mutual relationship between two human beings" (ibid.: 284).

While I accept that the psychotherapeutic process is inevitably asymmetrical, I also believe that it is vital for us to recognise and question "the unrealistic and unbalanced idea for both patient and therapist of the authority of the latter in sharp contrast to the inadequacy of the former" (Holmes, 1991: 33). Remen, May, Young, & Berland state that "there is no essential difference between the two people engaged in a healing relationship. Indeed, both are wounded and both are healers" (1985: 85). "Therapists who disavow their wounds run the risk of projecting onto the client the persona of 'the one who is wounded', while introjecting the persona of 'the one who heals'" (Hayes, 2002: 96). Searles cautioned analysts against "using the patient to bear the burden of all the severe psychopathology in the whole relationship" (1978: 62-63).

The split in the image of the wounded healer into healer analyst and wounded patient also involves a split *within* both analyst and patient. "If it is the case that all analysts have an inner wound, then to present oneself as 'healthy' is to cut off part of one's inner world. Likewise, if the patient is only seen as 'ill' then he is also cut off from his inner healer or capacity to heal himself" (Samuels, 1985: 187).

> When the therapy relationship is dichotomized into one who is wounded and one who heals, the therapist becomes locked into a position in which her own wounds cannot be used in service of the client, and the client's inner healing capacities are denied. (Hayes, 2002: 96)

Guggenbuhl-Craig argues that "real cure can only take place if the patient gets in touch with and receives help from his 'inner healer'. And this can only happen if the projections . . . are withdrawn" (1971: 128).

The idea of an inner healer has achieved credibility in psychoanalytic as well as Jungian world. Langs, for example, argues that the "patient as enemy and as resisting dominates the analyst's unconscious images, while the patient as ally and as curative is far less appreciated" (1979: 100). Money-Kyrle regards one aim of analysis as being "to help the patient understand, and so overcome, emotional impediments to his discovering what he *innately already knows*" (1971: 104; with emphasis added by Samuels, 1985: 186).

Essentially, the wounded-healer paradigm punctures therapeutic omnipotence by arguing for the importance of the analyst internalising his/her own "wounded" pole, and realising like "the Greek physician, [that] only the divine healer can help . . . the human doctor merely can facilitate its appearance" (Guggenbuhl-Craig, 1971: 96). Kirmayer writes:

> Participation in the process of wounding and healing holds great danger for mortals. Identifying with these powerful forces, the healer can become 'inflated', filled with the delusion that it is her who does the healing and not some supra-individual or transpersonal process acting through him. (2003: 256)

In the historical development of the wounded-healer paradigm, Groesbeck (1975) took up Guggenbuhl-Craig's perspective and showed how actual wounded-healing might take place. He "posits the possible reconstitution of the split archetypal image of the wounded healer in the psyche of both patient and analyst" (Samuels, 1985: 188), and articulated the healing process with a series of complex diagrams showing various permutations involving connection with the underlying "wounded-healer" archetype.

## The beauty

The contributions of Martin Buber (1923/1970) in regard to the facilitation of healing have been widely acknowledged (e.g., Baldwin Jr., 2000; Clarkson, 1991; Hycner, 1995; Miller & Baldwin Jr., 2000, Wheway, 1999; Zohar, 1991). Buber characterises the common form of human interaction as "I-It", in which the other is an object. Subject deals with object. Buber decries this simple "I-It" relationship as superficial and basically meaningless. In contrast, he describes the "I-Thou" relationship, in which each person is both subject and object and is able to recognize the totality of the other in this common experience. He believes that the greatest thing one human being can do for another is to confirm the deepest thing within. Sometimes the deepest things within healers are wounds.

Healers who relate openly and totally with patients model the I-Thou relationship. The beauty of the wounded-healer work lies in the I-Thou genuine encounter. "It involves mutual participation in the process and the recognition that each is changed by the other" (Clarkson, 1991: 156).

Kreinheder writes:

> If you are going to be a healer, then you have to get into a relationship. There is a person before you, and you and that other person are there to relate. That means touching each other, touching the places in each other that are close and tender where the sensitivity is, where the wounds are, and where the turmoil is. That's intimacy. When you get this close, there is love. And when love comes, the healing comes. The therapist is an expert in the art of achieving intimacy. When you touch each other intimately and with good will, then there is healing. (1980: 17)

I believe that wounded-healing entails intimacy and that healing intimacy entails love.

In intimacy, the real person of the therapist and the real person of the client affirm common human brokenness and vulnerability. This can bring life-giving energy and healing to both therapist and client. Miller & Baldwin Jr. discuss that such a flow of energy between therapist and client, generated by the healing encounter, may be a sustaining source for a true healer. They even say that "healers who cannot avail themselves of this profound source are more likely to experience loss of professional energy and effectiveness" (2000: 258).[4]

Todaro also recognises that the wounded healer model "provides therapists with the opportunity for what Mahoney has called 'accelerated psychological development' (1991: 370), that is, the accelerated emotional growth which results from the privilege of therapeutic intimacy" (1995: 22).

> Bugental (1978) states that he has been changed by the practice of therapy in ways that are more than the sum of education, time, and life events outside of the therapy room. What has wrought this change, he believes, has been his participation in the lives of many people. (Todaro, 1995: 31).

One of the greatest things that could happen in the interactive exchange between client and therapist is the realisation of their human potential to be whole, as a result of both experiencing greater awareness and integration of their woundedness. Miller & Baldwin refer to "the origin of the word *heal*, which derives from the Anglo-Saxon word *hal*, meaning whole. To heal, *haelen*, is to make whole" (2000: 253). They argue that "in general, factors facilitating healing also facilitate a sense of wholeness through recognition and acceptance of all of one's parts and polarities" (ibid.). For the therapist, his/her exposure in therapeutic work with clients perhaps provides a way "to stay in touch with himself and find roots and sources of wholeness to the degree that he can stay in some kind of balance" (Groesbeck, 1975: 144).

[4] Professional burnout and vicarious traumatisation are important issues on the other side of the coin. Although my focus in this article is on how psychotherapy can be healing for therapist as well as client, I acknowledge that psychotherapy can also be damaging to the therapist. Nevertheless, a possible implication here is that the well worked wounded-healer would be less vulnerable to these problems. While this calls for thorough consideration, it is beyond the scope of this dissertation.

## Summary

To sum up, the paradigm of the wounded-healer is based on the acknowledgement that although the therapist is presumably healed enough, he/she is never totally free from at least "inevitable residues of one's own wounds" (L. Harvey quoted by Sedgwick, 1994: 108), which can be stirred up by the client's wounds and conflicts. The wounded-healer paradigm recognises that the healer has a hidden inner patient, while the patient has a hidden inner healer. It questions "the unrealistic and unbalanced idea for both patient and therapist of the authority of the latter in sharp contrast to the inadequacy of the former" (Holmes, 1991: 33) and promotes mutuality or equality between the two people engaged in a healing relationship. The beauty of the wounded-healer work lies in the I-Thou genuine encounter. One of the central ideas is the integration of wounded and healer polarities in both participants through the unconscious interaction.

## Case Illustrations

In this section, I discuss my own subjective experiences with two clients in my very beginning clinical practice in an attempt to illustrate some aspects of wounded-healing reviewed above.

### *Mu Lan and me*

Mu Lan was my first ever client. My countertransference started even before I met her. On reading her assessment form, I noticed some similarities between Mu Lan and myself - we immigrated to New Zealand in the same year from Asian countries, we were both solo (divorced) mothers of one child, in our late thirties and had no family in New Zealand. I thought our encounter was no coincidence. The similarities I found between us generated especially warm feelings in me, a desire to befriend her and a fantasy to be friends with her.

On the other hand, I was also aware how different our life stories were, and found her extremely complicated, emotionally unbearable, childhood disturbing. Her mother married and divorced three times. Her father was her mother's second husband. He left the marriage when she was very young. She didn't know her father. She grew up feeling ashamed of not having a proper family, not even knowing what her father looked like and what on earth happened to cause him to leave her. . . .

*Women who love too much*

Something powerful happened in only our second session. I saw her experiencing what might be called 'disintegration anxiety' (Kohut, 1984: 16). What she was going through was much more than just a relationship break-up for her. It was about her life, which seemed to be proving a repetition of her mother's life completely against her intention. She was "falling apart", or "treading water in the middle of the ocean with nothing solid to touch, no one nearby", as Baker and Baker (1987:5) describe.

This took me back to my own experience of disintegration anxiety - the darkest, lowest place I have ever been. For several days I lived under the effect of this big session with Mu Lan. I was probably "feeling feelings or thinking thinkings which are really those of the patient" (Zohar, 1991: 108). There was something of parallel depth or parallel confusion going on in me. Theoretically, the mechanism by which this happened is understood as projective identification, and I as the therapist needed to hold it until the client becomes aware of the unconscious problems and their source, and give it back to her only little by little.

However, I was not convinced that those feelings and thinkings I was feeling and thinking were really hers. They felt somehow more personalised in me. They were even causing me sleep disturbance. It made sense to me that "projective identification may be conceived as a kind of fusion which involves the mixing and muddling up of subject and object, of inner world and outer world; it involves the undoing of boundaries" (Zohar, 1991: 108-109). It did feel like a process that "involves the transformation of the [therapist] as well as the [client] stirring up in [my] personality the layers that correspond to the [client]'s conflicts" (Ulanov, 1996: 126).

If archetypes were constellated for both of us to be changed in the process of coming to terms with them as Ulanov (ibid.) suggests, I think an archetype of "women who love too much", borrowing Norwood's (1997) phrase, was one of them.

> When being in love means being in pain, we are loving too much. *(January 1)*
>
> Loving turns into loving too much when your partner is inappropriate, uncaring, or unavailable, and yet you cannot give him up - in fact, you want him, you need him even more. *(January 2)*

*Daily meditations for women who love too much* (Norwood, 1997)

I suppose I was unconsciously trying to keep safe by calling it madness (privately, of course) that she drove to his house to sneak a glimpse of him, for example.

But then I thought about the fact that I also sometimes looked at the photos of someone who I longed to be with but could not. While I wanted to think that I was a reformed woman who loved too much, this made me see that the reform process was not quite complete yet. I hate to admit this, but it was in fact only a matter of a few years that separated me as the therapist from her as the client. A consolation for me was "I do not think that complete resolution is either possible or essential; to help, the therapist needs to be only a step, not a mile, ahead of the client in the healing process" (Hayes, 2002: 97). At the same time, it was crucial for me to be aware that I was not only dealing with her pathology but also my own pathology so that I did not project all the wounding on to her, while introjecting the healed.

*Easterner/Westerner*

In the following sessions, it became apparent that her psychodynamics were chained up to her cultural values, beliefs, and ways of being in the manner that they were feeding each other. She proudly advocated collectivistic values such as self-sacrifice and a sense of obligation and responsibility, whereas she almost completely lacked appreciation of individualistic values such as self-reliance and independence. At the centre of her values and beliefs was the traditional notion of "good woman" who could make her man feel good. She cherished the subservient role of a woman and valued giving and forgiving which justify the excessive compromise and sacrifice that she made in order to make and keep her man happy (and emotionally abusive). She was even trying to accept what was absolutely unacceptable to her psyche, that a man is allowed to have more than one woman (in fact four wives) simultaneously, whereas a woman is not allowed to even know more than one man, because that was how her boyfriend (who is Muslim) thought and behaved. Essentially, her notion of "good woman" corresponded to the notion of "women who love too much". I seriously wondered whether it would be helpful for me to refer her to the book by the same name, but somehow figured out that she was not ready.

As we progressed, I found myself growing frustrated. She really was not motivated to increase her sense of internal control to cope with problems. She wanted to be helped, but she wanted to stay helpless. Considering her belief that a woman should be looked after by a man (in return for her service to him), I could imagine that being helpless had been a means of survival for her. My frustration was caused by my wish (or need) to liberate her. My wildest fantasy perhaps was that all she had to do was to follow my footsteps. I wanted to show her the way to recovery

and liberation. Presumably, it was my woundedness that made me this eager. I did not have much tolerance for her helplessness because it would have been too painful for me to look at my own helplessness. Since I knew a way out of the unbearable helplessness, which was to adopt individualistic values from Western culture, it was tempting for me to educate and convert her as well. But I was well aware of my bias against collectivistic values and for individualistic values.[5]

Here I think was another archetype constellated between us, which I call "Easterner/Westerner". Roughly, this archetype represents (for me) either imbalance or balance between individualism and collectivism in one person's psyche. It is based on a belief that racial groups are *not* immutably different and that everyone has individualistic and collectivistic needs. I have learnt from my own life journey that individualism and collectivism are not two separate entities from which we choose one or the other. They are more like masculinity and femininity in every one of us. We need to develop both sides.

Both Mu Lan and I lacked such balance. My pathology was that because I had been so wounded by the oppression of collectivistic values, I idealised individualistic values to devalue collectivistic values. Hers was just opposite. (She not only cherished collectivistic values but also criticised individualistic values with passion.) And I was actually helped by her to re-appreciate the good things in the Eastern culture because she respected them so steadfastly. In my relationship with her, I came to realise that I needed to retrieve those virtues from my original culture that I dropped in exchange for Western ideals.

I imagine (hopefully) that I have also helped her to see the good things in Western culture by being who I am, that is a very acculturated person. While she seemed to just assume that I would think like her and feel like her presumably because we both came from Asia, since I did not identify with those projections, some sort of reorganisation must have happened in her unconscious. Implicitly, I was modelling a different way of being an Asian woman.

### *Helen and me*

Helen was a 47-year-old Pakeha woman, but looked somewhat older than her age. Wondering what made her look older, I thought of the dryness I saw in her.

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[5] I am a Japanese woman born and brought up in Japan. I have been oppressed by collectivistic values that condemned "self-realization" as an undesirable selfish pursuit in my original culture. In my experience I was liberated by individualistic values that I adopted from Western culture. I therefore favoured Westernculture to retaliate aganst my original culture

Her hair looked dry, her skin looked withered, and most noticeably her tongue looked thirsty. Dry mouth may have been a side-effect of the anti-depressant she was taking, and dry hair was probably due to repeated colouring. But to me, the dryness in her physical appearance seemed to capture her inner dryness. It made sense for me to think metaphorically that perhaps she has been dehydrated because she hasn't been drinking enough love.

Helen had been living on her own since her 24-year-old daughter moved out two years ago. Her ex-husband left her or she left him when her daughter was 18 months old because he became seriously abusive. Since then, Helen had never had a relationship with anyone else, while her ex-husband has married and divorced two more times and is now in Australia with another woman. She was still carrying her ex-husband's family name, living in the same accommodation that she moved into with him when they got married, and hoped that one day he would come back. In fact, there was a period of about three years during his third marriage when he did come back and seemingly enjoyed having her as a mistress. It had been 23 years since the break-up of her marriage, but she had not come to terms with it and said that she never would.

Primitive defences such as denial, splitting, and idealisation were clearly operative in Helen. She did not have the ego strength necessary for acknowledging and adapting to reality. She did not have access to enough goodness in her. She needed a lot of caring and life- enhancing experience, and I aimed to give those things by accepting and mirroring her. However, despite my genuine wish to help her, I had also been aware that she was the last person I would consider presenting and/or writing about in my assignments, that she was often the last client I discussed in my supervision and I probably spent least time on her. This corresponded to how she was typically regarded by people. Somehow she was not worth much. Somehow she had no significance. While I imagined how awful it must be for her and wished to give her different, reparative experience, I must admit that deep inside my unconscious my attitude toward her was not so different from many other people in her life.

