Ka mua
Ka muri

Celebrating 75 years
New Zealand Association
of Psychotherapists

Ata: Journal of Psychotherapy Aotearoa New Zealand

Volume 26, Number 2

Special Issue: Papers from the NZAP "Ka mua, Ka muri" online conference, and other papers.

December 2022

Ata: Journal of Psychotherapy Aotearoa New Zealand

Ata

Ata is a small word with a magnitude of meaning that encompasses the spiritual and the relational, and reflects what we consider essential to a Māori indigenous therapy. Ata refers both to the actual as well as to the symbolic and thus allows us to explore meaning and possibility. Ata connects us to the natural world, entices us into relationship, caressing and encouraging human potentiality in the most subtle and gentle ways. Ata is used as a connector which invites a variety of meanings:

Ata — referring to early morning; ata pō, before dawn; ata tu, just after sunrise or dawn; as well as ata marama, moonlight.

Ata — referring to form, shape, semblance, shadow, reflection, and reflected image, as in whakaata, to look at one's reflected image; wai whakaata, a reflection to look into.

Ata — used to express accuracy, or to validate.

Āta — (noun) indicating care, thoughtfulness, as in ātawhai, showing kindness and concern; (verb) to consider; (adjective) purposeful, deliberate, transparent; (adverb) slowly, clearly.

Ata also appears as a component in other words such as ātāhua, beautiful, pleasant; and waiata.

We take inspiration from this word ata and embrace the way in which it supports us all to shape, inform and inspire the psychotherapy community in Aotearoa to reflect the essence of and challenges to our people and our landscape. Nga mihi nui ki a koutou katoa.

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Contents

Editorial: Psychotherapy in Aotearoa New Zealand: Past, present and future
John O'Connor and Wiremu Woodard 7

Born in '47: A personal journey through the changing zeitgeist of psychotherapy in Aotearoa
Rod Sandle 11

Imagining a future for psychotherapy in Aotearoa
Claire Miranda 25

Opportunities and challenges for psychotherapy in Aotearoa New Zealand's new health system: A 2022 national District Health Board psychotherapy workforce survey and related discussions
Craig Whisker 31

Research and practice: Contributions to the discipline of psychotherapy
Keith Tudor and John Francis 61

"The unconscious is a shy beast: don't pounce!" The making of psychotherapy (and a psychotherapist) in Aotearoa New Zealand
John O'Connor, David A. Nicholls, Mark Thorpe and Wiremu Woodard 91

Notes on notes: Note-taking and record-keeping in psychotherapy
Keith Tudor and Kris Gledhill 123

My journey toward becoming a psychotherapist: Reflections on a long career
Carol Worthington 145

Book Review: "Between the Harbour and the Mountain: Reflections on the Ordinary and the Profound" by Patricia Williams.
John O'Connor 151

Editorial: Psychotherapy in Aotearoa New Zealand: Past, present and future

John O'Connor

Jungian Analyst, Psychotherapist, Auckland

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Psychotherapy Practitioner, Auckland

Korihi te manu	The bird sings
Tākiri mai i te ata	The morning has dawned
Ka ao, ka ao, ka awatea	The day has broken
Tihei Mauri Ora!	Behold, there is life!

E ngā mana, e ngā reo, e ngā manu tioriori, tēnā koutou, tēnā koutou, tēnā koutou katoa!

I[1] woke today to discover that my clinical office had flooded. The devastation which was the Auckland floods had crept stealthily into my office, not causing too much damage, puddling throughout, soaking rugs and nibbling at the base of bookcases. The clean-up has not been too arduous, and the damage, distressing but not devastating.

Nevertheless, nature's power rocked me, attempting I think to wake me from my somnolent desire to avoid the seemingly inevitable destruction we all face. Slowly, I began to glimpse how disturbingly uncomfortable I felt about my own contribution to the climate induced destruction I saw around me, and how upset I felt about the distress of others who, on this occasion, had been so much more significantly directly affected than me, by these floods. Thomas Ogden (1999) wrote a very helpful paper entitled *Analysing forms of Aliveness and Deadness of the Transference Countertransference*. In it he explored how he tracks his own subjectivity in order first to attempt to make sense of forces of creativity and/or destructiveness in the transference countertransference; then to seek, either gently or forcefully, to invite the patient to recognise both their own creative life-giving impulses, and their potential destructiveness.

1 Use of the first person "I" refers to the first author, John O'Connor, in this editorial.

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As the New Zealand Association of Psychotherapists (NZAP) celebrates its 75th year we have much to be proud of, to celebrate, to recognise and acknowledge. The *Ka mua, Ka muri Conference*, out of which many of the papers in this issue of *Ata* have emerged, was a wonderful and creative celebration of the work of many. We are very grateful to the conference organisers of this stimulating and fruitful event. It celebrated the wisdom of our ancestors, the depth and energy of contemporary practitioners, and the many potentially creative opportunities and difficult challenges before us all. Our hope is that in engaging with the papers in this issue of *Ata*, these papers might invite us to consider how we are contributing clinically, as inhabitants of this planet, and as Association members, to creativity and life-giving possibilities, and also to reflect upon our own self-destructive capacities; to challenge ourselves to notice the ways in which we might engage with each other as an Association that might be deadening rather than enlivening. And, as Ogden (1999) suggested in his paper on aliveness and deadness, we hope this may assist us to continue to creatively associate, to reach across our differences, to understand, support, challenge, and enable each other and our remarkable Association. With these musings in mind, we are delighted to outline the creative and challenging papers which make up this issue of the *Journal*.

We begin with Rod Sandle's moving, generous, and thoughtful reflections on his experience of engaging with the practice of psychotherapy in Aotearoa New Zealand, and the lessons learned through his membership of our Association. Claire Miranda then challenges us to face the urgency of the climate crisis that so powerfully impacts us all. Craig Whisker provides a thorough and provocative analysis of the opportunities for psychotherapy in Aotearoa New Zealand's newly restructured public health system. He draws together a wide range of information, including his survey on the psychotherapy workforce in the public sector, provoking many questions and possibilities. Keith Tudor and John Francis reflect upon psychotherapy research undertaken by recent students of psychotherapy at Auckland University of Technology, and its significant potential to inform us all. John O'Connor, David A. Nicholls, Mark Thorpe and Wiremu Woodard utilise a Foucauldian lens to explore the discourses that have made psychotherapy possible in Aotearoa New Zealand, and then utilise clinical vignettes to consider possible clinical implications. Keith Tudor and Kris Gledhill provide a very helpful exploration of the principles and practice of notetaking and record keeping in psychotherapy. Carol Worthington offers a moving reflection on her many decades as a psychotherapist. And lastly John O'Connor offers a stimulating review of the engaging book *Between the Harbour and the Mountain: Reflections on the Ordinary and the Profound* (2021) by Patricia Williams.

We hope you will find these papers, and the celebration they are of 75 years of NZAP, an enriching read, one that provides both hope and challenge for the next 75 years.

We thank Hineira Woodard for her generous and expert work providing te reo Māori interpretations of the abstracts; tēnā koe, Hineira. Our deep thanks to our creative, skillful, and eagle-eyed designer, Katy Yiakmis; tēnā koe, Katy. Thank you to Nikky Winchester for her dedicated and skillful work as assistant editor: tēnā koe Nikky. And we thank Luisa Maloni for her careful and unfailingly accurate work in assisting the editors in numerous tasks, large and small. Finally, we thank you, the reader (NZAP member or subscriber), for

your continuing support of the journal; we hope you will find this issue an evocative, provocative, enjoyable, and engaging read, and we look forward to editing the next issue.

Tēnā koutou, tēnā koutou, tēnā koutou katoa.

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Born in ’47: A personal journey through the changing zeitgeist of psychotherapy in Aotearoa

Rod Sandle

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Abstract

Just like a personal ego, the zeitgeist of a practice such as psychotherapy is constantly changing, influenced by both internal and external events. As with the personal ego, not only is it changing but it is also resisting change, leading to a state of imbalance and potential conflict. A psychotherapeutic relationship can help an individual re-establish balance in the changing world and live more fully in the present, but the relationship with an organisation or group can be more challenging. Just as we can identify with our ego, so can we identify with a group: does the onus fall more on the individual or the group to adapt, both to change and to the resistance to change? What can help in this process of adaptation? With the Freudian concept of the erotic bonds of love and hate in the background, I will call on my personal story as a psychotherapist born in the year the New Zealand Association of Psychotherapists (NZAP) was founded, with the aim of exploring these questions with a focus on the changing zeitgeist of NZAP.

Whakarāpopotonga

Rite ki te āhua whaiaro, ko te wairua o te wā pēnei i tā whakaoranga hinengaro e nekeneke tonu ana, e ai ki ngā awenga o ngā huihuinga ā-roto ā-waho rānei. Pērā i tō te āhua whaiaro, ehara ko te rerenga haere anake, engari e whakatenetene anō ana hoki ki te huri, koia nei he ara whakaaranga tūnga pīoioi, ā, tae atu hoki ki tētahi huarahi taupatupatunga. Mā tē haere ki te tētahi kaiwhakaora hinengaro e taea ai te whakahoki tūnga tōtika i roto i te ao hurihuri e noho tahi anō ai i roto i nāianei, engari he wero atu anō te whakapiringa ki tētahi tōpūtanga rōpu rānei. Rite tonu ki tā tātau tautohunga āhua whaiaro, ka pērā anō tā tātau tautohu ki tētahi rōpū: kā tau te taumahatanga ki te tangata kotahi ki te rōpū rānei ki te whakawaia, ōrua ki te huri ki te whakatumatuma rānei ki te whakahuri? Me pēhea e taea ai te āwhina i te hātepe whakahuringa? Kia horapahia hei papa te aria herenga karihika aroha, karihika kiriweti a Wheretiana, e huri ake au ki tōku ake matawhaiora i tōku tūnga whakaoranga

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hinengaro i whānau mai i te tau tīmatanga o te Tōpū Kaiwhakaora Hinengaro o Aotearoa, ko tāna nei whāinga ko te wherawhera i ēnei pātai me te arotahi atu ki te huringa wairua o NZAP.

Keywords: groups; erotic bonds; vagina dentata; phallus; zeitgeist; ego; self; relationship.

Introduction

Like NZAP, I was born in Christchurch, New Zealand, in 1947. The zeitgeist was dominated by the Second World War. Approximately 75 million people died in this conflict and many more were injured, both physically and psychologically. The primary founder of NZAP, Maurice Bevan-Brown, had initiated the formation of a psychotherapeutic War Neurosis Group and Clinic for the treatment of service personnel. At the time, indications were that psychotherapy was "often regarded at best with scepticism and at worst derision by many people in both medicine and the wider community," and its Christchurch practitioners described as "that sexy crowd on Andover Street" (Manchester & Manchester, 1996, pp. 11-12).

The "sexy crowd" presumably referred to their interest in Freud's sexual theory and I'd like to look briefly here at the Freudian bonds of love and hate, particularly as they apply to groups. I'll be holding these in mind as I explore the changing zeitgeist of NZAP over my time as a member.

Freud (1921) said of groups:

> And, finally, groups have never thirsted after truth. They demand illusions, and cannot do without them. They constantly give what is unreal precedence over what is real; they are almost as strongly influenced by what is untrue as by what is true. They have an evident tendency not to distinguish between the two.
>
> We have pointed out that this predominance of the life of phantasy and of the illusion born of an unfulfilled wish is the ruling factor in the psychology of neuroses. We have found that what neurotics are guided by is not ordinary objective reality but psychological reality. A hysterical symptom is based upon phantasy instead of upon the repetition of real experience, and the sense of guilt in an obsessional neurosis is based upon the fact of an evil intention which was never carried out. Indeed, just as in dreams and in hypnosis, in the mental operations of a group the function for testing the reality of things falls into the background in comparison with the strength of wishful impulses with their affective cathexis. (p. 79)

What Freud calls the mental operation of a group, I see as the group's ego structure, and as with an individual, I see the group also has a stable element, a sense of group self: something beyond the wishful impulses that Freud speaks of.

As I grew up into the Fifties, the focus of adults around me was one of making the best of the absence of war and the avoidance of talking about and processing the tragedy that had recently occurred. Instead, as children we were shown war propaganda in both primary and secondary school as if the war were continuing, and there was much sharing of "war comics" among the boys, which continued this blatant propaganda. In my home, this was frowned

upon and as a consequence I hid the comics and read them secretly. There was only one war story shared in the family, which was of my uncle, my mother's brother, who, as a conscientious objector, had refused to carry a gun during service in North Africa. He was assigned to the Medical Corps who had the job of collecting the corpses from both sides of the conflict. He did not speak of this to me, but other family members shared the story of him removing the body of a German soldier from the barbed wire and recognising himself in the unruly shock of platinum blond hair of this man, just like his own. In an effort to play a part in avoiding further wars, he joined the Communist party with the hope of helping unite the peoples of the world.

Bevan-Brown and his colleagues had their own approach to creating a better world, through the promotion of natural childbirth and the support of parents, teachers and Plunket nurses in promoting healthy child nurture (Manchester & Manchester, 1996, p. 14). In the aftermath of the trauma of war, repression and idealism were dominant in the zeitgeist, and psychotherapy, although caught in this zeitgeist, was working to establish some appreciation of reality.

Regarding the bonds of love in groups Freud (1921) said:

> We will try our fortune, then, with the supposition that love relationships (or, to use a more neutral expression, emotionalities) also constitute the essence of the group mind. Let us remember that the authorities make no mention of any such relations. What would correspond to them is evidently concealed behind the shelter, the screen, of suggestion. Our hypothesis finds support in the first instance from two passing thoughts. First, that a group is clearly held together by a power of some kind: and to what power could this feat be better ascribed than to Eros, which holds together everything in the world? Secondly, that if an individual gives up his distinctiveness in a group and lets its other members influence him by suggestion, it gives one the impression that he does it because he feels the need of being in harmony with them rather than in opposition to them. (p. 91)

And regarding hate he said:

> Therefore a religion, even if it calls itself the religion of love, must be hard and unloving to those who do not belong to it. Fundamentally indeed every religion is in this same way a religion of love for all those whom it embraces; while cruelty and intolerance towards those who do not belong to it are natural to every religion. If another group tie takes the place of the religious one — and the socialistic tie seems to be succeeding in doing so — then there will be the same intolerance towards outsiders as in the age of the Wars of Religion; and if differences between scientific opinions could ever attain a similar significance for groups, the same result would again be repeated with this new motivation. (pp. 97- 98)

Psychotherapy was struggling to transcend these primal forces, including the "hatred" between scientific opinions within the medical fraternity; and no doubt helping ease the struggle in New Zealand, was the second Secretary of the Association of Psychotherapists, a

woman who was to become my first landlady in Wellington and later, a mentor in my work; Ilse Macaskill. Ilse escaped from the Nazis with the help of the Quakers in the lead-up to the war, but not before being imprisoned for being Jewish and tattooed with a prisoner number on her forearm. She studied psychology at Victoria University, Wellington, and sought psychoanalysis with Mario Fleischl, a Jewish refugee from Austria who had received analytic training from Hans Sachs and Paul Federn. I first met Ilse when in my mid-twenties, living in a flat with my wife at the back of her house. Her consulting room was at the front of the house and I can remember being somewhat daunted by what I thought of as the "mad" people who came to visit her. She emanated common sense and was very willing to stand up to opinions she considered controlling. I remember her saying that she would not let anyone tell her she could not offer a cup of coffee to her patients.

I will talk a little now about the development of my own interest in groups and in psychotherapy. I had navigated my way through the Fifties and early Sixties relatively unscathed and went to Canterbury University, where I studied zoology and psychology. Although we were introduced to Freud's ideas there, the mood was dominated by the ascendency of behaviourism. I largely escaped the application of this in the human realm by working in the field of animal behaviour, in particular with rats. In effect, the rats taught me about the importance of relationship in a way that the human applications of behaviourism seemed to miss. One of my jobs was to teach students how to train a rat. Some would come to me and claim to have a dud rat that was untrainable. My job was to help them focus more on the rat and less on their desire to make it do something, and many were surprised to find that their rat was not a dud. In essence, I was encouraging them to form a relationship with the rat, and in retrospect I see this as my initial training in psychotherapy; developing a focus on the relationship. In focussing on the relationship with our clients we lessen the chance of getting caught in the transference and countertransference, and Ilse was a primary teacher for me regarding this.

After University, I travelled to Germany with my wife, who had obtained a scholarship to study there. The zeitgeist of the Fifties was still present enough in the early Seventies for travelling to study in Germany to be a little transgressive; to be collaborating with the enemy. On the other hand, revolution was in the air; the students in Europe were rebelling and demanding greater control of the curriculum and partnership with their professors. Interactions were characterised by replacing the polite form of "You" (Sie) with the more intimate "Du". There were many different Communist groups among the student body, often in conflict with each other.

Returning to New Zealand after about two years in Europe, I worked for the Department of Health, promoting various aspects of health with a wide variety of community groups, from schools, to industry, to Plunket, WEA, YMCA and others. I found myself approached by a number of participants to work on an individual level with them and in response to this I undertook an internship in counselling and psychotherapy with the Presbyterian Support Counselling Centre in Wellington. This was in the early Eighties and the freedoms that I had experienced in Germany in the Seventies were beginning to filter through and affect the zeitgeist in psychotherapy in New Zealand. The mood was of eclecticism and experimentation with an emphasis on brief therapy and what worked. There was an interest in "growth groups", which was basically group psychotherapy for people who did not necessarily

consider themselves to be suffering from mental problems — part of the “Human Potential Movement”. In this environment, boundaries were tested and stretched in the field of psychotherapy and conflict was generated as a consequence of this. This was especially so, regarding sexual ethics and mores.

In what follows, I will hold the sexual underpinnings of the ego, both of the individual and of the group, as I describe the changes in NZAP during my time with it. Before doing so, however, I’d like to talk a little more about what I see as the symbolic representation of love and hate. In doing this I will call again on Sigmund Freud and also on the work of Sabina Spielrein (1994/1912). As I have discussed elsewhere (Sandle, 2020), I believe Spielrein brought important insights to the nature of symbolism. A prominent symbol for Spielrein was what she called “the Mothers”, a creative and destructive force which has also been called the vagina dentata. A central symbol for Freud, on the other hand, which is also both creative and destructive, is the phallus. As someone born in Aotearoa and exposed to Māori mythology, I link the vagina dentata to Hine-nui-te-pō and the phallus to Maui. Each of these symbolic representations deal with both creativity and destruction, but in different ways, and with important relevance to the life of groups. If we can hold these powerful symbols in mind they can help us navigate the tendency toward emotional dysregulation that I believe contributes to group formation and maintenance (Sandle, 2020). Spielrein says of this, “The symbol is analogous to the painful image, but it is less differentiated than an ego image” (1991/2012, p. 161). The painful image she speaks of is different for each of us but is of an experience we have failed to process fully, such as the war trauma of returning soldiers from the Second World War. She describes the nature of the symbolic image as follows:

> The deeper we penetrate the unconscious, the more universal and typical the images. The depth of the psyche knows no “I” but only its summation, the “We”. (p. 160)

And:

> Every sexual symbol in a dream, as in mythology, possesses the significance of a life and death-bringing god. (p. 167)

Freud focussed on the Greek hero Oedipus who, like Maui, carries the symbol of the damaged phallus. Oedipus, or “swollen foot”, a reference to the phallus, is analogous to the painful image of his father’s attempted infanticide of him, which was driven by his father’s sexual fears. Maui is represented by a bent phallus, symbolic, among other things, of his attempt to enter the toothed vagina of Hine-nui-te-pō, which led to his death.

My experiences of the changing zeitgeist of NZAP seen through conferences I have attended

I will next talk about NZAP through my experiences at conferences. My focus will be primarily on aspects of these that made a personal impact on me as I developed as a psychotherapist.

My first NZAP conference was in 1985, the theme being *Unity and diversity*. This reflected the zeitgeist I have named above of diversity and eclecticism. I remember well the initial

warm-up, "A beginners guide to role confusion", a psychodrama directed by my supervisor at the time, Dick Fowler, which led to Evan Sherrard (like Dick, a Presbyterian minister) being hoisted up into the rafters of the dining room of the Central Institute of Technology (CIT) in Upper Hutt, to be God. This was facilitated by Peter Read and Peter McGeorge, both of whom were to become President of NZAP in later years. The mood was definitely creatively phallic in its playful and competitive nature. Evan was my wife's brother-in-law and we had stayed with him and my wife's sister in Ann Arbor, Michigan, on the way back from Europe. At Evan's invitation, I had attended a Transactional Analysis training group, which was run largely as a "growth group", with an inner circle of people doing the work and an outer circle of observers, of which I was one. This made a deep impression on me as part of becoming a psychotherapist and Evan was someone who I identified with in this regard.

The creative aspect of the feminine was also represented at this conference. Dale Dodd spoke about the importance of the alchemical "well-sealed vessel", the therapeutic container in which transformation can take place, and Isla Lonie of the containing nature of idealising and mirroring transferences in work with people with borderline disorders. Isla was born in Christchurch ten years before NZAP was founded and became an important person in teaching psychodynamic therapy in Australia and New Zealand. She presented at several of our conferences.

Ilse Macaskill also presented on brief intervention. Seventy at the time, and with approaching forty years of experience as a psychotherapist in New Zealand, her ability to attune to the zeitgeist (brief intervention) and to maintain her pragmatic, relational self shone through. I think I can speak of Self (with a capital S) here as well. Although fascinated by theory, Ilse had a direct presence in the moment which may be felt in this short extract:

> A sense of stillness is preferred, as the patient in his vulnerable, hypersensitive state may be disturbed by the continuing dialogue in the therapist's mind. Don't listen too long to recitals of specific events, as it wastes valuable reconstruction time, but be sure to see recurring patterns in the story. Avoid filling up your place of work with too much gloom, and introduce very early positive factors in the patient's life — be light-hearted, but not discounting of pain or the seriousness of the patient's predicament. Put your own relevant cards on the table. Personal experience of the therapist, if sincerely reported, is a gift to the patient, and makes for some mutuality. Do not forget the person's body language and body state — be sure there is some laughter in the first session and that he/she leaves in a better frame of mind than he/she came with. (Macaskill, 1985, p. 9)

She also attuned to my growing interest in psychotherapy proper, giving me her well-thumbed copy of Jung's autobiography *Memories, dreams, reflections* (Jung, 1967).

This interest of mine was deepened further at the 1987 conference at Knox College, Dunedin — *The inner world*. Two presentations come to mind: those of Peter Callachor and of Isla Lonie. I recall that each of these presenters took me on a journey of exploration into the inner world by means of stories and metaphor, both historical and more recent. I can remember thinking, "This is the psychotherapy I am interested in." In retrospect, I can see their presentations followed the theme I have named, of the destructive and creative

aspects of the masculine and the feminine. Peter's stories, many biblically based, but including Greek myths such as that of Oedipus, were of the competitive struggles of fathers, sons and brothers, of murder and intrigue, often in search of power, but also of redemption. Isla's were of the unknown, of darkness and the twilight zone, particularly as part of the creative process. One of her stories that stuck with me was of the women who knitted the Fair Isle jerseys for their men, while they waited for their return, or news of their death at sea. The patterns knitted into the jerseys were unique to each man and served as a means of recognising them if their sea-changed bodies were washed up after drowning.

The New Zealand Association of Psychotherapists and Counsellors, which it had been since 1981, changed its name back to the New Zealand Association of Psychotherapists at this conference. This was one sign of a movement away from the difficulties brought by many diverse views on what the profession should be. There was resistance to this move. Following the conference, George Sweet (1987) wrote of his concern that, inevitably perhaps, the organisation was moving from a free-spiritedness towards exclusivity and elitism, to be followed by irrelevance. I had spoken with George at the Dunedin conference and failed to convince him that a deepening and focussing of the psychotherapy process was not necessarily the same as a hardening of the psychotherapeutic arteries.

In the year following that in which George wrote his letter, a conference was held in Auckland which carried a particular intensity. I did not attend and only heard about what happened second hand. The issue revolved around who could call themselves a 'psychotherapist' and in particular, Bert Potter's claim to the title. Potter was the leader of the Centrepoint Commune, a residential therapeutic community which, by a number of accounts, had produced beneficial outcomes for some individuals. Potter, however claimed that having sex with clients was a therapeutic intervention (Tudor, 2017). In order to encourage the move to registration of psychotherapy so as to protect clients from people such as Potter, the conference planning committee invited him to speak in order to demonstrate to the wider psychotherapeutic community the dangers of his practice and the need to exclude him from the community. As one of the planners, Evan Sherrard put it:

> Powerless to do anything about Potter's offensive grandiosity, some Association members displaced their anger onto the conference arrangements committee. … [and] the point that we were trying to make, that psychotherapy was gaining a bad name in Auckland and people were being damaged by its so-called practice, was side-tracked. (Tudor, 2017, p. 323)

Here we have an example of the importance of what I have called the ego of the group, the name "psychotherapist", as a protective container, but also as a source of conflict.

Also, part of the zeitgeist at this time was a calling into question of Freud's theory of childhood sexuality and a return to his earlier theory of child abuse by adults, the seduction theory. The zeitgeist moved away noticeably, if not completely, from the depths which had attracted me in Dunedin, and from the place of sexuality in the therapeutic process that was there in Freud's theory. This was accompanied by an increasing emphasis on ethics in the profession.

This shift was marked in the 1989 conference held at Victoria University, Wellington, which had the title *Change*. In my notes for this conference, I have noticed the prevalence of polarity and of attempts to control it through ethics and the structure of the therapeutic relationship. There was a shift in focus to the here-and-now and away from the unconscious. I had a sense of "How do we best ride out the storm and keep ourselves safe?"

At the first NZAP conference to be held in the Central Districts, at Flock House in 1993, the conference theme was *Being ourselves* and opened with a powhiri by Ngāti Apa. The President, Lewis Lowery, commented:

> At last we have both Māori and Pakeha cultures acknowledged in our title [Te Rōpū Whakaora Hinengaro] — to me it is no accident that the Māori translation was given birth at the Central Districts Conference. The land speaks to us of our Māori brothers and sisters and it was they who welcomed us here" (Manchester & Manchester, 1996, p. 101)

For me, the acknowledgement of Māori tikanga brought back again a recognition of the deep processes which had been operating, perhaps at an unconscious level, since Bert Potter was given an opportunity to speak in Auckland. Potter had blatantly enacted the phallic and had been countered by the vagina dentata. Māori tikanga is familiar with these unconscious forces and has ways of working with them that allows them to re-enter conscious process. A teacher of mine, Ta Tipene O'Regan (1974), considered that the tikanga of the marae in Aotearoa developed following European immigration as a means of enabling warring iwi to cooperate in order to deal with this influx. By this means (the protocols of the marae) a process of integration can be established in the face of a tendency to split.

When the conference returned to Auckland in 1994 with the title *Integration and learning in the teaching and learning of psychotherapy*, the memory of Potter rose again in the background from the last Auckland conference. In the foreground however, the keynote speaker, Katherine Murphy spoke of her experience of an integrative approach moving away from splitting and towards rapprochement, thus avoiding 'dogma eats dogma' (Murphy, 1994). For me, an important presence was my mentor Ilse Macaskill, who transcended dogma into the realm of the Self with a presentation with the evocative title, "The joys of psychotherapy."

Back at the CIT in Upper Hutt in 1995, the theme was *Substance and shadow*. I remember a very lively public symposium, particularly the interactions between three of the presenters: John Briere, Margaret Mahy and Kim Hill. The zeitgeist at this time had swung from attention to the blatant sexual abuse of Potter and his like, toward a focus on the so-called "industry" of recovered memory of sexual abuse, which was seen to be imaginary. With the Freudian theory of childhood sexuality having drifted somewhat into the shadow, there was a tendency to split into a belief that all memory of abuse was real on the one hand, to the belief that it was imaginary on the other. The reality of the symbolism of the unconscious process got seriously blurred in this process. Kim Hill had been challenging the so-called "recovered memory industry" on her radio show and John Briere was well-known for his work with trauma, including sexual abuse trauma. In between these two sat Margaret Mahy, prize-winning children's author, with her book *A lion in the meadow* (1972). This book explores the relationship between a young boy and his mother as the boy develops his

autonomy through exercising his imagination. Margaret Mahy, seated between the other two, was the first to speak. She stood and looked to the left and right, sniffing the air. "I smell conflict," she said, "and at my age I'm no longer so interested in conflict between people. I may look like an eccentric old lady but I'm actually a secret scientist. On one side of my bed is a pile of *Scientific American* and on the other *New Scientist*; I read them avidly. I'm much more interested in the conflict between the horse brain and the crocodile brain than conflict between people." After Margaret had spoken, John stood. He picked up the wodge of paper on the lectern in front of him and dropped it, before expressing some apprehension about the impact of media criticism regarding clinical practice in relation to the treatment of sexual trauma. I don't remember much of what Kim said, but as a listener to her radio interviews, I noticed a softening in her style following her appearance at this conference; a greater tendency to listen instead of challenging.

In 2001, I was on the planning committee for the Wellington conference, *Weaving the threads*. The question arose as to the nature of a pōwhiri and whether to have one at all. I was strongly in favour so the task fell to me to contact tangata whenua. I arranged a meeting with a representative of the Wellington Tenths Trust and he asked what I wanted. When I told him about the conference we were planning, I was challenged about the integrity of our pōwhiri request and responded by affirming that, "we are holding this conference on Te Ati Awa's whenua and want to honour that." After a moment of silence he said he would ask his elders and see if something could be arranged.

Following the conference, Charlotte Daellenbach (2001), President of the NZAP, wrote:

> I am grateful for the pōwhiri which creates such a potent way of welcoming us onto the site of our common explorations. I am grateful for the messages from Paraire Huata and Mihiteria King which, through their parallels and through their divergence, offer us a compelling challenge and a reminder that we need not search for the right way to be in relation with the tangata whenua — there may not be a right way — but we need to continue the dialogue. (p. 5)

At the conference in Christchurch in 2003, entitled *The ebb and flow of relationship*, one of the keynote speakers was Reverend Maurice Manawaroa Gray, Upoko o Te Runaka ki Otautahi o Kai Tahu. Listening to Maurice, I felt again my interest in the deep process of psychotherapy being addressed. He named the tidal process of the flow between "all of us" (tatou) and "ourselves" (ko au), and the place of Maui in the process of healing. Describing our life force, our mauri, as the Maui in us, he linked this to being ill (mauiui) and to recovery (whakamaui); the trauma of Maui's birth symbolising the trauma which permeates the world and which is reborn again and again. He described this rebirth as symbolised in the Maui cycle where Maui moves through the elements, from the spiritual (fire, symbolised by his mother's topknot) to the emotional (water, symbolised by his mother throwing him into the arms of Tangaroa) to the psychological (air, symbolised by him being lifted up by Ranginui) to the physical (earth, symbolised by his return to Papatūānuku). As I remember this now I am linked to the theme of this 2022 conference *Ka mua, Ka muri* — the tidal and cyclical nature of life. The Maui story, as with that of Oedipus, brings together for me the temporal, with its constant change, and the eternal — the ongoing stability of life.

In 2006, with the theme of the *Performance of meeting*, the tide went out again, with no pōwhiri. Biculturalism was addressed by looking at it, as against engaging in it, but in 2007 in Napier, the tide came in again with a rush. The conference was in the war memorial on the foreshore, with an eternal flame burning in the foyer in memory of the war dead. Outside my hotel room in the Masonic Hotel, also on the foreshore, was the statue of a grieving soldier leaning on the butt of his rifle which was pointed to the ground. In retrospect, I see these as symbols of the underlying process I have named; that of the vagina dentata or "the Mothers" and that of the phallus. The war memorial was the container for an intense big group process led by Teresa von Sommaruga Howard, one of the rules of which was to remain seated when speaking. (von Sommaruga Howard (2012) writes of her experience of this group in her article *To Stand Sitting! Bi-Cultural Dilemmas in a Large Group in Aotearoa New Zealand*). Intensity developed around whether to sit or stand to speak, which had a quality of cultural conflict in it, with a risk of the container being breached. I experienced this intensity as an engagement between two taniwha, spiralling in the group. Individuals were processing what emerged for them within the group and this increased the intensity. The following morning the Māori caucus clearly challenged the group's (mono)cultural assumptions underpinning sitting and standing. With some trepidation I got up from my seat and, along with Paul Solomon, stood alongside the Māori caucus. When I sat down again, I was cautioned about my apparent and unwelcome Pākehā idealism — the death of Maui, aue!

Following this conference, two major events emerged out of the struggles within the zeitgeist of NZAP — the establishment of the Māori caucus under the name Waka Oranga, and the registration of psychotherapy in Aotearoa. These changes in the structure of the organisation can be seen as the outcome of the interaction between the erotic bonds of love and hate within it and within the wider society at the time. For me, this conference stands at the heart of what I am exploring here; the destructive and creative aspects of the erotic bonds in the group as a whole.

At the conference in Waitangi the following year, I slept on Te Tii Marae, but the event that had the most impact on me happened on the upper marae and involved Professor James Ritchie. Ritchie described himself as an ethnopsychologist with forty years' experience of working in the Māori world as a Pākehā. I have written elsewhere of the important connection I made with him on the harbour cruise (Sandle, 2013), where his wisdom helped me deepen my connections biculturally, but what happened on the upper marae was different. It felt to me as if the taniwha from Napier had not yet gone to sleep but had shifted their focus from the cultural boundary between Māori and Pākehā to that between men and women. We were gathered in the wharenui and James was speaking of his experiences when he was told to sit down and give space for women to speak, reawakening for me the Napier taniwha.

In 2009, at Te Puna Wanaka in Christchurch, the theme was *Challenge and change*, with a focus on biculturalism and registration. What emerged was the process of strengthening the container for NZAP, and for me the depth that was opened up within the container. In the large group, the metaphor and reality of the burning down of homes emerged — the destruction of the container — and the need to grieve for this as well as the failure to accept the deep grief. The theme had returned to the zeitgeist at the foundation of NZAP. It was the

Saturday of the conference, ANZAC day, and we were reminded of the aftermath of the destruction of the Second World War which was one of Bevan-Brown's motivations for establishing the Association. I slept on the marae beneath the big pou with members of Waka Oranga and their families and others, and experienced the depth of the wellspring of knowledge — te puna wanaka. Paraire Huata had spoken about this wellspring as having no ownership and as belonging to all — a healing experience. I spoke with Fahkry Davids, psychoanalyst from London, regarding the nature of the container and challenges to it. "What would you say to a patient who said 'I want to work with you but not do psychoanalysis'?" I asked. "Not a problem," he replied, "it's only a conversation." (Personal communication, 2009, NZAP Conference)

Back in Wellington in 2012, the theme was *Tona kanohi — The face of the other*. In the continued settling of the zeitgeist since Napier, the strengthening of female presence and that of tangata whenua was noticeable. Almost twice as many of the presenters were women and about a third were tangata whenua. Most memorable for me was the presence of tangata whenua healers offering mahi wairua. The concept of wairua was presented to us in a way which made immediate sense to me in my practice and as a way of staying present in the face of the changing zeitgeist. Wairua stands for the two streams — wai, rua — the ego stream and the soul stream. We were told that the task of the healer was to stand in the soul stream and when we do that the ego stream becomes much more visible to us and is available to be worked with. A further task is to avoid getting caught up in the ego stream and to stay standing in the soul stream. The ego stream both changes and resists change, whereas the soul stream stays constant and unchanging and provides a basis for ongoing relationship.

The mahi wairua workers were also present at the conference the following year on Orakei Marae in Tamaki Makaurau. As we walked on to the marae and approached the wharenui, Tumutumuwhenua, the leader of the mahi wairua group, called out to the ancestors in what to me sounded like ancient te reo Māori. It sent a chill down my spine. Subsequently, a trusted cultural mentor of mine, who was also present at this conference, told me in a matter-of-fact way that he spoke to the ancestors in the language they spoke. It was at this conference that I presented my paper on the sexual aetiology of violence in the form of a TED talk (Sandle, 2013) within the body of Tumutumuwhenua. In my mind, then and now, was the phallic potency of Tumutumuwhenua to rise and stand up in the face of the destructive colonising powers and also his place as a container for integration. A potent film by Merata Mita, *Bastion Point — Day 507* (1980) captures some of the history of this.

This conference marked a shift in my relationship with NZAP. As Maurice Gray had spoken of in his presentation in Christchurch in 2003, the tide for me was turning away from tatou to ko au. Following Spielrein, I think of this as a move from the general to the specific, from the unconscious process into the conscious, and a strengthening of the ego. This was also marked by my beginning to write and present at NZAP and Bioenergetic conferences and in the *Transactional Analysis Journal*. My individual creativity in the field of psychotherapy was finding a voice: I no longer had to hide the phallic as I had hidden the war comics as a young child.

Back in Christchurch in 2015, the post-earthquake conference was entitled *Shifting ground*. The ground had shifted for me personally in two major ways. Earlier in the year I had been hospitalised with a life-threatening lung abscess, and decided to begin my retirement

by not taking on new clients. In addition to this I decided to help my brother repair the seriously quake-damaged family house in Christchurch. There was a sense for me of "coming home" and I spoke of this with guest presenters Fakhry Davids and Pele Fa'auli on an orienting drive. I took them on to the surf beach at Sumner. Fakhry spoke of the surf in South Africa where he had his initial training and Pele stood with his bare feet in the water and gazed out to sea.

It may be that the zeitgeist of NZAP was also becoming less focussed on the organisation itself and more on the work; a parallel move from tatau to ko au. At the 2016 conference in Hastings, tangata whenua challenged our group at the pōwhiri. They described that "our young people" are dying by suicide, and vigorously questioned what we were doing about it. In the wharenui that night, we were encouraged to keep our mattresses close together to stop the ghosts getting in. I lay there and listened to Haare tell a local version of the Hine-tītama story as I fell asleep. Hine-tītama is the dawn and is impregnated by her father Tane and in shame enters the realm of the dead, becoming Hine-nui-te-pō. This symbolic story of day and night contains within it the elements I have named at the beginning of this paper. The story Haare told was much more earthy and connected me to the dying young people named during the pōwhiri. What I remember from my half-asleep state is that an old fisherman was entranced by the beauty of the dawn and pursued her, eventually making love with her. In shame, she threw herself off a local cliff into the ocean.

I have written about my experience at the 2020 conference, *Wiwini wawana wehi ihi — Terror in the transference*, elsewhere (Sandle, 2020), but in conclusion, I'll return to it here, with a quote from my 2020 presentation, which relates to the impact of the Covid pandemic which was just starting in New Zealand at the time.

> I watched online as the conference began to unravel and felt both frustrated and deflated when local presentations, one of which I was to deliver, were cancelled. I turned up to the venue early, not knowing what to expect but wanting to offer what support and help I could to the planning committee. I helped setting up chairs for the pōwhiri and was encouraged by Cherry to speak if the opportunity arose. I spoke in te reo of the earth, the ancestors and the house, Whaia Pu Aroha, Mother Aubert (Munro, 1996). For me the ancestors continued their presence from the belly of the earth, both supportive and challenging. As Tangata Whenua spoke of Mother Aubert's encouragement for us to live in the present, I found myself thinking of Maui, and how his attempt to find eternal life could be seen as the challenge we all have to live in the present and adapt to change. His death in the pounamu teeth at the entrance to the womb of Hine-nui-te-pō, was close to the theories of Sabina Spielrein I had been exploring in my paper. His companion Piwakawaka, the fantail, had led to Maui's death when he awakened Hine-nui-te-pō as Maui tried to enter her womb as a Namu (sandlfy) larva, and she crushed him with the pounamu teeth of her vagina dentata. I thought of him as a schizoid structure, his injury being abandonment at birth by his mother Taranga, which led to his ongoing search for her in the underworld.
>
> Larry, the keynote speaker, isolated in his hotel room, spoke by Zoom from the big screen, and as he did so Piwakawaka (a fantail) came into the room and flew about, calling out. I felt fear come upon me, who was going to die? Several possibilities

> passed my mind, including myself and Larry. I noticed Larry blowing his nose and feared he might have the virus.
>
> My voyage into the symbolic realm in the presence of Larry and the virus and its consequences chastened me and renewed me, helping me accept the "death" of the conference and my presentation. (Sandle, 2020, pp. 34-35)

I later presented this paper online and it has informed what I am presenting today.

Conclusion

How do we hold these deep, archetypal forces safely enough, both as we work with our clients but also as we relate to each other through the many groups we belong to? In the time of Covid, they rise up and may divide us and those around us. In the social media world they take on new forms such as the Alt Right on the one hand and Cancel Culture on the other. I have presented Sigmund Freud and Sabina Spielrein as hero figures in our history as psychotherapists, embodying the phallic and the "Mothers". As hero figures they were subject to challenge and denigration in their time and their theories have suffered a similar fate, being modified over time and returning again to their archetypal roots. I see each of us as also following our own hero path, negotiating our individual encounters with the archetypal forces of love and hate. In Aotearoa our biculture has given us the opportunity to meet these archetypes in a different form from what we are familiar with and perhaps see, as Spielrein noticed, their basic similarities, and the fact that they emerge for each of us from the individual traumas we experience in life.

Through my personal recollections of my journey as a psychotherapist in Aotearoa and in particular of NZAP conferences over the time I have been a member, I have attempted to throw a light on the changing nature of its zeitgeist and also its underlying essence, stable in the presence of the alternating pull of the erotic bonds of love and hate.

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Rod Sandle, a Certified Bioenergetic Analyst, Transactional Analyst and member of NZAP for thirty-eight years, has a long interest in the relationship between individuals and the groups to which they belong. In recent years he has sought to deepen his understanding of the nature of this relationship with regard to sexuality, spirituality, aggression and creativity, and the way in which psychodynamic theory helps with this exploration. His understanding of time is informed by the myths of Oedipus and Maui and the Yoga Sutra of Patanjali.

Imagining a future for psychotherapy in Aotearoa

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Abstract

This paper discusses Donna Orange's idea that Levinas's philosophical position of radical ethics, when combined with the psychoanalytic concept of intersubjectivity, could unravel blindness to the climate crisis. Genocidal colonisation by Europeans across the world is a disavowed history that has been ruinous not only for the colonised, but also for the internal worlds of the colonisers. We remain in the grip of a destructive competitive mindset, driven by the forces of shame, shame anxiety, and envy. Psychotherapists could play a part in a better future by articulating the emotional defences at play in ecocide and strengthening our own workforce and those who are fighting against the climate crisis, with group work.

Whakarāpopotonga

E whakawā ana tēnei tuhinga i ngā whakaaro o Donna Ārani, mō te tūnga tirohanga ā-whakaaro a Rāwinia tino rerekē inā honoa atu ki te ariā tirohanga ā-hinengaro whakawhitiwhitinga kaupapa hei huri whakaaro ki te whakatūpatohanga o te huarere. He mate i tau, kaua ki ngā tāngata taketake anahe, engari ki āna momo tirohanga ao hoki , te whakaurutanga kōhuru a ngā Iuropīana huri noa i te ao, he hītori whakahēhia kau ana. Kai te aro nui tonu tātau ki te here o te ao whakataetae arohaehae, takia ake e te wairua whakamā, pōraruraru me te hao. He wāhanga whakahiranga pai ake kai konei mō anamata mā ngā kaimahi whakaora hinengaro ki te whakaputa kōrero mō ngā tūwatawata o te taiao ka whakakaha ake hoki i ā tātau me te rōpū e whawhai nei i te kaupapa mōrearea.

Keywords: radical ethics; Donna Orange; climate crisis.

Introduction

This paper is the text of an oral presentation at the New Zealand Association of Psychotherapists' (NZAP's) *Ka mua, Ka muri* online conference in February 2022. The

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conference theme of looking to the future by looking to the past was discussed over three days with other panels highlighting NZAP's past, while this panel was invited to imagine a future for psychotherapy. The presentation focused on the global predicament of ecological overshoot. It discussed Donna Orange's idea that Levinas's philosophical position of radical ethics, when combined with the psychoanalytic concept of intersubjectivity, could unravel blindness to what is referred to in the media as "the climate crisis". It makes the case that genocidal colonisation by Europeans across the world is a disavowed history that has been ruinous not only for the colonised, but also the internal worlds of the colonisers. Many in the world remain in the grip of a destructive competitive mindset, driven by the forces of shame, shame anxiety, and envy. By using an informal tone in the presentation, I intended to show a rejection of elitism which I see as a key driver of the climate crisis, and to give a living experience of how being touched by the emotion of the climate crisis can be inspiring. I made the case that psychotherapists could play a part in a better future by articulating the emotional defences at play in ecocide and strengthening our own workforce, and those who are fighting against the climate crisis, with group work.

Presentation

Kia ora koutou, I am Claire Miranda, and I live in Te Whanganui-a-Tara. I acknowledge the Ngai Tara as the tangata whenua here. I appreciate being asked to do this panel because I am scared about the future of psychotherapy in Aotearoa. I'm wondering how we could have a future at all, because we need a habitable environment for a future psychotherapy. We are assaulted with continual "unthinkable" disasters such as, recently, both poles of the earth hitting 10-30° hotter than usual, and an ice shelf in Antarctica the size of Rome falling in the sea last week — an event that was not even predicted by scientists (Wilkins, 2022). It is accelerating. Twenty million of our fellow human beings in Africa are going to starve in famine this year (Davies, 2022), not at some time in the future. Climate communicators in the media keep reporting environmental impacts of carbon pollution, to zero effect, because they seldom have any clue what drives our destructive behaviour. Governments continue to preserve the fossil fuel industry above preserving life on the planet, which makes no sense at all, and shows that climate change is a psychological problem.

Sally Weintrobe (2021) observed that Westerners are living quite ordinary lives in an unconscious, complacent bubble of "uncare" while the sixth mass extinction takes place. I took from her presentation at NZAP's 2021 webinar series *The Climate Crucible — Te Ipu Taiao* that we need to feel the crisis, and that psychotherapy's role could be to hold the heartbreak of the losses we face. I have held a group since then called *Te Ipu Taiao Hui*, and it has indeed strengthened and motivated group members. Donna Orange (2016), the psychoanalyst and philosopher, builds on Sally Weintrobe's work. She sees social justice as inextricably linked to achieving sustainability (which is well understood in the climate movement), she lays out the history of Westerners' blindness, and she describes the emotional causes of it. She says there are three feeling states that keep us double-minded about the ecological crisis: shame, shame anxiety and envy, which create an evasion of knowing. Echoing *Ka mua, Ka muri*'s first panel, she says the world's murderous colonial history is so shameful that it has attacked our

very sense of self. Europeans enslaved people and stole indigenous lands, then committed genocides and erased cultures so it could all be forgotten. The process of colonisation still carries on today and colonisers are vastly wealthy because of those crimes. Did our forebears feel shame for those acts? I think they did. The Pākehā inheritance is not only a big house deposit from Mum and Dad, it is also a weakened sense of self. Shame is described as "an affect reflecting a sense of failure or deficit of the self" that paralyses and silences (Morrison, cited in Orange, 2016, p. 66).

Pākehā can't fully know about being complicit in climate change in the same way we can't fully acknowledge past land theft and genocide. Exploitation still goes on as we sit here right now using devices made in the "third" world, the world we are used to not caring about. Donna Orange (2016) says,

> shame in the psycho-analytic system belongs neither to the patient nor to the analyst, but is intersubjectively generated, maintained, exacerbated, and we hope, mitigated, within the relational system. Likewise, shame, hiding our vulnerability and inadequacies in the face of climate change, emerges intersubjectively. (p. 67)

It is a vast Pākehā mental cobweb that disorients us and makes us feel like losers. Shame anxiety is felt when we fear that people will see that we are disorientated losers. Shame anxiety looks like narcissism in the individual; in society it looks like toxic, "tough guy" masculinity; in the world it looks like militarism. The US military budget is currently 782 billion USD, 500 billion more than its nearest counterpart! Yet the USA hawkishly and sometimes ludicrously (Bush, 2022) points the finger at other regimes as warmongers, human rights abusers and psychopaths. Donald Trump's "Make America Great Again" is a widely resonating expression of coloniser shame anxiety.

Orange (2016) believes that envy arises out of shame. Envy is anguish about your position and your place, thinking that a better position will solve that nasty shame feeling. Unlike jealousy, which is wanting what someone else has, envy is wanting more than them, wanting their position. If I could just be stronger, thinner, younger, have a PhD, then I could stop being this unimportant loser. A by-product of emotional deprivation and contempt, it has been called "rankism" (Fuller, cited in Orange, 2016, p. 76) and it drives the mindless consumption and degradation of the environment. While we can just buy things to make us look as though we are of higher rank, envy blinds us to the people we push out of the way to reach that better rank. Those suffering are totally ignored, forgotten and looked down on in classism and racism.

When I think about possession of Aotearoa being taken by essentially armed robbery, and then being sold and resold ad infinitum, and developed, i.e., ruined, just for the sake of avoiding the shame which the exploitation itself generates, the tragedy of it causes me so much pain. I trust Māori to look after the whenua, more than I trust the psychopathic market. At late-stage capitalism, there is nothing to lose, the rising sea will soon show us what Pākehā really possess anyway.

Orange (2016) proposes radical ethics as a counterforce to the climate crisis. Based on the work of the philosopher Levinas, whose idea was that we are "hyperbolically" obligated to the face of the suffering other, she says, "to address the crisis we are living in we must

come to feel the destitution of the homeless, starving and persecuted as our own persecution" (2016, p. 126). Orange says that "radical ethics means we cannot go on as we did yesterday, self-satisfied we are doing our best, shifting our personal responsibility onto the system… their faces forbid me to sleep comfortably and command me to respond" (p. 128).

To come out of this death wish, double-minded "bubble" thinking and become single-minded, we need to think and act for others all the time as though we owe them, let alone that we actually do owe reparations. You can't be bystanders if you believe you are obligated to suffering people. Neville Symington (2008) talked about following a generous impulse as a way of forming a more creative self. If we had creative selves, we would not be in a state of shame, shame anxiety, and envy, gnawing the earth for coal and lithium, because shame and envy are held intersubjectively, individual acts of care and generosity to people who are suffering will help unravel the whole system.

If we used radical ethics, which just sounds like manaakitanga, psychotherapists would be compelled to contribute to the fight against the death of our ecosystems. Currently the urgency of the crisis is not being expressed publicly by most psychotherapists and psychoanalysts. An exception in Aotearoa is psychotherapist Rick Williment who held a hunger strike at Parliament in 2021. What is missing from the climate movement are communications that cut through and reach the public consciousness about the seriousness of what is to come. In our clinical work, it is stepping back and thinking that moves the work along rather than only listening to content. At the moment the world is only listening to content and not enough is changing in time, so I encourage you to become hybrid psychotherapists and opinion piece writers, using the taonga of psychotherapy to analyse this human impasse that imperils earth and all its creatures, even if you are not high ranking stars like yesterday's Adam Phillips and Patricia Gherovici!

We could form relationships with artistic organisations to collaborate in storytelling, music and drama. Perhaps this would end up on Netflix and be watched by audiences currently glued to their devices, cosily avoiding climate reality. Did you know Jane Campion used a Jungian dream analyst in creating the film, *Power of the Dog*? (Monks Kaufman, 2021). The film explores power abuse, shame and envy.

Groups are a way out of lonely shame and envy. Donna Orange says about envy, "[i]f I felt that I fully belonged in the human community, I would not be interested in what you have, except to rejoice with you" (2016, p. 77). Robert Romanyshyn (2021) poetically described that there is a community of belonging in our profound climate grief. Another important role for psychotherapists is supporting activists, scientists and media people by conducting groups for them to help hold the immense fear and grief they are feeling. We can lend our weight and leadership to them, like Virginia Edmond has done by coming to every *Te Ipu Taiao Hui*.

I imagine we could help get other psychotherapists into the profession. Trainees could have placements working at our offices when we have left for the day, especially helping find placements for Māori psychotherapists. There are one hundred first year students this year at AUT. Could we help them get the experience they need? Could we increase our use of group supervision, even perhaps including less experienced people in our own supervision sessions to show them how we work? Because politics is such a numbers game, the activist in me wants to double or triple our numbers and gaining members through generous

sharing of knowledge and resources would generate the same generosity in them. All these things could continue to happen outside the economic system, the paradigm that truly matters.

You can join *Te Ipu Taiao Hui* on the first Monday of the month, online from 7-8pm.[1]

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Claire Miranda is a Pākehā psychotherapist who has been working in private practice in Whanganui-a-Tara since 2011. Initially trained in Hakomi in Sydney, she returned to New Zealand and did further training through AUT and completed the NZAP Advanced Clinical Practice qualification. Currently, Claire is training as a group therapist, partly as an exploration of how psychotherapy could adapt to the climate crisis and mitigate it. She is interested in how psychotherapy and psychotherapists can help end the Age of Oil.

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Opportunities and challenges for psychotherapy in Aotearoa New Zealand's new health system: A 2022 national District Health Board psychotherapy workforce survey and related discussions

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> We see psychotherapists playing an important role in the new [national health] system, bringing skills and experience into services across the spectrum of care. There is a huge opportunity to get involved, and we welcome ideas and initiatives to increase the number of psychotherapists and the promotion of psychotherapy across Aotearoa New Zealand. (Robyn Shearer, Deputy Director-General, Evidence Research and Innovation, Ministry of Health, 2022)[2]

Abstract

The dawning of a new national public health system in Aotearoa New Zealand offers opportunities and challenges for psychotherapists. This paper discusses these against three data sets, namely, a 2022 national District Health Board psychotherapy workforce survey, a video recording of the Psychotherapy and Public Worlds panel event at the 2022 New Zealand Association of Psychotherapists' (NZAP) conference, and psychotherapist registration statistics supplied by The Psychotherapists Board of Aotearoa New Zealand (PBANZ). The expansion of short-term, risk-based, manualised interventions during the former DHB era did not improve mental health at a community level (Mulder et al., 2022) nor promote equity and sustainability (Berg et al., 2022). Placing Te Tiriti o Waitangi, the Treaty of Waitangi (1840) (Te Tiriti) at the centre of the new health system suits psychotherapy,

1 Opinions expressed in this paper are those of the author or cited contributors and are not made on behalf of Te Whatu Ora, Te Toka Tumai, Auckland. The author acknowledges and thanks the many contributors to this paper, including those from two 'blind' peer reviews organised by the editors of *Ata: Journal of Psychotherapy Aotearoa New Zealand*.

2 Personal communication (email) to author on 27 April 2022.

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whose wholistic worldview of health and wellbeing aligns with te ao Māori better than most other Western psychological approaches. Kōrero about the indigenising of psychotherapy in Aotearoa has been around since at least the 1980s. The Ministry of Health (the Ministry) has recently invited psychotherapists' advice on workforce policy development and how to promote psychotherapy in the new health system. This task will largely fall on the psychotherapy associations and some psychotherapy training organisations. A major challenge may be whether these entities can sustain the expenditure of human and other resources necessary to represent their memberships in continuing dialogue with the Ministry and its operational partners, Te Whatu Ora, Health New Zealand (Te Whatu Ora) and Te Aka Whai Ora, Māori Health Authority (Te Aka Whai Ora). Key opportunities include the recruitment of overseas psychotherapists and the greatly expanded provision of psychotherapy student placements in public health services to stimulate new psychotherapy training programmes and workforce growth.

Whakarāpopotonga

Kua wātea mai he huarahi ahu whakamua, whakaohooho ake ki ngā kaiwhakaora hinengaro i te pūaotanga ake o te pūnaha hauora hou ā-motu i Aotearoa. E whakawhitiwhiti kōrero ana tēnei pepa mai i ngā kohinga e toru, arā, he uiuinga a te Poari Hauora kaiwhakaora hinengaro ā-Rohe, he hopunga whakaata a te huinga paewhiri i te wānanga a te 2022 NZAP, me te tatauranga kaitohu kaiwhakaora hinengaro homaihia e te Poari o Ngā Kaiwhakaora Hinengaro o Aotearoa Niu Tīreni. Kāre i piki ake te oranga o te hauora hinengaro ā-hāpori (Murata etahi atu., 2022) kāre hoki i whakanuia te ōritenga me te toitūtanga (Pēke me ētahi atu., 2022) i te wā o te wā o te Poari Hauora Hāpori o mua. Ki te whakauruhia te Tiriti o Waitangi hei pūnaka pou tokomanawa mō te hauora hou ka hāngai ake ērā manawapā i ngā tirohanga whakaora hinengaro Whakatēuru. Nō te tau kotahi mano iwa rau waru tekau te pōtereterenga o te kōrero kia whakauruhia mai ki Aotearoa, te tūāpapa whakaoranga hinengaro a tangata whenua. No kō tata ake nei ka puta mai te pōhiri a te Minita Hauora ki ngā kaimahi whakaora hinengaro kia āwhinahia atu ki te whakatakoto whanaketanga kaupapa here, ā, me pēhea hoki te whakatairanga whakaoranga hinengaro ki roto i te pūnaha hauora hou. Ko te nuinga o tēnei mahi ka tau ki ngā rōpū whakaora hinengaro ko ētahi ki ngā rōpū whakangungu whakaora hinengaro. Ko te tino wero pea ko te wā taea e ngā rōpū te whakawātea kaimahi me ētahi atu rauemi hei kanohi kitea whakawhitiwhiti kōrero ki te Manatū me ana hoa kaimahi, a Te Whatu Ora me Te Aka Whai Ora. Ka uru mai ki ngā whiwhinga te rapu kaimahi whakaora hinengaro o tāwāhi me te whakawhānui whakaūnga nōhanga tauira whakaora hinengaro i rō ratonga hauora tūmatanui hei whakaohooho hōtaka whakangungu whakaora hinengaro hou me te whakapihinga kaimahi.

Keywords: Te Tiriti o Waitangi; public health workforce; mental health and additions workforce policy; DHB psychotherapy workforce survey; PBANZ registration statistics; NZAP conference panel; promotion of psychotherapy; health equity.

Whakapapa

The whakapapa of psychotherapy in the public health system of Aotearoa New Zealand is young compared to psychotherapy in the public health systems of older societies, such as in parts of Northern Europe, and consequently, the understanding and demand for psychotherapy in Aotearoa New Zealand is in a nascent phase.[3] This situation creates a psychological treatment vacuum that is currently being filled by the importation of contemporary public health discourses from overseas, largely centring on short-term cognitive approaches.

The whakapapa of this paper is Pākehā through its author's strong connection to te ao Pākehā, the Western worldview. If that whakapapa had included an equally strong connection to te ao Māori through an equitable partnership between Māori and Pākehā researchers, knowledge bearers, and co-authors, this paper may then have reflected the mana of those tangata whenua who have been kaitiaki to their people's mental health over many generations. Instead, its whakapapa is limited by the partial nature of the author's collaborations with Māori working in the new health system, in the former District Health Boards, in professional associations, regulatory and training organisations, and as practitioners.

The whakapapa of the author is Pākehā going back five generations in Aotearoa New Zealand to County Armagh, Ireland, on his father's side and two generations to southwestern Scotland through his mother. He grew up under the gaze of Pukemoumou in Te Awa Kairangi ki Uta, Upper Hutt, within the rohe of Te Rūnanganui o Te Āti Awa. Between 1991 and 2005 he worked in child and family mental health services at both the Wellington and Hutt hospitals, progressing to senior family therapist. Currently, he works part-time as the psychotherapy professional leader at Te Whatu Ora, Te Toka Tumai, Auckland, where Te Rūnanga o Ngāti Whātua are mana whenua, and in private practice as a psychodramatist, family psychotherapist, and educator.

Introduction

By the time this paper is published, the 21-year tenure of the 21 District Health Boards[4] (DHBs) established throughout Aotearoa New Zealand by the Fifth Labour Government in 2001 will be over. In their place, a bicultural organisational partnership is being steadily constructed comprising the Ministry and two new entities, Te Whatu Ora and Te Aka Whai Ora. On 1 July 2022, when this new structure took responsibility for the national health system, current clinical positions and services rolled over, including those in public mental health and addiction services where the majority of the registered psychotherapists employed by the DHBs are located.

In this exceptional moment, Te Tiriti takes its rightful place in the very heart of the

3 My thanks to Charmaine Gupta for this conceptualisation of psychotherapy in Aotearoa New Zealand (C. Gupta, Service Clinical Director, Te Whatu Ora, Te Toka Tumai, Auckland, in a panel discussion on the topic: "In times of high demand and stretched resources, what place does long-term psychotherapy have in the public health sector?" at the Opportunities for Psychotherapy in Te Whatu Ora, Health New Zealand, Professional Development Day for psychotherapy staff and students in Te Whatu Ora, Te Toka Tumai, Auckland and Waitematā, on 14 November 2022).

4 In 2001, the government established 21 DHBs; however, in 2010 the Otago and Southland DHBs merged to form the Southern DHB.

health system of Aotearoa New Zealand. The aim is for nothing less than improved and equitable health outcomes for Māori, which is something the DHBs did not achieve. DHB mental health and addiction services were dominated by medicalised, risk-based models of practice that encourage short term, individualistic, 'tick box' interventions to manage episodic care, often cyclically with the same tāngata whai ora (Durie, 1994), public health service users. These practices do not fit taha Māori understandings of health and wellbeing (Awatere, 1981; Durie, 1985; Keelan, 1986). Placing taha Māori understandings at the centre of mainstream services is one of the challenges the new health system faces. With challenge comes opportunity, and this is where psychotherapy has the potential to contribute equitable mental health and addiction solutions.

Psychotherapy does what clinical psychology and psychiatry — the dominant disciplines in public mental health and addiction services — generally do not do, which is to treat people as whole beings with interrelated mental, emotional, physical, relational, social, political, and spiritual realities. It builds a profound alliance between the psychotherapist and the person they are working with to enable broad, deep work, sometimes over lengthy periods, to achieve lasting change. It invites complexity, including the unconscious aspects of self, and seeks to integrate all parts of a person humanely rather than narrowing clinical focus to behaviours or cognitions to relieve symptoms.

The promotion of psychotherapy in Aotearoa New Zealand's new health system invites new policy work on the part of the Ministry. This paper aims to provide the Ministry and its operational partners, Te Whatu Ora and Te Aka Whai Ora, with perspectives from registered psychotherapists on how DHB mental health and addiction services have come to measure outcomes the way they do, how this influences the way services are provided, the difficulties and deficits that arise from such provision, and the opportunities psychotherapy provides should they choose to respond more wholistically to the challenges that our mental health system is currently facing.

In the remainder of this paper, I present data and or discussion on the following:

Section 1: A brief account of psychotherapy, including indigenous psychotherapies, and mental health and addiction services in Aotearoa New Zealand.

Section 2: A 2022 national DHB psychotherapy workforce survey.

Section 3: A report on the Psychotherapy and Public Worlds panel convened at the NZAP conference in 2022.

Section 4: Statistics and commentary on the psychotherapy workforce in Aotearoa New Zealand based on data collected by PBANZ.

Section 5: Opportunities and challenges presented to psychotherapy in Aotearoa New Zealand by the new health system.

Section 1: Psychotherapy in mental health and addiction services in Aotearoa New Zealand

Psychotherapy's heyday in Aotearoa New Zealand's mental health and addiction services probably occurs in the therapeutic communities nestled in large public mental hospitals between the 1960s and the late 1980s before a wave of deinstitutionalisation sweeps the Western world, bringing that era to a close by the early mid-1990s (Brunton, 2003; McNeish, 2017).[5] By then, the Fourth National Government is implementing a market-driven approach to the provision of health services by turning public hospitals into Crown Health Enterprises (CHEs) to be managed by business people whose salary bonuses are linked to the return of profit on the Crown's 'investment' in the health market (Cooper, 1994; Kelsey, 1995; Upton, 1991). With competitive market forces determining the viability of one service over another, individuals, organisations, and professions seek to position themselves to take advantage of market trends or, where possible, to directly influence those trends. In mental health, psychiatrists' medical primacy and legislative powers ensure they retain control in the clinical hierarchy, while among the allied professions clinical psychologists establish the New Zealand College of Clinical Psychologists in 1990 to formalise and expand their workforce's capacity to implement the emerging psychological paradigm of 'evidence-based practice'. This paradigm develops distinct theories, postulates, research methods, and standards for what constitutes legitimate contributions to clinical knowledge and practice, including the certification and credentialling of practitioners and the accreditation of training programmes in the mental health marketplace.

Despite the return to a not-for-profit national health system in 1997 and the subsequent establishment of 21 DHBs by the incoming Labour-Alliance Coalition Government in 2001, managerialist priorities that emphasise risk monitoring and 'tick box' outcomes predominate in the health system for the next 20 years, subjugating the health needs of the most vulnerable New Zealanders who cannot afford to access a wider range of services in the private sector. These priorities predispose DHBs to employing short-term, tightly focused, individualistic, manualised interventions, centred within the purview of clinical psychology, to meet the increasing demand for mental health services; however, "the expansion of those services and treatments is not leading to improvements in mental health at a community level" (Mulder et al., 2022, p. 90). This may be because evidence-based practice marginalises political context and produces healthcare models that fail to promote equity, sustainability, or to respond adequately to emerging healthcare challenges (Berg et al., 2022).