Our fifteenth session was a breakthrough for me (and hopefully for Helen as well). As soon as we both sat down, she said, "I feel fat today," and we spent the first half of the session on the theme of her feeling fat. She was so unhappy and angry with herself. She criticised herself harshly by words such as "disgusting" and "a big fat 47-year old who's got nothing". She was also busy trying to tell me that the "big fat" person in front of me was not really her because she was not like that before. As I listened to her, I became aware how slim I might appear

in her eyes. (I am actually slim. I wear size 8.) I made a couple of interventions to direct her to "here and now" or what was happening between us by bringing my presence into the scenario. It was crucial for our relationship to acknowledge that I did not share the problem of being "fat" and accept her annoyance with thin people. In fact, she was very envious of me being small.

| | |
|---|---|
| Helen | Because I see all those thin people around, and I, well, you know. |
| Shizuka | And I'm probably one of those thin people. |
| H | Yeah, you are a bit smaller than my daughter. |
| : | |
| : | |
| S | So you are probably saying that I'm different from you, because |
| H | Yeah. |
| S | "You are not big." |
| H | Yeah, and it annoys me because my daughter and I go out and she can eat anything (S: yeah). And she doesn't put on weight. (S: mmm, mmm) She has put on a little bit now, (S: mmm) but she still can fit into a size 8 or a size 10. |
| S | Yeah. That annoys you. |
| H | Well, before I actually had Cheryl, I was a size 10. |
| S | Uh-huh. |
| H | I was your size. |

This was an eye-opener for me. It made me realise how I had been unaware of my size, whereas I had been very self-conscious about my Asian look. It illuminated to me how we tend to be self-conscious about those features that cause us emotional distress, but unaware of other features that do not cause us pain but rather give us power. We just take them for granted. I thought I understood for the first time how white people and/or English speakers in general may be unaware of their power and unappreciative of difficulties that others might experience. I could also understand why it had never been an issue for Helen, contrary to my anticipation, that I was Japanese. Just like I did not think much of her size until she brought that up, she probably did not think much of my ethnicity.

Essentially, I was relating to her pain of feeling fat through my experience of feeling Japanese. It helped me to understand that the pain was partly about being different from others and judged as undesirable by the society (or people who

were not different). And something was shifting in my unconscious organisation. Although such an inner process of the therapist does not surface in the session, it is possible that through the intersubjective field between the therapist and the client the shift in the therapist's unconscious may affect the client's unconscious. My hope is that as her neutrality to, or acceptance of, my racial difference brought about a change in my unconscious organisation, my neutrality to, or acceptance of, her body size affected her unconscious organisation.

On the surface, there may seem to be more differences than similarities between Helen and me. For example, she is a native European New Zealander, while I am a non-European immigrant. She speaks English effortlessly, while I speak it with much effort. Helen is older than me by seven years, but looks somewhat older than her age, while I probably look younger than my age. I am educated and she is not. I am small and she is not. However, we are both women and more importantly both human beings. We both cry. We both laugh. We both love. We both hate. . . . And of course, we are both wounded.

For the last 15 minutes or so before the end of the session, Helen talked about her nephew who had committed a crime and was expecting a serious sentence. As I commented on her genuine concern for her family members no matter what and her big-heartedness, I made a link back to the earlier theme of her being fat.

Shizuka I notice you have a lot of love to give to those people and I think you are big-hearted.

Helen Too big at times.

S Mmm, but I think that actually matches your slightly bigger size that you worried about. I mean, you know, I appreciate you want to lose weight. (H: yeah) That's fine. But I think that's your beauty, that big-heartedness, and that probably shows (H: mmm) in your appearance. And it's beautiful, to me.

H Thank you.

S Mmm.

H But I still want to lose weight. (Big buoyant laughter)

S Sure, sure.

I was pleasantly surprised to be able to give such a word like "beautiful" to her without being untrue, and delighted that she received it by simply saying "Thank you." And I had never heard her laugh so buoyantly before.

## Concluding Remarks

In this paper, I have essentially argued that the therapist's woundedness can be useful and indeed has wonderful potential for therapeutic effectiveness. In order to be able to utilise his/her own woundedness in the service of healing others, the therapist first needs to be aware of it. When the therapist is in touch with parallel woundedness in him/herself, he or she feels understanding passionately, as well as compassionately. This passionate understanding goes beyond empathy as a technique. It is more 'personalised' and the therapist relates to the client as one human being to another. Here is a potential for a real human connection, or intimacy.

There are two important distinctions that I hope this paper has made clear. One is the distinction between wounded and impaired or dysfunctional on the therapist's part. The other is the distinction between asymmetry and mutuality in the therapeutic relationship. (That is, although the psychotherapeutic relationship is inevitably asymmetrical, it does not preclude it being mutual as well.) I trust that these distinctions help demystify and justify wounded-healing as effective psychotherapy.

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# Psychotherapy as Fiction

## Philip Culbertson

### Abstract

This past year, two major psychotherapists each published a novel. Struck by this coincidence, I decided to explore the historical relationship between novels and psychotherapy, focusing on psychotherapy by novels, psychotherapy in novels, and psychotherapists as novelists. Particular attention is given to Slavoj Žižek's theories of the detective story as an analogue for psychoanalysis.

One subject that seems to get little attention among New Zealand's psychotherapy community is how psychotherapy influences, and is influenced by, the contemporary arts. We have an active sub-community of art and dance therapists of course, including the pioneering work of Jennifer de Leon. But the generally unaddressed question amongst us is how deeply the arts and culture affect our work with clients in our therapy rooms. From time to time, clients seem to assume that I have seen the same movies they have, or read the same best-sellers (recent examples include *The Da Vinci Code*, Mitch Albom's *The Five People You Meet in Heaven*, Neale Donald Walsch's *Conversations with God*, the recent biography of David Lange, and—horrors!—*Desperate Housewives*). When our clients want to discuss books or film with us, are they attempting to seduce us, twin with us, compete with us, fight with us, or to avoid their own work? These are not questions easily answered, but they seem to touch on the complexities of the interface between authoring a novel and authoring a life.

For the past few years, I've had a growing interest in the relationship between fiction and psychotherapy. On investigation I discovered that the conversation between these two arts takes on three forms: psychotherapy by novels, psychotherapy in novels, and psychotherapists as novelists.

I began to think more intentionally on this topic when I noticed that in 2004, two particularly influential psychotherapists—Christopher Bollas and Neville Symington—had each published a novel. Of course all psychotherapists could claim a place as novelists, because we write case studies, which, because they are countertransferential, are actually works of fiction. Slovenian analyst and philosopher Slavoj Žižek has explored detective stories as an analogue of

psychoanalysis, beginning with the observation that the very scenario of classic detective fiction is one in which "normality" is itself a lie, carefully constructed to efface the traces of "the criminal's" activity (his pertinent works in this area are included in the Reference List below; see also Mead: 2003).

French feminist psychoanalyst Julia Kristeva also understood well the interplay between fiction and creative psychodynamics, and indeed herself wrote detective stories as a break from her brilliant work as a psychoanalytic theorist. Discussing the detective novels of Julia Kristeva, Colin Davis also references Žižek (2002: 294-95):

> Like the detective novel, psychoanalysis is an invention of the late nineteenth century, and it is now almost commonplace to compare the detective and the psychoanalyst. Both search out the relevant clues that point to a hidden truth. However, while noting the similarities between the Sherlock Holmes-type detective and the analyst, Slavoj Žižek insists on their essential difference. A crime has been committed, and we may all be murderers in the unconscious of our desire; but by reconstructing the true story of the crime, the detective guarantees 'that we will be discharged of any guilt ... and that, consequently, we will be able to desire without paying the price for it' (1992:59).... Whereas psychoanalysis confronts us with the price that has to be paid for access to our desire, the detective novel lets us off the hook. A crime has been committed, but not by us.

Žižek's comments seem to resemble Aristotle's argument about why people go to the theatre. For Aristotle (de Poetica: 1448b), the pleasure of attending a tragic drama in the theatre is that it prompts us to imitate the ultimate good, and then to experience the reward of self-respect when we recognize the results of that good within ourselves. This imitation becomes possible only through the clear depiction of the tragedy that has befallen another, such as "the forms of the lowest animals, and dead bodies". To the insightful, such depictions yield catharsis as opposed to pride, that is, a firmer resolve to rededicate oneself to higher values. In other words, a tragedy that is someone else's allows us to disassociate ourselves and rededicate ourselves to the higher good ("A crime has been committed, but not by us"). However, in psychoanalysis, we are left with the realization of our complicity in the murder of our own desire—a corrective to narcissism, and a "welcome home" to the human condition.

## Psychotherapy by novels

When I did my initial interview panel with the NZAP several years ago, I had been reading about "bibliotherapy," and so listed it on my application as one of my interests. A panel member declared that she'd never heard the term. When I explained it to her, I sensed a strong negative reaction, which I was in turn too nervous to pursue. But bibliotherapy is a recognized supplement to face-to-face counselling in the US, and to a lesser degree in England.

Janice Maidman Joshua and Donna DiMenna, the authors of *Read two books and let's talk next week,* write:

> The road to recovery and healing is not only based on what happens in an hour-long session in our office; it is also based on what happens between sessions....[B]ibliotherapy is the clinical technique of recommending books to clients for guidance in solving their problems. It is often used as an adjunct to standard therapy techniques. Counseling is a collaborative process with therapists acting not only in the therapeutic role, but also as coaches and teachers...The goals of bibliotherapy are not to replace counseling, but to assist the helping professional to enhance and increase the resources available to the client. (2000: xxxiii-iv):

Joshua and DiMenna go on to point out three potential problems with bibliotherapy: that reading must never become more than an adjunct to face-to-face work; that clients may intellectualize what they read and thus avoid its transformative potential; and that not all clients are comfortable reading. I would add a fourth—perhaps a question, rather than problem: bibliotherapy seems to assume that books consciously chosen can effect changes, or at least increased awareness, in one's unconscious world, but can they? Psychotherapy, like detective stories, seeks to bring the unconscious "into the light", but do things work the other way too? Again, a question not easily answered. Ethicist Wayne Booth (1988) claims that choosing a novel to read is actually an ethical choice: will reading this book make me more healthy or less healthy? Who we are, who we will be tomorrow, depends, Booth claims, on our ability to read critically (1988:484).

Twenty years of teaching at tertiary level have taught me that some books are too toxic for students to engage with in the normal course of academic expectations. In the US, I eventually had to stop using Samuel Osherson's *Finding our fathers: The unfinished business of manhood* because of the way it disturbed the internal defenses of my students. The male students in particular told me that the book repeatedly reduced them to tears. Here in New Zealand, I've had to stop using

Alice Miller's *The drama of the gifted child* for the same reasons. More than one of my female students told me that she threw Miller's book out the window in a fit of rage. Perhaps had these been therapeutic relationships instead of academic ones, such strong reactions could have been put to constructive use. Personally I am disappointed when students are resistant to letting assigned readings speak to their unconscious. I believe that both ministry training and psychotherapy training are formative disciplines, rather than straightforward academic ones, and that part of that formation occurs through cathartic reactions to texts. It may be that some texts actually can encourage health.

In retrospect I can understand better the apparently-negative reaction of the NZAP panelist to my interest in bibliotherapy. The psychodynamic psychotherapy so privileged in the NZAP would possibly consider that for a therapist to suggest a book to a client is a form of "leading," and I appreciate the truth of such an argument. However, my clinical experience tells me that not everyone who walks through the door of my counselling room is able to afford, or capable of engaging in, long-term psychodynamic psychotherapy, and for those who are seeking a more short-term counselling relationship, bibliotherapy might have something to offer as an augmentation of the direct personal work.

Perhaps a subset of "Psychotherapy by novels" would be books produced by novelists who have been offended by psychoanalytic interpretations of their fictional work. A classic and early example is D. H. Lawrence's response to the psychoanalytic criticism of his novel *Sons and lovers.* Artistically (narcissistically?) wounded by Freudian interpretations of his novel, Lawrence responded by writing two books on Jungian psychology: *Psychoanalysis and the Unconscious* (1921) and *Fantasia of the Unconscious* (1922). The first is a popularization of basic Jungian concepts. The second is a more serious attempt (though some of Lawrence's worst writing!) to combine the empirical neurology of Kundalini Yoga with Lawrence's own interpretation of Jung's psychology and with a theory of sexuality which may be either his own or derived from popular, occultist, esoteric texts.

## Psychotherapy and psychotherapists in novels

As with television (*The Sopranos*) and film (*Analyze This*), so with American and British fiction: psychotherapy, psychoanalysis, and their practitioners seem almost ubiquitous. After an internet search, I was left wondering why our profession seems so absent in New Zealand fiction other than the writings of Janet Frame. A brief selection of overseas novels in which a psychoanalyst or psychotherapist plays a role includes:

*A Mind to Murder*, a very early P. D. James, in which Dalgleish of Scotland Yard is called in to investigate the murder of a psychiatrist;

*August*, by Judith Rossner, which even has a Freudian couch on the cover!;

*Freud's megalomania*, by Israel Rosenfeld, in which a lost sequel to *Moses and Monotheism* is discovered, wherein Freud retracts his theory of unconscious drives, stating that the greatest force in human nature is self-deception;

*In the Floyd Archives*, by Sarah Boxer, a cartoonist's parody of many of Freud's most famous case studies;

*Pilgrim*, by Timothy Findlay, in which Jung is the doctor who treats a visionary schizophrenic;

*Portnoy's complaint*, by Philip Roth, an insanely comic novel about the American Jewish experience, virtually all of which takes place on the analyst's couch;

*Running with scissors*, by Augusten Burroughs, who was a guest of the Auckland Writers' Festival this recent May (as a child, Augusten's mother couldn't cope, so she simply gave him to her therapist in payment for her bill);

*The bell jar*, by Sylvia Plath, a semi-autobiographical novel of a young woman's therapy for depression and suicidal ideation;

*The fig eater*, by Jody Shields, in which Freud's famous patient Dora is found dead in a Viennese park;

*The white hotel*, by D. M. Thomas, a truly brilliant fictionalization of Freud's analysis of Frau Anna G.;

*The world is made of glass*, by Morris West, in which Jung becomes the therapist for a wealthy woman with demoniac fantasies;

*Therapy*, by David Lodge, the story of an aging British sitcom writer's discovery of his primitive self.

After compiling this list, I found myself designing a new course in my head, and I fantasized about calling it "The Fictional Psychotherapist".

## Psychotherapists as novelists

If novelists write about psychotherapists, then it should come as no surprise that psychotherapists themselves write novels. Yet it keeps surprising me anyway: try

as I might, I can't rid my busy head of that caricatured therapist who says little beyond "Um-hmm" and "Tell me more." After some investigation, I discovered that some therapists do indeed have a fictional voice, and just like non-therapist novelists, produce fiction that is sometimes brilliant, and sometimes not.

I have already mentioned French feminist psychoanalyst Julia Kristeva. Thus far she has three novels to her credit. Her first novel, *Les Samouraïs* (1990; published in English translation as *The Samurai*) in which Barthes, Derrida, Foucault and Lacan all appear as characters, is a tale of sex and excess, picturing French intellectual revolutionaries "as modern counterparts of the Japanese warriors who also were poets and calligraphers and who were completely willing to face death in order to experience everything." Her second novel, *Le Vieil Homme et les loups* (1991; published in English translation as *The Old Man and the Wolves*) is an experimental novel about murder and grief which one reviewer described as "an iridescent gem glinting with psychoanalytic speculations, shards of myth and classical lore and musings on death, hate, love and the imagination." Her third novel, *Possessions* (1997; published in English translation under the same title), begins with a woman's beheading following a dinner party. The woman's friend must then sleuth out who committed the murder, by interviewing the dinner guests. A reviewer has described the novel as "a gripping mystery as well as a philosophical novel, full of sensuality and psychological insights, especially relating to the mother/child relationship." Interestingly, none of the novels has sold very well, and all three have been described by various reviewers as an exercise in Kristeva's own narcissism—a point to which I will return.