In the meantime, psychotherapists in Aotearoa New Zealand are being trained broadly in the amelioration and resolution of mental health problems, including psychiatric disorders, by bringing psychodynamic, wholistic, and systemic thinking, grounded in theories of human development, to bear on their clinical assessments, formulations, and practices (ADHB, 2020). Psychotherapists seek to integrate people's mental, emotional, and physical wellbeing, their wairua and spirituality, their relationships with whānau, family, friends, and nature, and their sociopolitical lives. By viewing people as embedded in these wide-ranging contexts, psychotherapists may orient to working for longer term, deeper change with people, which

5 In McNeish (2017), see chapter entitled: John Saxby (pp. 5-110) for descriptions of innovative psychotherapy developed and practiced within the therapeutic community at Tokanui Psychiatric Hospital during the 1980s.

may in turn lead to them being anecdotally critiqued as less time efficient than episodically focused treatments. Furthermore, with the current ideological focus on evidence-based practice "there has been a growing sense that psychodynamic[6] [psychotherapy] concepts and treatments lack empirical support or that scientific evidence shows that other forms of treatment for mental health issues are more effective" (Lummis, 2019, p. 1).

If this sense is real, then it is not accurate. Reputable research, including meta-analyses, finds psychotherapy to be as or more effective and efficacious over similar time frames as currently more favoured treatments, such as manualised cognitive approaches (see: Cuijpers et al., 2013; Gaskin, 2014; Leichsenring & Steinert, 2019; Mensi et al., 2021; Munder et al., 2019; Shedler, 2010), including, for example, the use of short-term psychodynamic psychotherapy to treat preadolescents and adolescents affected by psychiatric disorders (Mensi et al., 2021).

Kaupapa Māori psychotherapies

The adverse effects on Māori health and wellbeing resulting from the Crown's attempts to eradicate kaupapa Māori healers and their traditional health knowledges through the Tohunga Suppression Act (1907),[7] and other punitive assimilative strategies, are visible in the health inequities that persist in Aotearoa New Zealand today. During the Māori cultural renaissance of the early 1980s, the kōrero of Māori elders on marae around the country revived kaupapa Māori concepts of health, which Mason Durie documented as the four cornerstones of Māori health (1985) or Te Whare Tapu Whā (1994), namely, wairua (spiritual), whānau (family), hinengaro (mental), and tinana (physical). Other Māori psychotherapies also appear in the literature, including Whai Ora (Rankin, 1986), Powhiri Poutama (Huata, 1997), Te Wheke (Pere, 1997), Paiheretia (Durie, 2003), Whanaungatanga (Huriwai et al., 2001; Lyford & Cook, 2005), whānau-based interventions (Durie, 2005), the Meihana Model (Pitama et al., 2007), whakapapa narratives and whānau therapy (Swann et al., 2013), Whai Tikanga (McLachlan et al., 2017), and collaborative indigenous mental health therapies (NiaNia et al., 2017).

From these practices, the tikanga or correct procedures for psychotherapy from taha Māori perspectives can be seen to involve the following:

- Manākitanga: expressions of aroha, hospitality, generosity, and mutual respect build unity through humility and giving;

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6 "*Psychodynamic psychotherapy or psychoanalytic psychotherapy* [terms used interchangeably] refers to a range of treatments based on psychoanalytic concepts and methods that involve less frequent meetings and may be considerably briefer than *psychoanalysis* proper. The essence of psychodynamic psychotherapy is exploring those aspects of self that are not fully known, especially as they are manifested and potentially influenced in the therapy relationship. […] Seven features reliably distinguish psychodynamic therapy from other therapies, *as determined by empirical examination of actual session recordings and transcripts*" (Shedler, 2010, p. 99, emphases in original), namely: (1) focus on affect and expression of emotion; (2) exploration of attempts to avoid distressing thoughts and feelings; (3) identification of recurring themes and patterns; (4) discussion of past experience/developmental focus; (5) focus on interpersonal relations; (6) focus on the therapy relationship; and (7) exploration of wishes and fantasies (Blagys & Hilsenroth, 2000).

7 The tone of the Act is well represented in its opening statement: "Whereas designing persons, commonly known as tohungas, practise on the superstition and credulity of the Maori people by pretending to possess supernatural powers in the treatment and cure of disease, the foretelling of future events, and otherwise, and thereby induce the Maoris [sic] to neglect their proper occupations and gather into meetings where their substance is consumed and their minds are unsettled, to the injury of themselves and to the evil example of the Maori people generally" (p. 26). The Act is not repealed until 1962.

- Whanaungatanga: rights and reciprocal obligations that recognise, bind, and affirm individuals and their contributions to collective interdependence;
- Kaitiakitanga: spiritual and cultural guardianship of te ao Māori, and active responsibility for resources and people that promotes growth and development;
- Rangatiratanga: the attributes of rangatira, including leadership with humility, generosity, altruism, diplomacy, and the promotion of self-determination;
- Wairuatanga: belief in a spiritual existence alongside the physical, with connections to atua Māori maintained through daily practices in the everyday lives and worldview of Māori. (Drawn from Mikahere-Hall et al., 2019)

The growing body of literature generated by Māori psychotherapists and based on kaupapa Māori research methods, locates kaupapa Māori psychotherapies deeply within te ao Māori (Fleming, 2018; Hall, 2013; Mildon, 2016; Morice & Fay, 2013), where:

> The need for a Māori psychotherapy is relatively obvious to anyone who is Māori. The purpose of a Māori psychotherapy is no different from the purpose of Pākehā psychotherapy for Pākehā or tau iwi. However, as long as psychotherapy remains monocultural, it will remain unable to meet the needs and aspirations of Māori practitioners and Māori clients. (Morice, 2009, p. 15)

The reality for psychotherapists working in the DHBs

Psychotherapists employed in DHB mental health and addiction services are generally required to be generic keyworkers who are allocated caseloads of service users and who work in clinical teams predominated by other generic keyworkers, and this situation may lead to frustration at not being able to practise the discipline for which they have trained. Specialist psychotherapy services have been closed or 'reformed' around the country. In some DHBs, child psychotherapists are not offered supervision with another child psychotherapist (J. Bruce, Treasurer, New Zealand Association of Child and Adolescent Psychotherapists (NZACAP), personal communication, September 7, 2022). As pressure mounts on services to reduce waiting lists, imported clinical management systems, such as CAPA,[8] direct clinical focus onto short-term interventions that aim to turn the majority of service users around near the door. Subsequently, psychotherapists either adapt by genericising their work and utilising prescribed evidence-based practices, such as, cognitive behavioural therapy (CBT), dialectical behaviour therapy (DBT), acceptance and commitment therapy (ACT), or mindfulness processes, or they step away into private practice.

With the advent of a new national health system in Aotearoa New Zealand on 1 July 2022, the Ministry is now "stepping into a stronger national leadership role for mental health and addiction workforce development" (R. Shearer, personal communication, April 27, 2022). It may assist the design and commissioning of mental health and addiction services to have accurate baseline data on how many registered psychotherapists are employed in DHBs throughout Aotearoa New Zealand immediately prior to the health system change. The following national DHB psychotherapy workforce survey is an attempt to provide that data.

8 CAPA: Choice And Partnership Approach (Fuggle et al., 2016; Pajer et al., 2022). Also, see: https://wharaurau.org.nz/CAPA for a New Zealand perspective.

Section 2: 2022 national DHB psychotherapy workforce survey

Survey method

The survey utilises six quantitative questions and one qualitative question to ask:

1. How many registered generic psychotherapists are employed in each DHB?
2. What is the total FTE of registered generic psychotherapists employed in each DHB?
3. How many registered child and adolescent psychotherapists are employed in each DHB?
4. What is the total FTE of registered child and adolescent psychotherapists employed in each DHB?
5. In what services are registered psychotherapists employed in each DHB?
6. How many psychotherapy students are on placement in each DHB this year?
7. What comments do respondents wish to make about psychotherapy in their DHB?

A significant limitation of the survey, pointed out to me by a Māori colleague (personal communication, November 7, 2022), is the non-collection of data on ethnicity that might have indicated the level of lived Māori experience in the national DHB psychotherapy workforce and the likelihood of tāngata whai ora being exposed to cultural inequities. Such data might also assist the gauging of the success of any subsequent recruitment initiatives.

Implementing the survey involves contacting each DHB by phone to ascertain who the relevant person or persons might be to undertake or delegate its completion. This is most often the allied health director or equivalent, though professional leaders of psychotherapy and/or psychology, a mental health service manager, a nurse manager, and a social worker are also nominated by their respective DHBs. The survey is available for completion online via Google Forms, though half of all respondents reply via email or phone.

Survey results

Eighteen completed surveys covering all 20 DHBs[9] are received between the third week in February and the first week of March 2022, some four months before the arrival of the new health system. Thirteen DHBs make zero returns, meaning they do not currently employ any registered psychotherapists, and seven choose not to comment on psychotherapy in their DHB.

Questions 1–5: Registered generic psychotherapists and child and adolescent psychotherapists

The entire DHB psychotherapy[10] workforce in Aotearoa New Zealand is 20.6 FTE, the equivalent of one fulltime registered psychotherapist per DHB. This total breaks down to 11.1 FTE of registered generic psychotherapy (RP)[11] working in adult services (including one FTE

9 Capital and Coast DHB, Hutt Valley DHB, and Wairarapa DHB were collectively represented by MHAID, the regional Mental Health and Addiction, Intellectual Disability service launched in 2015 (Fairley, 2015).

10 This workforce comprises persons employed as registered psychotherapists. There are approximately six other DHB employees who qualify to apply for registration as psychotherapists but who are employed under another profession and associated registration framework, such as, in addiction services through the Addiction Practitioners' Association of Aotearoa New Zealand (DAPAANZ), or in social work through the Social Workers Registration Board (SWRB).

11 In this survey a registered generic psychotherapist (RP) refers to a psychotherapist registered by PBANZ under either the Psychotherapy Scope of Practice or the related Interim Psychotherapy Scope of Practice,

of vacancy) spread over 13 employees, and 9.5 FTE of registered psychotherapy with child and adolescent specialism (RPCA) over 14 employees. These results are tabulated below in Figures A and B, respectively.

Figure A: Registered generic psychotherapy FTE (with number of RPs) in all DHBs in Aotearoa New Zealand

DHB	FTE (Number of RPs)
Auckland	5.2 (7 RP)
Waitematā	3.0 incl. 1.0 vacancy (2 RP)
Southern	1.6 (2 RP)
Canterbury	1.0 (1 RP)
Capital & Coast, Hutt Valley, & Wairarapa	0.3 (1 RP)
Bay of Plenty	0
Counties Manukau	0
Hawkes Bay	0
Lakes	0
Nelson-Marlborough	0
Mid-Central	0
Northland	0
Tairāwhiti	0
Taranaki	0
South Canterbury	0
Waikato	0
West Coast	0
Whanganui	0

and who is working in adult mental or physical health services; whereas a registered child and adolescent psychotherapist (RPCA) refers to a psychotherapist registered by PBANZ under either the Psychotherapist Scope of Practice with Child and Adolescent Psychotherapist Specialism or the related Interim Psychotherapy Scope of Practice, and who is working in child and adolescent/youth mental or physical health services. Psychotherapists can be registered under an Interim Scope of Practice for up to five years while they complete 900 hours of postgraduate supervised clinical practice with weekly face-to-face clinical supervision for the first 24 months of practise and at least fortnightly thereafter, plus 120 hours of personal psychotherapy to complete full registration. In this survey, no differentiation is made between full and interim registration.

Figure B: Registered psychotherapy with child and adolescent specialism FTE (with number of RPCAs) in all DHBs in Aotearoa New Zealand

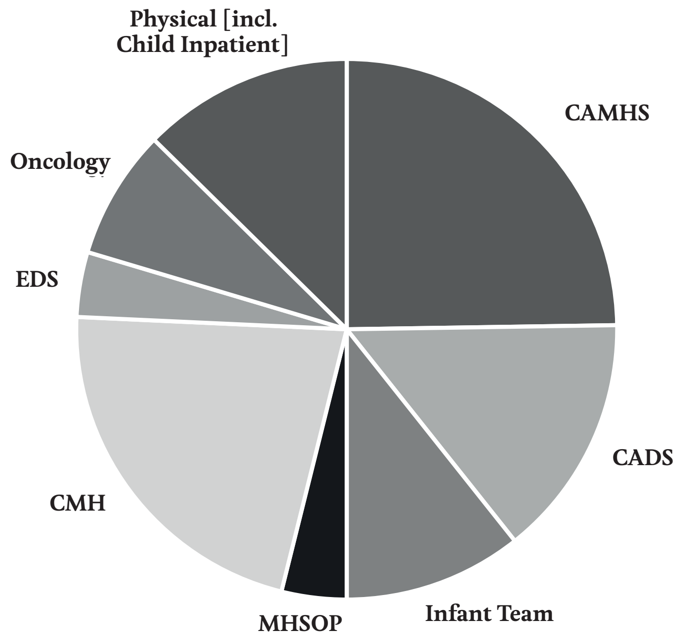
DHB	FTE (Number of RPCAs)
Waitematā	4.1 (5 RPCA)
Auckland	3.8 (6 RPCA)
Capital & Coast, Hutt Valley, & Wairarapa	1.6 (3 RPCA)
Canterbury	0
Bay of Plenty	0
Counties Manukau	0
Hawkes Bay	0
Lakes	0
Nelson-Marlborough	0
Mid-Central	0
Northland	0
Tairāwhiti	0
Taranaki	0
South Canterbury	0
Southern	0
Waikato	0
West Coast	0
Whanganui	0

On the following page, Figure C depicts the distribution of the 20.6 FTE of registered psychotherapy across services located in the five DHBs that report employing registered psychotherapists.

Question 6: Psychotherapy students

Only two DHBs provide clinical placements for psychotherapy students, namely, Auckland with 12 students and Waitematā with two. These DHBs are the most proximate to Auckland University of Technology (AUT) — though Counties Manukau DHB is also located within Auckland City and does not employ psychotherapists nor take psychotherapy students — whose Master of Psychotherapy is the only psychotherapy training programme in Aotearoa New Zealand seeking placements in the DHB context.

Figure C: Location of 20.6 FTE of psychotherapy by DHB service in the five DHBs who report employing registered psychotherapists



Question 7: Comments about psychotherapy made by DHB respondents

Comments by survey respondents about psychotherapy in their DHB fall into three main categories, namely, the need for more talking therapies[12] in both mental and physical health services, the widening of the pool of practitioners who can provide talking therapies beyond psychotherapists and psychologists, and the lack of awareness about how the psychotherapy workforce might be utilised in contemporary mental health and addiction services.

Presently, Covid-19 in both its short and long forms is focusing attention on the need for psychological services across the whole health sector, including physical health services.

> Long Covid, which has elements of ongoing anxiety and fatigue, alongside other physical manifestations, will put demand on a health service which is already stretched.

12 Talking therapy is a generic term for a variety of interpersonal methods that utilise speaking, listening, discussion, reflection, etc, to assist people to understand and make changes to their thinking, behaviour, and relationships in order to relieve distress and improve wellbeing.

> We need to be thinking what other services are required within the physical health space to work alongside clinicians when patients and whānau present with an array of symptoms. (Allied Health, Scientific and Technical Officer #1)

Increasing pressure on service provision is leading to practitioners not traditionally associated with talking therapies to train in DBT, CBT, ACT, mentalization-based therapy (MBT[13]), or single session therapy (SST), to work with individuals or lead therapy groups in mental health and addiction services.

> We have five nurse therapists working in our [...] programme. This team treats people with borderline personality disorder [...] and these nurses have been trained in [a group psychotherapy model] but are not registered psychotherapists. Another of our specialty services also employs a social worker, occupational therapist and two nurses [who] have training and experience in CBT but they are also not registered psychotherapists. Plus we have nurses trained in Maudsley Family-Based Therapy working in our Eating Disorders Service. (Psychology Professional Leader #1)

It seems counter-intuitive that broadening the capacity of mental health and addiction services to deliver talking therapies might marginalise the role of registered psychotherapists, yet this may be the case.

> We have in the past employed psychotherapists at the DHB; however, [we] have recently moved away from that. I think the issue around psychological support services to our community needs a complete revamp and we need to explore all options and opportunities and not just work with the current options, as the demand [for services] will never be able to be met by how we operate currently. I think it needs to extend beyond psychotherapists and psychologists, and include other mixes and options, including options tried elsewhere, like the UK. There is great opportunity, also, to upskill the wider workforce. Co-design with the community as well. (Allied Health, Scientific and Technical Officer #2)

Reference to the UK likely points to their Improving Access to Psychological Therapies (IAPT) programme (Clark, 2022) which began in 2008, a younger cousin to Australia's 2006 Better Access programme (Services Australia, 2022), with both national initiatives aiming to improve the treatment and management of mental illness through a network of trained talking therapy practitioners working at a local community level. Aotearoa New Zealand is also creating its own Big Community approach to wellbeing and community, as conceptualised in the Wellbeing Manifesto within *He Ara Oranga, Pathways to Wellness*, the report of the Government Inquiry into Mental Health and Addiction (2018, pp. 36–37, 90) and funded through the Labour Government's (2019) *Wellbeing Budget*.

"A key workstream in this [resulting] Access and Choice work programme is the

13 MBT is an integrative form of psychotherapy bringing together aspects of psychodynamic, cognitive-behavioural, systemic, and ecological approaches. See Bateman and Fonagy (2013) and their subsequent publications.

Integrated Primary Mental Health and Addiction (IPMHA) service [… that] provides easy access to mental wellbeing support in GP sites across the country" (Ministry of Health, 2021, np). Such support is to be provided by a new primary care workforce of Health Improvement Practitioners (HIPs) (Te Pou, 2022),[14] whose task is to help 325,000 people per annum with mild to moderate anxiety and depression by 2024 — approximately 6.5% of population coverage (Bastiampillai et al., 2019) — via brief-intervention consultations 'on the spot' as people present to GP practices. HIPs are practitioners registered variously under the Health Practitioners Competence Assurance Act (2003) (HPCAA) or by SWRB, DAPAANZ, or NZAC, and while registered psychotherapists are eligible via the first of these four broad gateways, the training experience in psychotherapy for thousands of other eligible registered practitioners could conceivably amount to the four days of face-to-face or eight half-days of online training required to begin practising as a HIP.

When we have an expanded workforce capable of delivering talking therapies, will we have lost sight of what psychotherapy offers that is distinct from the short-term, manualised, evidence-based practice so popular in medicalised and managerialised health services?

> [We] did have two [psychotherapists] several years ago in CAFS [Child and Family mental health Services] for 2-3 years but they struggled to work under our generally time limited model of care. Currently, [we] have two social workers with psychotherapy training working in CAFS as social workers. (Psychology Professional Leader #2)

It is as if there is no bona fide home for psychotherapy in the DHB mental health and addiction workforce because those services are controlled by medical doctors whose expertise is medication; patients are predominantly managed by nurses, occupational therapists, and social workers as generic keyworkers; clinical psychologists are the recognised specialists of talking-therapy treatments in the form of DBT, CBT, mindfulness and mentalisation; and psychotherapists do not easily fit into any of the above. Instead, they are often seen as offering a specialist 'procedure' within a rigid framework — such as when a child psychotherapist works in a playroom or an adult psychotherapist pursues medium- to long-term humanistic goals — rather than possessing a general knowledge that easily translates into a variety of skills fit for episodic care.

Perceptions of psychotherapists as lacking adaptability or needing more time than the health system can afford to undertake their specialist procedures, point to a lack of awareness or understanding about how the psychotherapy workforce could add value to contemporary mental health and addiction services.

> We see this [survey] as an opportunity to consider registered psychotherapists to be employed in our DHB. Ongoing shortages of clinical psychologists are problematic and the need for talking therapy is increasing. (Nurse Manager)

> We need to consider how we diversify our workforce to be able to provide choice and

14 Te Pou is a not-for-profit national workforce centre for mental health, addiction, and disability in Aotearoa New Zealand.

> increase capacity for the delivery of psychological therapies. (Allied Health Director)
> There needs to be greater awareness of the role of psychotherapists and how this workforce can be utilised. (Allied Health, Scientific and Technical Officer #3)

Diversification of the mental health and addiction workforce and the role of psychotherapy in the new health system are also matters of concern for NZAP members as they gather online — due to Covid-19 — for their annual conference from 1–3 April 2022. To stimulate informed thought and debate, a Psychotherapy and Public Worlds discussion panel is convened for an hour on the Saturday afternoon, with the invited inclusion of Robyn Shearer, the Ministry's Deputy Chief Executive and Deputy Director General of DHB Performance and Support.

Section 3: Psychotherapy and Public Worlds panel, NZAP conference, April 2022

The abstract for the panel session printed in the conference programme reads: "Psychotherapy exists in a rapidly changing mental health environment. This panel [...] discusses its impact on our prospects, vitality and livelihood" (NZAP, 2022a, 6). In addition to the constant stress of an evolving Covid-19 pandemic, that rapidly changing mental health environment includes the gathering pace of generational change in the national health system. On 1 July 2022, 15 months of intensive planning — mostly undertaken away from the glare of detailed public scrutiny due to the pandemic — takes effect when the existing 20 DHB regional governance structure is superseded by a new "single service" organisational partnership between the Ministry, as chief steward and kaitiaki, and two new entities: Te Whatu Ora, who take over the day-to-day services and functions of the DHBs, and Te Aka Whai Ora, who work alongside Te Whatu Ora "to improve services and achieve equitable health outcomes for Māori" (New Zealand Government, 2021, np).

Robyn Shearer represents the Ministry on the panel, whose roles in the new health system are policy, strategy, regulation, and monitoring, without the responsibility for funding and managing contracts. The other panellists are all NZAP members: Alayne Mikahere-Hall (Ngāti Whātua, Te Rarawa, Tainui, and a founding member of Waka Oranga National Collective of Māori Psychotherapy Practitioners), Kyle MacDonald, myself, and the panel Chair, John Farnsworth, who is also Chair of the NZAP Public Issues Committee.

John introduces the panel session by predicting it will be "pragmatic and outward looking, and concerned with the larger world in which psychotherapy takes its place", and Robyn's response, as the first invited speaker, is to affirm the roles of the Ministry and NZAP as partners in support of mental wellbeing in Aotearoa New Zealand at a time when the Ministry's health reforms "are focused on equity, person-centred care, increasing choice, and many more community solutions" (NZAP, 2022b).

Robyn gives an overview of the Access and Choice service delivery programme, noting that by the end of its roll-out approximately 60% of its workforce will be non-clinical, enabling the Ministry "to grow more options for people, have better reach out, and ultimately respond better to people's needs" (NZAP, 2022b).

In relation to the future of the current mental health and addiction workforce, Robyn

foresees new opportunities for psychotherapists in supporting emerging workforces associated with expanding the provision of talking therapy, for example, through training and supervision, "so you will play a pivotal role, and I'm looking forward to hearing from you about what opportunities you think exist in that regard and what part psychotherapists play in the [health] system now and going into the future" (NZAP, 2022b).

When the panel is invited to respond to Robyn's address, Kyle MacDonald advocates for expediting the recruitment of overseas trained psychotherapists and psychologists via immigration so that when Te Whatu Ora expands the talking therapy workforce it does not trade workforce quality for speed of establishment. Robyn confirms that the Ministry recognises Aotearoa New Zealand does not have the ability to grow its own workforce of mental health clinicians, which is why they are on the priority list for immigration; however, she does not know whether this goes beyond nurses and psychiatrists to include allied health and, specifically, psychotherapy.[15] She notes, as a related matter, the lack over many years of a "good workforce policy and having that longer term view of how we grow our capacity and capability across the sector." As Te Whatu Ora takes responsibility for the day-to-day issues in the new health system, the Ministry expects "to be able to focus on 'where are we going in the future', look at trends, look at what's happening internationally to help inform tertiary education and things like immigration as an opportunity" (NZAP, 2022b).

Alayne Mikahere-Hall also raises the issue of workforce development by acknowledging that Te Rau Ora [16] "has been working consistently hard in this space for a long time now," and asks Robyn what investment the Ministry will make towards the development of training for Māori and, potentially, for Māori psychotherapists. Robyn affirms the work of Te Rau Ora and the existence of funds in the Ministry's budget for such training, while also emphasising the importance of Te Whatu Ora investing in the Māori clinical workforce as part of its Te Tiriti partnership obligations rather than leaving that to Te Aka Whai Ora. In relation to Te Whatu Ora's kaupapa to pursue diversity in the mental health workforce, Alayne cautions that this may compound the existing problem of Māori voices [17] not being heard, though she welcomes the inclusion of Te Aka Whai Ora in this regard (NZAP, 2022b).

My [CW] questions for Robyn [RS] are informed by the 2022 national DHB psychotherapy workforce survey presented in Section 2 of this paper, and how the situation of psychotherapy might change under Te Whatu Ora.

CW: I'm aware of a survey I made recently around the 20 DHBs and there are 20 FTE of psychotherapy in the total DHB workforce, and they are in five DHBs only, so 75% of DHBs don't have a psychotherapist employed. Only two DHBs have a psychotherapy student. [...] My question to you is what will be the role of

15 See the subsection on overseas recruitment in Section 5 of this paper.

16 Te Rau Ora is a kaupapa Māori organisation dedicated to transforming Māori health and social service workforces to improve Māori health and wellbeing.

17 Mikahere-Hall adds that "the Māori voice is often the last or final voice at the decision making table. We should be there from the outset and consulted with independently as Māori, in a respectful Te Tiriti based engagement, irrespective of what our NZAP colleagues regard as best psychotherapy practice. [... T]he decision for NZAP to become a registered health profession was not inclusive of Māori. We were barely considered in the process. We had just arrived at the NZAP Council table to speak to Māori development within the professions and the establishment of Waka Oranga, when important decisions were being made about our professional future" (A. Mikahere-Hall, personal communication, December 15, 2022).

psychotherapy in Health New Zealand when the DHBs are gone, and [there is] that great need — as you say — for diversity, for person-centredness, and choice, yet there is an idea that psychotherapists have got to adapt to a new world, when actually we are relevant in the wider world currently, and will continue to be relevant. Really, I am wondering, in terms of the design of services and the commissioning of services, where the Ministry sees psychotherapy placed given those statistics?

RS: I think this is a longstanding issue about educating the people who are recruiting into those roles about the opportunities. [...] I think there's still a fairly traditionalist element in the recruitment of roles in many of the mental health services [...] where it tends to be nursing and psychiatry and some allied health, but dominated by nursing and psychiatry, and I think there is an opportunity for us [the Ministry] to be giving better guidance around: "If you have a vacancy, look for your opportunity to consider psychotherapy in the mix of people who could support communities or be part of a multi-disciplinary team approach." [...] I think there's a lot of policy work to do around that. In my view, it's still a shift we need to make around the type of roles in specialist mental health services that could be broadened out that are more helpful, and perhaps also, the enhancement of the community aspect, so [as] more people[/service users] are being driven out to the community, there needs to perhaps be a re-balancing of how many people[/clinicians] are employed in specialist mental health and how many are employed in primary [care in the] community. That's not going to be an easy thing because there's always lots of anxiety about [there being] not enough specialist mental health services. We have lots of vacancies, so it feels like there's a whole piece of work that needs to be done from a — if you like — a policy and innovation research perspective.

CW: Could I just follow that up with another comment, which again comes through the survey. There is quite a lot of hope for diversity [among survey respondents] and there are nurses, occupational therapists, and social workers being employed to run all sorts of mental health services: mentalisation, DBT, CBT, etc; so that when it comes to advertising for a mental health professional there is often, these days, quite a broad category of people who could fit in. [...] My concern is that there is a genericising of roles and what psychotherapy offers gets lost. So, [in relation to] the education of those in recruitment roles, it feels like there has already been education around diversity and somehow psychotherapy gets lost in that because there are all these other options.

RS: In response to that, if there's any advice or promotion from you as a network that could help us in describing and promoting the role, [...] Really happy to take that up because I do think it's about profiling what psychotherapy does, what's unique, and how you support people in their journeys, and the type of roles you are doing. I think it's really a great opportunity if we could work together on that — knowing

> that we're going through a whole lot of reform work [at the moment], but it would be really good, I think.[18]

Robyn's invitation for psychotherapists to advise the Ministry on policy matters relating to the role of psychotherapists in the mental health and addiction workforce creates opportunities for increasing both the presence of psychotherapy and the quality of public health in Aotearoa New Zealand. This paper is a response to that invitation. It attempts to contextualise the inherited DHB mental health and addiction workforce in terms of its ideological premises, practices, and pitfalls, and to promote psychotherapy as a Te Tiriti-honouring, culturally relevant, efficacious, effective, and humanising psychosocial treatment practice. In these respects, psychotherapy easily integrates within the cultural values emerging from the new health system.

If psychotherapists are to play a larger role in public health, the ongoing development of their workforce is required to ensure a sufficient number of practitioners are trained locally or imported from overseas and professional standards maintained. Statistical data on the psychotherapy workforce between 2008 and 2021 is presented in the following section, together with descriptions of initiatives that address issues relating to future workforce development.

Section 4: Psychotherapy workforce in Aotearoa New Zealand

The first attempt to formally organise psychotherapists in Aotearoa New Zealand into a workforce — in a broad sense of that term — goes back to the founding of NZAP in 1947 (Manchester et al., 1996). Over 60 years later, members of that Association "ceded our autonomy and self-determination to Government" regulation under PBANZ, "the regulatory authority and registration body for psychotherapists" (Fay, 2013, p. 32), as set out in Section 118 of the HPCAA. Since its inception in 2008, PBANZ has collected statistics on the national psychotherapy workforce and these are summarised overleaf.

Figures D and E depict the number of psychotherapists registered by PBANZ each year from 2008 to 2021. Starting with existing members of the profession who take up the opportunity for registration during the first two years, new registrations have steadied to between 21 and 37 per annum for the past decade. Notably, the number of registrations in the child and adolescent psychotherapy scope of practice are modest, with only nine new registrants over the past ten years, which is due to there being no training programme for a number of years. The existing programme at AUT is small and "should have greater [Government] support to ensure the longevity and success of the training, to increase the numbers of child psychotherapists who can potentially work and supervise clinicians in public mental health services" (J. Bruce, Treasurer, NZACAP, personal communication, September 7, 2022).

18 Also, see the appendix for additional notes provided by Robyn Shearer, dated 27 April 2022.

Figure D: Line chart of psychotherapists registered each year by PBANZ 2008-2021

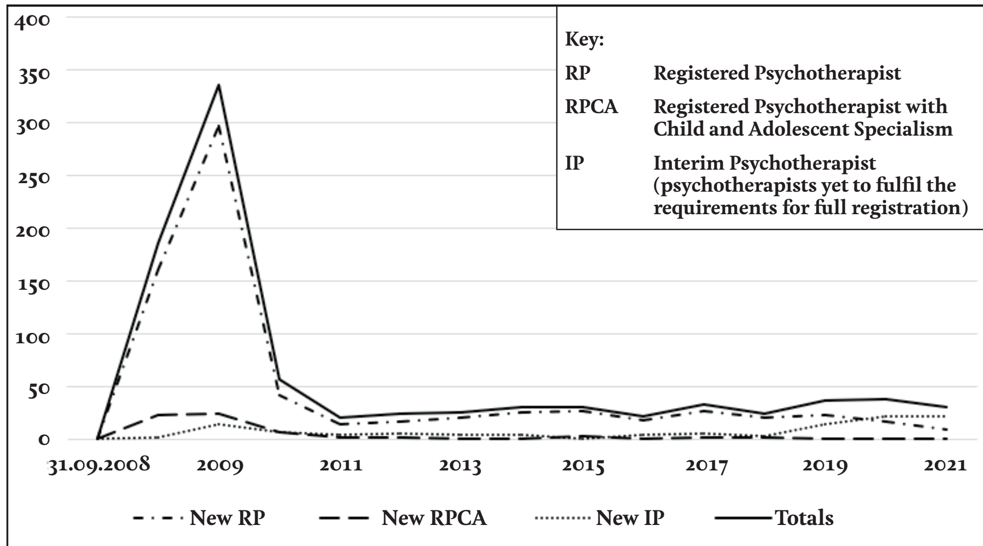


Figure E: Table of psychotherapists registered each year by PBANZ 2008-2021[19]

Year	New RP	New RPCA	New IP	Totals
Up to 31.09.08	0	0	0	0
01.10.08 – 31.12.08	161	23	1	185
2009	297	24	14	335
2010	42	7	6	56
2011	14	2	3	19
2012	16	2	5	23
2013	20	0	4	24
2014	25	0	4	29
2015	26	3	0	29
2016	18	0	3	21
2017	26	1	5	32
2018	20	1	2	23
2019	23	0	13	36
2020	16	0	21	37
2021	9	0	21	30
Totals	713	63	102	879

19 Data gratefully received from Janet Hay, PBANZ Kairēhita/Registrar, and her team in May 2022. Figures D, E, and F relate to each calendar year rather than PBANZ's Annual Practising Certificate year from 1 Oct to 30 Sept.

Figure F: Broad categorisation of qualification pathways for PBANZ registration 2008–2021[20,21]

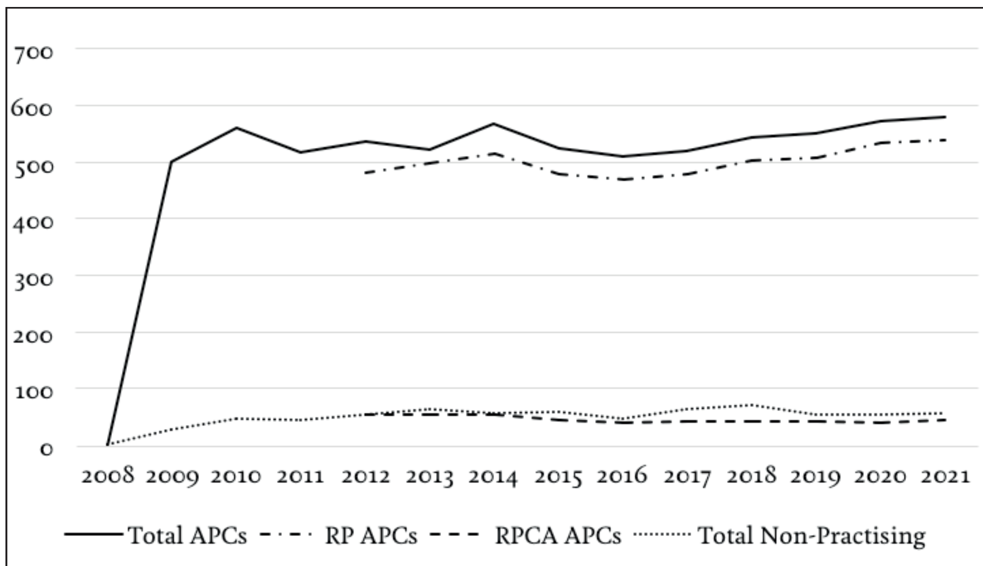
Qualifications	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Totals
PBANz	38	93	17	6	5	9	7	8	4	11	4	4	6	5	**217**
AIT/AUT Dip	36	73	9	-	1	-	-	-	-	-	1	-	-	-	**120**
ANZAP Dip	13	10	2	1	-	-	4	1	-	-	-	-	1	-	**32**
Ashburn Clinic	3	1	1	-	-	-	-	-	-	-	-	-	-	-	**5**
AUT MHS/MP AP	17	36	9	4	12	9	9	9	13	12	12	13	13	14	**182**
AUT MHS/MP CAP	2	-	-	1	-	-	-	1	-	-	-	2	6	5	**17**
Bioenergetics	1	2	1	-	-	1	-	-	-	2	-	-	1	1	**9**
Gestalt	9	23	5	4	3	1	4	5	1	2	-	2	1	1	**61**
Jungian	1	4	-	-	-	-	-	-	-	-	-	-	-	-	**5**
NZAP ACP	29	35	1	-	1	-	-	-	-	-	-	-	2	1	**69**
Psychoanalytic	1	3	1	-	-	-	-	-	-	-	-	-	-	-	**5**
Psychodrama	2	8	1	1	-	1	2	-	-	-	2	2	-	-	**19**
Psycho-synthesis	6	20	4	2	1	1	2	3	2	1	3	10	1	-	**56**
TA	17	19	1	-	-	2	1	2	1	4	1	3	6	3	**60**
UO PGDip CAP	10	8	3	-	-	-	-	-	-	-	-	-	-	-	**21**
UA PGC ICAMH	-	-	1	-	-	-	-	-	-	-	-	-	-	-	**1**
Totals	**185**	**335**	**56**	**19**	**23**	**24**	**29**	**29**	**21**	**32**	**23**	**36**	**37**	**30**	**879**

20 Excludes supervised clinical practice and personal psychotherapy experience requirements.

21 Abbreviations: PBANZ — Final assessment accredited or set by PBANZ 2008-2010 and comparable overseas qualification assessments; AIT/AUT Dip — Auckland Technical Institute/Auckland University of Technology, Graduate Diploma of Psychotherapy; ANZAP Dip — Australia and New Zealand Association of Psychotherapy, Diploma of Adult Psychotherapy; Ashburn Clinic — Ashburn Clinic Certificate of Completion; AUT MHS/MP AP and AUT MHS/MP CAP — Auckland University of Technology, Master of Health Science (now Master of Psychotherapy), with Adult, and Child and Adolescent pathways respectively; Bioenergetics — Certified Bioenergetic Therapist; Gestalt — Diploma of Gestalt Psychotherapy; Jungian — Accredited Jungian Analyst with ANZSJA and/or IAAP; NZAP ACP — New Zealand Association of Psychotherapists, Advanced Clinical Practice; Psychoanalytic — Membership of the New Zealand Institute of Psychoanalytic Psychotherapy; Psychodrama — Australian and Aotearoa New Zealand Psychodrama Association, Certified Psychodramatist; Psychosynthesis — Diploma in Psychosynthesis Psychotherapy; TA — Certified Transactional Analyst; UO PGDip CAP — University of Otago, Postgraduate Diploma in Child and Adolescent Psychotherapy; UA PGC ICAMH — University of Auckland, Postgraduate Certificate in Health Sciences in Infant, Child and Adolescent Mental Health.

Figure F tabulates the number of registrants coming through each available qualification pathway between 2008 and 2021. "In these times of upheaval and existential crisis," — states the NZAP Northern Branch's advertisement for an address to be given by Elizabeth Day, Head of Department of the AUT psychotherapy training programme — "the escalation of mental ill-health calls for an exponentially larger workforce, trained to support people in ways that fit time and place" (Northern Branch NZAP, 2022). AUT's response is to centre their work in Te Tiriti-honouring practices, draw on and broaden the research base of their training, and increase access to their programmes through nationalisation and by increasing student numbers at their Auckland base. The proposed nationalisation involves opening at least one new training site satellite to Auckland in 2024 for an additional 20–25 students, with clinical placements located around that satellite required by 2025. Current estimates for annually increasing student numbers for the next few years on the existing Auckland programme range from a 10% increase in the adult (generic) stream, to 20% in the child and adolescent specialism stream (E. Day, personal communication, August 22, 2022).

Figure G: Line chart of Annual Practicing Certificates (APCs) issued by PBANZ and non-practising registered psychotherapists 2008-2021[22]



The total number of APCs issued to registered psychotherapists and registered child and adolescent psychotherapists by PBANZ are shown graphically in Figure G. The net annual increase over the last 10 years is 75 (from 516 in 2012 to 581 in 2021), with the representation

22 Data on the total number of APCs issued and the number of non-practicing registered psychotherapists without an APC, is drawn from PBANZ's Annual Reports (2008-2021) for the period 1 October to 30 September each year. Data on the split between RPs and RPCAs is provided by PBANZ; however, such figures were not available for the period 2008-2011.

of the child and adolescent specialism decreasing from 9.1% (n = 47) to 7.7% (n = 45) in the same period.

The 2021 figures roughly equate[23] to there being 11 registered psychotherapists per 100,000 New Zealanders, as compared to 74 registered general practitioners, 1100 registered nurses, 72 registered clinical psychologists, 58 counsellors,[24] and 8 registered psychiatrists, where each of these comparative professions is recognised as being in a mental health and addiction workforce crisis by the Association of Salaried Medical Specialists/Toi Mata Hauora (2021).

"To protect the health and safety of members of the public" (HPCAA, 2003, Sec. 3.1) PBANZ is at work on a five-year strategy to expand access and choice to mental health treatments in Aotearoa New Zealand. It identifies two main strategies for doing so, namely, (1) a commitment to PBANZ's work reflecting Te Tiriti and responsiveness to tangata whenua, and (2) the equitable access to, and availability of, psychotherapy through workforce development. With respect to Te Tiriti, PBANZ actively engages in considering the needs of both tangata whenua whānau and tangata whenua psychotherapists, and its aim is for 50% of Board members to be tangata whenua. With respect to the psychotherapy workforce, PBANZ is developing an accreditation process for psychotherapy training providers that will enable existing 'grandparented'[25] providers to have their programmes gazetted, and for new training programmes to emerge. PBANZ is also reviewing its psychotherapist scopes of practice to ensure that specialisms reflect the current profession and take into account the needs of the public, including those relating to public mental health and addiction services (PBANZ, 2022).

It can be seen from the various statistics and commentaries above that psychotherapy is a relatively small professional discipline in Aotearoa New Zealand, but one with opportunities to take and challenges to meet in the newly emerging bicultural health system, and these are discussed in the section below.

Section 5: Opportunities and challenges

The mana[26] of psychotherapy

The new health system presents a generational opportunity for public mental health and addiction services to shift away from the DHBs' ideological paradigm of cyclic, risk-based, episodic modes of care, to more equitable, person-centred, diversified, accessible, and sustainable healthcare practices. As the epigraph to this paper conveys, the Ministry foresees psychotherapists playing an important role in shaping and contributing to that system. That the Ministry invites input and advice from psychotherapists is an indication of the mana of the latter; and indeed, it is a significant event when a person's mental wellbeing is

23 These figures have been calculated from workforce data available online from relevant professional bodies and dated between 2018 and 2021.

24 Counsellors are not regulated by legislation in Aotearoa New Zealand. NZAC offers a registration "for members who meet our rigorous training, qualification and professional development standards" (see: https://nzac.org.nz/). The "per 100,000" figure given above is based on NZAC having around 3000 members.

25 Here grandparenting refers to an exemption for specific psychotherapist training providers, past and present, in recognition that their training courses meet the requirements for registration until such time as PBANZ develops a new accreditation process.

26 Mana: "Prestige, authority, control, power, influence, status, spiritual power, charisma. Mana is a supernatural force in a person, place or object" (Moorfield, 2011).

wholistically supported and restored, perhaps lastingly, which is how psychotherapy has gained mana in Aotearoa New Zealand through its appropriate use over many decades. Psychotherapists stand in their mana when forging partnerships with the Ministry through their professional associations, NZAP and NZACAP, or as workforce training providers. The challenge is whether the voluntary leadership teams of these entities can sustain the expenditure of human and other resources necessary to represent their memberships in continuing dialogue, not only with the Ministry but also with Te Whatu Ora and Te Aka Whai Ora as clarity is gained about which policy and operational responsibilities sit with each organisation.

Te Tiriti o Waitangi

Psychotherapy can assist the new health system to be a good Te Tiriti partner. It can do this because psychotherapy's worldview of people's health and wellbeing appears to align more closely with te ao Māori than the individualism of psychiatry and clinical psychology. In responding to the dearth of psychotherapists employed in DHBs (as depicted in Section 2 of this paper), Te Aka Whai Ora advocates for the long-term benefits of psychotherapy:

> It would seem appropriate for all DHBs to employ at least one (if not more) psychotherapists, as the support they can offer tāngata whaiora would be critical and beneficial to *longer-term* wellness and hauora (improved health). (L. Cassin, Clinical Director, Oranga Hinengaro, Te Aka Whai Ora, personal communication, August 10, 2022; emphasis added)[27]

Moreover, NZAP has developed deep relational roots with Iwi Māori during several decades of difficult discussion about psychotherapists' conscious and unconscious racism, and these roots sustain an ongoing Te Tiriti partnership with the Waka Oranga National Collective of Māori Psychotherapy Practitioners. The perennial challenge is decolonisation and Te Mana Motuhake o te Iwi Māori — self-determination and control for Māori over their health and wellbeing — which has implications for the legal status of current and future kaupapa Māori practice, training, and accreditation pathways. While meeting its Te Tiriti responsibilities is still very much a work in progress for psychotherapy, its partnership experiences and those of its regulatory authority, PBANZ — who have set a five-year strategy that includes tangata whenua comprising 50% of its Board's membership — may usefully inform their contributions to broader discussion on cultural equity in the health system.

National mental health and addiction workforce policy

The aims of the new health system — to achieve greater equity, diversification, and person-centred care in public mental health and addiction services — would be enhanced by providing the option of psychotherapy to more tāngata whai ora, thus giving Māori the choice to access psychotherapy if they want to. The Ministry is offering to guide health recruiters toward psychotherapy and it envisages roles for psychotherapists in training and supervising community-based HIPs under the Access and Choice scheme; however,

27 At the time this quote was made, the regional hospital and specialist service entities in Te Whatu Ora had superseded the DHBs.

recruiters do not design national workforce policy and there are good reasons why psychotherapists have shied away from public health under the DHBs.

This appears to be a Ministry workforce policy issue, and in recognising this the Ministry is inviting psychotherapists to provide them with ideas and advice about how to promote psychotherapy. In effect, this is an opportunity for psychotherapists to market psychotherapy through such means as disseminating eye-catching research unique to the Aotearoa New Zealand context in contemporary media, such as television, radio, and Twitter — like Kyle MacDonald[28] does — and in promotional videos and self-help apps that feature real life and digital/cartoon formats.

This mahi is likely to fall largely on the psychotherapy associations and psychotherapy training providers who depend on market growth for survival; however, the promotion of psychotherapy in Aotearoa New Zealand has not been a straightforward issue (Tudor, 2011, 2012). Despite being motivated to have more psychotherapists employed in the public sector when lobbying the Ministry for registration 20 years ago (Bailey & Tudor, 2020), the DHB psychotherapy workforce survey in Section 2 of this paper gives reason to wonder whether enough has been done to promote psychotherapy since. Among modality training, the gestalt, self-psychology, and psychosynthesis institutes are currently without sufficient faculty or trainees to be active; while practitioners newly certificated in psychodrama, transactional analysis, and bioenergetics do not necessarily seek psychotherapy registration. These dynamics present further challenges to public health policy; namely, to extend its diversification more widely so that these readily sought after modalities within the private sector *are also made available within the public sector.*

Other workforce-related opportunities include undertaking local mental health and addiction needs analyses to determine, among other strategic matters, whether a review of the widespread closure of specialist psychotherapy services around the country is required. For example, person-centred care means matching treatment with needs, which could include making greater provision for long-term, specialist psychotherapy with particular populations of service users. The provision of short-term psychotherapy in physical health settings, such as immunology, cardiology, and sexual health is another workforce diversification option.

Psychotherapy workforce development

"One of the obvious brakes on the number of psychotherapists available to work in [public health] is the very limited opportunities for training through current tertiary institutions" (L. Holdem, Past President, NZAP, personal communication, August 15, 2022). There are signs those brakes might be easing. PBANZ is developing training standards that provide opportunities for both current and new training providers. AUT aims to nationalise its psychotherapy training courses through satellite centres, the first opening in 2024. NZAP's Academy (NZAP, 2022) is almost ready to launch its online learning community, which will include training workshops suitable for HIPs and other mental health providers. The opportunities that new or expanded psychotherapy training programmes offer public

28 See Kyle's *New Zealand Herald* column, Mind Matters, at https://www.nzherald.co.nz/author/kyle-macdonald/, his co-hosting of The Nutters Club on Newstalk ZB at https://thenuttersclub.co.nz/tags/kyle-macdonald, and his Twitter feed at https://twitter.com/kylemacd.

health rely on the health system making psychotherapy student practicum placements and psychotherapy-trained placement supervisors readily available throughout the country to encourage training providers to set up around regional public health services. An incentive for the health system is that the recruitment of students into postgraduate public health career positions is enhanced through them bonding with the teams they complete their placements in. Alternatively, students could be paid a financial bond during their clinical placements to secure their services for a minimum time following the completion of their training.

Overseas recruitment

The former Long Term Skill Shortage and Essential Skills work visa schemes have been replaced in the past year by an Accredited Employer Work Visa framework. Positions must have been unsuccessfully advertised in Aotearoa New Zealand before being eligible for overseas recruitment. Psychotherapy is included with psychiatry, clinical psychology, nursing, occupational therapy, and general practice, as a Tier 1 Straight to Residence role among Immigration New Zealand's Green List roles.[29]

The Ministry of Health is currently developing a national Health Immigration Service, with close ties to Immigration New Zealand, to handle overseas recruitment for the whole health system. Given the traditional strength of psychotherapy in Australia, the United Kingdom, South Africa, the United States, France, Germany, and Canada — who are seven of the top ten sources of migration to Aotearoa New Zealand over the past ten years[30] — the odds are that there is a significant pool of experienced psychotherapists who are ready to bolster our local workforce.

Concluding comments

The opportunities and challenges highlighted in this paper are not exhaustive. They are intended to stimulate discussion and action to aid the expansion of psychotherapeutic services in Aotearoa New Zealand's new health system. In my opinion, it is no exaggeration to say that by looking back to the origins of our bicultural statehood to be able to see forward to the health of future generations — ka mua, ka muri — the Government's vision for equitable transformation in a constantly changing healthscape is remarkable. It is another significant step towards a more just society where the health and wellbeing of everyone living in Aotearoa New Zealand is of equal importance. And what role will psychotherapy play in this collective healing? We wait to see.

29 "Psychotherapy: ANZSCO 272314, Tier 1 role eligible for straight to residence. Industry: Health and social services. To be eligible you must be working for an accredited employer or have a job offer from one. If you meet all the visa requirements you can apply for a Straight to Residence Visa now. [...] Qualifications, registration or experience required: You must have NZ registration with the Psychotherapists Board of Aotearoa New Zealand." See: https://www.immigration.govt.nz/new-zealand-visas/apply-for-a-visa/tools-and-information/work-and-employment/green-list-occupations

30 Source: http://infoshare.stats.govt.nz/#

Appendix

The following notes were provided by Robyn Shearer of the Ministry on 27 April 2022:

We need a robust, expanded, and diversified workforce to deliver initiatives to enhance mental wellbeing. As pointed out in *He Ara Oranga* [Government Inquiry into Mental Health and Addiction (2018)], "All the dreams of the Inquiry will come to naught if we don't have a workforce."

We've taken a "whole of workforce" approach focusing on growing the existing workforce, developing new workforces, and supporting and upskilling the current workforce. This applies to workforces in targeted prevention programmes, and both primary and specialist mental health and addiction services.

Some of the approaches we are taking are:

Strengthen the national strategic leadership

The Ministry's Mental Health and Addiction Directorate has stepped into a stronger national leadership role for mental health and addiction workforce development, working with other government agencies and also with the four national mental health and addiction workforce development centres.

Growing and upskilling mental health and addiction workforces

New investment includes a focus on expanding training and development, equity initiatives for people and groups which have poorer outcomes, and increasing the number of people entering the mental health and addiction workforce. Examples of these initiatives include:

- Increasing the number of clinical psychology interns from 12 to 28;
- Doubling the number of scholarships for Māori and Pacific studying towards a mental health and addiction career;
- Increasing the numbers able to access the New Entry to Specialist Training;
- The new MHA nursing campaign we launched recently.

We are also looking at upskilling opportunities for areas such as talking therapy — working with a wide range of providers, including the University of Auckland, the University of Canterbury, Te Rau Ora, and Te Pou to broaden the skillset of our existing workforce. We have funded ten post graduate courses covering talking therapies and brief interventions and a Kaupapa Māori talking therapies training.

Changing the workforce mix and models of care

Through the Access and Choice programme, we are embedding the support workforce, including peer support workers, cultural support workers, and health coaches, to work alongside the clinical workforce in primary mental health and addiction services.

By the end of the rollout, a significant percentage of the workforce delivering Access and Choice services will be non-clinical workers. This shift will help services to grow more quickly, reach more people, and ultimately better respond to people's needs.

New initiatives and innovations

We will continue to expand beyond traditional workforces, building understanding of mental wellbeing for staff across other government agencies. For example, we have a Request for Proposal on GETS at the moment for Maternal and Infant Mental Health Competency training for the broader workforce. This will be available to both mental health and addiction staff and to the wider workforce such as Whānau Ora.

We are working with the New Zealand Association of Counsellors on processes to accredit individual counsellors to work in MHA services, and hope for this to be in place later this year.

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Research and practice: Contributions to the discipline of psychotherapy

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Abstract
This article reports on research into 25 dissertations written by students in the Master of Psychotherapy programme at Auckland University of Technology in the two years 2021 and 2022. The article focuses specifically on the contribution that these dissertations make to the discipline area. This is contextualised with reference to three gaps, or perceived gaps: between research and practice, researchers and practitioners, and publishing and reading. Based on an empirical-deductive approach to the analysis of the dissertations reviewed, the article reports these contributions; assesses their tone; and suggests that, while the sections of the dissertations regarding these specific contributions are varied and, in some cases, limited, the students/researchers make some important points about the discipline area of psychotherapy with regard to practice and education/training.

Whakarāpopotonga
He pūrongo tēnei mō te rangahautanga i ngā tuhingaroa e rua tekau mā rima a ngā tauira i roto i te akomanga hotaka Paerua Whakaora Hinengaro i te Whare wānanga Hangarau o Tāmaki-makaurau o ngā tau 2021 - 2022. Ko te aronga, ko te koha tau mai a ēnei tuhingaroa ki te kaupapa o tēnei wāhi. Ka whakahāngai tōtikahia atu te tirohanga ki ngā puare e toru, puare pōhewa rānei: i waenga i te rangahau me te mahi, ngā kairangahau me ngā kaiwhakaora, te tānga me te pānuihanga. Ko te tūāpapa ko te tirohanga mai i runga ki raro hai momo tātarihanga i ngā tuhingaroa i whakamātauhia, ka kōrerohia ēnei koha; ka aromatawaia ō rātau āhua; ka kī tērā pea, ahakoa te rerekē o ngā wāhanga o ngā tuhingaroa o te whakataunga whiwhinga, ā, i ētahi he iti noa, e puta ake ana i ngā tauira/kairangahau ētahi whakahau tino

Francis, J., & Tudor, K., (2022). Research and practice: Contributions to the discipline of psychotherapy. *Ata: Journal of Psychotherapy Aotearoa New Zealand*, *26*(2), 61–89. https://doi.org/10.9791/ajpanz.2022.10

hira mō te wāhanga o te Whakaora Hinengaro pā nei ki te whakaharatau me te mātauranga/ whakangungu.

Keywords: psychotherapy; dissertations; discipline; profession; research–practice gaps.

Introduction

This article reports on research conducted by the authors into the contribution that Master dissertations make to the discipline field of psychotherapy in Aotearoa New Zealand. In the first part of the article, we frame the research in the context of discussions in the field and the literature about the perceived gap between research and practice, and the researcher and practitioner, as well as that between publications (some of which are inaccessible to the profession) and the practitioner/reader. In the second part of the article, we report on the research itself: summarising the dissertations reviewed; and analysing the contributions in terms of their focus (colleagues, education/training providers, etc.) and tone (in terms of recommendation, suggestion, statement direction, and non-directive statement), as well as offering some discussion with regard to the outcome of the research.

Context

The first part of this article discusses and address three gaps — or perceived gaps — between research and practice.

The research–practice gap

In most if not all practice disciplines, there is a perceived gap between research and practice, a situation which is no less true in psychotherapy (Fourie, 1996; Lilienfeld et al., 2013; McLeod, 2003; Moodley, 2001; Morrow-Bradley & Elliott, 1986; Owenz & Hall, 2011). Over the years, this has been reflected in the relative lack of engagement of education/training programmes with research — which suggests that there may also be something of a research–training gap — with the result that students/trainees lack and feel their lack of knowledge about research in the field (Widdowson, 2012).

In Aotearoa New Zealand, there are a number of programmes that offer an education/ training in psychotherapy to qualification, all of which require some written work in order to complete the course or programme, but only some of which require students/trainees to engage in research (see Table 1).

From this we can see that research is only referred to in four programmes and only forms a significant part of formal study in one programme, which, not surprisingly, is the one programme based in a tertiary educational institute. However, what is striking, at least to us, are the references in these documents to “case study”.

The development of psychotherapy is founded on case studies, from Freud (1901/1953; 1909/1955; 1911/1958) onwards, including, notably, Watson (Watson & Rayner, 1920) and Rogers (1942), who published the first fully recorded, transcribed and published psychotherapy case of “Mr Bryan”. However, as Tudor (2018) observes:

Table 1: Psychotherapy education/training programmes available in Aotearoa New Zealand and their research components

Qualification/ Programme	Institution	Written requirements/ Research component	Notes
Accredited Jungian Analyst	Australia New Zealand Society of Jungian Analysts, International Association for Analytic Psychology		Students are required to produce a project and long case study.
Accredited Psychoanalyst	International Psychoanalytical Association (IPA)	All training groups must complete "research and organizational tasks" (IPA, n.d., Appendix, part B, para 22).*	The extent of the research component of the training is unclear.
Certified Hakomi Therapist	International Hakomi Institute (USA)		Students are asked to engage in a systematic study of experience, though there is no clear requirement in the curriculum to complete a research component.
Certified Bioenergetic Therapist	New Zealand Society for Bioenergetic Analysis		Trainees need to complete experiential and written assignments.
Certified Transactional Analyst (Psychotherapy)	International Transactional Analysis Association (ITAA)	Trainees are required to complete a written examination (24,000 words) which includes a case study (8,000 words), and six of 13 essays, one of which asks the candidate to "Describe a research project you are aware of or have been involved in and discuss the implications for TA theory and/or practice" (ITAA Board of Certification, 2022, p. 16).	This essay is optional, though TA associations in some jurisdictions (e.g., the UK) have made it mandatory for those candidates seeking (voluntary) registration as psychotherapists.
Certified Psychodramatist	Australia New Zealand Psychodrama Association		Trainees are required to write a thesis (of the length of a journal article), which is expected to be an original contribution to the psychodrama literature, based on the trainee's experience of applying psychodramatic theory and methods to an area of clinical practice.

Diploma in Adult Psychotherapy	Australia New Zealand Association of Psychotherapy		Trainees are required to produce essays pertaining to clinical work throughout the course and are required to produce “an 8,000 word treatise” on a topic chosen by the trainee.
Diploma in Psychosynthesis Psychotherapy	Psychosynthesis South Pacific		Course currently under development.
Master of Psychotherapy **Master of Psychotherapy (in Child & Adolescent Psychotherapy)**	Auckland University of Technology (AUT)	One research course (15 points, i.e., 150 hours’ study), assessed by two assignments; and one dissertation (45 points) of c. 15,000 words (AUT, 2022a).	For details, see discussion below.
Membership	New Zealand Institute of Psychoanalytic Psychotherapy		Information unavailable.
The Advanced Theory of Psychotherapy	Ashburn Clinic	Students are asked to research and write “a focused thematic presentation” (Ashburn Clinic, 2022, p. 11).	This training programme takes the form of a paid apprenticeship.

*Note: In the IPA, different training functions are organised as “groups”, not as an individual status or function. The groups are: Admissions Group, Supervision Group, Teaching Group, and Analysis Group, each of which is charged with conducting one specific aspect of training. Analysts request admission to any one of them, but can be members of only one group at a time. (IPA, n.d., Appendix, part A)

> … it is also clear that, as a research method, the case study is most vulnerable to the criticisms of its subjective bias from the dominant research traditions of medicine/psychiatry and psychology, as well as its apparent lack of verification and generalisability, both of which are considered problematic and even unethical. In terms of levels of evidence for intervention — and funding — it is equally ill-considered. (p. 176)

Tudor goes on to suggest two responses to this vulnerability: firstly, to assert that, by and large, psychotherapy operates from a different paradigm than medicine and psychology, and, therefore, to reclaim the methodologies that support this (e.g., Fourie, 1996); and, secondly, to develop the case study as a form of research, thereby substantiating column 3 of Table 1 (see Hillard, 1993; McLeod, 2003; Thomas-Anttila, 2015; Wall et al., 2017). Neither of these are easy as they run counter to the current dominance of empiricism in research in psychology and health, and its gold-standard method, that of randomised controlled trials — but both are important if psychotherapy is to distinguish and promote its particular contribution(s). Fourie (1996) argues that the gap or discontinuity between research and clinical practice is epistemological, i.e., one based on different theories of knowledge,

namely those based on realism, which asserts that there is a reality and a truth out there, independent of the observer, and others based on constructivism, which asserts that what is observed is constructed by the observer and the observed. He goes on to suggest that, by definition, a constructivist perspective closes the research–practice gap (see also next section).

The programmes represented in Table 2, as well as others that are no longer offered (see Tudor et al., 2013) predate the registration of psychotherapists in 2009. When the Psychotherapists Board of Aotearoa New Zealand (PBANZ) came into being in 2007 (as a Responsible Authority under the Health Practitioners Competence Assurance Act 2003 [HPCA Act), it gained the power "to prescribe the qualifications required for scopes of practice within the profession, and, for that purpose, to accredit and monitor education institutions and degrees, courses of study, or programmes" (HPCA Act, Section 118(a)). To that end, the PBANZ conducted a series of consultations about the accreditation of training with the result that, last year, it published a document on its Accreditation Standards (PBANZ, 2021) by which programmes will be accredited from 2023. Its Accreditation Standards contains the following references to research:

- As one of four principles guiding the formation of its accreditation standards: "The Board seeks to support the growth and vitality of psychotherapy as a relational, therapeutic health practice including profession-specific theory and academic research" (p. 3).
- As one of its education and practice standards, that trainees will be able to "critically evaluate and utilise psychotherapy research and literature to inform their practice" (p. 7).
- As a distinct standard on Rangahau/Research, that:

> As part of their training/supervision, trainees will develop the capacity to evaluate and critically reflect on psychotherapy-related research and apply it to their written mahi and clinical practice. Programme/pathway providers will describe how trainees gain access to current research material relevant to psychotherapy practice. (p. 10)

This is significant in two respects. The first is that that those education/training institutes which currently do not make research part of their programmes will need to do so; the second is that these requirements will help close the researcher–practitioner gap at source, i.e., from the beginning of the student/trainee's experience of learning/training.

The researcher–practitioner gap

One the effects of the research–practice gap is on the people involved, thus creating a gap or discontinuity and even some antagonism between practitioners and researchers. There is some evidence that clinicians do not tend to use research articles to inform their practice, or see the relevance of taking such an approach to their work (Castonguay et al., 2010; Cohen et al., 1986; McLeod, 2003; Morrow-Bradley & Elliot, 1986). This appears to be due to a certain scepticism about the value and relevance of research, and a criticism of research that it

ignores the complex realities of therapy (Morrow-Bradley & Elliot, 1986). In his discussion of this problem, McLeod (2003) suggests “reframing the relationship between researchers and practitioners” (p. 185). This includes acknowledging that, in the field of psychotherapy (and counselling), new ideas have tended to come from practitioners; and that, for researchers in psychotherapy, who are, by and large, also practitioners, there is no personal gap between research and practice. Further, if we consider that a crucial part of the process of psychotherapy is that the practitioner reflects on the process of psychotherapy, we may consider psychotherapy itself as a research activity, as, indeed, have a number of heuristic practitioners/researchers — see Beck (1989), Moustakas (1990), O’Hara (1986), Merry (2004), and Stevens (2006). To this, we would add that, as psychotherapy is predominantly if not exclusively a postgraduate profession, i.e., one based on graduate entry, and that postgraduate degrees usually require some element of research, most practitioners have some experience of studying, reviewing, and writing about research — and some have experience of conducting, analysing, writing, and publishing research.

One explanation as to why therapists do not utilise research, as identified by Morrow-Bradley and Elliott (1986) is that the research questions in published papers are not relevant to clinical practice. This suggests that we would do well to heed McLeod’s (2003) advice that, in order to close this gap, a) it would be useful for researchers to find out what practitioners want to know; b) researchers could use their own experiences as practitioners to be truly reflexive, and to communicate that; and c) we — in the field, profession, and discipline — need to consider the therapeutic value for clients of participating in research. To this, we would add that, with regard to conducting research in this country, it is important to consider its benefit to Māori and to assess its ethical purpose and processes against *Te Ara Tika Ethical Framework* (Hudson et al., 2010), specifically with regard to relationships (in terms of consultation, engagement, and, ultimately, kaitiaki); our cultural and social responsibilities (in terms of cultural sensitivity, cultural safety, and, ultimately, manaaki); justice and equity (in terms of mana tangata, mana whenua and, ultimately, mana whakahaere); and research design (in terms of mainstream, Māori-centred, and, ultimately, kaupapa Māori).