Existential psychotherapist Irvin Yalom has authored a great many works, five of which are frequently classified as novels, though with Yalom, the line between a case study and fiction is a fine line indeed. *Love's Executioner* (1989) and *Momma and the Meaning of Life* (1999) are both described as part memoir, part fiction, and are often compared to the work of Oliver Sachs. These two books are funny, insightful, and honest about the fact that therapy doesn't always work. The therapist is very human in both cases, which may be a comfort to us all. In *When Nietzsche Wept* (1991), Freud's mentor, Josef Breuer, attempts to cure Friedrich Nietzsche of suicidal despair in the clinics, cemeteries, and coffeehouses of 19th-century Vienna. The young Sigmund Freud also wanders through these pages. *Lying on the Couch* (1996): in Yalom's fictional world, the relationship between therapist and patient is a tricky one indeed, and it's sometimes hard to tell who needs advice and counselling more—the patient lying on the couch or therapist sitting nearby. Nor is it easy to tell who is "lying". In *The Schopenhauer Cure* (2005), a successful older therapist agrees to supervise a younger therapist-in-

training, if the younger man will both join the older man's therapy group, and teach him Schopenhauer as means of facing impending death. Interestingly, Yalom's most recent novel has not been as critically acclaimed as his previous work, and one reviewer described *Cure* as "self-referential and narcissistic". There's that word again.

Which brings me to the reason I started this essay in the first place: the publication of new novels by two of psychotherapy's most prominent theorists.

Sydney-based Neville Symington is well known to us in New Zealand. *Narcissism: a new theory*; *The making of a psychotherapist*; *Emotion and spirit: Questioning the claims of psychoanalysis and religion*; *A pattern of madness*; *The blind man sees*—these and so many others are an honored part of the theory base which shapes us. Perhaps that's why I was so disappointed in Symington's new novel, *A priest's affair.*

On the surface, I know what this novel is about: an older backward-looking Catholic priest, a younger forward-looking Catholic priest who is sent to train with the former, and a beautiful but delusional grief-stricken widow. Each of the three characters is devious, and each, like each of us, carries the seeds of his or her own destruction. But what is this novel "about"? The publisher's blurb on the back cover says "By way of this multi-faceted exploration, the author describes processes which find parallels in many contemporary institutions". But the connection between the novel's plot and any other contemporary institution is thin, even at an allegorical level.

Ironically, I was reading this novel as a new pope was being elected in the Vatican. Is the novel about the recent struggle of the Catholic church over whether to elect a traditional or a moderate Pope? Possibly, since it was published before the election of Benedict XVI, and since Symington himself studied to be a Catholic priest earlier in his life. Or is it perhaps about our struggle within psychodynamic psychotherapy over whose theory base will prevail? Or is it a parable about what happens in psychodynamic groups—some look backwards and some look forwards? Is it a parable at all? In Greek "para-bole" means "something thrown alongside something else", with the intention that when the two things are seen together, both can be understood in a new light. If Symington's book is a long parable, then I'm not sure what its being "thrown alongside of" was intended to illuminate.

As much as anything, I was troubled by the successive waves of negative countertransference I experienced while reading this novel. There was no character I liked, nor one that I could significantly identify with. (I hope that

doesn't say more about me than it does about the characters!) Certainly it is the case that human beings are riddled with narcissism. For most of us, we disguise that relatively well. These characters—the priests in particular—were so caught up in the competitiveness of their doctrinal rigidity that their narcissism was too blatant for me to tolerate. I kept remembering a woman I knew once, whose narcissistic delusion was that if she could just get a priest to fall in love with her, it would prove (to herself) how special she was in God's eyes. In the end, try though I might, I could not warm to this novel. Ironically, for an honoured expert on psychodynamic theory to publish such an amateurish novel is an act of narcissism. And there's that word one more time.

Like Symington, Christopher Bollas is the author of any number of books which form our theory base as New Zealand psychotherapists—*The shadow of the object: Psychoanalysis of the unthought known*; *The mystery of things*; *Cracking up: The work of unconscious experience*; *Being a character: Psychoanalysis and self experience*—these and so many others. Unlike Symington's novel, Bollas' novel, *Dark at the end of the tunnel,* is superbly written, perhaps because in addition to being a psychotherapist, he is a professor of English at the University of Massachusetts.

Bollas' book is actually four short novellas, related through the conceit of a central character and an overshadowing event. The central character is "the psychoanalyst" who, because he is nameless, could be any one of us—"something of a comic hero, always a bit behind in coming to terms with the issues he considers and the context in which he lives," and a bit slow in tracking his clients! The overshadowing event—The Catastrophe (ever present but never defined)—has changed something in the world, so there are suddenly bigger questions for the psychoanalyst to ponder, such as the meaning of life, or what happens when we die.

Bollas' novel is about how "the psychoanalyst" thinks outside of sessions, during a cancellation, on a morning walk, over a cup of coffee, at the fish market, during a dinner party conversation. Though each novella is constructed around one of the analyst's clients, there are no case studies in the book, and no resolutions. But the "wondering" is delightful, challenging, and a model of the sort of questioning mentality that rightfully marks our trade. *Dark at the end of the tunnel* is, among other things, a brilliant fictional example of how important spirituality and the existential meaning of life are to the therapeutic process.

(As an interesting aside, it should be noted that British psychoanalyst Janet Sayers (I use her book *Mothers of Psychoanalysis* in the classroom) published a book

recently, entitled *Divine therapy: Love, mysticism and psychoanalysis*, described as a series of love stories. Sayers' book draws on the philosophical and psychological writings of William James, Sigmund Freud, Carl Jung, Sabina Spielrein, Simone Weil, Erich Fromm, Paul Tillich, Viktor Frankl, Melanie Klein, and D. W. Winnicott. She ends with insights from Christopher Bollas, Neville Symington and Julia Kristeva—ironically, three of the novelists under review here. Sayers reveals how strongly she is influenced by Christian theology—a theme that also pervades these novels of Symington and Bollas.)

## Wrap up

Near the beginning of this essay, I asked: "When our clients want to discuss books or film with us, are they attempting to seduce us, twin with us, compete with us, fight with us, or to avoid their own work?" Surely, the same questions should be applied to the unconscious agenda of every book reviewer as well. Perhaps I was "seduced" by the normalcy of Symington's novel: after 35 years in ordained ministry, the todeskampf between a conservative older priest and an iconoclastic younger priest looked just like "a normal scenario" to me, and I missed all the clues that a better detective would have caught (or maybe, because I've spent so much of my life being iconoclastic, I was avoiding my own work, the "traces of my 'criminal' activity"). Maybe I wanted to fight with Symington. Reading Bollas, on the other hand, was a defensible ethical choice for me: I thought differently after reading the book, just as I would like my students to learn to do in their formation.

On my way out of the country in mid-April for a beach holiday, I picked up a copy of *Therapy*, Jonathan Kellerman's latest pot-boiler. Kellerman is a child psychologist who, in addition to novels, has written three academic books on violent children. The plot revolves around a patient and his female therapist, both of whom get murdered in seemingly unrelated incidents (why are there so many novels about therapists who get murdered, and what sort of subliminal wish is that?). The book is, however, not about psychotherapy, though it is generously sprinkled with therapeutic language, such as parallel process, sublimation, projection, and an anxious fantasy about how corrupt we can become when insurance schemes dictate what we offer to clients.

My recommendation? Read Bollas by a cold night's fire as soon as possible; take Kellerman on your mid-winter-Christmas beach holiday; and skip Symington. I suspect Symington has a good novel in him somewhere, but *A priest's affair* isn't it.

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# Love - Rights - Solidarity: Psychotherapy and the Struggle for Recognition

## Gudrun Frerichs

### Abstract

The aim of this paper is to explore overarching principles that need to be present in each therapeutic encounter, no matter what orientation the therapist has and independent of the status of the client's mental health. Such overarching principles can be drawn from 'Recognition Theory', a philosophical concept developed by critical social theorists that offers a language that moves away from pathologising and labeling clients as ill or deficient and towards identifying those experiences that are understood as necessary for identity formation and self realization.

### Introduction

Recognition theory has been developed as a means of understanding complex social processes. Its aim is to identify the parameters of ethical life and a just society from a critical social theory's point of view. Such broad parameters make it impossible to discuss the theory in depth in this paper. However, this paper will introduce the basic principles as a starting point to discuss its usefulness for psychotherapeutic practice.

Recognition theory has been developed by Axel Honneth, presently the director of the Institute fuer Sozialforschung, Frankfurt, Germany, better known as the Frankfurt School, a main centre for critical social theory. He succeeded Habermass and other critical socialists such as Horkheimer, Adorno, and Marcuse, who in the broadest sense followed the Marxist tradition of understanding social problems to arise from capitalist distribution of goods and resources.

In contrast, the new generation of critical theorists understands social struggle differently by emphasising that social justice relies on more than the fair distribution of goods. Indeed most present social conflict is rather a struggle for recognition of people's way of life (political separatism, homosexuality), their dignity and status as a person (disability, refugees), and the inviolability of their physical integrity (Amnesty International, UNICEF).

The word 'recognition' has two different meanings in the English language. One is referring to re-identification, such as voice recognition, pattern recognition and so on. The way it is used by Honneth refers to ascribing a positive status to someone. For example the PLO recognises the state of Israel or a physicist is recognised with the Nobel Prize.

## Recognition Theory

The importance of recognition is based on inter-subjective processes by which people arrive at a sense of self and a sense of identity. Following George Herbert Mead, identity formation is an interactive process by which a person is able to view herself through the perspective of the 'other'. A strong and healthy sense of self depends on a person having a certain sense of him or her self which is affirmed and recognised by the 'other' (Mead: 1934).

It is at this junction that recognition theory reveals its close connection with psychoanalytic concepts. Winnicott, Bowlby, and Stern have described our need to be recognised by another person whom we in turn recognise and value. This need for reciprocal recognition can be observed in early mother-infant interactions through to adult sexuality and public life. Winnicott clearly stated that feeling alive and being real can only be achieved through mutual recognition (1971). Developmental psychodynamic theories that stress the importance of a positive early environment where the infant experiences support and love as well as stage-appropriate challenges for optimal growth have long informed psychotherapy. "These factors lead to positive affect regulation, biological homeostasis, and a quiet 'internal milieu' allowing for the consolidation of the experience of subjectivity and a positive sense of self" (Cozolino: 2002:26-27).

Social life then starts with the individual as he or she encounters the 'other' and is reproduced by acts of mutual recognition. Therefore recognition is much more than a nicety, politeness, etiquette, or a means of receiving feedback. It is a core element of social interaction, the quality of social life and human integrity, and it is vital for the formation of identity, which is a precondition for persons to be autonomous and individualised and to be able to sense, interpret and realise their needs (Taylor: 1992; Honneth: 1995).

In turn lack of recognition is a threat to a person's self-development and can bring the identity of a person as a whole to the point of collapse. Prime examples of this are dissociative identity disorder or other disorders with identity disturbances. The severity of the impact of withheld recognition or acts of disrespect on a

person depends largely on which form of recognition is at stake. Generally speaking, lack of recognition can restrict the freedom of individuals and it evokes very strong feelings of shame, rage, hurt, indignation, and of being insulted or humiliated. It is for that reason and for expressing their need for individualisation and for claiming their subjectivity that individuals are compelled to remove any constraints to mutual recognition.

Recognition theory then posits that for persons to be able to sense, interpret and realise their needs they must develop **self-confidence** (the capacity to express one's needs and desire without fear of abandonment), **self-respect** (one's sense of universal dignity of personhood, being capable of raising and defending claims, viewing oneself as entitled to the same status and treatment as others), and **self-esteem** (the sense that one has something to offer that is valuable, able to contribute something worthwhile to society).

Honneth (1995) has identified the following three forms of granting and being granted recognition as necessary to develop these self-relations. They are recognition through LOVE in primary relationships, through the granting of RIGHTS through legal systems, and through SOLIDARITY within one's community.

## Love

"The experience of love represents the core of all forms of life that qualify as ethical" (Honneth: 1995: 176), highlighting the primary position recognition through love has in achieving a just society. It is the first and most important path for the development of identity and provides the foundation for all other forms of recognition. Recognition through love is experienced in primary relationships in which strong attachment bonds are formed. Although all love relationships are important for a person's development of identity, the most significant relationship is the parent-child relationship because it lays the foundation for a person's self-relations.

Honneth (1995) refers to object relations theory when he posits that, when all is well, being recognised by being loved helps the child not only to develop a basic trust in its own abilities and the environment and a sense of self and identity, it also helps to differentiate between self and environment, to coordinate sensory and motor experience, and to develop a body-scheme. It enables the child to develop self-confidence, which means it is able to sense and express its needs and desires without having to fear abandonment or rejection.

The lack of loving recognition from the parents or caregiver has the most devastating impact because of the child's total dependency on the parent. It erodes the child's systems of attachment, it erodes basic trust, and as we know from neuro-psycho-biology it arrests or impedes the growth of the limbic area of the brain, causing lasting damage (Siegel: 1999; Schore: 2003; Lewis: 2001). Acts of abuse or neglect deprive a person of freely disposing of their body and therefore represent degradation, shame, humiliation, and denial of subjectivity. This form of disrespect impacts more destructively on a person's development of identity than any other form of disrespect. It erodes or interferes with the child's systems of attachment, it erodes basic trust in one-self and in the environment, and it distorts or arrests a child's relations-to-self and with its body (Honneth: 1995).

*Relevance for Psychotherapy*

We know from clients who have been abused or neglected in childhood that they lack self-confidence in the sense that they don't trust themselves and equally don't trust their environment. They may have built a whole value and belief system based upon their own inadequacies and often lead lives that reinforce their beliefs. They may not have learnt how to express their needs adequately. More often than not they don't express their needs at all and when they do they might go about it in unhelpful ways. They might struggle with transference phenomena where the therapist is either experienced as the aggressor, their victimised self, or the idealised parent. Needless to say, all of these positions create considerable distress for the traumatised client and therapist alike.

Like the parent-child relationship the relationship between therapist and client is asymmetrical in that they are not equal partners in interaction. The child is completely dependent on the parent as a source of recognition. This dependency lessens with the increase of social interactions as the child matures. Although the parent receives recognition from the infant, the main thrust of the interaction is rather one-directional and completely focused on the child's being. Young parents' position of asymmetrical recognition makes them very vulnerable to emotional stress and depression. They need the protective recognition of a third party to be able to continue care-taking of the dependent child.

A similar process manifests itself in the therapeutic relationship. The client may enter psychotherapy in a state of utter chaos and disorganisation and for a while may be completely dependent on the therapist as a source of recognition – or better positive recognition. As therapists connect with their clients with care and positive regard or recognising them through love therapy becomes the nurturing path of mutual recognition.

Like young parents therapists also need recognition from a third party to be sustained in their demanding work. That recognition may come from a supervisor, peer, one's workplace, from society or the community, or for example ACC. If that recognition is not forthcoming or worse, if therapists are subjected to acts of disrespect, they may struggle just as the young parent does. Burnout and compassion fatigue are clear signs of the lack of recognition. This may be particularly concerning for therapists who work in the isolation of their home or in agencies with poor support and/or poor supervision arrangements.