The starting point for the research on which this article is based was a curiosity about the extent to which students writing Masters’ dissertations at Auckland University of Technology (AUT) fulfil one of the learning outcomes for the dissertation course, which is to “Reflect on and evaluate the significance of the research in the discipline area” (AUT, 2022b, p. 127). We think that this learning outcome is important precisely because it encourages — and requires — that, whatever their research interest, subject, methodology and method, students face out to the profession. In order to ascertain whether this requirement is reflected more widely in the “discipline area”, we considered and researched three elements of this:

- Other psychotherapy education/training courses in Aotearoa New Zealand (Table 1) — and found that, by and large, it was not.
- Other psychotherapy education/training courses at tertiary education institutes overseas (in Australia and the United Kingdom) — and, from an initial survey, found no equivalent learning outcome or requirement.
- Professional psychotherapy journals, specifically their submission requirements (Table 2) — and found that it was. We restricted this research and analysis to those

Table 2: Psychotherapy journals aims and scopes

Journal	Submission Requirements			
	Practice	**Policy**	**Theory**	**Other/Notes**
American Journal of Psychotherapy	"advance evidence-informed psychotherapy practice... [and] shape clinical practice"		"advancing the theory ... of psychotherapy"	
The Arts in Psychotherapy	"inform the development of new services and the refinement of existing... practices"	"inform the development of new services and the refinement of existing policies"	"contributions that present new and emergent knowledge"	
Asia Pacific Journal of Counselling & Psychotherapy	"focus on best practice in the field"			
Ata: Journal of Psychotherapy Aotearoa New Zealand				Ata "supports us all to shape, inform and inspire the psychotherapy community in Aotearoa to reflect the essence of and challenges to our people and our landscape"
British Journal of Psychotherapy	"We invite papers on clinical work"			"encourages dialogue between private practice and institutionally based practice"
Canadian Journal of Counselling & Psychotherapy	"advancement and improvement of counselling practice and the counselling profession... [and] Increase understanding of individuals, groups, and Canadian society about the practice and profession of counselling"		"Provide a forum for the dissemination of scholarly information on the contemporary theory... [and] research"	"Act as a catalyst for critical analysis and scientific review and discussion within the discipline of counselling"
Clinical Psychology & Psychotherapy	"an integrative impetus both between theory and practice"		"an integrative impetus both between theory and practice"	"an integrative impetus... between ... different orientations within clinical psychology and psychotherapy"

Counselling & Psychotherapy Research	“dedicated to linking research with practice… [and] informs and develops counselling and psychotherapy practice”	“Each paper should include… one implication for policy”		
European Journal of Psychotherapy & Counselling	“practitioners can present their wealth of expertise and innovations… [and] researchers who want to address a larger clinical audience with clinically relevant issues … [and] The nature of psychotherapeutic knowledge and its implications for practice”		“The nature of psychotherapeutic knowledge and its implications for... theory”	“The contributions from and debates between different European theoretical approaches to psychotherapy and counselling”
European Journal for Qualitative Research in Psychotherapy	“authors are encouraged to explore critically and explicitly the relevance to, or implications for, psychotherapy practice… [and] advances the... practice of psychotherapy”		“advances the theory… of psychotherapy and supports practitioner-orientated research”	
Group Analysis: The International Journal of Group-Analytic Psychotherapy	“explores the… practice”		“explores the theory”	“explores the application of group analysis in the wider context of medical and psychiatric institutions and community mental health care services”
Healthcare Counselling & Psychotherapy Journal	“debate on practical or professional issues… and best practice”		“new perspectives on current thinking… [and] theory discussion”	“shared experience”
International Journal of Group Psychotherapy	“empirical work on topics germane to group practice [and] personal, scholarly narrative on topics germane to group practice [and] reviews … relevant to group practice [and] special issues on … group practice”		“integrate existing group theory”	
Journal of College Student Psychotherapy	“full-length or brief articles on… practice”			“explores significant issues in the field of college student mental health [and] professional issues… or research findings”

Journal of Cognitive Psychotherapy	"implications for clinical practice"		"clinical implications of theoretical development"	"describing the integration of cognitive-behavioral psychotherapy with other systems"
Journal of Contemporary Psychotherapy	"critically analyze… practice"		"critically analyze theory"	
Journal of Psychology & Psychotherapy				"explores the complexities and controversies facing psychotherapists"
Person-Centred & Experiential Psychotherapies	"including… practice"		"including… theory"	"stimulate… creativity and impact in a broader professional, scientific and political context"
Psychology & Psychotherapy: Theory Research & Practice	"understanding the processes which affect outcomes where mental health is concerned"		"theoretical… development" and "theoretical advancement"	"behaviour and relationships; vulnerability to, adjustment to, assessment of, and recovery"
Psychoanalytic Psychotherapy	"impact on the practice of psychoanalytic therapy and/ or the applied work of analytically informed practitioners"	"papers addressing policy issues… [and] development of mental health policy"	"development of a specific theoretical point"	"constructive debates within and between the diverse traditions"
Psychotherapy	"examples of practice-relevant issues … [and] why they are important to clinical practice"		"practice theory"	
Psychotherapy and Counselling Journal of Australia	"Demonstrate relevance to research and/or practice in the counselling and psychotherapy field"			"Make a significant contribution to the evidence base of counselling and psychotherapy"
Psychotherapy and Politics International	"explores the connections and interactions between politics and psychotherapy, both in theory and in practice"	"focuses on the application to political problematics of thinking… [and] application within the field of psychotherapy of political concepts and values internationally"	"explores the connections and interactions between politics and psychotherapy, both in theory and in practice"	

- journals whose titles contain the word "psychotherapy" (and where the information about aims and scope was available). We reviewed the aim and scope of each journal as well as specific instructions for authors with regard to submissions.

Table 2 shows that all but two of the journals of psychotherapy published in the English language specifically require submitting authors to relate their writing and research to practice, which, we suggest, represents encouraging evidence of one part of the discipline area closing the gap between researchers and practitioners. However, only five of these 19 journals are accessible to readers outside the membership of the professional associations of which they are the society journal, or to other colleagues who pay the subscription to the journals, and to academics whose institutions pay for access to such journals (see Table 3).

Table 3: Open access psychotherapy journals

Journal	Society/Owners	Publisher	Access
Ata: Journal of Psychotherapy Aotearoa New Zealand	New Zealand Association of Psychotherapists	Tuwhera Open Access Publications	https://ojs.aut.ac.nz/ata/
European Journal for Qualitative Research in Psychotherapy	European Association for Integrative Psychotherapy (sponsors)	The journal	https://ejqrp.org/index.php/ejqrp/index
Journal of Psychology & Psychotherapy	Longdom Publishing	Longdom Publishing	https://www.longdom.org/psychology-psychotherapy.html
Psychotherapy and Counselling Journal of Australia	Psychotherapy and Counselling Federation of Australia	Psychotherapy and Counselling Federation of Australia	https://pacja.org.au/
Psychotherapy and Politics International	The Black, African and Asian Therapy Network	Tuwhera Open Access Publications	https://ojs.aut.ac.nz/psychotherapy-politics-international/

What this aspect of our research reveals is a third gap: that between publication and readership.

The publication–readership gap

Here we identify two elements of this: one of access, and the second concerning the nature of publications in and about psychotherapy.

All psychotherapists incur certain costs with regard to their practice, including: their initial education/training, personal therapy, supervision, professional insurance, membership and/or registration fees, continuing professional development, room rental (if they are in private practice), travel, and so on. Apart from receiving a copy of the society

journal (if they are a member of an association that produces a journal), reading any other publication costs money. One example of this is Psychoanalytic Electronic Publishing (PEP), an extensive database comprising 83 journals (and more than 139,000 articles) and 100 classic books, which costs an individual an initial fee of NZ$1,868.64 and a further NZ$230.56 per year to maintain the subscription. Those interested in behavioural and/or humanistic psychotherapy would need to subscribe to the individual journals in these parts of the field.

Whilst academics have access to PEP and other databases, as well as to professional journals in the field, most practitioners do not, and, even when a practitioner can access these resources, they may experience further institutional barriers. For example, the second author, a practising psychotherapist, is also a graduate of AUT with access to online databases, including PEP. However, on enquiring further about this access, he was told that it was only possible through a physical portal on campus and could not be accessed remotely, which is a barrier to a practicing clinician having easy access to the most recent research in the field.

The second manifestation of this gap concerns the nature of the publication. Whilst academics are expected to research and publish and to facilitate others to do so, there is within the governance and management of academic institutions a privileging of certain types of publications, notably peer-reviewed journal articles over everything else (including books), and of certain journals, i.e., those with a high impact factor (which doesn't necessarily correlate to publications that are respected within the profession). This leads to a number of problems with regard to the quality of research and writing (Dinis-Oliveira & Magalhães, 2015; Sarewitz, 2016); the quality of publishing and, specifically, the increase in predatory publishing activities (Gasparyan et al., 2016); the translation into practice (Harley, 2019); and the perishing of academics if they don't publish (Aprile et al., 2021). Of course, the irony of this, especially for researcher/practitioners, is that this privileging and these problems

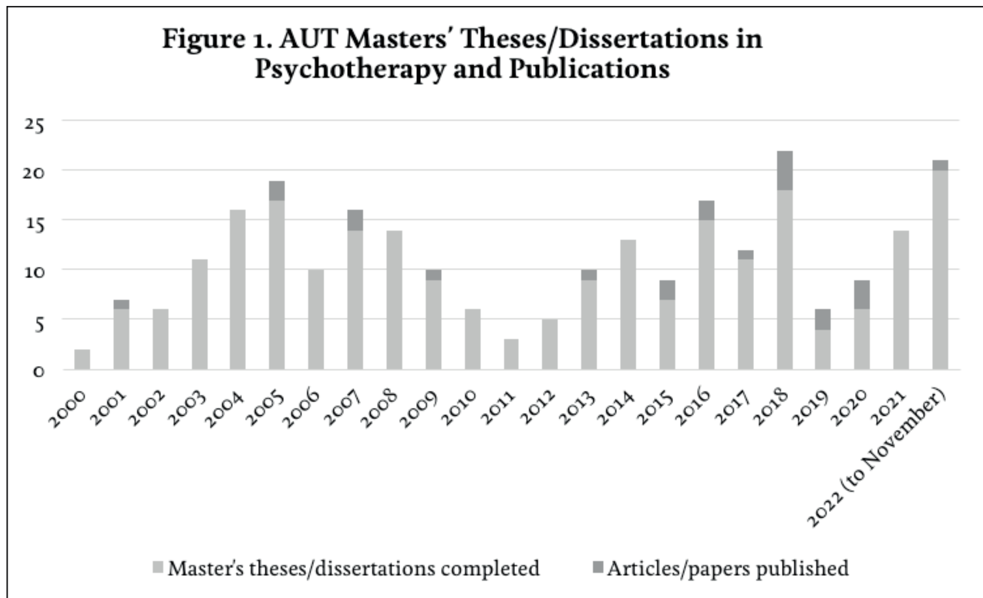

Figure 1. AUT Masters' Theses/Dissertations in Psychotherapy and Publications

institutionalise the research–practice gap. Fortunately, these authors (cited above) and many others are pushing back in various ways, including making the case for the place of books in publishing (for a local articulation and example of which, see Tudor, 2021), and for open access journals.

Figure 1 shows the distribution of articles published from completed Master's theses or dissertations in psychotherapy from AUT. These have been predominantly published in *Forum: The Journal of the NZAP* (1995-2010) and *Ata: Journal of Psychotherapy Aotearoa New Zealand* (from 2012 onwards), which is now an open access journal (see https://ojs.aut.ac.nz/ata/) and is currently publishing back issues of Forum. As the majority of psychotherapy journals are not published as open access, this constitutes a rare and real contribution to the field, both nationally and internationally.

As may be seen from Figure 1, to date, there has been a relatively low rate of conversion from Master's theses and dissertations (n=236) to published articles (n=22), i.e., 9.32%, though this has picked up over the past seven years. Moreover, due to a publishing project specifically designed to present students' work over the past 21 years of the Masters' programmes at AUT (Tudor & Green, 2022, by the end of this year, this will almost double to 18%.

The research

In this context, we — an academic who also has a small private/independent practice, and a psychotherapist who is also a research assistant — looked at two years of dissertations at one institution (AUT) in order to test our thesis that students' research is not widely disseminated, and, therefore, not widely known. Specifically, we were interested in the extent to which one of the learning outcomes (LOs) for a postgraduate dissertation at AUT is fulfilled, i.e., that students "Reflect on and evaluate the significance of the research in the discipline area" (AUT, 2022b, p. 127).

We chose dissertations from the last two years to ensure that the research was contemporary, and, in terms of the number of dissertations, manageable. We compiled a list of the dissertations by searching university records, which revealed 13 dissertations submitted and marked in 2021, and 19 in 2022 (up to 30th November), a total of 32. We excluded those that are the subject of permanent or temporary embargoes as, by definition, they are not (yet) in the public domain. This reduced the total number of dissertations in our data set to 25. From each dissertation, we extracted statements that specifically relate to the students' contribution to the discipline, viewing this as an example of document analysis (Bowen, 2009; Rapley, 2007) and, thus, in this article, we focus on presenting and analysing the students' contributions to the discipline. In a separate article, we will offer an analysis of the fulfilment of this LO across a number of health disciplines.

Summary of the dissertations reviewed

Here we present the data we reviewed in the form of brief summaries of the subject of the dissertations.

- **The therapist's bilingualism and countertransference experiences** (Amiri, 2021). This dissertation focuses on the unique experience of the bilingual therapist. The author

suggests that the bilingual therapist has, to this point, not been adequately explored despite acknowledgement in early psychoanalytic thinking. Three main themes are elucidated: a dual sense of self, inadequacy, and connection.

- **Support for young people in managing stress** (Batts, 2021). The author seeks to answer the question "what educational support is currently provided to increase young people's capacity to manage stress?" (p. 7). Conclusions pertain to the promise of using psychotherapeutic modalities including acceptance and commitment therapy, cognitive behavioural therapy, and adventure therapy to treat stress in young people through educational support programmes.
- **Settler descendent relationship to land** (Brett, 2022). The author's focus is on the influence of nature and land on mental wellbeing. Brett identifies four main themes: "shadow, coloniser, climate crisis, and queerness" (p. 36) and argues for an increased awareness of the impact of ecological loss and alienation on mental health.
- **Hidden assumptions of culture in child psychotherapy** (Cadogan, 2021). This research comprises a literature review that explores the interplay between culture and the therapeutic encounter in child psychotherapy in Aotearoa New Zealand. Cadogan concludes that, within psychotherapy theory, training and practice in Aotearoa New Zealand, Indigenous knowledge has been largely obscured by dominant Western paradigms. Cadogan calls for further acknowledgement of biculturalism and multiculturalism in the therapeutic space.
- **Empathy in cross-cultural dyads** (Chandra, 2022). This research explores some of the challenges regarding therapist provision of empathy in cross-cultural therapeutic relationships. Chandra observes that empathy is understood differently across cultures and thus encourages therapists to explore their own cultural differences and consider how this might impact on their ability to provide empathy.
- **Forgiveness in psychotherapy** (Chesterfield, 2022). The author explores the idea that forgiveness, when examined in psychotherapy, can be advantageous for clients. In particular, the research focuses on forgiveness as repair and a movement toward reconciliation. Chesterfield concludes that forgiveness can facilitate the resolution of anger, repair relationships and improve overall wellbeing.
- **A psychotherapist's experience of abrupt endings** (Chue, 2021). This research explores the experience of the psychotherapist when clients abruptly end treatment. The author offers personal insights to help understand the therapist's experience and concludes that it is likely that difficult endings will disturb the therapist and good enough endings will be bittersweet, underscoring the "impossible" nature of the psychotherapeutic process (Freud, 1937).
- **A therapist's experience of humour in psychotherapy** (Ciurlionis, 2021). This research seeks to understand the relationship between psychotherapy and the very human phenomenon of humour. The author unpacks the assumption that using humour in therapy is "risky" and offers two conclusions: that humour and power are intricately related and that humour is ultimately a crucial part of language which provides an opportunity to deepen connections between people.
- **The remedial potential of body-centred psychotherapy for children** (Engelbrecht, 2021). This research seeks to understand how movement as a therapeutic modality can

alleviate the suffering of those who have experienced trauma in childhood. The author acknowledges the mind-body connection and explores the literature emerging from the body-centred psychotherapy community, concluding that the body provides an entry point to the psyche and thus a means by which one might recover from trauma.

- **Self-discovery (through the book *A Monster Calls*)** (Fung, 2022). The author employs a unique approach to her research, examining self-experience through the lens of the book *A Monster Calls* (Ness, 2011). Fung highlights the potential of using literature to explore and better understand "parts of self that may be hidden, blind to ourselves, or too painful to consciously process" (p. 83). The reader is encouraged to consider books or stories "imaginary analysts", capable of facilitating play, warmth and safe boundaries.
- **Christians coping with a crisis of faith** (Grayson, 2022). This research investigates how individuals who identify as Christian cope with a crisis of faith. Based on a thematic analysis of semi-structured interviews with five clients, Grayson identifies three themes and a number of sub-themes from their experiences. She also draws out a number of implications for clinical practice, including the value of addressing religion and crises of faith in therapy, understanding countertransference, and being aware both of the historic divide between religion and psychotherapy and of the reservations some Christian clients have when entering therapy.
- **Māori identity as a student psychotherapist** (Hill, 2022). This research examines the experience of identity as it pertains to Māori psychotherapy students. Hill observes that said experience is unique in that Māori psychotherapy students are training in a Western perspective within Western academic institutions, perspectives which are likely to contradict their customs and values. Hill explores the ensuing challenge, questioning how one can locate identity while being in multiple, often contradictory, value systems.
- **How parent-infant psychotherapy can facilitate transformative communications of maternal distress** (Hiskens, 2021). This research explores infant experiences of maternal distress, seeking to understand the parent-infant-therapist triad and how these relationships can transform the infant's experience of their mother's unwellness. Hiskens establishes that the infant has the ability to participate in the therapeutic process and concludes that said relationship is an important platform for relational change.
- **The infant's emotional world** (Hooper, 2022). This research focuses on the psychoanalytic literature on psychic development in earliest infancy. This is realised through a hermeneutic literature review which is interpolated with the researcher's personal experience of the literature. The research finds coalesce around the elaboration of felt experience and the importance of the infant's developing subjectivity.
- **The experience of the young child bereaved by sibling stillbirth** (Jackson, 2021). This research focuses on the unacknowledged loss of siblings bereaved by stillbirth and postulates that "the stillborn sibling becomes a lifelong constant companion for the bereaved young child" (p. 2). Jackson reflects on the importance of privileging the subjectivity of the bereaved child and inviting play and culture. These function as mechanisms by which to access the fullness of the child's experience.
- **Working with chronicity** (Lampard, 2022). This research seeks to understand "how

Bion's interpretation of negative capability could support an understanding of the complexity of chronicity when working with the whole person treatment approach" (p. 2). To this end, the research identifies two significant roadblocks: the culture of biomedicine, and the human tendency to split and retreat; and presents four potential ways of bridging these roadblocks: developing an internal container, curiosity, allowing doubt, and patience.

- **A psychotherapist's experience of self-disclosure, when practising in the digital era** (Longley, 2021). This research explores the interface between the therapist's personal and professional worlds in the digital age, and asks what "the struggles and the benefits" (p. 5) may be when one has a large and revealing online presence. The author encourages therapists to hold a certain wariness of the challenges recent advancements in technology present, and acknowledges the impossibility of maintaining a truly anonymous online presence in today's digital world.
- **The impact of emigration** (Lu, 2022). Based on a heuristic enquiry, this research explores the impact of emigration of a Chinese 1.5 generation immigrant, and specifically on the researcher's sense of belonging. The researcher reports on their own physical and psychological journey and considers the impact emigration — and immigration — has had on their internal psyche, as well as how this shapes their relationship with their surrounding family, friends, society, and physical space.
- **Racial microaggressions** (McCann, 2022). The research explores the often unintended and unrecognised, yet injurious microaggressions that can emerge from a difference in racial realities. This research encourages consideration of meaning, unconscious racialisation, the interplay of subjectivity, and questions whether racial microaggressions may, if approached non-defensively, provide an opportunity for greater understanding.
- **Hakomi and the treatment of anorexia nervosa** (Powers, 2022). This research explores whether Hakomi, a mindfulness based, mind-body psychotherapy, might serve as a useful approach to the treatment and understanding of anorexia nervosa. Powers questions whether current specialist treatments are effective, and whether a novel approach is necessary.
- **The art of mourning — exploring the impact of artistic creation upon the psychotherapist** (McCall, 2021). This research explores the significance of the therapist as artist and, specifically, "loss in the creative and therapeutic experiences of the author" (p. 2). McCall hypothesises that opening to loss can facilitate a recalibrating of self and concludes that the therapeutic and artistic strands can synthesise to support transformation.
- **Prisoners (well-being through rehabilitative services)** (Ramanjam, 2022). This research explores how rehabilitative services in prisons might better support prisoner wellbeing. Ramanjam posits that existing services are focused on mitigating criminogenic behaviour, arguing for a better understanding of the prisoner's internal world and emphasising the need of the prisoner to be seen and heard. Ramanjam discusses the benefits and limitations of practising psychotherapy within a system of incarceration.
- **The experience of pilgrimage** (Walsh, 2022). This research, in part based on the

researcher's own experience on and of pilgrimage, investigates how the experience of pilgrimage affects pilgrims. The research comprises a hermeneutic literature review, weaving the author's own process, including her own experience, cultural background, and role as a psychotherapist. In identifying ways in which pilgrims are affected by pilgrimage, the study attempts to act as a bridge between pilgrimage and psychotherapy.

- **Ruptures and repairs in the therapeutic relationship with adolescents** (Wong, 2021). This research discusses rupture and repair and their relationship to culture, and elucidates some of the challenges involved in utilising this as a therapeutic intervention. The author concludes that rupture repair within the therapeutic relationship can enhance meaning and affords an opportunity for clients and therapists alike to be understood differently.
- **What has happened to the diagnosis of hysteria?** (Woods, 2021). This research situates itself firmly within a Lacanian and psychoanalytic paradigm and explores the "phenomena of hysteria, hysteric experience, and the treatment of hysteria" (p. 5). The author opens a question regarding thinking, teaching and clinical work with hysteric clients and explores why individuals with hysteric presentations can be "siloed" to the fringes.

Table 4 summarises these dissertations with regard to their method and methodology, as well as the theoretical orientation that informs the research and the researcher's thinking and practice.

Table 4: Master of Psychotherapy dissertations: method, methodology, and underpinning theoretical orientation

Subject	Method	Methodology	Theoretical orientation (where noted or relevant)
Abrupt endings (Chue, 2021)	Self-search enquiry	Heuristics	Psychoanalytic
Bereavement (by stillbirth) (Jackson, 2021)	Literature review	Hermeneutics	Largely psychoanalytic
Bilingualism (Amiri, 2021)	Literature review	Hermeneutics	Psychodynamic and psychoanalytic
Body-centred psychotherapy for children (Engelbrecht, 2021)	Thematic analysis	Semi-systematic	Body-centred psychotherapy
Christians coping with a crisis of faith (Grayson, 2022)	Thematic analysis (of semi-structured interviews)	Thematic analysis, qualitative descriptive	
Chronicity (working with) (Lampard, 2022)	Literature review	Hermeneutics	Whole person treatment approach and psychoanalytic
Culture in child psychotherapy (Cadogan, 2021)	Hermeneutic literature review	Social and cultural constructionist	

Emigration (the impact of) (Lu, 2022)	Heuristic	Heuristics, phenomenology	
Empathy in cross-cultural dyads (Chandra, 2022)	Literature review	Hermeneutic, interpretive	Relational and humanistic
Forgiveness in psychotherapy (Chesterfield, 2022)	Literature review	Hermeneutics, qualitative	Object relations, attachment theory
Hakomi and the treatment of anorexia nervosa (Powers, 2022)	Literature review	Hermeneutics	Hakomi
Humour in psychotherapy (Ciurlionis, 2021)	Self-search enquiry	Heuristics	Relational psychodynamic
Hysteria (Woods, 2021)	Literature review	Hermeneutic, psychoanalytic	Lacanian
The infant's emotional world (Hooper, 2022)	Literature review	Hermeneutics	Psychoanalytic
Land (settler descendent relationship to) (Brett, 2022)	Self-search enquiry	Heuristics	Relational psychotherapy
Māori identity as a student psychotherapist (Hill, 2022)	Self-search enquiry	Heuristics	Social constructivist and humanistic
Maternal distress (Hiskins, 2021)	Literature review	Hermeneutics	Object relations
Mourning, artistic creation and the psychotherapist (McCall, 2021)	Self-search enquiry	Heuristics	Eclectic, within a psychoanalytic context
Pilgrimage (the experience of) (Walsh, 2022)	Literature review, and enquiry	Hermeneutic, interpretive	
Prisoners (well-being through rehabilitative services) (Ramanjam, 2022)	Literature review	Hermeneutics	Psychodynamic and generic
Racial microaggressions (McCann, 2022)	Self-search enquiry	Heuristics	Psychodynamic
Ruptures and repairs in the therapeutic relationship with adolescents (Wong, 2021)	Literature review	Hermeneutics	Developmental psychodynamic perspectives, informed by attachment theory and neuroscience
Self-disclosure in the digital era (Longley, 2021)	Self-study	Heuristics	Psychoanalytic and psychodynamic
Self-discovery (through the book A Monster Calls) (Fung, 2022)	Self-study	Heuristics	Psychoanalytic and psychodynamic
Young people and stress (Batts, 2021)	A modified systematic literature review	Critical theory	

Findings

Reading and analysing the text of the dissertations specifically for what the students identify as the contribution to the discipline area or field, we found two features: the first was the particular focus or foci of their contributions, and the second was what we refer to as the tone of the contribution.

In concluding their dissertations, most students make some comments about what they viewed as the contribution to the discipline. These are framed with reference to psychotherapists; education/training institutions and programmes, and students/trainees; clients, including parents; and the broader field, including ecopsychology, the Pasifika community, medical professionals, and funders (see Figure 2). Most students refer to more than one focus group or population.

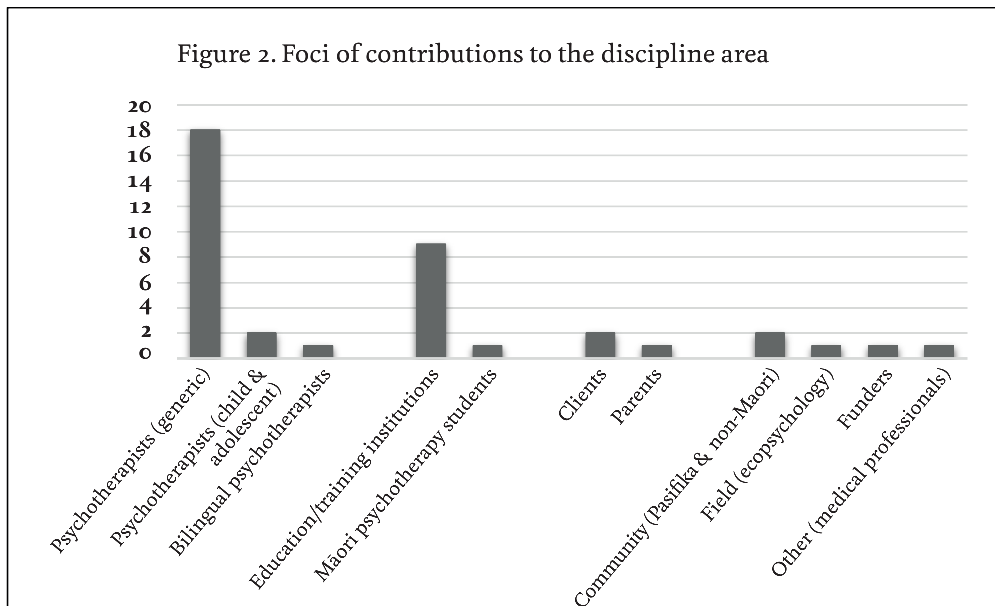

Figure 2. Foci of contributions to the discipline area

Unsurprisingly, given students' identification with becoming psychotherapists, the main focus of this element of the majority of the dissertations is on what students consider to be their contribution to psychotherapists, both themselves and others, for example "[i]t is essential for psychotherapists … to learn about and consider the developmental needs and drives of adolescents" (Wong, 2021, p. 63); "[w]ith such potent power to unravel the therapist, this research argues that it is crucial for therapists to encounter their experiences of abrupt endings, in life and in therapy" (Chue, 2021, p. 59); and "practicing psychotherapists may … consider what their online presence is, and how it may impact current or future clients" (Longley, 2021, p. 54). Hooper (2022) suggests that both infant observation and hermeneutic research allow the clinician to take time, and not to rush to action; and, indeed, "to flounder and to be able to exist for a time without reacting" (p. 42). In addition, and given their

association or identity, some students make particular points about specific psychotherapists, thus: "[i]t is worthwhile for the child and adolescent psychotherapist, for all clients of all presentations, to discuss with the parents and caregivers the developmental history of the child and family history" (Jackson, 2021, p. 64); and "bilingual therapists need to identify and be aware of their language-related self-experiences and language-related emotional experiences in order to prevent burnout and feeling exhausted" (Amiri, 2021, p. 45).

The second most common focus of students' contributions is statements about educational/training institutions, programmes and students:

- "The study suggests that Māori students in psychotherapy education/training and academia face the challenge of carrying multiple identities in becoming a psychotherapist" (Hill, 2022, p. 2).
- "... a strong foundation in recognising and addressing unconscious racialisation in the self, begins through the training process" (McCann, 2022, p. 78).
- "... beginning/training psychotherapists would greatly benefit from being provided a space to experience support for attuning to their embodied responses as a way into accepting and defining their personal approach to practice ... with some additional support from inviting practicing psychotherapists to talk to about how they elaborate their felt experience and use this in their work" (Hooper, 2022, p. 43).
- "... offering both time and encouragement for trainees to engage with their own extracurricular creative modality would likely see these become invaluable adjunct spaces to further the embodied learning that is deeply relevant to trainees' emerging clinical capability" (McCall, 2021, p. 58).
- "...psychotherapy programmes need to encourage bilingual trainees to discuss the challenges and advantages of working in their second language" (Amiri, 2021, p. 44).
- "The training implications of the roadmap are in providing a structure that helps to familiarise both psychotherapists and medical professionals with the likely roadblocks that may be encountered in using the [whole person treatment approach] to work with chronicity" (Lampard, 2022, pp. 62-63).
- "... it is crucial that psychotherapy trainings prepare developing therapists for abrupt endings in therapy" (Chue, 2021, p. 60).
- "... [t]his dissertation will assist Māori students at a foundational level who are learning to translate western psychotherapeutic theory into something that is understandable through a cultural lens" (Hill, 2022, p. 42).

The third area of focus is on clients, including parents, for example, Jackson (2021) makes a number of comments about working with parents with regard to bereavement by stillbirth, suggesting that "when parents can appropriately share their grief process with their young children, the parents remain more accessible to their living children both in their own grief process but also in growing generally" (p. 66). Chesterfield (2022) suggests that "[i]t would be advantageous for clients to be more aware of the significance of forgiveness as a possible part of their healing from past hurts" (p. 94); and Chue (2021) suggests that the model she has developed in relation to working with abrupt endings can be used by clients as an experiential tool. Based on her own experience of self-discovery through a specific

book, Fung (2022) suggests that using literary books and written stories may be helpful for clients as a means of exploring parts of self that may be hidden or too painful to process consciously, and Walsh (2022) suggests that "A pilgrimage could … provide an effective 'bridge' through which to introduce the client's spiritual beliefs and concerns into their therapy" (p. 58).

A fourth area of focus is on the broader field. For instance, McCann (2022) describes her intention to "benefit … the Pasifika community" (p.4); and Hill (2022) suggests that "[t]his dissertation can also offer non-Māori readers an opportunity to learn and expand their own understanding of our [Māori] unique cultural perspective" (p. 42). Brett (2022), who explores the complexities of relationship to land, concludes that her research "has implications for ecopsychology, wider mental health care, and ecological activism" (p. 43). Writing about Broom's whole person treatment approach (Broom, 2007), Lampard (2022) suggests that "for other medical professionals working in a biomedical context, the challenge is to see the subjective as co-emergent with the objective, and allow a space for both" (p. 62), and that it may be better for funders to divert funding from biomedical procedures to working with the whole person treatment approach.

Our second finding with regard to the learning outcome requiring students to reflect and evaluate the significance of their research in the discipline area, relates to the tone used by students, especially in the chapters or sections to the discussion of their findings and conclusions, which we categorised as follows. Firstly, we note students' recommendations which are named as such in the dissertations, and are direct and specific. Secondly, we note those suggestions that are specific and as a result of the research, but which are made more in the spirit of putting something forward for consideration. Thirdly, we note other statements which students make, usually in the category of a declaration, with regard to or as a result of reflecting on the contribution the dissertation makes to the discipline area, though they vary in tone from the direct and/or directive (usually indicated by the use of words such as "should" or "must") to the indirect (in the form of a hope or a wish).

Only five students make specific recommendations — and, indeed, one (Walsh, 2022), specifically states that "It is beyond the scope of this study to offer comprehensive recommendations" (p. 44). Those that do, make recommendations:

- With regard to bereavement by stillbirth, "that parents acknowledge the loss of the bereaved young child by talking to them about their sibling and modelling healthy ways of expressing feelings" (Jackson, 2021, p. 66).
- With regard to bilingual therapists (Amiri, 2021):
    - "to highlight the role of language in academic programmes and the clinical workplace" (p. 43);
    - for psychotherapy programmes "to encourage bilingual trainees to discuss the challenges and advantages of working in their second language" (p. 44), and for university departments "to increase specialised training for bilingual therapists in the context of Aotearoa New Zealand" (p. 45);
    - for students "[to receive] language-related supervision during training" (p. 44); and
    - for bilingual therapists "to identify and be aware of their language-related self-

experiences and language-related emotional experiences in order to prevent burnout and feeling exhausted" (p. 45).
- With regard to pilgrimage (Walsh, 2022), that it be prescribed for clients with sufficient ego strength and emotional stability "and utilised as a holistic intervention, alongside regular psychotherapy" (p. vii).
- In response to racial microaggressions, that a formal process be introduced within institutions which allows trainees "to address cultural issues (unconscious racialisation) that arise in cross-racial supervision relationships" (McCann, 2022, p. 79).
- With regard to rehabilitative services, for such services "to have more depth and … to be aligned with the needs of prisoners" (Ramanjam, 2022, p. 57).