In the widest sense, recognition theory affirms what has been the core of most psychotherapeutic theories and encourages therapists to focus on the basic principles of attending with empathy and care to the relationship with the person that comes to us for help. It is under those conditions that the client then can develop a sense of self-confidence, a vital stepping stone to improving or developing her self-relations.

## Rights

Recognition through rights refers to those individual claims that a person can legitimately raise and defend because he or she participates with equal rights in the institutional order as a full-fledged member of a community. The experience of being granted rights through legal systems therefore enables adults to understand their own actions as the universally respected expression of their own autonomy (Honneth: 1995).

In contrast to physical integrity, love and concern, rights have been subjected to change over history. Originally they were linked to a person's status and/or gender, for example the rights of aristocracy, the lack of rights of slaves, rights to inherit. Over time rights expanded with civil rights guaranteeing liberty, protecting a person's life and property (eighteenth century), political rights guaranteeing participation in public will-formation (nineteenth century), and social rights guaranteeing basic welfare and a fair share in the distribution of basic goods such as education, health, and social assistance (twentieth century).

Through the experience of being granted legal recognition individuals are able to view themselves as equal to other members of society, which leads to a sense of self-respect. They are able to respect themselves because they deserve the respect of everyone else. Self-respect is not so much understood as having a good opinion of oneself but rather "a sense of oneself as a morally responsible agent capable of participating in discursive will-formation" (Honneth: 1995: xv). Only when

rights exist that provide the opportunity for persons to exercise that capacity is a basis created for the development of self-respect. Women being granted the right to vote would be an example of this thesis.

Being structurally excluded from the possession of certain rights within a society leads in the widest sense to social exclusion and a sense of inequality in social interactions. "The kind of recognition that this type of disrespect deprives one of is the cognitive regard for the status of moral responsibility that had to be so painstakingly acquired in the interactive processes of socialisation" (Honneth: 1995:134). Honneth describes the outcome of 'legal under-privileging' as dismantling a person's moral self-respect, causing crippling feelings of social shame that can only be lifted by protest and resistance.

*Relevance for Psychotherapy*

When reflecting on the parameters of therapeutic action the intersubjective relational sphere of recognition through love stands out most clearly, given that therapy to a large extent is about assisting in developing, resourcing, or repairing a person's sense of self-confidence and trust. Nonetheless, recognition through rights or rather the lack thereof is underlying many issues that clients bring to psychotherapy. I am referring to experiences of disrespect in the form of neglect, abuse, or violence that clients may have had in their lives.

Not only that, by using mental health services clients may encounter a range of situations in which their right to be autonomous and self responsible is compromised. Clients report being treated disrespectfully: for example, decisions being made for them rather than with them, privacy being invaded, and confidentiality not being observed. A mental health service provider may not investigate whether the person has a history of sexual abuse, thereby depriving them of the option to access ACC funded counselling or compensation. Likewise policies and procedures that are designed to cut costs (i.e. allocating a limited amount of hours, frequent assessments), or triage access to services (i.e. providing treatment only for the most symptomatic patients), or other procedures that may compromise clients' sense of dignity and therapeutic needs to meet administrational or financial priorities of service providers or funding agencies.

Clients' rights may also be compromised by diagnostic practices, in particular the labelling and treating of a traumatised person as mentally ill or suffering from a mental disorder. This way what is in most cases a normal or rather understandable response to an extreme experience becomes a problem located in the client's psychological make-up. The therapist's way of interacting with the client may be

another factor. Is the client treated as fragile, incompetent, and unable to look after herself, or is the style one of fostering empowerment through collaboration, where the client is seen as equal partner in the therapeutic project?

All the above examples have in common a regrettable lack of understanding and consideration for client's needs in the face of at times strong psychological distress. By personalising clients' problems and exploring them in terms of their internal conscious or unconscious processes therapists may collude with systems that are structurally oppressive, excluding, and perpetuate violence in society. Unless we pay attention to the social and political background that shapes clients' experiences, we have to examine the ethical question whether we help clients to feel better or be more resilient under abusive and unjust circumstances. "Counsellors might achieve greater understanding of the human psyche if they spent more time examining the nature of the socio-economic soil from which we all emerge and via which we are nurtured, defined and constrained" (Howard: 2000:273).

The pivotal question then is whether psychotherapists have a mandate and the responsibility to assist clients in gaining recognition for these rights. To what extent is advocacy part of psychotherapy? And if we have such a mandate how should advocacy be practised to maintain clients' right to be equal partners in the therapeutic encounter – presupposing that the client already enjoys this right in the therapeutic relationship?

Before concluding this section I would like to comment on therapists' need for recognition. Psychotherapists seek recognition from the health and mental health field for being qualified and capable health practitioners who provide specialised and effective services. This struggle is best reflected in the effort to ensure that psychotherapy becomes a registered profession, which implies that experiences of disrespect or non-recognition have preceded this effort.

Examples of this are employment policies that discriminate against psychotherapists in public health services, (funding) agencies interfering with the provision of appropriate care for clients, or third-party-funding pressures creating situations where psychotherapists' professional integrity and standards of ethical conduct may be threatened.

## Solidarity

Recognition through solidarity is closely linked to a person's honour, dignity, status, or social standing in the community. What society deems to be a valuable

contribution has seen significant changes in the history of social development. For example the status of an actor in the Middle Ages was close to that of a beggar or other low status persons living on the fringe of respectability. Actors today enjoy a very high status with high income and at times obsessive admiration of the general public.

As people are able to experience that social value is attributed to their abilities and their individual forms of life and manners, thus being esteemed by their peers or their community, they will be able to develop self-esteem.

If peoples' traits and abilities are devalued as inferior they will lose personal self-esteem, a phenomenon that we can observe for example with people who have been made redundant or have been unemployed for some time. The lack of social approval and group solidarity postulates the devaluation of one's patterns of self-realization. They can not relate to their mode of life as something of positive significance within their community, which leaves them feeling denigrated and insulted. We can regularly observe such reactions in clients who struggle with the legacies of lack of recognition due to poverty, solo-parenthood, abusive family dynamics, or mental health issues.

They may also be affected by negative recognition in the media and the general public, for example the recovered memory debate, debates by members of parliament regarding fraudulently acquiring treatment or compensation from ACC, or the recent debate about getting beneficiaries back into the workforce. Likewise, the inconsistency with which mental health issues are discussed in the media: either beautified (the young, beautiful, smiling aunt with bipolar disorder surrounded by her loving family), sensationalised (the elderly ex-convict who applied for government funded sex-change) or ignored (the vast amount of physical and sexual abuse in families), certainly gives conflicting messages. Such inconsistent or negative patterns of recognition can easily reinforce abuse-based beliefs about not being OK or not being entitled to financial help. Clients may also be inclined to discount their experience, or they feel ashamed and humiliated for needing help, for their inability to function independently, for their inability to work, and for being on the benefit, to name a few issues.

The lack of recognition often is accompanied by lack of interpersonal relationship skills needed to engage socially with people who could offer support and solidarity. To develop good self-relations and in particular self-esteem is under these circumstances an up-hill battle. This is made even more difficult by lack of understanding by both clients and the general public of mental illness or childhood abuse and their long-lasting and intrusive psychological scars.

Psychotherapists can facilitate recognition through solidarity by being mindful that they may be the client's first experience of having someone else assign value to their being or way of living. However, the strongest experience of recognition through solidarity will be provided in groups. These can be therapy groups or groups involved in sports or other forms of recreational interest. Here group members are able to empathise with their various ways of coping with the legacies of mental illness or abuse. In groups they have the opportunity to esteem each other for their achievements and their courage, and to offer mutual support, understanding, and appreciation.

## Conclusion

This paper has elaborated on recognition theory as a useful, additional lens for psychotherapists in understanding their clients' struggle and in indicating pathways towards psychological well-being. Although recognition theory is firmly grounded in the psychoanalytical concepts of development and attachment, there is no aim to compete with any psychotherapeutic models. Instead it may be used as an over-arching sociological principle that may give an appreciation for a person's continuing need for recognition not only over the life-span but also from a variety of sources. These sources are primary relationships, legal systems, and a community of peers. They are necessary for the individual to attain self-confidence, self-respect, and self-esteem, the building blocks for a person's positive sense of identity, positive self-relations, and self-realisation within the context of all social relationships.

This brief overview has shown that psychotherapy has the potential to provide important re-constructive experiences in all three spheres of recognition as psychotherapists engage compassionately with their clients in their struggle for recognition of the inviolability of their person, their autonomy, and their value as members of society.

I have also given some examples of recognition theory as a useful tool of analysis. Dynamics in the interactions between psychotherapists and clients, clients and public health services, clients and funding agencies, psychotherapists and other health professionals, psychotherapists and psychotherapists, psychotherapy and society are very complex and intricate. Their analysis using recognition theory might reveal interesting results that could enhance the social interactions between all parties involved.

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# Uncanny Phenomena in Psychotherapy: Loving Messages, Quantum Non-locality or Madness?

## Linde Rosenberg

### Abstract

This paper is based on my master's thesis research into Pakeha and Maori psychotherapists' and counsellors' experiences of inexplicable phenomena while working with clients. These phenomena may take the form of 'uncanny' knowings, 'synchronistic' dreams, bizarre visual images, or 'spirit forms'. The experiences create feelings of profound loving connectedness and of being part of a greater whole where self and other, dream and reality, and time and space are not as distinct as they appear in everyday life. At these times, therapists and counsellors often describe feeling as if they have access to universal knowledge or are being spoken to by an intelligent Other. I discuss these experiences and interpretations and the problematic place these phenomena have within psychoanalytic theory whereby they have largely been excluded from discussion.

### The participants

I interviewed eight psychotherapists and counsellors, of whom three were Maori and five Pakeha.

### The experiences

Therapists described a variety of different experiences that took the following forms:

1) Seemingly being able to know things about clients, which the everyday view of the limitations of our senses tells us cannot be known.

   Example 1: In a session, one therapist felt an " intuitive impulse" to go onto the deck outside her therapy room, pick the one rose that was there and give it to her client. The client then burst into tears and said, "I just dreamt that you did that".

   Example 2: A therapist found herself wandering around her practice, while

waiting for a late client, looking for ice in the freezer, then going into the bathroom noticing a flannel. She didn't need ice or a flannel but noted to herself that they were there. When the client arrived, late, after having had had a minor car accident in which she had hurt her leg, the therapist quickly got the ice and flannel and put them on the client's bruised leg.

Example 3: Several therapists knew things (in a conscious coming to mind), about what clients were about to do or say, ahead of time: for instance a therapist thinking of a client they hadn't seen for ages, not long before they phoned.

2) Seeing subtle visual changes in clients' appearances, which appeared as external and distinctly different from something imaginary, and sometimes heralded something a client was just about to speak about.

   Example 1: Suddenly seeing the texture of a client's skin as like thick paint just before she began to speak about a painting.

   Example 2: Seeing the face of a woman superimposed upon that of a male client.

3) Having intense, embodied emotional experiences, which felt like experiencing the internal life of a client, in a very real way, either in the room or in a dream.

4) Dreaming of clients in scenes that were later recounted and described as having taken place in 'reality' by the client.

5) Communication, involving all senses, with moving 'spirit forms'.

These phenomena raise a lot of questions about perception, fantasy and reality.

In this paper, I will mainly concentrate on the experiences, which were described as 'knowings'. The word knowing was used in different ways: knowing by making correlations, knowing experientially, and knowing intuitively. During the research, I asked about two areas in relationship to these experiences:

1) The state of being the therapists and counsellors were in at the time the experiences took place.

2) The meanings they made and the explanations they gave themselves about their experiences.

## The state of being

Descriptions of the states of being were remarkably similar. Everyone described themselves as being in either 'an altered state' of consciousness, a 'meditative state' or a 'reverie'.

This state was characterized by:

- An openness or receptivity to 'whatever' may come to mind
- A heightened sensitivity or attunement to the atmosphere
- A lack of self-consciousness
- The differentiation between inside and outside seeming less clear
- Time feeling slowed down, or there being a feeling of timelessness or the future and past being all being present at once
- A sense of being in 'a part of', or 'attuned to' the world

This also accords with spiritual states of mind, described by practitioners of meditation, where everything seems interconnected in some way, where there is a sense of timelessness and the boundary between self and the world seem to dissolve in such a way that self and the world seem as one. This is different from the everyday concept of ourselves as being in three-dimensional space and linear time. It is what phenomenologist Max van Manen (1990) calls the 'lived experience' of space and time. Merleau-Ponty suggests that this is the closest we may come to "re-achieving a direct and primitive contact with the world" (Van Manen, 1990:38). Van Manen refers to this direct contact with the world as "awakening the soul to its primordial reality" (1990:50). Here Van Manen uses the word 'reality', not to refer to a concept of something outside himself, but to the 'soul's reality', which is embedded in the world. However in psychodynamic psychotherapy the idea of being in primitive direct contact with the world is problematic and generally treated as an unrealistic, wish-fulfilling fantasy. I will discuss the effect of this more as I go on.

In the hermeneutic phenomenological view everything is interpreted from within a historical and cultural context. The 'world' is not the environment-as-object as described by science, nor is it internal, as symbol. Rather, 'world' is neither 'held in the mind' nor 'out there' to be apprehended. Because we are embedded and embodied in the world, we can never be objective. Thus the possibility of absolute truth does not exist. Also, within hermeneutic philosophy, "atemporal, or transcendent knowledge is impossible" (Leonard, 1989: 50). Phenomenologists also define the word 'unconscious' in a different way to psychotherapists. Merleau-

Ponty says, "Unconscious is to be absent from oneself while being present in the world" (Romanyshyn, 1982:156).

In contrast to this I believe that although psychodynamic psychotherapy is also an interpretative art it is still fundamentally based in a Cartesian worldview. This worldview is the everyday view of the world in which the self is a subject and the world, or the environment, an object. The self contemplates the external world of things, which exist, via representations or symbols that are held in the mind. Also, unlike phenomenology, psychotherapy speaks of an atemporal realm of 'unconscious mind', which exists for itself beyond the perceived world.

The Cartesian worldview is dualistic and conceptual and so objects and experiences are divided into inside and outside, fantasy and reality, self and other. The ability to make these distinctions is very important for healthy functioning in the world and the inability to make them is central to what we call mental illness. For this reason, experiences in which the separation between inside and outside, fantasy and reality, self and other is not so clear have tended to be pathologised within psychoanalysis and viewed as omnipotent or regressive fantasies and as indicative of a lack of ego development. However the possible meanings we make of these phenomena vary according to the cultural worldview used to interpret them.

## Interpretations

Although the interpretations varied according to the cultural influences that had given the therapists and counsellors some way of making sense of their experiences, (eg psychotherapy literature or spiritual beliefs, including the Maori worldview) there were some striking similarities between them. Psychodynamic psychotherapists initially tended to use language from the psychotherapy frame: for instance, they interpreted experiences of seemingly being able to know inexplicable things about their clients as being able to access their clients' unconscious minds. This was envisioned in different ways. Some therapists described being in a 'merger' with clients as if 'the unconscious' of the therapist and client were overlapping in some literal way. Others spoke of 'the unconscious' as being 'between' themselves and clients, as in a field, which it is possible to 'enter into'. Others spoke of 'the unconscious' as a timeless realm in which knowledge of other times or places might 'exist ' and be accessible. Some envisioned a transmission between unconscious minds, using a metaphor of having antennae with which to pick up information from the atmosphere. The unconscious was

generally spoken of as intelligent and communicative. These ways of speaking of the unconscious are common amongst psychotherapists.