One of these students and four others make the following suggestions:

- With regard to abrupt endings, "that therapists might protect against this terror and powerlessness, by focusing on ways to retain or regain power when managing endings in therapy" (Chue, 2021, p. 59).
- With regard to body-centred psychotherapy for children, that there is "the need to unlearn the ways we may repress our own embodied knowing" (Engelbrecht, 2021, p. 65).
- With regard to forgiveness (Chesterfield, 2022):
  - that "[t]he training of psychotherapists should include building an understanding of forgiveness both conceptually and practically, in terms of how this can be appropriately transferred into therapy" (p. 94);
  - that "[p]sychotherapists (and their clients) could benefit from embracing the concepts of forgiveness into their clinical practice as appropriate" (p. 94);
  - that "[i]t would be advantageous for clients to be more aware of the significance of forgiveness as a possible part of their healing from past hurts" (p. 94).
- With regard to racial microaggressions (McCann, 2022):
  - that "a strong foundation in recognising and addressing unconscious racialisation in the self, begins through the training process" (p. 78);
  - "that tutors and supervisors do the work of self-reflection, to explore their own unconscious racialisation so they can facilitate discussions as allies, and speak to normative unconscious processes and power asymmetries when they come alive in the classroom or experiential training setting" (p. 78).
- With regard to self-disclosure in the digital era, that "[t]raining institutions may look to provide guidance and awareness of how one's online activity may become part of the therapeutic relationship" (Longley, 2021, p. 54).

Finally, other statements about the contributions to the discipline include:

- With regard to culture in child psychotherapy:
  those of us who come from the dominant Western worldview must become more aware that ours is just one of many streams and a large proportion of the people we work with do not share that view.… that in child psychotherapy, we can be "culturally encapsulated" (Wrenn, 1962, p. 444), so we may remain oblivious to many of the

underlying assumptions, biases, and prejudices in the culturally-bound system in which our theory and practice are embedded. (Cadogan, 2021, p. 46)

- With regard to empathy in cross-cultural dyads:
  [Addressing] therapists' cultural belief systems within psychotherapy training may benefit the therapeutic alliance and improve outcomes for clients. I propose that cultural competency through the use of a cultural genogram to ascertain cultural beliefs and values may be helpful to include as part of an assessment process. (Chandra, 2022, p. 48)

- With regard to humour in psychotherapy:
  [Greater awareness of] both unconscious or conscious avoidance of lighter or "transgressive' moments" … could create a sense of freedom within practitioners who are inclined to laugh at life, once they had understood their internalised expectations of what is and isn't "permissible" within the therapy space. This also feels important around other modes of being that may be stifled in a therapeutic setting such as exuberance and excitement. (Ciurlionis, 2021, p. 53)

- With regard to hysteria, "there is something about the hysteric's questions which causes many to turn away from her … this whole project has been my questioning of the master's discourse and of playfully encountering the master signifiers of my fundamental fantasy" (Woods, 2021, pp. 73-74).

- With regard to land and the settler descendent relationship to it, "[a]s a whole, it [this project] speaks to the complexity of relationship to land, the distress and disowned ambivalence it may contain, and the defensive use of denial, disengagement, and avoidance to navigate these uncomfortable affects" (Brett, 2022, pp. 42-43).

- With regard to mourning, artistic creation and the psychotherapist, "[t]his research suggests the potential for core therapeutic capacities to be developed within the artistic experience including the negotiation of depressive anxieties, furthering of self-knowledge, ability to contain and symbolise material, and fostering of negative capability" (McCall, 2021, p. 57).

While this document analysis takes an empirical approach to the text, in this case of 25 Masters' dissertations, we think that the recommendations, suggestions and other statements in these texts with regard to the discipline of psychotherapy convey — and, indeed, are based on — underlying values about psychotherapy and the world, which would be worthy of further analysis.

Conclusion

From our reading of the dissertations reported in this article, it is clear that the majority of student/authors take their work and research seriously. While, as practitioners at the

beginning of their careers, they may lack clinical experience, they do not lack the ability to research an area of interest at some depth; to undertake a review of the relevant literature; to articulate a method of research informed by an underlying methodology; and, by and large, to reflect critically on their work in articulating its contribution to the discipline area, albeit to varying degrees (as evidenced by the fact that the dissertations are graded). There are and probably always will be debates in the field about the nature of research in psychotherapy and the place of research in psychotherapy education/training programmes. Those programmes based in the tertiary education sector will always be open to the criticism that too much of the student's time is spent on research, at the expense of other areas of knowledge, practice, and skills. Equally, those programmes based in the private sector (see Table 1) are open to the criticism that too little or no time is spent in encouraging or requiring their trainees to read and conduct research.

For a long time (over 75 years) psychology has developed the scientist-practitioner model (Shakow, 1942), which calls for graduate programs to engage and develop psychologists in psychological theory, field work, and research methodology. Whilst the emphasis in this model is on empirical research, the model itself ensures that there is little or no gap between the psychologist practitioner and researcher, at least in the fields of applied psychology such as those of clinical, counselling and rehabilitation psychology. In the field of psychotherapy, as we have discussed, we have a much wider gap between research and practice, which suggests that, we need the collaboration of all parties, i.e., students, educators/trainers, and the profession, to develop our own version of the scientist/artist–practitioner (Hoffman & Weinberger, 2014; Schore, 2012), drawing on a wide range of qualitative as well as quantitative research methods and methodologies (Bager-Charleson & McBeath, 2020, 2023; Tudor & Wyatt, 2023-in press).

Specifically, we suggest that clinicians could be encouraged and supported to do more research:

- Firstly, by being introduced to a range of methodologies and methods appropriate to psychotherapy research, preferably during their initial education and training.
- Secondly, by being encouraged to publish, again preferably during or shortly after their initial education/training. All psychotherapy programmes in this country and internationally require students/trainees to write some form of case study, some of which could well contribute to the literature on what is now a rare form of psychotherapy research. For an example, see Bondi (2023-in press), and for a discussion, see Thomas-Anttila (2015).
- Thirdly, by having access to the literature, including academic journals. We suggest that this requires not only the clinician to look to the academy, especially tertiary educational institutions in the public sector, but also the academy to look outwards to the professional community and to offer such access to their students, as well as opportunities to research and publish.
- Fourthly, by considering research as a legitimate avenue of continuing professional development, and one that could and should count as part of any reaccreditation or recertification plan.
- Fifthly, by having professional associations fund research projects — which NZAP

currently does through its Education Fund. Although, at present, this is relatively small (the total amount of grants available per year has, to date, been around $5,000), we would hope that the Association can increase this Fund and, therefore, the opportunities it affords to its members to engage in research.

We hope that, in some small way, this article contributes to the field of psychotherapy here in Aotearoa New Zealand and beyond, not only by reporting on certain contributions to the field and in doing so, alerting readers to their presence and availability, but also, in minding about the research–practice gaps, helping to close them.

Legal statute

Health Practitioners Competence Assurance Act 2003

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“The unconscious is a shy beast: don’t pounce!” The making of psychotherapy (and a psychotherapist) in Aotearoa New Zealand

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Abstract

Psychoanalysis, psychotherapy, and Jungian analytical psychology, it could be argued, have as their centrepiece the encounter with the other, both within and without, and the attempt to bring an understanding mind to these others. In this we grapple, encounter, and receive the often-disturbing forces of the unconscious mind, including the implicit early relational experiences which in combination with our biological, and arguably spiritual, template, form the mind into the subjectivity that we experience as the self. But what if the very systems of thought which we utilise to inform our understanding of, and attempt to guide our encounter with, the unconscious, are themselves manifestations of a cultural unconscious, discourses which actually fabricate our very subjectivity as therapist and

O’Connor, J., Nicholls, D. A., Thorpe, M., & Woodard, W., (2022). “The unconscious is a shy beast: don’t pounce!” The making of psychotherapy (and a psychotherapist) in Aotearoa New Zealand. *Ata: Journal of Psychotherapy Aotearoa New Zealand*, *26*(2), 91–122. https://doi.org/10.9791/ajpanz.2022.11

patient, thus constituting the very subjectivity which, by contrast, psychoanalysis and Jungian psychology, suggest is innate and a priori of discourse? This paper explores these complex tensions and how they may inform the construction of psychotherapy in Aotearoa New Zealand. The paper concludes with an exploration of the possible clinical implications of these ideas, including consideration of some clinical vignettes.

Whakarāpopotonga

Me kī rā ka taea te tautohe, ko te aronga nui a te wetewetenga hinengaro, te whakaora hinengaro me te wetewetenga hinengaro Hūniana, ko te tūtakinga ki tērā atu ōku, ā-roto, ā-waho me te whakatau kia mau mai he hinengaro mātau ki ēnei tāngata atu nei. I tēnei ka whātōtō, ka tutuki, ka tangoa mai ngā awenga whakararurarunga o te hinengaro maurimoe, ngā mātaunga wheako whaiora o mua anā ki te honotahi ki ō tātau āhua koiora, tae atu pea ki te hua wairua, ka ahua te hinengaro ki te aronga mōhiohia nei e tātau ko kiritau. Engari, ka pēhea ki te tūpono ko ngā pūnaha o whakaaro whakamahia e tātau hai whai mātauranga, ka whakamātau ai ki te taki i ā tātau tukihanga i te hinengaro maurimoe, ngā whakaaranga ake a te ahurei maurimoe, ēnei kōreroreronga whakaara tirohanga ā-kaihaumanu ā-tūroro, anā he whakaahunga ake i te ngākaukino arā ko te ahurei wetewetenga hinengaro me te hinengaro Hūniana, e kī ana he āhua nō mua noa atu o te whakawhitinga kōrero. E wherawhera ana tēnei pepa i ēnei whakararunga uaua, ā, tērā pea ka whakahouhia te āhua o te whakaora hinengaro i Aotearoa Niu Tīreni.

Keywords: Foucault; psychotherapy; Aotearoa New Zealand; psychoanalysis; Jung; discourse; truth.

McNay (1994) noted French philosopher and historian Michel Foucault's proposition that "The central problem of contemporary thought is its inability to think the other" (McNay, 1994, p. 80):

> … we are afraid to conceive of the other in the time of our own thought … The history of the order imposed on things would be the history of the same (Foucault, 1966, p. xxiv, cited in McNay, 1994, p. 80).

Psychoanalysis, psychotherapy, and Jungian analytical psychology, it could be argued, have as their centrepiece, the encounter with the other, both within and without, and the attempt to bring an understanding mind to these others. In this we grapple, encounter, and receive the often-disturbing forces of the unconscious mind, including the implicit early relational experiences which in combination with our biological, and arguably spiritual, template form the mind into the subjectivity that we experience as the self.

But what if the very systems of thought which we utilise to inform our understanding of, and attempt to guide our encounter with the unconscious, are themselves manifestations of a cultural unconscious, discourses which actually fabricate our subjectivity as therapist and patient, thus constituting the very subjectivity which, by contrast, psychoanalysis and Jungian psychology, suggest is innate and *a priori* of discourse?

Janet Frame

In 1945, prior to publication of her first book, renowned Aotearoa New Zealand author Janet Frame was first admitted to Seacliff Mental Hospital. There her subjectivity was arguably constructed by medical psychiatric discourse leading to an inaccurate diagnosis of schizophrenia and numerous ECT treatments. Michael King (2000) described how close she came to a leucotomy, before the publication of her first book garnered positive attention. In 1951 in Avondale Hospital, King further described,

> Because of what her hospital notes described as a 'strong resentment' of ECT, medical staff attempted to reduce the severity of the symptoms by the prolonged use of insulin shock therapy. This treatment produced comas and convulsions, accompanied by writhings and moanings, believed to have beneficial effects for schizophrenics. It had no discernible beneficial effect on Frame, other than to leave her drowsy and 'mentally numb' in the immediate aftermath. (p. 105)

Arguably, the subjectivities of the clinicians of the time in these hospitals were also fabricated by psychiatric discourse that medicalised emotional distress. Subsequently, when in England in 1957, Frame was admitted to the Maudsley Clinic where Dr. Alan Miller advised, as Frame herself put it,

> I had never suffered from schizophrenia, … I should never have been admitted to a mental hospital. Any problems I now experienced were mostly a direct result of my stay in hospital. I smiled. "Thank you", I said shyly, formally, as if I had won a prize. (Frame, 1989, p. 375, cited in King, 2000, p. 186)

The unconscious, like Frame, is indeed a shy beast. We are wise not to pounce.

Discourse

Foucault (in Simon, 1971) proposed that during each historical era there is a "distinctive epistemological structure — an 'episteme' — that governed how thinkers would think" (Garland, 2014, p. 369). Foucault suggested,

> … what I am trying to do is grasp the implicit systems which determine our most familiar behaviour without knowing it … (Foucault in Simon, 1971, p. 201, cited in Garland, 2014, p. 369)
>
> My problem is essentially the definition of the implicit systems in which we find ourselves prisoners: what I would like to grasp is the system of limits and exclusions which we practise without knowing it; I would like to make the cultural unconscious apparent. (Foucault in Simon, 1971, p. 198, cited in Garland, 2014, p. 369)

Ruptures in the possibilities for what it is possible to think or do are often indicated by heated passions, as taken for granted truths are interrogated and new possibilities for

thinking and doing arise. As Rose (1996) noted,

> What today appears marginal, eccentric, or disreputable, was frequently, at the time it was written, central, normal, and respectable (p. 43).

This paper explores these possible "implicit systems" in which we find ourselves prisoners, the "cultural unconscious" that fabricates the possibility of psychotherapy in Aotearoa New Zealand. I[1] articulate four systems of thought in relation to the nature of the self, which I suggest make possible the practice of psychotherapy as a doable and thinkable thing in this country. The paper concludes with reflections on clinical moments and how these discourses might construct my and our subjectivities as psychotherapists, as well as considering the possibilities for transcending such discursive construction.

Discourse 1: The saviour and the one to be saved; Christian missionary discourse and the formation of "New Zealand"

Sociologist Nikolas Rose has written extensively about the discourses that have made possible the now relentless prevalence of what he described as the "PSY" disciplines, including psychotherapy, in all aspects of our lives, from the psychiatric report in criminal trials, to the self-help books in our book shops, to the so-called "relationship experts" that pop up on our television screens as we addictively consume uncomfortable episodes of *Married at First Sight*.

He suggested that the discourses of the PSY disciplines have "entered into the true" in contemporary society, and have claimed as their exclusive territory the lens through which we come to understand and know the "truth" of the workings of human subjectivity; the very fabric of ourselves. Further, he described the violence of the contests that lead to the emergence of such truths, commenting:

> … truth is not only the outcome of construction but of contestation. There are battles over truth, … [to] force something into the true … Truth that is to say, is always thrown by acts of violence. (1996, p. 55)

In relation to the conditions of possibility that made possible psychotherapy in Aotearoa New Zealand, this violence of the contest of the true preceded colonisation.

Aotearoa New Zealand pre-colonial and colonial context

On 19 March 2019, a few days after the Christchurch mosque attacks, anthropologist, sociologist and historian Anne Salmond wrote an article in the *New Zealand Herald* in response to Prime Minister Jacinda Ardern's statement that "They are us"; that those who have been hurt are us, and Ardern's assertion that "he", the violent perpetrator, is "not us". This is an idea that quickly took hold in the collective, that the violence that was perpetrated was not us, that the violence was in the other. In response, Salmond commented that, in

1 Throughout this paper, use of the first person 'I' refers to the first author, John O'Connor.

fact, the doctrine of white supremacy was foundational to the forming of New Zealand. She wrote,

> White supremacy is a part of us, a dark power in the land. In its soft version, it looks bland and reasonable. Eminent New Zealanders assure their fellows that Māori were lucky to be colonised by Europeans, that Te Reo Māori is worthless, that tikanga Māori has nothing to teach us. … And in its hard version, it's violent and hateful, spewing out curses, incarcerating young Māori in large numbers, denying them a decent education, homes, and jobs, telling them they have no future and are better off dead.

When I first read this, I felt the part of me that wanted to disavow it, that wanted to say, "that's not me, I don't perpetrate that kind of violence." However, I suggest, murderous racial violence is embedded in the discourse of this country, in me, and inevitably, in the practice of psychotherapy in Aotearoa New Zealand.

Pre-European contact with the Indigenous New Zealand "other"

The construction of the "indigenous other", prior to European contact, was profoundly influenced by Christian missionary discourse, in which the self is constructed as a soul to be saved, intertwined with Christianity's "Great Chain of Being" hierarchy, later supplemented by evolutionary Darwinian discourse, with God at the apex, white British men just below, and natives much further down. (For discussion of how racialised hierarchies became mapped on to the Great Chain of Being see Robert Young's (2004) *White Mythologies*). It is this Christian discourse, and the missionary zeal it informed, which enabled the construction of the "other" in the eyes of the British colonists, as a heathen native, inferior and in need of, indeed worthy of, saving.

Captain James Cook's 1769 voyage to Aotearoa New Zealand was sponsored by the Admiralty and the Royal Society of London (Salmond, 1991). The President of the Royal Society, the Earl of Morton, provided Cook with a set of "hints", intended to guide Cook and his men in how they should interact, should they encounter "natives" during their Pacific voyages. Morton, in 1768, in part, advocated,

> To have it still in view that shedding the blood of these people is a crime of the highest nature:— They [Natives] are human creatures, the work of the same omnipotent Author [God], equally under his care with the most polished European. …
>
> Therefore, should they in a hostile manner oppose a landing, and kill some men in the attempt, even this would hardly justify firing among them, 'till every other gentle method had been tried.
>
> There are many ways to convince them of the Superiority of Europeans, without slaying any of those poor people — for Example. — (sic) By shooting some of the Birds or other animals that are near them … (cited in Salmond, 1991, pp. 112–113)

Morton attempts to have it both ways: on the one hand recognising the essential equality of

all humans as equal in the eyes of God, whilst nevertheless asserting the superiority of "polished" Europeans. The discourse of the humanitarian Christian is implicit, assuming as it does the universal truth of one Christian God. Such texts set the scene for later missionary zeal in relation to Indigenous New Zealanders, for the civilising of the heathen native via this "omnipotent author".

The tensions of humanitarian impulses and assumptions of European superiority also informed British instructions by Lord Normanby, Secretary of State for the Colonies, in 1839, to William Hobson, prior to Hobson's journey to New Zealand to seek agreement with Māori for the signing of Te Tiriti o Waitangi, the Treaty of Waitangi. These instructions include the following text:

> Believing, however, that their own [Māori] welfare would, under the circumstances I have mentioned, be best promoted by the surrender to her Majesty …, and persuaded that the benefits of British protection and laws administered by British judges … (in Buick, 2020, p. 71)
>
> There are yet other duties owing to the aborigines of New Zealand which may be all comprised in the comprehensive expression of promoting their civilisation, understanding by that term … [the] advancement of mankind. For their religious instruction liberal provision has already been made by the zeal of the missionaries, and the Missionary Societies in this kingdom, and it will be at once the most important and the most grateful of your duties to this ignorant race of men to afford them the most encouragement, protection and support to their Christian teachers. … until they can be brought within the pale of civilised life, … (in Buick, 2020, p. 74)

Perhaps most revealing of the discourses underpinning this "missionary zeal" are these comments by Reverend Samuel Marsden in 1815,

> The natives of New Zealand are far advanced in civilisation, and apparently prepared for receiving the knowledge of Christianity more than any savage nation I have seen. Their Habits of Industry are very strong: … they only want the means … the more I see of these people the more I am pleased with, and astonished at, their moral ideas and Characters. … (cited in Orange, 2013, p. 10)
>
> Their [the Māori] *minds appear like a rich soil that has never been cultivated, and only want the proper means of improvement to render them fit to rank with civilised nations.* [Emphasis added] ... there was only one remedy which could effectually free them from their cruel spiritual bondage and misery, and that was the Gospel of a Crucified Saviour (cited in Salmond, 2017, p. 61).

Christian discourse constructs Māori as promising prima materia, but in need of alchemical Christian transformation: the transformative substance is Christianity itself. As Salmond (2017) noted,

> The upper [European] end of the Great Chain of Being (with God at its apex, followed by the ranks of "civilised people") was lit with the light of knowledge and understanding; the lower ranks … was sunk in primeval darkness. The missionary enterprise was understood as taking the Gospel of God to savages lost in epistemic murk, and raising them up to enlightenment. (p. 60)

At the centre of this Christian discourse is the conceptualisation of a self and a soul beyond discourse, a self and soul that is God's creation and in need of God's salvation. This same notion is implicit in subsequent psychotherapeutic discourse: a self *a priori* of discourse in need of liberation from inner imprisonment. Such systems of thought underpin Mika and Stewart's (2016) observation of the

> very primal need of the West to control how and when Māori will manifest as this or that, including as a wanting entity … the West has … canonically guessed Māori in advance as either needing or wanting something in particular, or generally being needing and wanting … Māori need and want and are henceforth productive; they ontologically match the expectations of the coloniser. (p. 305)

Thus, the fabrication of New Zealand was profoundly informed by the formation of a binary pair, the superior British saviour, and the indigenous other in need of being saved. And the scene is set for the psychotherapeutic white saviour of the heathen native patient's soul.

Discourse 2: Soma, sickness, and insanity — the self as a sick soma in need of healing

Subsequently the hegemony of Christian discourse in which the self is constructed as a soul in need of salvation was by the nineteenth century considerably under threat, as the influence of Enlightenment science, and the medical model informed by this science, increasingly challenged Christianity's monopoly on the discourses which fabricated the idea of the self. As Salmond (2017) noted,

> … the *Endeavour* expedition was a travelling sideshow of the Enlightenment, lavishly provided with scientific equipment to scan the heavens, collect and examine plants and animals, and explore the remote corners of the planet. … a mechanistic, quantitative vision of reality was going viral. Many aspects of life were transformed … As the mind's eye replaced the Eye of God, people were separated from Nature, and eventually from each other. … This "Order of Things", as Michel Foucault has called it, lay at the heart of Enlightenment science. (p. 34)
>
> … the *Endeavour* voyage epitomised this way of understanding the world. (p. 36)

Nietzsche (1887) argued that in the generations pre-dating Luther, the authority of the Church as the holder of the truth of the human soul was beyond question (see also Bluhm, 1956). Previously priests, and the written Bible, readable only by the minority literate

population, to which priests and monks were a central part, were the holders of all knowledge, and indisputable truths arose from the word of God. Now in the "contest of the true", the nature of the "essential" "truth" of the "self" profoundly shifted. With the emergence of industrialisation, and the Enlightenment's emphasis on science, emerged a perspective in which the world could be known and the universe measured, a perspective which, for example, gave rise to the subjectivity of the botanist Joseph Banks and his scientific endeavours to measure the botany of the South Pacific in his voyages with Captain James Cook (Salmond, 2017).

Such scientific rationalism made the world, and the "souls'" who inhabited it, knowable in a way that the priesthood never could. Not only was the gaze of Enlightenment science turned upon the natural world and the hierarchy of human "races", but moreover this gaze, through the lens of medical science, came to penetrate the inner world of "man".

Insanity and asylums

An effect of this contest of the true was the emergence of Western mental health treatment in Aotearoa New Zealand, via the transportation of imperial medical scientific knowledge and the consequent manifestation of "insanity" in the Aotearoa New Zealand context, and thus the fabrication of lunatic asylums, in the mid-nineteenth century, eventually built throughout Aotearoa New Zealand, reflecting a Western medical lens that gazed piercingly into the mind and body of the human soma, and constructed madness, like the Indigenous of early colonial contact, as a thing to be disciplined, contained, surveyed, controlled, and perhaps even saved and cured.

Emergence of asylums

With the transnational transportation of imperial medical scientific knowledge into the Aotearoa New Zealand context, the self was no longer only a soul to be saved, but now also a sick, insane, soma to be treated, confined, disciplined, and perhaps healed. The power knowledge nexus of British imperial medical science gave rise to the most bizarre of imperial constructions, the asylum. As a correspondent to the Nelson Examiner wrote in 1864 in a letter to the Editor, entitled "The Lunatic Asylum":

> I see the lunatic asylum subject is again revived. What, then, is lunacy? …We know the common idea of lunacy is, that a person deprived of reason is mad, or does not know what he is doing, … But what does lunacy mean? Is it to believe that to be true which is false? …Very well; let us see how this rule will work in practice. One set in religion believes that to be true which another believes to be false and absurd. Are, then, those who were thus "labouring under delusion," as they say, to be put into a Lunatic Asylum, or, rather, Lunatic Prison? … according to the principles of the firm of Lunatic Asylum and Co., it ought to be done. I am, &c., The Ghost of Samuel. (sic) (3 March, 1864, p. 3)

Foucault (1967) observed in his lengthy *History of madness* that, "The language of psychiatry … is a monologue of reason about madness" (Foucault, 1967 cited in Rose 2019, p. 150). If psychotherapy is another manifestation of this "monologue of reason about

madness", then the vast Gothic inspired fabrications of the asylum, and with it the dominance of so-called "moral treatment", are the physical discursive effects of this "reason monologue". For example, in 1884 Seacliff emerged in Aotearoa New Zealand, complete with panoptic tower, housing the insane, who were constructed as mentally unwell.

Michael King, in his biography of Janet Frame (2000), described the Seacliff of 1945 thus:

> In keeping with Otago's predominant culture of origin, the hospital's architectural style was known as "Scottish baronial". To non-residents, who feared both its patients and its staff, the turrets and mock battlements gave the building the appearance of a castle out of a Gothic novel or a horror movie.
>
> Seacliff was, in fact, a Victorian lunatic asylum, with all the qualities that designation implies. It was vast — the largest public building in the country for 50 years from the time it opened in 1884. ... the institution functioned in effect as a prison for most of the more than 1200 patients deemed to require custodial care. Treatment was limited to traditional work therapy [moral treatment], which for women patients meant sewing or cleaning duties, to electro-convulsive or insulin shock therapy, or to the operation known as prefrontal leucotomy, which severed many of the fibres connecting the front part of the cerebral cortex to the remainder of the brain and reduced some patients to a vegetative, albeit less anxious, condition. (p. 72)

By the mid-nineteenth century in England the medical monopoly over madness was firmly in place. As Knewstubb (2011) noted,

> These were the years of high imperialism in which the medical profession played an important part. Britain trained doctors for colonial settlements and imperial administrations ... Medical networks operated across national boundaries and the role of doctor as an agent of Empire is a story still unfolding. (Crowther & Dupree, 2007, p. 5, cited in Knewstubb, 2011, p. 27)
>
> Lunatic asylums were no exception to the operation of these medical "webs of empire". Doctors for colonial asylums brought British medicine as part of the expansion of "civilisation" to the new world (Knewstubb, 2011, p. 27).

Between the 1850s and the 1960s New Zealand constructed numerous vast asylums, later called mental hospitals. In less than a hundred years from Cook's first arrival, a union of transnational knowledge and power, in the form of the European medical model of the nature of self, had emerged, via the nexus of imperial dominance and Enlightenment science, enabling the construction of lunatics as people that needed to be housed in hospitals, and madness as needing to be treated, not "just" prayed over.

Asylums: moral treatment

The emphasis of therapeutic treatment in asylums in the nineteenth century was termed "moral treatment", and was captured by medical discourse, though, as described below, there

was nothing very "medical" about it. It ostensibly focused on regular routines and occupational activities, outdoors for men and indoors for women. Cameron Duder (2007) noted in his history of Ashburn Hall,

> Moral treatment … worked from the assumption that insanity was curable. Practitioners thought that with an orderly return, everyday work tasks and a comfortable environment, patients would recover their self-control and master their illness. … *The individual's own desire to restrain him or herself was to be encouraged through social reinforcement, expectations, and rewards.* [Emphasis added] (p. 24)

As a description of a disciplinary technology, the idea that "moral treatment" might lead the individual to discover their "own desire to restrain him or herself" is evocative. As McNay (1994) noted,

> Far from being liberated, the mad are reduced, in the asylum, to a state of silence and shame and trapped under a perpetual, objectifying gaze that does not listen to madness in its own being, but obscures that beneath a condemnatory morality. (p 24)

Thus, Thomas Clouston, who had taught Dr Truby King, commented in relation to moral treatment,

> It is a law of our being that we must be orderly to some extent in our lives, while for the mentally unsound, order is an especially healing process. It is one of the chief symptoms of our patients that they have lost the sense of normal time and order which characterises sane and civilised men and women, and we must by our hospital arrangements endeavour to restore it to them. (Cited in Duder, 2007, p. 26)

The reference to "civilised" men and women reflects a handing of the baton from missionary discourse which informed the original colonial project to Aotearoa New Zealand in which the mind of the indigenous other, "psyche-nullius", was "discovered" as "fertile soil" to be transformed by the civilising substance which was Christianity; now civilisation was to be ensured by a medical discourse that permitted a moral regime to enable the transformation of the mad mind of the other to turn upon itself, to gaze into its own madness, and to transform itself into a civilised being.

However, the morality of this treatment was infused by the violence of the contest of the true, reflected, for example, in a newspaper article, appearing in the *New Zealand Tablet* in 1881, entitled "Infamy". It outlined concern for the humanitarian wellbeing of "inmates" in the Wellington Asylum.

> The report of the Royal Commission appointed to inquire into the condition of things in connection with the lunatic asylum in Wellington has been published, and the feelings with which it is read throughout New Zealand should be those of shame and burning indignation. The colony has suffered a deep disgrace, and human nature, in its most helpless and pitiable state, has been brutally used.

> Under the guise of a pleasing exterior, such as might well deceive the public eye, — a paraphernalia of billiard tables and pictures, periodicals, and entertainments, among which the patients were now and then exhibited, poor wretches who had incurred the displeasure of their keepers were exposed to the most atrocious treatment. *M'Cintosh*, a comparatively sane man, was taken from his bed at night, in the depth of winter, and subjected to a prolonged shower bath of ice cold water, from which he staggered out half fainting; *Feardon* was struck in the face with violence enough to bring blood from his ear; *Hall*, an inoffensive lunatic, was confined in that horrible instrument of torture, the straight-jacket, for several months until at last his release was enforced by a fall in which he broke his collar-bone. "A hasty word or act might call forth the fist of the superintendent, and a lunatic was punished for his lunacy." … All this is disgraceful to a civilised community, and reflects grossly on their Government. If madness were a crime it could not have been more harshly visited, or obtained less sympathy even on the part of those whose duty was its alleviation.
>
> The credit of the colony, then, so far as it is retrievable in this matter, depends on the fundamental alteration and amelioration of everything connected with the Asylum in question; It also depends to a considerable degree on the exemplary punishment of all found guilty of a part in the matter, according to these several measures. (April 22, 1881, p.13)

Indigenous "insane"

The links between humanitarian discourse, and medical discourse, in relation to the insane, is most profoundly revealed in the treatment of the "indigenous insane". As Swartz (2010) noted,

> Although [it was] not yet clearly apparent in the 1860s, colonial asylum doctors were soon to be faced with the problem of managing an insane population diverse not only in terms of class, but also of race, culture, and illness presentation. This opened a Pandora's Box of speculation on the psyche and insanity of indigenous populations, their intelligence and personality structure, emotions, and habits. Scholarly work inscribing the insanity in colonized populations as intrinsically different from that found in European countries became a thriving industry lasting well into the twentieth century. (p. 171)

Similarly, Burke's (2006) thesis examining the archive of the Auckland Asylum, in relation to the treatment of Māori patients, 1860 to 1900, reveals the "civilising" and "ordering" discourses infusing this treatment. She noted,

> In the colonial period, asylum authorities and physicians were preoccupied with the "civilising mission" for both Māori and non-Māori patients. The visibility of this language was particularly noticeable in descriptions such as "industrious in her habits", or "quiet and industrious, but stupid". Moreover, patients were categorised as "clean and orderly", as having "dirty habits", or as "prevailed on to stop his filthy

> habits". For Māori, like non-Māori, civilisation included cleanliness, orderliness and Christianity. However, for Māori, unlike non-Māori, it also meant the acceptance of Eurocentric notions of the "self" based on whiteness. For example, Hemi Te K's acceptance of this was expressed in his case records when he revealed that "he thinks he will have to lose his dark skin and become white". (p. 55)

Asylum summary

For 100 years, between 1852 and the late 1950s, asylums, later renamed mental hospitals, came to dominate the physical landscape, and the psychological territory, of the suffering human mind in Aotearoa New Zealand. They were places to survey, control, and ostensibly treat the suffering other. In the 1980s, liberal economic theory increasingly captured political discourse in Aotearoa New Zealand and informed the deinstitutionalisation of mental health patients and the move to "community-based" treatment. But this transition was preceded by yet another rupture in the systems of thought which informed the construction of the nature of self in Aotearoa New Zealand.