Although the Pakeha and Maori interpretations of meaning differed and some people did not know what to make of their experiences, many described their experiences as 'spiritual' or believed them to be a sign of the involvement of 'something more' than a transaction between themselves their clients alone. Many described this as either attuning or resonating with knowledge from another spiritual 'realm' or realm of mind or being a channel to messages, which are sent by a mysterious, intelligent Other (Unconscious, God, and Tupuna) that is communicating intentionally for the purposes of healing.

Some Pakeha referred to a mysterious force, God or knowledge that they believed to be 'everywhere'. Maori all spoke of being mediums to messages from ancestral spirits. All the Maori and one Pakeha had a strong belief in the 'living reality' of ancestral guides.

## So how do we understand this?

These phenomena raise a lot of questions about whether such experiences can be considered knowings and, if they can, how such knowings can be understood or explained. I will address some of the questions raised in the next paragraphs as well as some of the psychoanalytical debate and confusion about such phenomena and the beliefs and assumptions which therapists and counsellors base their interpretations. I also explore some explore some of the traditional and pathologising ways in which psychoanalysis has interpreted such phenomena and how this has meant that these sorts of experiences have largely been hidden from discussion within the psychotherapy community.

## Thinking about the questions

• Are these experiences of apparent 'knowing' explainable in mechanical ways?

Certainly some of the occurrences, especially those which we usually refer to as 'feeling what the client is feeling', which therapists commonly call 'projective identification', could be explained by subtle perceptions. Thomas Ogden expresses concern about the literal way psychotherapists speak of 'feeling a clients feelings' or a client's 'projecting parts of themselves into the therapist'. He is very clear that he believes projective identification to be a "group of fantasies" (1979:370). He says that even though the experiences feel real, they are not to

be thought of as real transmissions from one to the other. Indeed, there may be many explanations for these experiences when there is some contact between the people involved. Scientific research on mirror neurons shows how our own neurons actually fire when we see movements in another. Empathy is based on this. Vibrational information may be able to be reconstructed, for instance, from the tone of voice on the telephone. Freud, for instance, explained apparent 'telepathic' communications as the analyst having forgotten or being unconscious of having noticed something that was said by a client, in a session, perhaps some weeks previously, but which later appeared as a seemingly "uncanny" (Freud, 1925) knowing. It may also be that therapists or clients make too much of the similarities between the thoughts or actions and the later events when, in fact, they are a wishful makings of similarities due to a desire to believe in mysterious or magical communication. Doubting in this way is necessary for our thinking to be rigorous about these phenomena. However, I believe that many of the examples cannot be so easily explained as subtle perceptions, either because there has been no contact between the therapist and client for years, or the event 'known about' had not yet happened.

- What do psychotherapists believe about the unconscious mind and how it operates?

Does such a realm of mind actually exist?

Belief in the possibility of accessing other realms of knowledge or the past and future, often called divination, is common in many traditions and cultures: Celtic, Maori, Christian and others. However, although the idea of divination is not taken seriously with psychoanalytic theory, we do have a concept of 'the unconscious mind', which we believe to be real (as in existing for itself). The word 'unconscious' is used in many different ways, which reflect differences and contradictions in the theoretical language. In particular it is used to refer to both a place and an aspect of mind. This leads to 'the unconscious' being used to refer to the thing that is accessing information as well as the 'thing' or 'place' being accessed. Both Freud and Jung also use the word 'unconscious' in this double way. The unconscious is also often spoken of as not bound by time and space. This leads therapists to speak of it as literally extending in space and time, for instance as a field, or of a transmission of information through space which can be 'picked up' by the unconscious. 'The unconscious' is also used as if it is a form of consciousness. This common usage reflects the confusions in the theory.

I will be particularly referring to the ideas of Freud and Jung because the two men wrote about the sort of inexplicable phenomena explored in this study in a

way that few have since. Their different conceptualizations of 'the unconscious' mind and communication also underlie the way 'the unconscious' is commonly thought about today. Jung's vision of the unconscious came out of his own experiences of what he calls non-temporal states and the quality of objectivity that they had. He says:

> It is impossible to convey the beauty and intensity of emotion during those visions. The visions and experiences were utterly real; there was nothing subjective about them; they all had a quality of absolute objectivity. We shy away from the word 'eternal' but I can describe the experience only as the ecstasy of a non-temporal state in which present, past and future are one (1963:275).

Perhaps it was the sense of objectivity about these experiences that led Jung to conceptualise a collective unconscious that went beyond the bounds of the individual and was connected to divine wisdom, or universal mythic images (archetypes). He also described the individual ego as like a peak of a wave that emerges out of a deeper and more fundamental ocean of oneness or interconnectedness. Jung described these apparently acausal phenomena as 'synchronistic' events in which the "duality of soul and matter seemed to be eliminated" (Von Franz, 1978:27). Possibly influenced by the quantum science of his day Jung suggested that: "The unconscious, as the result of its spacio-temporal relativity, possesses better sources of information than the conscious mind, which has only sense perceptions available to it" (1963:292). Here he is speaking of the existence of an 'unconscious' aspect of mind, as if it is a form of consciousness, which is not bound by the time and space and which can access other sources of information than those that can be accessed by the senses. However Jung is not referring to the 'unconscious' as disembodied in the sense of being outside the body in space, for instance as in a field, but as operating in another way altogether, perhaps more like quantum non-locality. In a conceptual, Cartesian way, Jung is trying to describe and find explanations for paradoxical experiences in which there is a both sense of embeddedness in the world, at the same time as a sense of perceiving the world as separate from the self.

In contrast, Freud spoke of the unconscious as an aspect of the individual mind and as place of repressed memories and 'id' impulses. He also spoke of unconscious processes, which were timeless and operated on the pleasure principle. Speaking of 'the unconscious' as if it is a literal place associated with primitive impulses and wishfulfilling fantasies (the pleasure principle, as opposed to the reality principle), has become accepted into everyday language. Because of the apparently 'magical' nature of the experiences Freud treated them with doubt

and suggested that instances of the 'uncanny' "led us back to the old, animistic conception of the universe" (Freud, 1925:240.). Eisenbud suggests that Freud's wariness was based in two fears:

> That the future of psychoanalysis would be somehow endangered if analysts became preoccupied with the "occult" and that the work might bring him face to face with his old adversary – religion, perhaps in the sense that the data might be seized upon by hungry religionists as proof that the materialist conception of the universes has not given us a correct picture of reality after all (1946:259).

These concerns are understandable because in some ways seemingly 'telepathic' phenomena do challenge several of the assumptions on which psychoanalysis is based, particularly the premise that the mind is a thing in itself, which is separate from the world and others' minds, and the principles of projection and transference. Totton says that the possibility of "telepathy is not allowed to be 'real', but is forcibly aligned with the symbolic or the imaginary: in other words" (2003:201). In 1919 Freud said to Ferenczi, who wanted to present his telepathic experiments to the next International Psychoanalytic Association conference, "I advise against. Don't do it. By it you would be throwing a bomb into the psychoanalytical house which would be certain to explode" (Jones, 1957:42).

However, although Freud's reputation of being a reductionist scientist has become widespread, the mystical side of Freud who was interested in "the phenomena of thought transference", which he felt to be "closely allied to telepathy" (Freud, 1933:97) has not become so widely known. Despite his publicly expressed doubts, Freud remained secretly intrigued and in 1926 wrote to Ernest Jones saying: "When anyone adduces my fall into sin, just answer him calmly that my conversion to telepathy is my private affair like my Jewishness, my passion for smoking and many other things" (Appel, 2000:42). Today, these things still feel dangerous to discuss within psychoanalytic circles because of their associations with omnipotence, madness or "the black arts" (Eisenbud, 1946:260) and yet many therapists and counsellors have secret beliefs about their experiences that are withheld from discussion.

- Are these experiences omnipotent or psychotic fantasies?

One of the reasons the claims to these experiences as 'knowings' are treated with doubt in psychoanalytic terms, is that they seem to be omniscient on the part of the therapist and potentially omnipotent on the part of the client. Omniscience and omnipotence are considered not only to relate back to early states of mind

but also to be contrary to the development of secondary process and symbolic thinking, which comes with the ability to discriminate between inside and outside, self and other. Symington says: "It is through omnipotence that one hallucinates, distorts one's perceptions, obliterates memory, sabotages thought, banishes guilt and substitutes fantasy for reality. Through omnipotence, the processes of the mind and the minds objects are destroyed" (1996:175). Noel-Smith suggests that knowledge of the 'real' world is found only through the giving up of omniscient knowledge and coming into the boundaries of time and space.

> The arrogant assumption that one can actually know the outer world through *being* it, through incorporating it, must be relinquished and the loss of the possibility of an omniscient understanding of the real world, unbounded by our organising principles of time and space, must be relinquished (2003:20).

The attitude here is clear, the suggestion of direct experience of the world, or of another, is omniscient and arrogant. In terms of psychological development, these criticisms are valid. In an everyday way, the ability to differentiate self and other, and inside and outside, is important for metal health. The inability to make those differentiations necessarily evokes concern. However, although the therapists and counsellors, within my research, could be said to be interpreting the similarity of two events as a form of omniscient knowing, this is not the same as the sort of omnipotence that Symington means. An omnipotent defence is not relational. These therapists are engaged in the moment with clients in an embodied way when these experiences happen. More research might ascertain whether the therapists also have longings for oneness states leading them to either be more open to these experiences or to interpret them in ways which might not stand up to closer scrutiny. It may be that people who want to believe such things are 'true' are the ones who are most likely to experience them. However this does not necessarily make them into fantasies.

Experiences of seeing semi-transparent, still or moving, forms or hearing voices create even more worry within the psychotherapeutic community because they are associated with hallucination and psychosis. Indeed it is a serious question as to whether some of the experiences are hallucinatory or psychotic and, if they are not, how they differ. However, the fact that therapists and counsellors of repute, in the community experience these things means we need to think about them carefully before quickly dismissing them as psychotic. It may also be that 'psychotic' experiences are common in many people. In shamanistic cultures, for instance, someone who would be thought of as mad in western culture may play a very important function as a bridge between the 'spirit world' and the ordinary

world. Within the Maori community too it is traditionally well respected leaders (tohunga) who have the power to see and prophesise the future through dreams and makakite. For many Maori, experiences of communication with 'spirit forms' are lived experiences of the Maori worldview that the wairua of ancestors both dwell within the living and visit living people, often communicating through a medium (Orbell, 1995:85).

For them, this is not just an interpretation but also a living phenomenological reality.

Both Pakeha and Maori are reluctant to speak of their experiences as real perceptions as they fear this may create concern about their sanity. In order to be able to make both better use of the experiences and understand them we need to create an environment such that there is more openness to other interpretations of such experiences.

- Is there an intelligent higher mind / being which actively communicates with us?

Within psychoanalysis, belief in a greater spiritual being tends to be interpreted as a displacement of an infantile need for an idealized figure or a defensive fantasy, created to keep away the awareness of isolation, insignificance or death. Seeing a 'spirit' presence is likely to be interpreted as a projection of an internal image, or a hallucination and believing such things are 'real', a sign of psychosis. Beginning with Freud's desire to define psychoanalysis as a science as distinct from the religion of his time, spirituality has not found a recognized place within psychoanalytic theory. Although they may be recognized as a human need or right, both spiritual experiences and beliefs are often associated within regressive longings and primitive states of mind. From a phenomenological point of view, the experiences have characteristics that lead people to interpret them as being from an intelligent and active spiritual entity. Not only do they seem to have a life of their own but they covey complex, symbolic information that, as Jung says; we cannot ascribe to our own powers.

> The word of God comes to us and we have no way of distinguishing whether and to what extent it is different from God. It is not affected by the creation of our will. Our chief feeling about it is that it is not the result of our own ratiocinations, but that it came to us from elsewhere and if we have precognitive dreams how can we possibly ascribe them to our own powers (1963:313-314).

Although we cannot know if these experiences are the word of God, perhaps we might say that it is a phenomenological 'lived reality' that we relate to

inexplicable knowings as if they come from a living intelligent other. The desire to conceptualise our experience leads us to create metaphors to explain and make sense of our experiences.

- Are the boundaries of the mind/psyche actually different than those of the body?

Many therapist speak of being in a 'merger' with their client or as if they are literally experiencing another's emotional state. This may be informed by the way that Winnicott speaks of a mother and baby being at one. He says, "two separate people can feel at one but here at the place I am examining the baby and the object are one" (Winnicott, 1980:94). Although, it is not clear what he means by this, this literalism informs the way his ideas are used in common language. In a different way Jung also suggests that the boundaries of the body may not be identical with those of the psyche:

> It may well be a prejudice to restrict the psyche to being 'inside the body'. In so far as the psyche has a non-spatial aspect, there may be a psychic 'outside the body', a region so utterly different from 'my' psychic space that one has to get outside oneself or make use of some auxiliary technique to get there (Schwartz-Salant, 1998:81).

Jung is not speaking of the psyche as being literally outside the body in a spatial sense, but of the psyche as having a non-spatial aspect in the same way as he speaks of the unconscious. These ideas express the difficulty in describing something as ineffable as the lived experience of loss of boundaries between fantasy and reality, self and other, without using spatial concepts. More recently analysts like Thomas Ogden are moving toward a phenomenological way of speaking of 'mind' as something that is co-created in relationship. He suggests that, "it is no longer self evident what we mean when we speak of the analyst's or patient's "own" feelings or even the patients "own" dreams and dream associations" (2001:20). Although he is not addressing the sorts of inexplicable knowings I am writing about, much of Ogden's writing echoes the participant's descriptions of their experiences. For instance, Ogden (2000) says the analytic third may "take on a life of its own in the interpersonal field between the analyst and the patient". This may take the form of unconscious "acting out on the part of the therapist". He also speaks of the analytic third as having intentions. The "intention", he says, may be to heal or, indeed, it may have a pathological form e.g. it may have the capacity "to hold the analytic pair hostage" and prevent thinking (Ogden, 2000:491). In this way he speaks of this cocreated unconscious as intelligent and intentional. He also appears to experience himself as a medium for 'something', which comes through him, much as the participants did. He quotes poet A.R.

Ammons who he says can better convey this:

> not so much looking for the shape
> As being available
> To any shape that may
> Summon itself
> Through me
> from the self not mine but ours
> (Poetics, 1986:61.)

Ogden speaks of the differentiation between an analyst's and patient's experience and dreams as "no longer self-evident" but also refers to the analytic third as a "being coopted by the intensity of the shared unconscious fantasy/somatic delusion in which we were both enmeshed" (2000:89). In defining these experiences as fantasies, as opposed to reality, he seems to return to the Cartesian dualistic worldview, away from an interpretive co-created one and in so doing diminishes the realness, significance and the remarkableness of the experiences. These same confusions seem to occur throughout the theoretical language, as well as the common language used by psychotherapists. This may be because the philosophical assumptions on which psychotherapeutic theories are based are not well thought out.

- Do different laws of time and space apply when we enter different states?

The most remarkable thing about these experiences is that when therapists allow themselves to enter into states in which the barrier between themselves and world becomes less distinct, it seems possible to know or see things that it would not usually be possible to perceive. It is as if the bounds of time and space really can be traversed. This is reminiscent of quantum non-locality. Quantum physics describes electrons as being sensitive, not only to their own wave packet but also to information latent in the whole system, the movements of other electrons, and even the experimenter's intentions.