Discourse 3: Self and psyche: psychoanalysis and the mind

By the early twentieth century, the hegemony of medical science, and its dominance in claiming the mad body and self as its own, began to be challenged by a psychoanalytic discourse in which self now became constructed as a psyche in conflict, and in need of interpretation rather than medical intervention. The interface of these discourses and the tensions between them are revealed in newspaper articles of the time, as the medical man and the psychotherapist began to be fabricated by discourses of science, medicine, and psychoanalysis. For example, in an article in the Lyttelton Times in 1914, entitled "Science up-to-date: Psychotherapy", James Collier wrote:

> Our … universities in New Zealand … are still without this indispensable complement of efficient psychological teaching … What, then, does psychotherapy undertake? It undertakes, in the interests of health, to influence psycho-physical states — namely states of the mind-brain system, or occurring in other parts of the body that are somehow under the influence of the mind. It may be directed towards removing the sources of a disturbance, placing the patient under different conditions, curing the disease if possible, and acting "directly on the psychophysical state, inhibiting the pain, suppressing the emotion, substituting pleasant ideas, distracting the whole mind, filling it with agreeable feelings, until the normal equilibrium is restored". (January 17, 1914, p. 6)

In a follow up article Collier (1914, February 23) further commented:

> Professor Muensterberg is the ideal psychotherapist. … Following Freud, he invariably sets himself to find the origin of the particular obsession or disturbance, and its starting point. It is not always easy to find. Some strong emotional experience in early life had become the generating point of a persistent obsession; or it may have been a past episode, or an organic sensation, or only a chance experience … The antecedent

> cause may be indignation or fear, or surprise, or an accident. Having found it, his aim is to remove the freak idea, the unreasonable dread, the absurd consequence. He side-tracks it and switches it off by linking it with appropriate associations. All ways are to be used for this end. Sympathy and encouragement, reasoning (into which an element of suggestion often enters), persuasion (which is only a kind of suggestion), formal assurance are all to be tried. (p. 8)

In the *Ohinemuri Gazette*, 1920, an article entitled "Original sin girl: Mind healing cure" provides a description of a treatment by Dr Dodd,

> [a] specialist in the new treatment of psychotherapy or mind healing. … he first set about exploring the child's mind in an effort to discover some happening or emotion in the child's earlier life that had been "stowed away in the subconscious self" but was still upsetting the mental balance in another direction. … "This is a striking example of the wonders that have been worked by psychotherapy, or mind cure, which has been so extensively employed for the cure of soldiers suffering from war shock." (September 24, 1920, p. 3)

And in a letter to the Editor of the *Auckland Sun* in 1927, a correspondent entitled "Humanist" wrote of the need for psychotherapy rather than imprisonment of criminals:

> My opinion is that none of these unfortunate human derelicts should be dragged into court punishment at all, which is as inhuman as it is ridiculous. Their cases should be handled only by a trained psychiatrist who is the only one fully qualified to take charge of them. It is only psychotherapy which can get at the root causes of abnormality, and effect a cure, if possible, in the individual case … And in the meantime, the least one can ask is that any judge or magistrate called upon to deal with such cases should be first at any rate in the elements of psychotherapy. ("Sub-Normal Youths", August 12, 1927, p. 8)

Again, emerging from the transnational transportation of European knowledge, this time a psychoanalytic discourse, psychoanalysis transforms the sick body into a conflicted psyche, in need of the input from the expert of the psyche, still a medical man but now psychoanalytically informed. The confluence of psychoanalytic and medical discourse in the construction of subjectivity is further revealed in Dr Stuart Moore's article entitled "Psychotherapy", published in the *New Zealand Medical Journal* in 1913. In it he advocates for the benefits of Freudian informed analysis and hypnotism whilst describing the dangers of the non-medical quack:

> The subject [of psychotherapy] was far too long left in the hands of the unscientific. Unfortunately, by them it was submerged in a malodorous swamp of superstition, humbug and confusion of thought (p. 514) … this knowledge, which should permeate and influence our whole work in medicine, surgery, and midwifery, stands woefully neglected and quackery triumphant, spews forth its unscientific statement and

> superstitions on a credulous public. The overthrow of quackery must be brought about by the systematic attaining and dissemination of knowledge in the medical profession. … Despite all the nonsense with which this subject is popularly surrounded, I hope by giving a brief account of its modern scientific foundation to show that the line which divides true science from its counterfeit is here as everywhere, distinct. … Religion, morality, mysticism, have nothing to do with our subject. (p. 515)

And so emerged another battle for the soul and psyche of the citizens of Aotearoa New Zealand.

Founding of NZAP

These medical and psychoanalytic contests of the true are apparent in the words of Charles Bevan-Brown, the leading figure in the establishment of the New Zealand Association of Psychotherapists (NZAP) in Aotearoa New Zealand in 1947. Manchester and Manchester (1996) noted Bevan-Brown found New Zealand in 1940 to be a "psychiatric wilderness" and that "Medical students received little psychiatric training and almost no appreciation of the new neuroses and psychosomatic medicine" (p. 11). Further, they commented,

> [Bevan-Brown] expressed great concern that [medical] conditions of psychological origin or with a psychological component are too often treated by medication or even surgery. Those of us who looked back to the 1940s can remember surgical procedures regularly performed and talked about, that seem to be of only minor consequence and incidence today. [Bevan-Brown] is alleged to have said "God help the masochistic woman who meets up with the sadistic surgeon — she will almost certainly lose some of her organs." (p. 11)

His warning brings to mind Janet Frame's close call with psychosurgery. Bevan-Brown further perceived that the inhabitants of Aotearoa New Zealand appeared blind to the reality that central to emotional health is the care of the infant. Manchester and Manchester (1996) further commented,

> In putting forward new and radical ideas on "natural" childbirth, home confinements, mother-infant bonding, early child care practices, relaxation of the rigidities of the Plunket system, restraint on physical punishment of children and advocacy of abolition of corporal punishment in the school system, and radical reduction of the use of electroconvulsive therapy in the treatment of mental illness, Dr Bevan-Brown became surrounded by a somewhat "frosty" professional climate and to be regarded by some as an "impractical crackpot". (p. 15)

In the contest of what is able to "enter the true", there arises a new truth regarding the nature of self, a "psychoanalytic infant true self" and a governmental technology in the form of psychotherapy, that might facilitate this truth into existence. In more recent times, the apparently hostile companions of psychoanalysis, cognitive behavioural therapy, and the humanistic traditions, have gained more traction within psychotherapy in Aotearoa New

Zealand. Yet, whilst we erect fences of disagreement between them, these approaches all share a belief that the truth about, and freedom for, the self, rests in the power of the individual to liberate themself from inner constraint.

Discourse 4: Wairua and the indigenous challenge

Moreover, the hegemony of Western therapies in relation to the construction of psychotherapy and the nature of self in Aotearoa New Zealand have, in the past 40 years, ruptured again with the Indigenous challenge.

In 1986 a paper at the NZAP conference was entitled "Understanding the Maori", a title disturbingly resonant with Mika and Stewart's (2016) Māori other, a "needing and wanting entity". Since 1986, Māori authors and clinicians have vehemently asserted an Indigenous challenge to this positioning of Māori as the sick one in need of the white therapist's healing powers. In so doing we come full circle, as Indigenous Māori refuse the discourse that preceded and informed the colonial project in New Zealand, that of the superior white saviour and the heathen Māori other to be saved, instead articulating an Indigenous psychotherapy in which the need to free the "colonised self" is central. Paraire Huata, in his provocatively entitled paper "Māori psychotherapy — A cultural oxymoron" (2010), commented,

> Before you cross my border, let me give you some glimpses of what you will encounter.
>
> You will hear a different language. You will see a group, a community. You will smell a different aroma, you will taste food for the mind and spirit. You will touch beyond the constraints of the physical realm. In fact, you will be bombarded with a cacophony of sounds and images that may tell you that you are in a foreign land. Perhaps you are. (pp. 4-5)
>
> The term Māori psychotherapy is an oxymoron. As we know an oxymoron is a figure of speech that combines two normally contradicted terms. …
>
> Psychotherapy in many ways represents the clinical expressions for a Eurocentric modality best understood as being of the predominant culture. Is psychotherapy a noun or an adjective, I'm unsure.
>
> Under the notion of biculturalism then we are often forced into an oxymoron. (p. 5)
>
> I trust then that the journey you have as an association embracing all of your differences and struggling to not talk past each other will bear fruit that your grandchildren will gladly consume together. (p. 6)

Even in his assertion of the oxymoron of Māori psychotherapy, he gestures to the freeing of the Indigenous self, as Māori bombard non-Māori psychotherapists "with a cacophony … [from] … A foreign land". Subsequently, Māori clinicians such as Morice & Woodard (2011) have argued that,

> the need for a Māori psychotherapy is relatively obvious to anyone who is Māori. The purpose of a Māori psychotherapy is no different from the purpose of a Pākeha psychotherapy for Pākeha [non-Māori of European descent] or tau iwi [non-Māori]. However, as long as psychotherapy remains mono-cultural, it will remain unable to meet the needs and aspirations of Māori practitioners and Māori clients. (p. 15, cited in Hall, 2015, p. 80)

Therefore, Reidy (2014) for example, proposes a conceptualisation of a mana enhancing psychotherapy, whilst Fleming (2016) proposed that attachment to matauranga Māori, to whanau, and to the nonhuman world, is essential. Similarly, Hall (2015) argued that "for Māori, these attachments are fostered through a dynamic whakapapa system of Tūhonotanga" (p. 132).

Woodard (2008; 2019), also wrote of the Indigenous self, a self inextricably intertwined with whenua; that tangata whenua literally means "people — land", there is no "of" conjunction. Connell (2008) more broadly explored the production of knowledge within social sciences and articulated what she described as a Northern bias in the production of this knowledge. She argued for theories arising from and specific to a Southern perspective that might "present and represent experiences from the periphery and, therefore, that reclaim erased wisdom, knowledge and experience" (Tudor, 2018, p.132). Woodard (2014) also argued that the Tohunga Suppression Act (1907) is a painful example of an attempt to maintain the dominance of Western approaches to psyche and to disable Indigenous knowledge, whilst Morice et al., (2017) proposed that,

> through the lens of te Tiriti, Māori psychotherapy would be actively encouraged to develop itself, both as a modern, westernised approach to care for the psyche or soul, and as a contemporary indigenous social healthcare practice rooted in traditional Māori values, worldview, and healing practices. (p. 126)

Māori and the therapy of the psyche, prior to European contact

Of course, Māori therapy of psyche had been practiced for many centuries before European contact. Indeed, Tudor (2018) noted that the phrase "indigenous psychotherapy" has probably been utilised only relatively recently, citing Torrey (1970) as a possible beginning point, whilst suggesting that the practice itself may well have a much longer history (p. 66, and p. 76, footnote 116). For example, Salmond (2017) described the death of the Māori Rangatira Ruatara, in 1815, in which,

> Convinced that Ruatara's hau was being assailed by Atua (powerful ancestors), perhaps those of the Europeans, the tohunga (priest) isolated the young chief from all but his closest relatives, and tried to prevent the missionaries from visiting the tapu enclosure. … The scene was set for an ontological collision, with Ruatara's life in the balance. Competing cosmologies swirled around his sickbed. Ideas of ora and life, mate and death, tapu and the Christian God, atua and Satan, hau and the immortal soul battled it out over his wracked, tormented body. (p. 58)

It is the dominant construction of psychotherapy, rather than the fact of its Indigenous practice, that is now rupturing, as a further contest over what can "enter the true" is well under way.

Pastoral power and the violence of kindness

Each of these ruptures in the discourses constructing the nature of self were, and are, ostensibly informed by apparently benign attempts to tend to the wellbeing of humankind. Christianity, attempting to save the Indigenous other in service of our own souls; medical science, attempting to heal the sick soma; psychoanalysis, attempting to free the psyche from its conflicted torment; and Indigenous knowledge seeking to free a colonised self. Each in its own way appears to seek to participate in the emancipatory project of being a self, freely and truthfully, the utopian possibility of a self free of oppression and subjugation. As Nikolas Rose (1999) noted,

> Even when professional help is needed, one of its first tasks is to help individuals "come to a belief in their own ability to make changes in themselves and their lives". Therapy is no attempt to enforce conformity but apparently part of a profoundly emancipatory project of learning to be a self. (p. 242)

Of course, freedom and truth have been such central pillars of psychotherapeutic work. Winnicott's true self (1965), the spontaneous gesture of the infant held in maternal preoccupation; Brandchaft's (Brandchaft et al., 2010) imprisoned spirit, emerging from its intrapsychic cell; Jung's (1966) individuation from the collective; Bion's (1962; 1970) transformations in "O"; and Woodard's (2008; 2019) indigenous self of whenua and tangata, all speak to the idea that there is an inner self, whether intrapsychic, interpersonal, sociocultural, or transpersonal, seeking expression and freedom and truth.

However, paralleling the emergence of psychotherapy as a technology of self, ostensibly enabling truth and freedom, has been the development of Aotearoa New Zealand as a political entity based upon a capitalist and increasingly neoliberal economic philosophy. Neoliberal economic ideology also seeks to "free" us, but in a particular way: to be free to serve the needs of the market. As Dean (1999) noted,

> [in] The liberal economy of government … knowledge … from social economy … social statistics to criminology, educational psychology, sociology, and beyond, … become the "dialogical partners" (Weir, 1996) of liberalism's process of self-critique, self-review and self-renewal. (p. 128)

This birth of the emotionally "true" self serves the development of autonomous individuals free to choose to be the productive self required of the post-war colonial citizen. And the confessing psychotherapeutic self is the means by which we learn to become this self; a confessing self, ubiquitous in contemporary Aotearoa New Zealand, in which every aspect of our lives is psychologised, from body image, to sporting skills, and newspaper columns

provide psychological love life advice to the lonely and forlorn. Indeed, it is notable that the emergence of the psychoanalytic discourse of the confessing self within the Aotearoa New Zealand context, extending beyond the parameters of the psychotherapeutic office, is not a new phenomenon. For example, in a lecture entitled "Suggestive therapeutics" reported in *Kai Tiaki: The Journal of the Nurses of New Zealand* and given to the members of the Wellington Provincial Masseurs Association in 1923, the presenter, Dr Eardley Fenwick, proposed,

> I must just hark back for a moment to the cause of psycho-asthenic states. The emotions are at the bottom of all — fear, love, hate, anxiety — ... [The patient] succeeded however in suppressing, or rather repressing this shock. ... Now if this repressed incident, incidents, unpleasant experiences, or emotional disturbances can be discovered and brought to light, the patient is half way on the road to recovery. This is, roughly, the raison d'etre of a form of psychotherapy elaborated by Freud's psychoanalysis. And the essentials of it are the discovery of the repressed emotional injuries in the subconscious mind, and the bringing of them to the surface so that their relation to the present illness may be demonstrated to the patient, and that he may deal with this by a reasoning process of his conscious mind instead of allowing it to deal with him by an unreasoning emotional process of his conscious mind. (p. 99)

In Rose's (1999) critique of the psycho-therapeutically produced self, he suggested,

> Psychotherapeutics is linked at a profound level to the socio-political obligations of the modern self. The self it seeks to liberate or restore is the entity able to steer its individual path through life by means of the act of personal decision and the assumption of personal responsibility. It is the self — freed from all moral obligation but the obligation to construct a life of its own choosing, a life in which it realises itself. Life is to be measured by the standards of personal fulfilment rather than community welfare or moral fidelity, given purpose through the accumulation of choices and experiences, the accretion of personal pleasures, the triumphs and tragedies of love, sex, and happiness. (p. 258)

Winnicott's (1965) true self, Jung's (1934-39) transpersonal Self, and Freud's (Breuer and Freud, 1957) transformation from misery to ordinary human unhappiness, with the capacity to love and to work, all speak to this possibility of "freedom" to be a self, autonomous, independent, and productive. Tragically, psychotherapy is littered with the horrendous consequences facilitated by the minds of "free men" inhabiting the role of holder of truth and healer of the psyche, whilst hurting those we seek to heal.

Homosexuality and the dark other

Perhaps one of the most graphically painful manifestations of psychotherapy as a dangerous material effect of discourse is reflected in the history of the psychotherapeutic treatment of homosexuality, including here in Aotearoa New Zealand. Basil James, a

former President of NZAP, was one of many whose minds were captured by a medical and psychotherapeutic discourse that pathologised homosexuality. Whilst in Britain in 1962, he wrote a paper entitled "Case of homosexuality treated by aversion therapy". He described a disturbing behavioural treatment in which nude photographs of men were paired with an emetic dose of apomorphine by injection, inducing nausea, whilst

> The aversive effect of this pattern [of same sex sexual attraction] on [the patient] and its consequent social repercussions was then described in slow and graphic terms ending with words such as "sickening", "nauseating", etc., followed by the noise of one vomiting. (p. 769)

In 1967 in the *New Zealand Medical Journal*, James wrote an overview of behavioural therapeutic principles informing the 'treatment' of homosexuality, noting,

> Behaviour therapists view homosexuality as a symptom, a biologically and socially maladaptive response, … [and thus, aversive] techniques are roughly of two kinds — those using chemical and emetic agents and those using electric shock … apormorphine technique seems to have been largely replaced by the use of unpleasant electric shock delivered from finger electrodes as the aversive stimulus. (1967, p. 252)

Tragically, medical and psychiatric discourses in relation to race, gender and same sex attraction combined in even more disturbing ways, as outlined in Laurie Guy's article "'Straightening the queers': Medical perspectives on homosexuality in mid-twentieth century New Zealand". Guy (2000) described the psychiatrist Laurie Gluckman, who, in 1966, gave a diagnostic summary of 100 lesbians he had treated, labelling 68 with terms such as psychotic, prepsychotic, and psychopathic (p. 113). In relation to Māori, Guy noted, that Gluckman,

> once labelled certain Māori lesbians as suffering from "heterochromophobia", that is, from "a sexual neurosis in which sexual expression is stimulated by a racially different skin colour to that of the patient". (Guy, 2000, p. 113)

Similarly, the dark shadow of race theories appropriation of Darwinism and the Christian "Great chain of Being" (Young, 2004) is reflected in racialising discourses uncomfortably revealed by Johnstone and Reid (2000), in which the researchers interviewed 247 psychiatrists regarding their training and its effectiveness for helping work with Māori clients. They noted, "11.3% all male, all New Zealand born, and with 10 or more years' clinical experience, believed that Māori were biologically or genetically more predisposed than others to mental illness" (p. 135). Numerous racist qualitative comments included the following,

> This questionnaire is worthless! I mean the Maoris (sic) are always going on about the importance of land etc, etc, so why did they bloody well give it away. They went

> on about the importance of forestries and lakes and then that bloody idiot cut down the tree on One Tree Hill. I feel that they are getting the appropriate services they need, just not using them, medication is the answer — but they just don't take their pills — if cannabis was prescribed, I'd bet they'd bloody take that. (p. 142)

Me on the couch

As someone who has lain on the couch of psychoanalysis for decades, seeking to enhance my authenticity, authority, and autonomy, to quote Chris Milton (2013), it is frightening to consider how the discourses I have just described might course through the fabric of my being, and constitute my very subjectivity.

The Christian discourse of missionary zeal encouraged me to choose the confirmation name of Francis, as the shy 12-year-old that I was sought to inhabit the priest like identity of my Catholic faith, guided by the prayer of St Francis (2022):

> Lord, make me an instrument of your peace.
> Where there is hatred let me sow love;
> Where there is injury, pardon;
> Where there is doubt, faith;
> Where there is despair, hope;
> Where there is darkness, light;
> Where there is sadness, joy.
> O Divine Master, grant that I may not so much seek
> To be consoled as to console;
> To be understood as to understand;
> To be loved as to love.
> For it is in giving that we receive;
> It is in pardoning that we are pardoned;
> And it is in dying that we are born to eternal life.

The asylums, subsequently relabelled mental hospitals, infused my childhood; my aunt with whom I lived, worked as a social worker at Kingseat Hospital for decades. In the 1970s I would go to Kingseat open days, fairs, and picnics, mingling with the patients, doctors, and nurses, bewildered and enchanted by the strange and fascinating conversations that emerged. St Francis was right at home. These encounters shaped my choice of profession, as I discussed with my aunt the possibility of becoming a social worker, then discovered such a thing as a psychotherapist which seemed to inhabit similar terrain. I still immensely value residential therapeutic communities, having been part of initiating one with Segar House 23 years ago.

Psychoanalysis introduced me to an inner self, the shock of discovering an inner world perpetually bubbling beneath the surface, informing my every move; this now felt the answer to freedom and truth. Before Indigenous discourse shocked me out of my slumber, inviting me to wairua, to Māori, to hongi, mauri, and the breath of life. Perhaps the indigenous ally, rather than saviour, was my true psychotherapeutic home.

The true self

Foucault had little time for the concept of a "true self", an inner truth to which we might listen, and which might be enabled by the confessional act of psychotherapy. He critiqued faith in such a possibility as a misguided belief and enactment of Christian pastoral power and a regrettable belief in the idea that freedom might reside in the confession of one's inner truths. Such inner revelation, Foucault suggested, merely reflecting the emergence of a self fabricated by the discursive systems of thought of the time. Jung's dialogue between ego and the trans-personal and transcendent self is reduced, through a Foucauldian lens, to a self-deception, in which we mistake the phenomenological experience of freedom, inner truth and numinous connection, as evidence of relationship with a transpersonal Self, rather than, as Foucault would argue, yet another manifestation of discourse and its material effects.

Is my subjectivity inevitably formed by discourse, unable to transcend it, as I wrestle with the difficulties of staying with uncertainty, fear, and doubt, my own and my patients, in relation for example, to contemporary transgender experience, and the discourses that traverse this terrain? Will I inevitably repeat dangerous discursively informed clinical practice, even as I seek to do my "Christian Good", a white saviour repeating the cultural unconscious of our discursively constructed times? Or is there a way for me to inhabit my self, beyond discourse? I do not know. Nevertheless, clinical moments and the work of C. G. Jung, Thomas Ogden, Wilfred Bion and others inspire possibilities in me, as does Basil James.

Helplessness and ignorance

Subsequent to his dangerous pathologising of homosexuality, James, in 1999, offered an emotional reflection in which he regretted the harm which he had perpetrated. Guy (2000) quoted James as writing in a personal communication to him, that,

> The treatment of the [homosexual] patient which I published not only, it now seems to me, sought to incorporate some of the avant garde thinking of the day (learning theory) but much more importantly, *helped me to deal with my helplessness and ignorance*. [Emphasis added] (Cited in Guy, 2000, p. 117)

Helplessness and ignorance. Perhaps the feeling psychotherapists most fear is helplessness. We will do anything but feel helpless. Perhaps it is in this moment of utter incapacity, by which I do not mean a glib lip service to Bion's without memory, desire or understanding, Keats' negative capability, mystery, uncertainty, and doubt, but rather a determined willingness to surrender to such undoing states.

To feel, particularly states of helplessness and ignorance, fear, desire, hate, love, disgust, shame, or sexual passion, without evaluation of myself as a good or bad therapist. Such evaluation inevitably requires a flight from these disturbing affective states, leading us, I suggest, to take refuge in a submission to the contemporary systems of thought of the cultural unconscious which construct the "truth" of the psyche in any given episteme. When I flee such disturbing and affective states, I cannot dream my thoughts, as Bion

would encourage, I cannot bear the uncertainty of ignorance and helplessness. I am too tempted to reach impulsively for the refuge of certainty and action, of prescription drugs and electric shock treatment, with leucotomy as a last resort. I am too frightened to allow the pictogram of my dreaming mind to slowly form into a Lego block of thoughts about feelings.

By contrast, if I am courageous enough, is there the possibility of an emotional contact, an intimacy, unconscious to unconscious, that enables me to glimpse beyond these discourses? James hints at the possibility of transformation that exists in managing to bear our helplessness, of not being captured by the need to fix, heal, and cure. Do the discourses of Christianity, medicine, metapsychological psychoanalysis, perhaps even Indigenous critique, command my mind to know? Or can I bear the possibility of feeling something and knowing nothing?

Thinking and dreaming

The potency of Wilfred Bion, I think, is in his conceptualisation of the process of thinking that the mind is a pictogram, continually dreaming itself, an unconscious cinema, playing beneath the surface of our awareness. Ferro (2011) wrote,

> I believe that the "waking dream thought" (Bion, 1962) is the most significant and important of [Bion's] concepts. … our mind … constantly creates a continuous operation of "alphabetisation" of all the sensory stimuli and proto-emotions that we receive. The endpoint of this operation is the formation of alpha elements, which, when we put them into sequence, produce the waking dream thought (p. 155). … The mind that brings about this transformation does not only transform the proto-sensorial and proto-emotive chaos into affectively meaningful representation, but, through the constant repetition of this mental work, it also transmits "the method" [of thinking] employed to achieve this (a function). (p. 162)

What this means for how we might inhabit the therapeutic moment is poetically captured by Thomas Ogden (2001):

> … the analyst must be able to experience … what it feels like being with the patient; and yet, for the most part, these experiences are unconscious. The analyst is initially, and for quite a long time, more "lived by" these predominantly unconscious feelings than he is the author of a set of thoughts, feelings, and sensations that he experiences as his own creations and can name for [her] himself. A good deal of my work as an analyst involves the effort to transform my experience of "I-ness" (myself as unselfconscious subject) into an experience of me-ness, (myself as object of analytic scrutiny). (p.19)

Central to the phenomenology of what Ogden describes is the capacity for reverie: to hold the dream thoughts of our mind, evoked in the presence of our dreaming patient, in our mind, even as these fleeting fragments slip illusively from us.

Jung (1966) described, in his psychology of the transference, the encounter, unconscious to unconscious, of the pictogram of the mind of patient and analyst. Ogden (2001) and Bion (1962) encourage my phenomenological enquiry into these fleeting dreams thoughts, slowly allowing them to cohere into representation of inevitably disturbing affective states, and Foucault (1967) warns me that to react too quickly is to risk enacting the discourses of our time. To do so, I suggest, is to avoid inhabiting my self, feeling, dreaming, and eventually thinking, recognising the immense emotional labour such a stance requires. If psychotherapy is not to be a further "monologue of reason about madness", then our only hope is to surrender to, and linger with, the irrationality of the encounter, unconscious to unconscious, therapist, and patient.

The disobedient Foucauldian

In the end, I'm not a very disciplined or obedient Foucauldian.

Jung suggested that symbols of the self that emerge in dreams are the royal road to wholeness, and that the dream symbols of the self, are "the best possible representation of a relatively unknown fact" (Jung, 1971, p 474). It is from these origins that Fordham (1993) articulated the notion of a primary Self, a priori of early relational experience and of discourse. Such a formulation is in complete contrast to the Foucauldian perspective in which self is an effect of discourse. But if identity is formed by discourse, what then is discourse formed by? I suggest the systems of thought which give rise to our subjectivity, are also preceded by a Self that gives birth to these systems of thought. As Grotstein (2007) put it:

> Not only did a mind develop to harvest the "thoughts without a thinker", but another aspect of the mind had to originate those unthought thoughts. (p. 67)

And as Jung, in his articulation of the notion of a transpersonal self, continually emphasised, such a self can only be known via experience. He noted:

> … you cannot say anything definite about it [the Self] because it is greater than you. You can only stammer as if in the presence of a greater one. And you are right if you stammer and are embarrassed, not finding suitable terms or analogies. Then you do it justice. (Jung, 1934-9, p. 432, cited in Huskinson, 2002, p. 443)

In psychoanalytic psychotherapeutic work we are invited to listen for the derivative manifestations of the unconscious as they reveal themselves like fragments of a dream, elusive to our minds, but able to be glimpsed if we linger like Ogden, patiently and attentively. And perhaps it is this experience of subjectivity, which, if we are emotionally brave enough, might allow us to glimpse beyond discourse, beyond the nexus of power and knowledge that gives rise to much that we experience as subjectivity, and to encounter the numinous beyond our conscious knowing: the symbolic that allows a representation of otherwise relatively unknown experience, and the possibility of subjectivity a priori of discourse.

Clinical vignette one[2]

Michelle, whose horrific history of early relational horror had emerged relentlessly in the tumultuous first three years of our therapeutic work, arrived withdrawn and cautious. We explored her longing for closeness and Michelle said:

> You know how you sometimes talk about me holding you in my mind in between sessions. And how I don't seem too good at doing that. … I think when we have a sucky session … it seems that you stop existing in between sessions … I don't feel … you know, how to explain it. I know you are not really gone but you stop existing. I also know I can't contact you no matter how much I might want to because you stop existing.

She appeared fragile and I felt protective and anxious. She further expressed,

> It is hard to explain the disintegration I so dread. … a feeling unlike any other. As if someone picked up an eraser and started to slowly wipe me out of existence. They started at my feet, disconnecting me from the world around me. I can feel myself floating and I know that I have to stop them from erasing me entirely, for if I am erased completely, I will never be able to come back. I will not be able to re-form, and people will never be able to connect to me again.

In the next two sessions Michelle explored with me her impulse, when feeling as if neither she nor I existed, to make sexual contact on the internet, and her corresponding urges to seduce me, converting the feeling of powerlessness and disintegration into a feeling of contact, existence, and potency. Ogden's (2001) notion of the autistic contiguous position emerged in my mind: I wondered with her if sexual contact reflected a primitive longing to be physically held, offering the potential of a feeling of self when she felt no self existed. Michelle expressed her fear that if she was vulnerable with me this would expose "weakness" which I might exploit or abuse. I felt furious, my thinking disabled, as I remembered the cruelty of a man who had sexually assaulted Michelle in the very moment she had revealed vulnerability and longing. She had the following dream:

> I'm on a bike, there are a big group of about 20 people waiting for the light to turn green so we can all bike. Too late, I notice two police officers on the bikes, across the street. … They start chasing me on their bikes. … I fall off my bike. Two cops picked me up and want me to spend the night in jail. Then you're there, and you offer to keep an eye on me, and after you promise not to let me out of your sight, for even one second, they allow me to go with you, instead of taking me to jail … I want to move closer to you … But I'm scared you might find that inappropriate and send me to jail anyway.

The dream left me tender, and fearful: I feared that closeness could lead to danger, transgression, and imprisonment. I attempted to linger with the fear.

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2 Names and other identifying material have been altered to ensure client anonymity. As noted earlier, the use of the first person 'I' refers to the first author, John O'Connor, in relation to these clinical vignettes.

In a subsequent session I walked into my waiting room to find her barricaded with cushions between her and me, sitting on the floor hugging a soft toy. Taken aback, I said nothing. She looked sad. I glimpsed tears, not with my eyes, but with all aspects of my being, a pictogram of my mother's ferocious grief, my grandmother's soft and mournful tenderness, my brother's destructive losses. These passed my mind in an instance, like misty rain in the early morning, barely perceptible. And then my childhood cat, Tiger, curled onto my bed, comforting the seven-year-old in me from the winter cold. He snuggled with me safely, pricking my mind awake.

Looking straight ahead Michelle spoke quietly. "I don't want to see you today." The shame of my own shyness, hidden beneath my winter blanket, reassured me. Somewhere I knew this meant she wanted me to be with her, but not to look at her. I sat in a chair, in the waiting room, four or five feet from her.

> John: "That's OK … I'll just sit here."
>
> Quietly Michelle began to cry her tears. I looked out the window, avoiding intrusion. All the griefs of my life and hers were with me now.
>
> John: "You're sad today."
> Michelle: "Yes."
> John: "Do you want to tell me what you are sad about?"
> Michelle: "I'm just sad …"

Together we explored the many things she felt sad about, particularly the cruelty and reactivity of her family's rage and the empty terror this left in Michelle. Subsequently she wrote, in her journal:

> Today felt like a significant day. After more than three years with John … I cried with him for the first time. I have struggled so hard to keep myself from losing it. To keep myself from falling apart. Yet today the little girl inside me curled up in the waiting room, with her cloth rabbit clutched close to her chest, barricading herself in the corner with two chairs.
>
> And I cried. And cried. And John bore with me.
>
> He sat down on the remaining chair and respectfully allowed me my space by not looking directly at me and staying well away from my line of vision. We talked and we were quiet, and as the tears subsided I could feel myself slowly being reformed. I had dreaded this moment for months, years even, for fear of falling apart and not being put back together …That if I would start to fall apart, I would disappear, for John wouldn't be able to glue the pieces back together ... And yet today, this is exactly what seems to have happened.
>
> As the tears started falling, I could feel myself grow smaller. I … barricaded myself

> behind two chairs, where my quiet sobs would not be ridiculed, nor punished. And when John walked in to get me for my session, he just sat down and was gentle with the little girl sobbing on the floor and "held" her as much as he could, from one chair away.
>
> Today, I cried.