Information seems to pass between electrons without a transmission of energy and does not involve fields extended in space. Is it possible that, much as Einstein concluded about gravity, that no force or energetic exchange is necessary because it is a result of a warp in space-time? Although we need to be wary of taking these parallels as more than metaphors, they can enable us to be open to the possibility that, in states in which we experience ourselves as being in space-time, non-local effects may be created. A quantum explanation neither involves the

philosophical problems of disembodied knowledge and mind, or the passage of information through space, as in fields.

- What has love got to do with it?

Although these experiences often appeared as a receiving of 'information' they sometimes seemed to be an embodied response to a client's need. All the therapists describe the experiences leading to a deeper and profound of emotional connection with their clients and a sense of knowing them in a way which was more than just a knowing about. They were also very profound for the clients involved. It was as if the therapists' care and love for their clients had opened them up to them on a different level.

Sheldrake's research on nursing mothers discovered that "Mothers who are miles away from their babies can have a documented "let down" reflex at the precise moment of an unexpected and non-hunger based cry of their infants" (Martinez, 1999:217). This is a very clear example of an embodied and loving connection between mother and baby for which there is no physical explanation.

## Conclusions

These phenomena raise huge questions and few answers. The language used to describe them provides not only the context with which we can discuss and think about them but may also enable us to perceive them. Leonard says: "because the world is constituted by our common language and culture", [it] "is requisite in order for anything to be visible to us at all" (1989:44). Perhaps the main difficulty in finding language for these phenomena is they lead us to contemplate the nature of consciousness itself. This is a daunting, if not impossible, task because: "The structure of nature may eventually be such that our processes of thought do not correspond to it sufficiently to permit us to think about it at all" (Ogden, 2001:39).

Although the experiences are not frightening per se, thinking about their meaning arouses confusion and fear because they raise questions about the nature of reality, perception and mental illness. However, these experiences also have profound emotional effects on the therapists and counsellors and their clients. Because there is little validating therapeutic, language with which to discuss them, therapists and counsellors often resort to spiritual or scientific language and this means that the therapeutic benefits of phenomena, which have potential for healing, are untapped. I believe that the lack of theoretical language is central to the difficulty in bringing these experiences into open discussion as anything other

than psychotic or fantasy experiences. Hermeneutic phenomenology has led me to recognize the heavily conceptual nature of psychoanalytic theory. There are also theoretical contradictions between secular mechanical descriptions of the dynamics of the psyche, mystical thinking, and interpretive or hermeneutic views of mind being created with context and in an embedded relationship. Although this may be due to the fact that it is a changing field, there is also considerable prejudice towards these experiences because they seem alien to the principles and Cartesian assumptions about reality, time, space mind, and consciousness and unconsciousness on which psychoanalysis is based.

Although Jung's ideas address these phenomena more directly the split between the psychodynamic and Jungian groups in New Zealand remains strong. More conversations between the two modalities could be helpful in opening up these areas. Looking at the underlying assumptions we make in the psychoanalytic worldview, in a new way, I have also come to believe that we need to become more aware of the philosophical frameworks we base our thinking on, before we are can think about these phenomena in a rigorous way. I hope my study may go someway to opening up discussion about these issues within my own community. I was heartened in this to discover that Freud had once written to a psychic researcher called Carrington in 1921 saying: " If I had my life to live over again, I should devote myself to psychical research rather than to psychoanalysis" (Jones, 1957:32).

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# Honouring the Ancestors: James Lewis Lowery

**Wilson Daniel**

I feel privileged to have been invited to write in honour of Lewis as one of the tipuna (ancestors) of this Association. In this enjoyable exercise I have been helped greatly by the generous input of information from Joy Lowery, members of the immediate family, friends and colleagues who have shared a wide variety of perspectives. What follows is not meant to be a eulogy or a repetition of tributes offered already in the aftermath of Lewis's death, but rather a personal portrait of the man in his essential humanity.

Lewis was born in Dunedin on 7 January 1930, the youngest child and second son of two good-living and hard-working Christian parents who were devout Baptists. He had two older sisters. The family moved to Invercargill when Lewis was four years old. Lewis and I lived at opposite ends of the same street and became aware of each other at an early age. I was one year older but two years ahead at school, due to the entrance age having been changed from five to six. We both attended Park and Waihopai primary schools and later Southland Boys' High School, sometimes walking together through the beautiful, extensive Queen's Park and Golf Links and experiencing the marked seasonal changes reflected in the colours of the trees.

My two vivid early memories of Lewis were: first in 1946 when, as an officer cadet on a military parade ground inspection, I complimented him on winning the King's medal for .303 rifle shooting; and second, later that same year, tutoring him as a very anxious examination candidate in School Certificate or University Entrance Latin, then a prerequisite for training in medicine or law. Never a linguist, Lewis struggled valiantly with sight translation and conjugating irregular verbs, but fortunately scraped through - a good example of his life-long trait of perseverance!

As a true Southlander, like many of his fellow provincials, he developed from an early age a particular *Weltanschauung* based largely, no doubt, on the panoramic views of Murihiku's wide plains, the distant mountains of Fiordland and Mt Anglem on Rakiura (Stewart Island), the mighty trout-filled waters of the Mataura Oreti and Waiau rivers, the vast expanse of Oreti Beach, the turbulent Foveaux

Strait, and the wonder of the southern lights, the *aurora australis,* radiating heavenwards from Antarctica.

Invercargill is the second southernmost city on the planet. Naturally, Lewis became curious concerning what lay northwards in the world. This interest was intensified during World War II when most families had world maps on the kitchen wall, showing the countries of the British Empire coloured red, so that they could follow the advances and retreats of the Allied armies fighting against the Axis powers of Germany, Italy and Japan. Small wonder then that Lewis later studied geography at University. In other words, the world was to become his 'oyster', but not just of the Bluff /Foveaux Strait variety!

Lewis excelled at sport: in 1947 he played first XI hockey and was Southland Junior Tennis champion (both singles and doubles). His brother reports that Lewis was a 'deadly shot' with his father's .02 rifle, hunting rabbits. Much later, a close friend and colleague commented on Lewis's tennis prowess: "He had a vicious overhead smash which made trying to lob him risky. You didn't often put it over him."

Music was central to his core being. The Invercargill home was alive with music, laughter and humour. Lewis's two sisters played the piano and violin, while his older brother sang tenor. Lewis himself was to develop a fine baritone voice and also played the flute. Later Joy, who was an accomplished pianist, accompanied him and together they enjoyed attending symphony concerts.

His father, a builder of Scottish Covenanting origin, regarded Lewis as something of a dreamer, slow to absorb ideas, and not practical like his older brother. Much later Lewis became very skilled with his hands, a good carpenter who delighted in helping his older son, also a builder, to construct his and Joy's 'dream home' at Macandrew Bay, a few years prior to their move to Auckland. Lewis had an innate love of nature and the outdoors. His father encouraged the children to go camping in their old fold-out caravan trailer and to climb mountains to 'realise their dreams'.

On the home front Lewis's mother, of Cornish extraction and raised on a Central Otago farm, was kind and loving and created a relaxed and happy environment. She loved entertaining people, especially visiting missionaries from China and the Sudan. No doubt young Lewis's future interest in the world religions of Judaism, Islam, Buddhism and Hinduism, as well as the many branches of Christianity, was stimulated by listening to their stories. Years later this was all reinforced through working with overseas students from Africa, the Middle East, Asia and the Pacific.

Lewis loved and appreciated his mother, even though her scriptural teachings could be very strong and burdensome. In a moving eulogy delivered at her funeral in 1986 he said: "My folks gave me two incompatible things - a real farm 'earthiness' and fundamentalism - it was their unconditional love which made all the difference." Lewis's parents encouraged not only strict adherence to rules and the development of an ability to differentiate between right and wrong, but also enjoyment of simple family pleasures.

In his youth Lewis was a motor bike enthusiast and owned a Triumph Thunderbird (650 cc). On Oreti Beach he was challenged to a race by the driver of an old Model T Ford. Lewis accelerated so quickly that his brother, who was riding pillion, was thrown off and left sitting on the sand, watching Lewis disappear into the distance at high speed.

Following High School Lewis enrolled at Otago University while embarking on a two-year primary school course at Dunedin Teachers' College. During his undergraduate days he boarded privately with a maternal aunt. He plunged zestfully into student activities including Capping stunts and sang in the Concert sextet.

After graduation he spent 1953 in Christchurch while completing his secondary school certificate at Christchurch Teachers' College. Joy and Lewis were married in 1954 when Lewis graduated MA in Geography. They then spent a year in Invercargill where Lewis taught at the Southland Technical College. During that time Lewis decided to enter training for ministry at the Baptist Theological College in Auckland and was appointed to a student pastorate at the newly formed Howick Baptist Church. The years between 1956 and 1961 were very busy but happy with a heavy work-load of theological study, pastoral visiting, teaching and preaching. The births of their two sons were an added joy.

Lewis was greatly influenced by Dr David O. Williams, the principal of Trinity Methodist College and Director of the Methodist Mission Life Line Service, who introduced him to training in pastoral counselling, the non-directive client-centred therapy of Carl Rogers, and to the writings of Harry Guntrip, an early object relations theorist, and those of Howard J. Clinebell Jr and Seward Hiltner, pioneers in pastoral psychology.

In 1962 Lewis and Joy were ready to return to the south. Lewis received a call to Caversham Baptist Church, a conservative parish and a complete contrast to progressive Howick. Whereas his predecessor had conducted a popular evangelistic ministry, Lewis's style was more suited to teaching, but the going was tough. Despite providing some excellent pastoral care (he always kept tools and other equipment in the car boot for helping elderly shut-in female parishioners),

Lewis was becoming increasingly disenchanted with parish ministry. Wider horizons and greater challenges were needed.

In 1963 he was invited to become the first ecumenical Chaplain at Otago University, a position sponsored by the National Council of Churches and with a committee chaired by the then Anglican Bishop, Alan H. Johnston. Lewis was extended and challenged in this role. He immersed himself in new theological trends and read widely in Rudolph Bultmann, J.A.T. Robinson's 'Honest to God' debate, Paul Tillich's 'The Shaking of the Foundations', and many other radical writers.

In 1965 the embryonic Marriage Guidance Committee in Dunedin, with Elisabeth Duncan as Director, appointed two counsellors, of whom Lewis was one. They were sent on two initial training weekends prior to working with clients. In this tentative beginning Lewis insisted on having 'supervision' (a new term in New Zealand) from members of the Otago University Department of Psychological Medicine.

In 1971, on the basis of his reputation as Chaplain, Lewis was invited to set up the Counselling Service at the University of Otago under the direction of the Registrar, Douglas Girvan. Gradually, as Director of Counselling, he assembled a team of counsellors who worked alongside and with the Directors of the Student Health Service. Lewis occupied this position with distinction for 22 years, until he retired in 1993.

After two years as Director of Counselling Lewis made a decision which was to determine his future life direction, viz to become an ordained minister in the Presbyterian Church of New Zealand. For some time he had felt an inner conflict and had become convinced that his continuing in association with the Baptist Fellowship was reducing his effectiveness in the face of a strong Presbyterian influence both within and outside the University. Such a momentous move was not easy for either Lewis or Joy and carried considerable pain for some time. Gradually they both came to experience a new freedom to develop individually and as a couple. Lewis's main sources of professional support were teams in Marriage Guidance, Ashburn Hall colleagues, several psychiatrist friends, general practitioners, nurses, lecturers, professors, work people and office staff, all of whom he respected and regarded with affection.

As the pioneer and prime mover of Student Counselling Lewis invested his whole being and 'soul' in this enterprise. With a mixture of natural charm and astute networking he gained the support and respect of members of the academic

community and university administration for his pragmatic and innovative approaches in launching the fledgeling service.

During these highly productive years Lewis was also involved in a number of other professional activities. He participated in the educational and group therapy programmes at the Cameron Centre, Dunedin. He taught Intimate Systems in Marriage Guidance organisations throughout New Zealand. He developed with a colleague a course on Existential Psychotherapy.

Around 1973 Lewis was engaged in exploring with colleagues, Peter and Sue McGeorge, Don Kaperick and Liz McCabe, personal growth opportunities in the context of the encounter group movement. Out of this a Gestalt Training Programme was drafted and prospective trainees were interviewed and selected two years later. Although Lewis met and admired Fritz Perls, he sensed his egocentricity and gravitated more towards the connectedness of the Cleveland Gestalt Institute, Ohio.

Lewis emphasised the value and important benefits of professional development and kept himself up to date in researching new psychotherapeutic modalities, e.g. self psychology. He also became an enthusiastic exponent of 'time-limited therapy'. His first sabbatical leave in 1976 was spent on a training course at the Gestalt Institute in Cleveland, Ohio. He also visited counselling centres at Kent State, Harvard, Yale and North Western campuses.

In working with high-achieving students, especially those in schools like medicine, many of whom had come from upper income, status-conscious families and from prestigious private schools, Lewis realised that some were rather too much 'in their heads' and needed to be more 'earthed' if they were to be ultimately effective in their chosen professions.

Lewis had many admirers. Between 1991 and 1993 he exchanged 'soul poems' entitled 'Dialog' with a young, talented and beautiful female client. These had a romantic and spiritual content, style and flavour – reminiscent of the exchanges between Abelard and Héloïse. Many therapists discover their vulnerability to erotic transference and the dangers of acting out inappropriately. Joy and Lewis reached a mutual understanding and firm agreement about the importance of maintaining transparency coupled with confidentiality, the observance of clear boundaries and limiting of outside commitments to ensure a sensible balance between work and family life.

Lewis's involvement with NZAP spanned some twenty years from the early 70s to 1994 and constituted a major commitment. During this time he developed

significant links with colleagues at Ashburn Hall (for example, Reg Medlicott, Ken Bragan), with the Otago University Department of Psychological Medicine (Wallace Ironside, Basil James, Roy and Liz Muir), with Dunedin Marriage Guidance (Elisabeth Duncan), and at the Student Health and Counselling Service (Mary Cockburn and Marianne Quinn). An enthusiastic supporter of the Dunedin branch, Lewis served as a national Council member during the terms of his two immediate predecessors as President, Ruth Manchester and Jan Currie. Prior to his own election in February 1993, important progress had been made with the creation of a Supervision Committee and the adoption of the Constitution Rules, Handbook, Code of Ethics and Complaints Procedures.

Lewis once remarked to a colleague that he felt things had come too easily to him. Jobs had fallen into his lap without any competition. He had a surprising lack of self-confidence which sometimes puzzled those close to him. Among the realities of being human is the need to acknowledge and to accept that individually we are a combination of strengths and weaknesses located somewhere between the opposites of infinite potential on the one hand and distinct limitations on the other. His sense of humility, which arose largely from his home and church backgrounds, could be viewed as negative and a type of self-devaluation. But it was also one of the ingredients of his generosity and desire to help others. From generosity he allowed himself to be persuaded to stand for the presidency of NZAP in 1993. But his lack of certainty and worldliness did not prepare him well for the role. This became painfully evident when a complaint was lodged against a close friend and colleague for a breach of the Code of Ethics. Lewis found himself unable to separate his emotions from the prescribed role functions and expectations of President. Perhaps he, like so many of us, had difficulty in confronting his 'shadow' side. When he became President, the Association was going through a difficult, unhappy time struggling with several burning issues which required attention and resolution. Due largely to lack of experience, expertise and sophistication, the process of drafting a suitable Complaints Procedure within the Ethics Committee was sometimes agonisingly stressful for Lewis and his fellow Council members.

Leadership in any professional organisation can be demanding, particularly in its political aspects. Never openly ambitious or competitive (except on the tennis court, where he played to win), Lewis was not a politician, although he sometimes found himself in the role of peace-maker. Critics emerged, who felt that he was sometimes inflexible, driven, conflicted, perfectionistic and non-objective. Some considered him 'rather stuffy', but always prepared to share and learn. Like so many of us, Lewis had a tendency to overload himself with commitments when

he really needed to conserve his energy in the interests of self-care. His honesty, sincerity and integrity were unquestionable. A former President of the Association has wisely said: "Lewis's life and work need to be set in, and viewed from, the wider context of the evolution of the Association itself".

Having resolved to move to Auckland, where his three adult children were located, Lewis became beset by debilitating indecision, self-doubt and anxieties about finance, health and his ability to find work, despite assurances from colleagues in Auckland. Following arrival in Auckland in early 1994 he commenced some private work attached to the practice of a friend and colleague, taught part-time at the Auckland Institute of Technology and worked with a Maori group on the North Shore.

His sudden and untimely death on 29 November 1994, while on a tramping excursion in the Taupo area with Joy and a cousin, and while still in office as President, was a tremendous shock to the immediate family, relatives, friends and colleagues. Many tributes concerning his life and work were offered during the funeral at Maerangi Bay and later during a Memorial Service held in Burns Hall, First Church, Dunedin. Some were published in the Association's December 1994 Newsletter.

Nearly three years later, during the opening of the new University of Otago Student Health and Counselling building, Lewis was also honoured. A previous Medical Director, Dr Peter Strang, described Lewis's enormous contribution to the service as a father figure who had emphasised the importance of connection with past values together with hope for the future, and who had provided continuity at a period of discontinuity and change in the university's history.

Joy and her two sons and daughter have each written about Lewis, movingly and with great affection. During the children's growing up years he was always approachable, available and reliable, one who championed their moves towards independence. He had focused on their needs rather than imposing unrealistic expectations of performance or behaviour. He had given them the gift of touch. His sensitivity and compassion were demonstrated clearly in his caring concern for Joy in her rehabilitation from serious injuries in a near-fatal accident.

Lewis had an infectious love of life and exploration and became the practical joker in the family and among friends. Later in life his sense of humour was an asset and a source of relief. As befitted his ministerial training, he was a good raconteur and had a fund of racy, pulpit-unsuitable stories which he told with great relish. Some of these, however, revealed a certain sexism, based on a fixed

view of gender roles which stemmed from his fundamentalist background. Several female colleagues felt he never really understood modern women.

Despite this paternalism he was a person for everyone, egalitarian and inclusive. His watchword was: "Develop a real sense of self, treasure good authority, and hold on to your humanity". He was one of those 'unforgettable' persons, with his wide-eyed, open and alert expression, ready smile and direct eye contact. Now, ten years on, we continue to have our own individual and special memories of this complex and at times puzzling man. He will be remembered as a loyal friend, a wise and trusted guide and mentor, a dedicated teacher, a skilled practitioner of his art, and an esteemed colleague. For those of us who value our membership of NZAP he will always occupy an honoured place in our hearts and minds and in the annals of this association.

[Abridged and adapted by the editors with the author's permission.]

# Captain Cook had a Treatment Plan: Diagnosis and Treatment in Psychotherapy

**Roy Bowden**

## Abstract

This paper highlights questions regarding the relevance of *diagnosis* and *treatment* methods within psychotherapy. (Psychotherapy is viewed as a separate profession with links to psychoanalysis, psychiatry and clinical psychology). The theses are as follows: Diagnosis and treatment are concepts which prevent therapists from viewing the client as a whole person. Therapists who diagnose client difficulties overlay client presentations with their own favoured perceptions. Treatment plans are usually made according to a defined modality which views the world through a set of theories instead of ideas created by client and therapist together. Diagnostic formulations and treatment plans are also culturally bound instruments which may result in therapeutic colonisation.

Captain Cook set out on a journey which took him into the lives of people he had never met. Along the way he had to manage the process of change by first establishing effective relationships and then enhancing them by being engaged at a personal level. The methods Cook employed to establish relationships with people in the South Pacific led me to ponder psychotherapy as a profession in Aotearoa.

Cook had significant success on many occasions and some relationships were close and rewarding for both parties. Other relationships ended in confusion and there were those that ended in tragedy. The more I thought about the way we present our profession to enquirers, intending clients and trainees, the more I made links in my mind with Cook's missions. His training, experience and cultural formation influenced his approach to people he was meeting for the first time: people who thought differently, described their experiences differently and placed importance on different aspects of their lives. His journey seemed to parallel the journey embarked on by some psychotherapists. People are met with for the first time, a partial knowledge of their history is gleaned, a diagnosis or formulation is made and treatments applied from within a specific knowledge base. Sometimes the formula works, just as Cook found he was welcomed and

honoured by some people in the Pacific. Sometimes clients accept the words and actions of their therapist and view them as definitive. Some people in the Pacific believed in Cook's treatment methods so strongly that the unfortunate repercussions are still with us today.

Likewise some of our psychotherapy clients live with the idea that they suffer from psychological illnesses or traits defined by members of the profession. Just as some people in the South Pacific did not know there were alternatives to Cook's diagnoses and treatment methods, clients may not know there are alternatives to the practice of defining their dilemmas using psychological descriptors.

## Contemplations offshore

The following extract from Cook's log uses the language of his era. The summary he makes reminds me of the way diagnoses or formulations are constructed in some settings today.

> *1. the religion of the natives bear some resemblance to the George Islanders-*
>
> *2. they have a god of war, of husbandry &c but there is one suprem god whom the(y) call he made the world and all that therein is-by Copolatio*
>
> *3. they have many priests*
>
> *4. the Old men are much respected -*
>
> *5. they have a King who lives inland we heard of him in Poverty Bay*
>
> *6. They eat their enemies Slane in Battell - this seems to come from custom and not from a savage disposission this they cannot be charged with - they appearto have but few Vices - Left an Inscription*
>
> *Their behaviour was Uniform free from treachery...41*
>
> (quoted in Beaglehole: 1955: 538-9)

In her book *The Trial of the Cannibal Dog* Anne Salmond comments:

> For years, Cook held fast to these conclusions, that Maori were honourable people with 'few Vices' and that cannibalism was simply a matter of custom. In this judgment he was influenced by Enlightenment ideals rather than British popular culture, which linked cannibalism with witchcraft and demonic possession. Many of the crew, however, held opposite views about Maori,

> regarding them as 'savage' and 'treacherous', and these differences of opinion sowed the seeds of future dissension between Cook and his men about how Maori and other 'savages' ought to be treated. (2004:128)

When I read Salmond's book I was impressed with the personal qualities of the courageous Captain Cook and it was salutary to view the process of colonisation through a different lens. The intent was to discover new shores and explore the way people lived; a process not unlike psychotherapy.

The method was diagnostic and treatment-centred and the results were often tragic. Cook approached people with polite curosity but when they indulged in behaviour he could not understand he often meted out 'treatment' based on generalisations and categorisation.

## Welcome visitors to life onshore

My relationships with psychotherapists in New Zealand leave me in no doubt that there is real dedication to exercising the utmost care with respect to the lives of the people we touch. Therapists often live through pain, enlightenment and celebration with clients without forming a specific diagnosis or applying a designed treatment. What we name as transference is entered by these practitioners with trust and insight. The uncertain future of the relationship is surrounded by a faith that life has potential and promise. Clients welcome the therapist into their lives trusting they will hear meanings not yet expressed and hoping they will understand without judgment.

## Many ships flying different flags

What happens in the practice settings of most of my colleagues seems to be inconsistent with the way we present our profession to those who have not yet become members or to intending clients. If I stand back and view the public face of psychotherapy in most countries, including our own, I see a confused profession.

On the one hand, in practice we are primarily concerned to assist with making the unconscious conscious and in working with the complexities of the relationship between two people in a consulting room. Many of us follow a client's life story without using designed formulations promoted in the literature and in training programmes.

On the other hand, the public image of our profession is different. It is one of a divided self where modalities compete for attention and this supports the idea

that therapists use a variety of ways to diagnose and treat people. Our Association handbook does not mention diagnosis or treatment in relation to psychotherapy but when I am asked to assess a candidate for membership I am asked to forward the name of my main modality. All the modalities I have researched over the years have diagnostic formulae built into them and include treatment methods which are often designed to target specific conditions or aspects of personality functioning. Generic training programmes are few in this country and most training opportunities expect trainees to adhere to specific formulae which are diagnostic and promote preferred methods for treatment.

The word 'formulation' is often used instead of 'diagnosis'. The key question for me is whether the formulation comes from words and ideas formulated by the client or whether the therapist builds a formulation using constructs fashioned by a theorist or a modality.

## The chart in my cabin

My definition of psychotherapy is 'a process which encourages creative, well informed and safe contacts between two people in order to explore emotionally significant aspects which enhance or inhibit paths to healing, personal energy, creativity and secure intimate relationships'.

## Mapping the chart

In order to practise safe and effective psychotherapy we need to reflect on the way clients present, our personal and professional responses to their presentations and whether we and our clients are safe within the relationship. I have been taught many ways to reflect on the work I do. My formal education covered theology, psychology, social work and counselling.

Initial instruction in these disciplines encouraged me to search for certainty and to respect research findings because they contained facts. During philosophical studies I discovered that certainty is extremely elusive if it exists at all and we make meaning of the world by naming some phenomena as factual. The result is that I have an inner ambivalence toward any process which seeks to define, make certain or propose definitive pathways for people. I now reflect on my work with a conscious (or unconscious) rejection of any temptation to place a template over that which is within a client or that which is within me.

In psychology classes I was accepting of the idea that people's behaviours could be grouped into categories, symptoms could be put into 'sets' and specific

psychological illnesses could be established by combining these 'sets' of symptoms. Undergraduates were expected to trust textbook summaries listing the origins and expressions of depression, psychosis or 'abnormal' behaviour. There was often a footnote in these works pointing out there may be exceptions to the rules but somehow a small number of exceptions did not mean the conclusions might be invalid.

I worked in a psychiatric clinic for six months. Patients were known by their label. The 'obsessive compulsive' was in room three and the 'paranoid schizophrenic' in room five. In the 1970s and 1980s the search was on to find neurological and chemically based treatments for 'conditions' and this often clashed with the work many of us were trying to do using therapy, social work and family based interventions. We were attempting to work with the *person* and I had been trained to be *curious* about association patterns instead of deciding the patterns formed the basis of some kind of illness.

My formal training as a pastoral theologian, a counsellor and then as a social worker engendered a fascination with the way clients constructed their thought patterns, their intricate emotional life and the dreams they had.

I became a member of the Association of Psychotherapists in order to explore the intricacies of the psyche. On the one hand, I heard presentations at conferences highlighting the uncertain world of emotional existence and the powerful world of verbal and non verbal associations. On the other hand I heard presentations illustrating how much therapists wanted to categorise clients' emotional lives, find formulae for managing them and reassurance in what they perceived as predictability in thought patterns. Clients were often categorised as having patterns such as 'drives', 'injunctions', 'disorders', 'energy blocks', 'embedded trauma' 'projective identifications' or 'unhealthy attachments'. The tendency to place a template over the life of a client seemed to me to ignore the ever changing nature of human existence and to place the therapist in the role of an adjudicator. This tendency continues today as therapists make themselves feel safe by using modality -based language to re- name client dilemmas. The client story emerges as one which fits the therapist's view of human development.

## The ship's company

There is a place for diagnosis, formulation and treatment. I have never been certain where the boundaries are with regard to interventions appropriate for a psychologist, interventions best carried out by a psychiatrist and processes which belong in the psychotherapy setting but I am certain that many situations demand

competent diagnoses and treatment in order to keep clients safe and functioning well in their social and cultural settings. We refer some of our clients to professionals who are trained in administering treatments or interventions based on sound research. They apply medications or behaviourally focused management for clients who need expertise which lies outside our particular competence. We could not work without these colleagues. There are few definitive boundaries. In our association we have psychiatrists, psychologists, health specialists and medical practitioners who practise what I know as psychotherapy in addition to enhancing and saving people's lives using other appropriate interventions. Diagnosis has a place in psychoanalysis and I am making a distinction between psychoanalysis and psychotherapy. It is my view that in psychoanalysis analysis is *applied* to the client whereas in psychotherapy it is more likely the client will be assisted to draw their own conclusions.

There are situations where analysis and client initiated conclusions coexist and the question is whether clients should be ever be analysed, in the psychoanalytical sense, within a psychotherapeutic alliance. The distinctions between analysis and diagnosis are clear for some practitioners and theorists and not clear for others and I am aware that using the terms interchangeably raises more questions.

## Defining the strategy before approaching the shore

The following definitions are offered to facilitate discussion:

*Diagnosis or formulation* is the process wherein the therapist relies on a summary of symptoms, behaviour or communications which are then 'contained' in a category descriptor and used to find a way forward for the therapist. Where diagnosis encourages the therapist to expand their knowledge and participate in a critique of chosen diagnostic categories the process may be useful in challenging therapeutic assumptions. Where the diagnostic or formulation process defines the client and informs them they have a particular 'condition' or 'fault line' the therapist is ignoring multi- faceted aspects which impinge on client growth and development.

*Treatment* is the process wherein the therapist chooses to apply a formula for healing which relies on method, a belief that client dilemmas have causes which can be defined and a framework dependent on stages. Treatment ideas assist therapists to contemplate effective ways to communicate with clients. Treatment applied by adhering to defined methodology assumes the client will benefit from being treated in the same way as other clients and may ignore individual or cultural difference.

## Is the travel guide book helpful?

The idea that we can diagnose the person we are meeting as a client has its origins in the practice of dividing people into component parts. I am not sure what it is that psychotherapists can claim to diagnose with confidence. Are we confidently diagnosing 'psychological' factors? If this is the case do we know where the psyche is, where it begins and where it ends? Are we diagnosing presenting issues?

If so, how informed are we by the client in order to decide the extent of the dilemmas and how they link with facets we may not be competent to diagnose? Our diagnosis is probably based on having met the person in our consulting room. The relationships they have with other people are reported rather than experienced by us. Their social and cultural setting exists in a different atmosphere from that which we have created in our therapy room. Diagnosis or formulation often freezes people in a moment of time. It relies on stories having a beginning and an end, events existing in defined moments and the idea that client and therapist issues are the same today as they were yesterday. From this limited perspective we then choose a treatment. In most supervision sessions we would agree to "try something out and see how it goes" but the die is cast and the client is unaware we have been conditioned to approach them with a plan in mind in case we need it.

If we acknowledge psychotherapy as a 'process' rather than an 'intervention' we have a dynamic view of what is occurring within and around a client and ourselves as therapists. When clients tell their stories in therapy it is tempting to listen for themes which support therapeutic constructs we have been introduced to in training programmes. For example, we notice clients' association patterns and are tempted to refer to some clients as 'dissociating'. We have a tendency to follow the client story by giving it a form we construct in our own minds. The next step is to reach for an explanation as to why this pattern exists, diagnose it and then choose a treatment approach.

I have learnt from insights into the way our brains function and from the implications of quantum physics that it is impossible to separate one thought from another, one emotion from another and one state of being from another. Parts of each person have been given names and we continue to perceive them as separate entities. Mind, emotions and events are not separate states and do not exist on their own. The same is true of the patterns in a client's story. Patterns which seem to be there are formulations in the mind of the therapist and may not be perceived as such by a client.

Diagnostic procedure names emotions, behaviours and thoughts as if they have a continuous existence. The client whose personal and social history is known to us and seems to exhibit "a disruption in the usually integrated functions of consciousness, memory, identity or perception of the environment" may be described to a supervisor

the next day as being 'dissociative'. (DSM-IV: 1994: 477) The client who has had 'one or more manic and or depressive episodes' may be described to a supervisor as 'bi polar'. (DSM-IV: 1994: 350)

It is impossible for clients to have contracted a set of symptoms which, when summarised by the psychotherapist, fix the client in time as 'depressed' or 'disordered' or 'dissociated'. Sets of symptoms are put together by psychiatrists and psychologists using categories defined by selective research processes. Psychotherapeutic formulations which use theory-based categories to define client behaviour are much more subjective and questionable in my view.

I have seen clients struggling with their unique emotions and their overwhelming need to behave in ways that cause them pain but as a psychotherapist I resist giving these definitive descriptions such as 'repressed', 'depressive', 'bi-polar' or 'post-traumatic' episodes. It is more helpful to acknowledge patterns of thoughts, feelings and behaviour and discourage clients from viewing them as fixed within a category which indicates an illness of some kind.

Therapists usually agree that it is important to establish a relationship with the client as a whole person. Information from the scientific world encourages us to acknowledge that each time we intervene in one aspect of a person's existence we are having an effect on another. Intervention in emotional arenas has a profound effect on physical health, intellect, relationships, social and cultural connection. A diagnosis using psychological terminology drawn from a modality or from a psychiatric manual establishes the view that the psyche is separate from the rest of the person. It assumes healing will take place by attending to 'psychological' factors which inhibit growth. The person (or client) is now seen to be divided within themselves and dependent on psychotherapy in order to be healed.

When a physician diagnoses a person's physical ailments they usually point to a body part which can be touched, viewed via an electronic scan and repaired. In our profession we cannot point to the psyche and be sure that it exists. Once we have established a psychologically-based diagnosis we may diminish the person by accepting the notion that each person is the sum of separate parts and give them the message they are the same as every other person who has a similar set of symptoms. The idea that each person is unique has thus been jettisoned in order to make a generalised diagnosis or formulation.

Irvin Yalom writes

> A colleague of mine brings home this point to his psychiatric residents by asking: "If you were in personal psychotherapy or are considering it, what

> DSM-IV diagnosis do you think your therapist could justifiably use to describe someone as complicated as you?" (Rosenbaum, personal communication, Nov 2000) (Yalom: 2003: 345)

## This land is your land

The practice of assigning categories of psychological illness or disturbance across cultures is overdue for review. The culturally-based advice in the Diagnostic and Statistical Manual of Mental Disorders is being updated and research is being called for to address weaknesses in these publications.

The DSM–IV cautions psychiatrists by stating, "It is important that the clinician take into account the individual's ethnic and cultural context in each of the DSM-IV axes." It continues, " There is seldom a one-to-one equivalent of any culture-bound syndrome with a DSM diagnostic entity." (1994: 844) Unfortunately the next pages highlight comparisons between 'cultural syndromes' and categories in the DSM. A kind of psychiatric colonisation is attempted. The following serves as an illustration:

> ***Falling out or blacking out***: These episodes occur primarily in southern United States and Caribbean groups. They are characterised by a sudden collapse, which sometimes occurs without warning but sometimes is preceded by feelings of dizziness or 'swimming' in the head.
>
> The individual's eyes are usually open but the person *claims the inability to see.* The person usually hears and understands what is occurring around him or her but feels powerless to move. *This may correspond to a diagnosis of Conversion Disorder or Dissociative Disorder. (1994:846)*

It is possible that these symptoms have a cultural explanation which cannot be defined using concepts which originate in another culture. The DSM does what colonisers have often done; it attempts to fit aspects of human behaviour into its own frame of reference. The behaviour is labelled as an episode, and the symptoms are cross-referenced to categories designed by another culture. The behaviours are also viewed as 'disorders'.

## Landing with luggage

Early this year I accepted another invitation to work with Maori health professionals to teach them therapeutic theory and process normally taught in a Pakeha setting. I realised I would be taught by my students perhaps as much as I could teach them.

I expected to discover ways of adapting European-based theory and practice to make it relevant in a different cultural setting. I was not surprised to find myself re-examining some of the basic tenets of psychotherapy, especially the traditional notions of diagnosis and treatment. I have addressed some aspects of working cross-culturally in previous publications and that is a separate study. In this paper I am highlighting important issues for psychotherapy in *any* setting. These issues have been underlined by my experiences in teaching within a different culture. What follows is a set of questions which lead me to wonder whether diagnosis and treatment should ever be part of my practice.

## Diagnosis revisited

- Integration is built with support, initiatives and nurture embedded in cultural belief systems. Mind, emotion, physical form and spirit can all be spoken of as separate entities but they do not act in isolation from each other. If I address 'mind' I am addressing connections which are woven tightly together. A diagnosis which has its foundation in the separation of mind, body, spirit and emotions assumes disintegration has occurred. How can there be disintegration when there is no separation?

How can I make a diagnosis which addresses emotional forces within one person when those emotions are intricately bound to the emotions of another and to a spirit world woven into the world we call reality?

- Personal pain, described as emotional pain or trauma by European-based theorists, is not confined to the present moment and may exist on a timeline reaching deep into a timeless continuum. Associated events, relationships and formative intrusions may have happened to an historical figure in a cultural setting whose influence affects 'the client' in ways that remain in the shadows of anonymity. How can I form a diagnosis of human pain which sets it within a specific time frame or views it as existing only within the lifetime of one person?

- That which gives rise to personal pain or inhibition may not have a defined beginning. The idea that causes exist as separate entities is questionable within the context of life surrounded by constant ebb and flow. A diagnosis which postulates causes is likely to ignore the complexity of one life being a woven tapestry. To ask when pain began or when dis-ease was first formed is to ignore the interconnections scientists are examining and to reject the idea that there is a powerful collective unconscious.

- Individuals have a 'separate' physical body separated at birth and separate when death occurs. Does this separate physical body 'contain' and keep control of the psyche? The psyche (wairua) is heavily influenced and moulded by forces outside of the physical body which are connected with other bodies on earth and beyond. How can I be certain a diagnosis based on what I have heard from one person will be sufficient to explain individual pain, inhibition or unease? Where is my deep respect for people if I introduce them to a diagnostic explanation which narrows to concepts such as disorder, dissociation, depression, paranoia, repression, drives or injunctions?
- When there seems to be one client in the consulting room there may be others who are 'psychically present' whom we cannot 'see'. These people are not just held in memory or gathered in by association, they are there to be consulted. How can I proceed with a diagnosis of one psyche defining it as an entity within one person? How can I delineate its features using language created by people I have never met?

## Treatment revisited

- Treatment implies focus. It selects an aspect to be treated and keeps it in view. My experience leads me to the conclusion that I cannot be selective. Cultural formation is woven and the spaces in between speak of connection rather than selection. Where is the 'individual' who needs 'treatment'? Where is 'the person' to whom the treatment should be applied?
- Treatment is based on a formula. A formula implies a stepped process with a beginning, a mid phase and an ending. Where is the beginning, the mid phase and the ending when it comes to human process? Are all individuals able to respond to the beginning place, the middle phases and the endings which have been built into the formula? The formula is likely to have been tested in selective ways. The assumption is that the psychological profile of research subjects is exactly the same as the psychological profile of any individual client.
- Treatment is targeted. In psychotherapy treatment is usually targeted behaviourally, biologically, psychologically or emotionally. Treatment targets assume people are the sum of separate parts and they often assume a specific starting point somewhere within a separated system. Treatment is often designed to target 'disorder'. Where is the disorder and can there be a decision as to where to target treatment when are no separate entities?

- Treatment is applied. I have developed caution with regard to seeing myself as an agent of treatment especially when it comes to working across cultures. I do not possess any tangible evidence which people can see or touch to prove my expertise in applying therapeutic treatments. Treatment modalities exist in name, in a variety of publications and in the minds of people who view them through different lens. They do not exist as definable methods. I find it difficult to imagine where my authority would come from in order to give myself permission to treat a person with something as intangible as therapeutic method.

The establishment of relationships means being comfortable with uncertainty rather than certainty. It means acknowledging I can never really know a person of any culture (including my own) well enough to apply a method to their person.

- Treatment implies healing. The idea that pain or trauma can be treated and then be healed is an idea that seems to run counter to life that ebbs and flows within a constantly changing universe. What is it that is being healed through psychologically-based treatment? How can one aspect be healed without affecting another? If all aspects of the individual psyche are affected are they all automatically healed? If treatment is applied to an individual does this make them an agent in their own healing and how is this linked to the way healing is dependent on the lives of significant others who have not been invited into the treatment process?

- Treatment is usually applied within a specific context. The idea that treatment should be honed or narrowed to manageable steps is indicative of the belief that specific contexts are important. The separation of one context from another is a process applicable in some cultures but not in others. A whole of life view demands that change to one aspect of a nurturing system does not take place without taking care to include all aspects. Support for people should involve healers, advisers, historians, spiritual guides and links with ancestors to address any matters which may be inhibiting the fullness of life within the nurturing community.

Knowing this, it is difficult to imagine why I would contemplate treating one aspect of a person's life in any cultural setting without making associations with other aspects and without being as inclusive as possible. I may well agree to work with an individual but I will be aware that the idea of targeted treatment within a defined and separated context is a denial of the wholeness my profession espouses.

## Notes in the log

My conclusion is that definitive diagnoses constructed around the client rather than with the client are contrary to what we know about human development. I am also suggesting that treatment designed by a theorist rather than client and therapist together, fails to acknowledge clients' unique place in the world and their unique psychic development.

The psychotherapy profession has many practitioners who practise without needing to divide people into categories. The public face of psychotherapy is different. It promotes division and separation and suggests strong links with professions whose role it is to analyse, diagnose, treat and search for definitive solutions to ill health and dis-ease.

Training courses which perpetuate divisiveness through adherence to specific methodologies promote the belief that the psyche can be defined, analysed and changed using the same methods in any setting. I look forward to a time when psychotherapy develops theory and training opportunities which focus on how to manage complex relationships without applying designed formulae and methods. That will usher in a new era for psychotherapy and for clients.

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**Wilson Daniel**, semi-retired in Dunedin since 2001, is a qualified linguist, musician, barrister and solicitor, Presbyterian minister, psychotherapist, psychologist and Jungian analyst. Emigrating to the USA in 1968 and becoming a U.S. citizen in 1976, he trained in a variety of psychotherapeutic modalities and at the C.G.Jung Institute, L.A., in the 60s and 70s, completing a Th.D (Process Theology) and Ph..D. (Clinical /Humanistic Psychology) at Claremont, Southern California. He researched in correctional work and irreversible physical disability (spinal cord injury). Director of Cameron Centre (1977 - 1983), he joined NZAP in 1980. Entering private practice in Napier in 1983 he became a supervisor for Central North Island Region and was Convener of Training for the Australia/New Zealand Society of Jungian Analysts – C.G. Jung Institute for eight years.

**Sue Griffiths** enjoys living and working in Dunedin. She is a psychotherapist who coordinates a group private psychotherapy practice - The Psychotherapy and Counselling Centre - and is also a part-time counsellor at The Dunedin College of Education. From a training and background in psychodynamic psychotherapy, family therapy and group therapy, Sue completed her postgraduate Diploma in Adult Psychotherapy with The Australian and New Zealand Association of Psychotherapists in 2004. She is a full member of N.Z.A.P. and A.N.Z.A.P.

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**Seán Manning** is a psychotherapist in private practice with a background in psychology and social work. Raised in Belfast, Northern Ireland, he has lived in New Zealand since 1975. He has three grown up children and one grandchild. His primary modality is transactional analysis. He has published occasionally and is active in NZAP and two other professional organisations instead of having a social life. He once had a command of Te Reo, which is still better than his command of Irish. His addiction to collecting stringed instruments is almost under control and his ability to play them is just enough to get him into a series of unsuccessful Irish bands.

**Cilla McQueen** was educated in Dunedin at Columba College and Otago University. Three of her books have won the New Zealand Book Award for Poetry. In 1985 and 1986 she held the Robert Burns Fellowship at Otago University and in 1992 a Queen Elizabeth Arts Council Scholarship in Letters. Travel awards include a Fulbright Visiting Writer's Fellowship to Stanford University in 1985, an Australia-New Zealand Writers' Exchange Fellowship in 1987 and a Goethe Institut Scholarship to Berlin in 1988. In 1999 she was Artist in Residence at the Southland Art Foundation. *Markings* (2000) and *Soundings* (2002) contain her drawings of the landscape around Bluff, where she now lives. Her most recent collection is *Firepenny* (2005). All published by University of Otago Press, P.O. Box 56, Dunedin, NZ.

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**Felisa Roldan** is currently working part-time as a psychiatrist for Lower Hutt Community Mental Health and spends the rest of the time with her two year old son. She was born and brought up in Bilbao (Spain) where she qualified as a doctor. She then trained as a psychiatrist in the U.K.and specialized in psychotherapy. She emigrated to New Zealand in 1995 and trained as a Gestalt Psychotherapist (1996-1999). She is interested in bringing psychotherapy into psychiatry.

**Linde Rosenberg.** (MNZAP, B.Sc., Dip Psychotherapy) has trained in both psychoanalytic and archetypal psychotherapy in London. Since 1990 she has combined private practice work with group facilitation, supervision and teaching in therapeutic communities and counselling/therapy training programs, in both England and New Zealand. Since returning to NZ in 1998 she has been working in the AUT psychotherapy training programme, as well as being in private practice. She has explored many paths including shamanism and psychic development, and experimented with many forms of self-expression, including photography, mime, and theatre.

**Pat Snedden** is a Pakeha New Zealand businessman with a history of public service. He has been an advisor to Ngati Whatua o Orakei Trust, and a member of their Treaty negotiation team. He works as a business adviser to Healthcare Aotearoa, a not for profit bi-cultural primary health network. Currently he chairs Housing New Zealand Corporation and the Counties Manukau District Health Board. He is also on the board of Watercare and the ASB Trusts.

**Shizuka Torii** is a training psychotherapist presently completing a Masters of Health Science at Auckland University of Technology. She is Japanese and has been a New Zealand resident since 1991. Her career history includes work as a stewardess, which pleased Aphrodite but displeased Athena in her, and as an academic (holding a doctorate in linguistics from Victoria University of Wellington), which satisfied Athena but neglected Aphrodite in her. She is delighted to have finally found a vocation that she believes could fulfil both Athena and Aphrodite in her.

**Teresa von Sommaruga Howard** works in many different countries as an architect, organisational consultant in the public sector, group analytic psychotherapist specialising in median and large groups and lecturer. Address: 9 Westrow, LONDON SW15 6RH, UK Email: TeresaH@dial.pipex.com

# Guidelines for contributors

The notes that follow are intended to guide contributors in preparing manuscripts for submission to *Forum.*

## 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** and a **biographical note**, each no longer than 120 words.

The closing date for the submission of manuscripts is **30 April**. Changes in response to the editing process must be completed by **1 July**, when both a revised hard copy, and an electronic copy, are to be forwarded to the coordinating editor.

### Required format of manuscripts

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

> This client's state of mind might be summed up in 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 redical and quite fantastical conception of human nature which says we are ruled ( and sometimes inhinged) by events that we only imagined as small children . . . (Malcolm, 1984: 77).

**Citations**: The source of ideas from the work of other writers must 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 reponses of Eissler, Masson and Swales to Freud's archival legacy.

**References:** These must include a full list of texts referred to, arranged with authors' names (and initials) in alphabetical order. (A bibliography listing texts read but not cited in the paper is not required). The format for references is 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.

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