Existence

As my patient encounters her experience of not existing, and then in the tenderness of our therapeutic relationship discovers the possibility of being "reformed", what is this subjectivity that comes into "existence" in her own mind: is it a subjectivity formed by discourse? Or is there a self, prior to discourse, a primary Self as Fordham (1993) conceptualises, which comes into being, in the encounter between us, unconscious to unconscious? This is a question with which phenomenologists and Foucauldians have so often wrestled.

Subsequent dream

Many years later Michelle revealed the following dream:

> My parents are arguing, and I feel really tense. You walk next to me and you keep encouraging me: "You can do this now, you've come through way worse than this, it's ok, you can do this now." We walk close to each other, it isn't sexual, and it's not even fatherly. Maybe a bit fatherly, but the way a father would treat his adult daughter, not his young daughter. [A friend] treats me the same way if my parents drive me nuts. There's something really gentle about your presence. I feel myself calm down.
>
> … I felt really, really moved, comforted in a way; my dream this time was very different from any other dream I have ever had about you. It felt like we were a partnership, without that taking away from my adult self. I didn't have to be five years old to get your closeness and I didn't have to seduce you either. I felt encouraged by you that I had the strength to get through whatever I needed to get through.

Psyche had manifested what Jung had described as a symbol of the self, "the best possible representation of a relatively unknown fact" (Jung, 1971, p. 474), the "dream" union of her frightened child and the dream John within her who said "you can do this". Can we trust what psyche offers us? Can I offer a relational experience which facilitates this dream union, bearing the terror of my own helplessness and ignorance, neither fleeing to the medical discourses of clinical safety and from the dangerousness of sexual feelings within the brick mother of the clinical office, feelings, which, if I did not linger with them, I might, as Michelle once expressed, enact by "locking her up"? The word symbol comes out of the Greek syn, and ballien, meaning thrown together. Thus, a symbol is always something "thrown together" by the psyche, representing more than can be known by the conscious mind. This symbol formation capacity invites us to trust the fleeting pictogram of our mind, to feel and think, and think about feeling, allowing us to glimpse into a world beyond discourse, perhaps?

Clinical vignette two

After several years of frightening and moving work, the older Māori woman in front of me stood to depart for the last time. She walked towards me, I felt fearful: was she about to kiss me? The shy boy of my youth prepared to retreat. She slipped her hand into mine, used her other hand to pull my shoulder close. I glimpsed her intention to hongi. Unthought thoughts of the marae moments of my life filled me: All Black haka and tearful tangi, standing at the waharoa and the grief of the unmourned losses of my British ancestral history, heaved within. I lost all sense of my authority as white analyst. She pressed her nose into my nose. A hongi. We breathed the breath of life together. A uniquely Aotearoa New Zealand psychotherapeutic moment. In my relationship to St Francis, did I enact the white saviour? Or as our hands held each other's, my nose against her nose, our breath together, did this offer something new, as I surrendered to my ignorance and helplessness?

Is this what Foucault might mean by creating myself as a work of art each day? The art of feeling without submission, but with surrender, embracing my ignorance and my helplessness, and offering the possibility of feeling something with another?

Conclusion

Foucault once said,

> My point is not that everything is bad, but that everything is dangerous, which is not exactly the same as bad. If everything is dangerous, then we always have something to do. (Foucault, 1983, pp. 231-232)

I would rephrase his final word. Then we have something to feel, and to think. Bion once, perhaps apocryphally, is said to have advocated, "Don't just do something; sit there!" (Symington, 1986). This seems a counterintuitive, and indeed kind of mad, idea in a world as chaotic and as disturbed as we inhabit at the moment, that someone would encourage us to sit rather than to act. Certainly, action is important, when the madness of climate collapse, nuclear war, and pandemic terror threaten our very survival.

And yet there is in our world today such an absence of the counterintuitive impulse to think and feel, and feel and think, deeply about things, before acting reactively or prematurely. All of my many and sometimes dangerous clinical mistakes have come when I have refused to feel something of the helplessness, ignorance, and terror of my own inner world in relation to another's, and instead to enact a knowing, in so doing grasping whatever the discourses of the time demand of me, creating myself as the Christian saviour of the heathen other, avoiding, as James so honestly described, "my ignorance and helplessness". Yet there have been clinical moments of beauty. The sharing of breath, and the dreaming of feeling. As a loving supervisor once encouraged, the unconscious is indeed a shy beast, we are wise not to pounce.

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Notes on notes: Note-taking and record-keeping in psychotherapy

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Abstract

This article offers information and views about note-taking and record-keeping in the practice of psychotherapy in this country, in the context of the limited literature on the topic. It provides a brief review of what principal figures wrote about taking notes and making records, specifically Sigmund Freud and Eric Berne. It considers the purpose of making notes and keeping records, and presents key terms and conditions on the subject. Finally, it reviews relevant declarations and legislation regarding notes and records pertinent to the practice of psychotherapy in Aotearoa New Zealand.

Whakarāpopotonga

Ko tā tēnei tuhinga he whakatau koha mātauranga me ngā tirohanga whakapā ki te tuhi kōrero me te pupuri hopu puoro i roto i te haratau whakaora hinengaro i tēnei motu i runga i te tirohanga o te torutoru o ngā pukapuka mō tēnei kaupapa. Ka horaina he aromatawai poto a ngā kaituhi matua mō te kaupapa nei, inarā ā Hirimana Whereuta rāua ko Ērika Peene. Ka āta whakamātauhia te take o te tuhi kōrero me te pupuri puoro, ka whakaatu ake i nga whakaarohanga matua me ngā āhuatanga kai runga i te kaupapa. I te mutunga, ka tātarihia ngā whakataunga e hāngai ana me ngā ture whakapā atu ki te tuhi me te hopu kōrero e ai ki tā te haratau whakaora hinengaro i Aotearoa Niu Tīreni nei.

Keywords: notes; note-taking; records; record-keeping; privacy.

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Introduction

There are different perspectives on, as well as some confusion about, the nature and purpose of client (or patient) notes; the status of the practitioners' own notes, which may take the form of a private, reflective journal; and, more broadly, the nature and status of health records (and the extent to which all notes are part of health records). This is further complicated by the fact that different associations and accrediting bodies have different views and requirements, such that practitioners, who may be members of a number of such associations and bodies, are often confused about what is mandated and what is permitted. A final layer of complexity concerns the context in which practitioners work with regard to sector (public and/or private); organisation (commercial, education, health, justice, voluntary, etc.); third parties, e.g., when working for the Accident Compensation Corporation (ACC); and location (i.e., different jurisdictions): each of which may have specific policies and procedures about notes and records.

Somewhat surprisingly, there is very little clear guidance as to precisely what psychotherapists must do with regard to note-taking and record-keeping. In her book on *Record Keeping in Psychotherapy and Counseling*, and writing in the context of the United States of America (USA), Luepker (2022) comments that:

> ... few mental health professional organizations or states define and describe the characteristics involved in competent clinical recording keeping. There is little written about the therapeutic process of record keeping. This leaves practitioners to use what little they can learn in graduate schools or internships or to devise their own policies and methods in a virtual vacuum. (p. 19)

There is also very little literature as to what practitioners actually *do*. One survey of the record-keeping practices of clinical psychologists working in one region of the UK's National Health Service found:

> ... much individual diversity and uncertainty as to what constitutes good practice ... [and that] despite [then] recent guidance from the Division of Clinical Psychology and the Department of Health, many issues with regard to note-keeping are unresolved, ambiguous and subject to individual and local decision-making. (Scaife & Pomerantz, 1999, p. 210)

Accordingly, we have sought to adopt an interdisciplinary and collaborative approach to seek to identify whether relevant legal sources provide guidance. Based on a review of the literature, and of the law and relevant health policies as they stand in this country, this article clarifies the current situation with regard to notes, note-keeping, records and record-keeping in psychotherapy. We introduce this with a brief history of the place and purpose of notes and records in psychotherapy, following which we identify a number of purposes for taking notes and keeping records. In the third part of the article, we clarify various terms and conditions used in requirements and policies about this aspect of practice; and, in the fourth and final part, discuss the implications of this for practitioners and health care providers working in this field.

A brief review of the literature on notes and records in psychotherapy

Freud was an assiduous note-maker, an inveterate letter-writer, and the originator of the psychoanalytic case study. It is clear from a comment in a letter (written in 1896) to Wilhelm Fleiss, an early collaborator and friend, that this derived from Freud's personal habit or discipline: "I have booked lodgings in Obertressen near Aussee. I make daily notes about my health, so that they can be used to check special dates" (Freud, 1985a, p. 180). With reference to his clinical work, he wrote (in another letter to Fleiss, written in 1899) about "making notes on the results of my four analyses every evening" (Freud, 1985b, p. 384). An aside in *The interpretation of dreams* — "The dream — it is the only one of which I possess no careful notes" (Freud, 1900/2009, p. 599) — suggests that he usually made careful notes; though, in a letter to Carl Gustav Jung (written in 1907), Freud (1974) writes that "I am again taking notes on my analyses" (p. 58), which suggests that he didn't always make notes on patients, or had periods in which he didn't. In a letter to Karl Abraham (written in 1910), Freud (2002) refers to having the results of a case but not the notes, which suggest that he destroyed his case notes after a certain time. With regard to the nature of notes, in a letter to Sándor Ferenczi (also written in 1910) he refers to his notes having "intimations and confusions" (Freud, 1993, p. 147), which is why he says he couldn't show them to anyone, though he also refers to reading other analysts' notes (notably Fliess', Jung's and Ferenczi's) and to sharing his own case notes with them.

Interestingly, in his "Recommendations to physicians practising psycho-analysis", Freud (1912/1924) discusses the problem of keeping in mind all the details of patients and their lives and suggests the technique of "evenly-suspended attention" (p. 110). "In this way", he suggests, "we spare ourselves a strain on our attention which could not in any case be kept up for several hours daily, and we avoid a danger which is inseparable from the exercise of deliberate attention" (p. 110). He continues:

> deliberately concentrates his attention to a certain degree, he begins to select from the material before him; one point will be fixed in his mind with particular clearness and some other will be correspondingly disregarded, and in making this selection he will be following his expectations or inclinations. (pp. 110-111)

Berne (1966) echoes this in his comment on note-taking: "notes taken during the session are apt to recount in the most detailed way the least important aspects of the meeting, while the substance is only sketchily outlined" (p. 51).

Freud acknowledges that this technique suits his individuality. Elsewhere, Freud (1932/1973) refers to the fact that he "still possessed the gift of a phonographic memory" (p. 33) — and that others who are "quite differently constituted" (Freud, 1912/1924, p. 110) will adopt different attitudes and methods. Nevertheless, for him, this technique "rejects the use of any special expedient (even that of taking notes)" (Freud, 1912/1924, p. 110).

Writing in the same paper about taking notes, he advises against doing this in the session, not only because of "the unfavourable impression which this makes on some patients" (p. 112) but also because it would compromise the nature and quality of his attention, a point he had made in an earlier paper in commenting on the difficulties the physician has conducting:

> … six or eight psychotherapeutic treatments of the sort in a day, and [who] cannot make notes during the actual session with the patient for fear of shaking the patient's confidence and of disturbing his own view of the material under observation. (Freud, 1905/1977 p. 38)

Berne (1966) makes a similar point about not taking notes during the session and extends Freud's point about attention, arguing that:

> Notes written after the meeting are subject to the same criticism in a diluted form. If the therapist is distracted during the meeting by trying to remember what he is going to put in his notes, to that extent his therapeutic efficiency is diminished, and probably his effectiveness also. (p. 51)

For Freud, the exceptions to this rule are "in the case of dates, the text of dreams, or particular noteworthy events which can easily be detached from their context and are suitable for independent use as instances" (Freud, 1912/1924, p. 112), though he also says that he is not in the habit of doing this. Finally, he acknowledges that taking notes during a session "might be justified by an intention of publishing a scientific study of the case" (pp. 112-113), though he goes on to argue that "exact reports of analytic case histories are of less value than might be expected" (p. 113). Rogers (1942) took a different view when he published the first complete and unedited transcript of work with a client, Herbert Bryan, over eight sessions, together with his accompanying notes.

Writing about the supervision of group treatment, Berne (1966) suggests certain advantages to recordings of sessions, noting that: "Tape recordings are useful for beginners because the proceedings can be analysed transaction by transaction, and the therapist can develop his skill in observing and interpreting vocabularies, inflections, and nonverbal phenomena such as coughs, laughs, and grunts" (p. 52). He develops the link between supervision and the development of theoretically-informed practice of the transactional analyst in his next point:

> For more advanced students, notes taken after the session are most helpful because it is possible within the supervisory hour to get a quick view of the whole meeting so that games and other ongoing forms of social action can be picked out. (p. 52)

Also, writing in the context of supervision and promoting theoretical integrity, Mearns (1995), a person-centred counsellor, expresses his concern about the flight on the part of both therapist and supervisor into analysing the missing client, and asserts that "supervision as it is normally practised tells us absolutely *nothing* about the client" (p. 422). In order to prevent this flight, Mearns suggests:

> ... conduct[ing] supervision sessions under a strict policy of relating all statements about the client back to the counsellor. This not only serves to minimise the dangers of early closure on judgements about the client, but also increases the questions which the counsellor asks about himself or herself in relation to the work. (p. 423)

Mearns notes three ways in which the supervisor can have direct awareness of the client: through live supervision, which is rare, and usually only takes place in the context of training; by means of written verbatim, which used to be common in social work training, but is rare in therapy training; and through the use of recordings, which is more common but again, predominantly in the context of training.

With regard to the nature of notes, their confidentiality (or otherwise), storage, disposal, etc., in these brief references about notes, note-taking, recordings, and record-keeping, with their implications for method, we see the origins of current practices and concerns, at least as they are expressed in some of the current guidelines. In the next part of the article, we attempt to broaden and deepen these references by offering an overview of the purpose of making notes and keeping records.

The purpose of making notes and keeping records

In two articles on practical approaches to note-taking, McMahon (1994a, 1994b) suggests a number of specific purposes to this, including: as a memory aid; to monitor the client's progress; to aid the process of referral; for training and/or accreditation purposes; to assist therapeutic audits; for internal complaints procedures; and as a tool for reflection. Based on a study of clinical psychologists' note-taking practices, and writing from a more critical perspective, Newnes (1995) identifies three covert reasons for taking notes:

- as part of monitoring, that is "observing others and writing it down [which] become a prelude to observing ourselves or being observed, as if such observation is good for people" (p. 33);
- as a means to contain the anxiety of inexperienced practitioners and give the illusion that no harm results when "cases" are passed between practitioners; and
- as access to notes is seen as a consumer right.

Most recently, Luepker (2022) views systematic clinical records as "essential" (p. 20) as they:

- facilitate communication between therapists and clients;
- form the basis of sound diagnoses and appropriate treatment plans;
- provide for continuity of care;
- are necessary for clinical supervision;
- satisfy contractual obligations (she cites third-party payers or funders); and
- are best protection against allegations of unethical and harmful treatment.

From our reading of the literature, it appears that there are four main purposes for notes and records: accurate recall, planning treatment, professional development, and defending practice. There is also an underpinning value of acting so as to respect rights and dignity.

Accurate recall

Having adequate notes on a client enables the practitioner to recall information about them

accurately. This encompasses practical information (such as contact details), personal information (such as names of their significant others, other health practitioners with whom they are working, personal history, etc.), as well as other details of the sessions. In this sense, notes as an aide-mémoire may help refresh the practitioner's memory of relevant details about the client. Though, of course, this raises the question of what is relevant — and why? Whilst such information (as above) may appear innocuous, at least while it remains under the practitioner's lock and key, it becomes more problematic in the context of court proceedings in which context, as Jenkins (2002) observes: "the client cannot restrict or limit the disclosure of sensitive personal information .... This choice rests ultimately solely with the authority of the court itself" (pp. 6-7). The lack of legal protection for therapy records against an order for their disclosure (Cristofoli, 2002; Jakobi & Pratt, 2002), and clients' rights of access to therapists' notes under data protection legislation (Pollecoff, 2002) might suggest that practitioners — and clients — are better off relying on memory than on written record.

Planning treatment

Depending on the practitioner's approach to therapy, some plan their work with, or treatment of, the client more than others. For instance, transactional analysis, originally heavily influenced by the medical training of its founder, Eric Berne MD, has a number of treatment planning sequences (see Clarkson, 1992). In this context, having notes helps to plan "What next?" (Stewart, 1989, 1996). Other therapeutic modalities or theoretical orientations take different approaches to therapy and, therefore, note-taking and recording-keeping. Indeed, in its *Code of Ethics and Professional Practice,* and its only reference to notes, the United Kingdom Council for Psychotherapy (UKCP) (2019) privileges this when it states: "Make notes appropriate to the modality of therapy being practised" (p. 3). At the same time, UKCP acknowledges that clients' confidential information should be kept "subject to legal and ethical requirements" (p. 3). In the New Zealand context, the Psychotherapists Board of Aotearoa New Zealand (PBANZ) (n.d.b) is clear that "Legal precedence [sic] implies an obligation on all health professionals including psychotherapists to have health records relating to identifiable individuals" (p. 1). We outline the core legal obligations below.

Professional development

Notes are used at all stages of professional practice and development, from initial training to professional wills. Luepker (2022) writes positively about the benefit of competent record-keeping: "It becomes a dynamic aide in developing a framework for supporting the therapeutic relationship from the outset and through various stages of our collaborative clinical work with clients" (p. 19). Notes and records — and, indeed, recordings of sessions — are generally viewed as helpful, even essential for supervision, especially for students/trainees; and recordings of clinical work are required for examination (e.g., International Transactional Analysis Association International Board of Certification, 2022; New Zealand Association of Psychotherapists [NZAP], 2022).

Defending practice

We see this both in the positive sense, akin to the academic concept of defending a thesis, as well as the defensive sense of having to cover oneself in anticipation of criticism and,

potentially, litigation — which, Clarkson (2003) argues, leads to "defensive psychotherapy" (p. 60). The former is captured in the following: "All psychotherapists will be … able to articulate, and provide a substantive rationale for, their own professional opinion through verbal and written communications in clear, concise and accurate form, for example, in report writing and client records" (PBANZ, 2019, Section A.6d, pp. 4-5). The latter is captured in the guidelines of the New Zealand Psychologists' Board (NZPB) on the subject. Of the ten purposes of record-keeping identified by the NZPB (2017), only two relate to the process of the (clinical) practice, i.e., "to aid appropriate ongoing intervention … [and] As an aid to memory for the psychologist."(p. 1). One is "for the client's personal use" (p. 1). The other seven are for external or, we would suggest, defensive purposes, i.e.,

- … for any legal process, and to provide documented evidence in the event of any subsequent complaint or competence concern…
- To provide a record of contact for the client's use for insurance reimbursement and other health-related claims.
- To enable the transfer of care to another psychologist should that be desirable.
- To assist in the comparison of similar cases and assessing treatment approaches.
- To comply with relevant legislation.
- To support accounting processes and keeping statistical data. (p. 1)

Given the concerns that there might be legal pitfalls with regard to records of therapy, Cristofoli (2002) considers that therapists might adopt "a minimalist approach to note taking [which] would serve both an efficient record of the therapy provided to the client and would reduce the risk of detailed notes being used in later court proceedings" (p. 32). However, he also offers the alternative view, that:

> Detailed record keeping, particularly where the contractual and therapeutic relationships with the client become problematic and conflicted, may well be a necessary safeguard to provide evidence of the therapist's level of professional service, and of attempts to resolve points of contention that may have arisen. (p. 32)

There are a number of formulations and templates for record-keeping, of which Luepker's (2022) essential contents of "good records" (p. 40) is the most comprehensive as she includes: demographics (18 items), evaluation (13 items), treatment progress notes, termination or closing summary, other essentials (11 items), and preventative action taken (9 items).

Terms and conditions with regard to notes and records in psychotherapy

In this part, we identify and summarise key terms used in this field (see Table 1), following which we consider the conditions under which these terms may be understood.

Table 1. Key terms used with regard to notes and records in psychotherapy, their definitions and descriptions

Term	Definition(s) and descriptions
Access	In terms of access to personal information, the PBANZ (n.d.b) notes that: *The Health Information Privacy Code 2020* (Privacy Commissioner, 2020) states that an individual is entitled to receive from a health agency …upon request: • confirmation of whether the health agency holds any health information about them; and • access to their health information. When an individual is given access to personal information in response to such a request, that person shall be advised that they may request correction of the information. (p. 1)
Agency	The PBANZ also adds a note to the word "agency" (throughout), that this would include practitioners working in private practice.
Beneficence	A key ethical principle by which the taking, maintenance, and storage of notes and records may — and, arguably, should — be assessed (see Layman, 2020; Tudor & Grinter, 2014).
Clinical notes	The PBANZ (n.d.a) states that these are health records and that they include "a record of the therapeutic process and clinical thinking" (p. 1), and thus does not distinguish between health records/clinical notes and psychotherapy notes.
Destruction or disposal	In terms of the disposal of health information, PBANZ (n.d.b) notes that: "Health agencies … [including] practitioners working in private practice] need to be careful to dispose of patient records securely, either by shredding or otherwise destroying records themselves or by hiring a secure destruction contractor" (p. 2).
Good records	Luepker (2022) defines these as being "a clear 'picture' or 'mirror' of a patient" (p. 42) and discusses a number of characteristics of such records, i.e., that they are: legible, germane, reliable, logical, prompt (made soon after the session), and chronological.
Health information processes	In its *Information Sheet* on the subject, and based largely on the *Health Information Privacy Code 1994*, the PBANZ (n.d.b) considers health records in terms of access, protection, retention, and disposal. While this is a useful description of part of the process, it misses out the first stage, collection.
Open notes	The concept and movement that patients and clients (should) have complete access to all records about them.

Practitioner notes	Reflective notes, which are still subject to a process of discovery in a civil action.
Protection	In terms of the protection of health records, the PBANZ (n.d.b) notes that: *The Health Information Privacy Code 1994* states that an agency … that holds personal information shall ensure that the information is protected, by such security safeguards as it is reasonable in the circumstances to take, against: • loss; • access, use, modification, or disclosure, except with the authority of the agency that holds the information; and • other misuse.
Psychotherapy notes	Those usually more detailed notes made about a session which often include the practitioner's own reflections and feelings, and for the purpose of supervision and/or education/training. They may be distinct from an official or regular record, and kept separately. In the United States of America, the Privacy Rule in 45 CFR §164.501 defines psychotherapy notes as "notes recorded by a mental health professional that document or analyze the contents of a counseling session and that *are separated from the rest of a medical record*" (Department of Health & Human Services, 2005, our emphasis). In the New Zealand context, the PBANZ (n.d.a). does not distinguish between clinical notes and psychotherapy notes.
Retention	With regard to the retention of health records, the PBANZ (n.d.b) refers to the *Health (Retention of Health Information) Regulations 1996* which states that: • All providers must retain records of health services **for a minimum of 10 years**, starting from the day after the most recent treatment. • If the records are transferred to another provider or organisation, this obligation transfers with the records. • If the medium in which the records are held is likely to deteriorate to an extent that it places in doubt that the records will be able to be read or retrieved during the 10 year time period, it is sufficient to keep an accurate summary or interpretation of the original records. (p. 2; original emphasis)
Storage	*The Health Information Privacy Code 2020* (Privacy Commissioner, 2020) states that a health agency (and, therefore, a practitioner) that holds health information must "ensure (a) that the information is protected, by such security safeguards as are reasonable in the circumstances to take, against— (i) loss; (ii) access, use, modification, or disclosure that is not authorised by the agency; and (iii) other misuse" (p. 8). Even if the practitioner keeps separate health records/clinical notes and psychotherapy notes, the spirit, if not the letter of the *Code*, suggests that both are subject to the same rule.

By conditions, we refer to the various obligations, requirements, and guidelines as far as client notes and health records are concerned. These range from legal requirements contained in statutes, to requirements and guidelines for best practice of professional associations and organisations. In Table 2 we present them from the general and broad to the particular and specific, i.e., from those which encompass everyone, through those that apply to health care providers, to those that cover health practitioners.

Table 2. Conditions with regard to notes and records in psychotherapy in Aotearoa New Zealand

Framework	Application	Notes
Code of Rights under the *Health and Disability Commissioner Act 1994* *Privacy Act 2020*	To the whole population	This is of significance to the making and keeping of notes and records.
Health Information Privacy Code 2020 (Privacy Commissioner, 2020) *Pae Ora (Healthy Futures) Act 2022*	To all health care providers, including health practitioners	This is of significance to the making and keeping of notes and records.
Health Practitioners Competence Assurance (HPCA) Act 2003 *Health Practitioners Competence Assurance Amendment Act 2019* *Psychotherapist Standards of Ethical Conduct* (PBANZ, 2022) *Clinical notes information sheet* (PBANZ, n.d.a) *Health records information sheet* (PBANZ, n.d.b)	To all registered health practitioners, including psychotherapists	The HPCA Act refers to but does not define “clinical records” or “records”. The PBANZ provides certain standards with regards to notes (see below), as well as relevant information sheets about notes and records.
Code of Ethics (NZAP, 2018)	To members of the NZAP	There are no references to notes or records in this Code; there are references to the management of electronic communication, digital records (and record-keeping) as one of the criteria for assessment for its Advanced Clinical Practice Pathway and membership (NZAP, 2022) — and to the recording of clinical work to present for this assessment.
Code of Ethics (New Zealand Association of Child & Adolescent Psychotherapists [NZACAP], 2018)	To members of the NZACAP	There are no references to notes or records in this Code.

In addition to this, health care providers, psychotherapists, and psychotherapy students/trainees may be members of other professional associations and, with regard to our current interest, specifically accrediting bodies. Ones that represent the different therapeutic modalities in which it is possible to study currently in this country are: the Australia New Zealand Association of Psychotherapy, the Australia New Zealand Psychodrama Association, the Australia New Zealand Society of Jungian Analysts, the International Association for Analytic Psychology, the International Hakomi Institute (USA), the International Psychoanalytical Association, the International Transactional Analysis Association, the New Zealand Institute of Psychoanalytic Psychotherapy, the New Zealand Society for Bioenergetic Analysis, and Psychosynthesis South Pacific. Each of these also have terms and conditions for membership and accreditation, some of which may indicate what a member may or has to do with regard to notes, note-taking, records, and/or record-keeping.

Here we take the principal frameworks (noted in Table 2) and discuss their conditions with regard to notes and records.

Privacy Act 2020 and the Health Information Privacy Code 2020

The right to privacy is a key feature of the international human rights regime, which in turn informs domestic laws. *The Universal Declaration of Human Rights* ("the *UDHR*", United Nations [UN], 1948) was part of an attempt to reset the world not only after the atrocities of World War II and the Shoah (Holocaust) but also following decades of eugenics which proposes that, on the basis of genetics, some people are inherently superior to others. The *UDHR* indicates that people should be protected by law against "arbitrary interference with … privacy, family, home or correspondence," and against "attacks on honour and reputation" (Article 10). This informed Article 17 in the *International Covenant on Civil and Political Rights* (UN, 1966), which was designed to be a treaty with standards enforceable in international law and requiring states to modify their own laws to be compliant.

It should be noted that privacy rights are not absolute: "arbitrary" interference with privacy is precluded. Arbitrariness is not defined in the *Covenant*, but has become associated with needing to have a balance which requires the state (the government) that has breached, or allowed the breach of privacy, to show that there was a valid countervailing aim for breaching privacy, that the breach of privacy supported this aim, and that the fact of the breach was justified and a proportionate way of meeting the aim. The latter may lead to grey areas where reasonable people can differ, and where states can decide to draw slightly different boundaries. The need for the law to protect privacy means that the topic must be regulated in an adequately clear way, and in a way that draws a boundary that meets the relevant test for a breach of privacy.

So, in this context, what is "privacy"? It clearly covers matters relating to a person's health, both physical and psychological. For example, considering the "right to respect for his private life" in Article 8 of the *European Convention on Human Rights* (Council of Europe, 1963) (which is structured differently to Article 17 of the *International Covenant on Civil and Political Rights [ICCPR]* (UN, 1966) but, substantively, has the same effect), the European Court of Human Rights has noted that it is an undefinable but broad concept that covers a person's identity and autonomy. It also includes some aspects of interactions with others (such that, for example, the criminalisation of begging breached the right to contact others to seek help) (Registry of

the European Court of Human Rights, 2021). It has also been recognised that the right to privacy extends to the protection of data that is being generated in such a fulsome manner in modern society (Registry of the European Court of Human Rights, 2022).

The substantive test of arbitrariness means that not all information about a person is treated in the same way. Accordingly, some types of material are more deserving of protection than others and so require much stronger reasons for a breach of privacy. In the data protection context, this gives rise to the idea that there is data that is "sensitive", which includes health-related data. This has higher levels of confidentiality attached to it, not only because of its centrality to the sense of privacy of the person, but also because of the societal value attached to people having the confidence to discuss matters with health professionals.

To illustrate, take the following facts: the image of a person carrying a knife in public is captured on CCTV, the police are called, and the person is detained and referred for medical assessment because they are suicidal; the images from the CCTV are subsequently used in press releases and also in a reality television programme, thereby allowing the person to be identified. Although the original incident took place in public, it was determined that, without adequate steps to cover the identity of the person, the recording and its release was a breach of their right to privacy because it revealed their distress and state of mental health at the time. This case (*Peck v UK*, 2003) makes it clear that the recording and use of the record of something that occurs in public can be covered by the concept of privacy, since the use of the recording goes to a much wider audience. It could have been manipulated (by removing identifying details) to allow the story to be told without revealing that Mr Peck was the person involved.

This background explains the need for the New Zealand *Privacy Act 2020* (which has replaced the *Privacy Act 1993* with additional provisions) and the regime that is in place, through the Privacy Commissioner, to take privacy seriously. However, a caveat should be noted: the *New Zealand Bill of Rights Act 1990* does not fully replicate Article 17 of the ICCPR as it limits the main aspect of privacy to covering protection against unreasonable search and seizure (in Section 21). Thus, the principal statutory protection of privacy derives from the Privacy Act 2020, which is a dedicated regime, rather than through legislation setting out the broad requirement to protect fundamental rights.

Central provisions of the *Privacy Act 2020* are those setting out the "information privacy principles" ("IPP", in Section 22); allowing codes of practice to be issued in relation to them (Section 32), such as professional codes of ethics and practice; and allowing the Privacy Commissioner to investigate complaints about a breach of privacy (sections 70 and following), which may end up at the Human Rights Review Tribunal, to issue compliance notices in relation to breaches of the principles or a code (Section 123), and to enforce those notices through the Human Rights Review Tribunal (Section 130).

The IPP are set out in Table 3 below. They set out what an "agency" should do, and so its meaning is central: it includes individuals who are resident in New Zealand. In addition, one of the consequences of the introduction of the *Privacy Act 2020* was that the *Health Information Privacy Code 1994* has been replaced by the *Health Information Privacy Code 2020*. This is arranged around the privacy principles. It applies to such matters as information about health (including medical history), disabilities, and services being provided or provided in the past; and it applies to a wide range of professionals who provide health and disability services, which, for the purposes of the *Accident Compensation Act 2001* includes

public health services; units within larger agencies; psychotherapists and other psychological therapists; professional bodies; training agencies; insurers; district inspectors; and those who supply medicines or medical supplies. Thus, Table 3 sets out the general principles of the *Privacy Act 2020*, and the more specific rules of the *Health Information Privacy Code 2020*, together with some commentary about their implications for you the reader/practitioner.

Table 3. Information privacy principles applied to psychotherapy notes

Principle	Focus	Description	Implications for practitioners
1	Purpose of collection	The *Act*: Only information that is necessary for the lawful purposes or functions of an "agency" may be collected. The *Code*: Similar, in the context of lawful health functions, but with the indication that if information that can be collected without identifying information, the latter must not be required.	That you consider the relevance of the information you collect. Is it fit for purpose or suited to your task, or do you ask about it because you always do? For example, is a person's sexual history and identity relevant to the reason they have come to see you?[1] The *Code* provision relating to not collecting identifying information may be relevant particularly to public health functions, but it applies to all health agencies and so requires consideration.
2	Source	*The Act*: The individual must be the source of the information about them unless good reasons exist not to abide by this. *The Code*: Similar, and with clear instances of the good reasons, including that the person is not able to give their authority, or that the information is collected for statistical or research purposes and does not identify anyone.	That you have good reasons to speak to others (such as their family members or health professionals) about your client, and that they have given their informed consent for you to do so.
3	Information about collection	The *Act*: That reasonable steps are to be taken to make the person aware that information is being collected, why, who can access it, and how the person can access and correct it; this is subject to various exceptions for good reasons. The *Code*: Similar, rephrased for the health context.	That you consider this and have a standard or consistent way of providing this information.
4	Manner of collection	The *Act* and the *Code*: The means of collection have to be lawful, fair and not unreasonably intrusive.	That you consider these three elements in the collection of information about your client, as well as the balance between gleaning the information necessary in order to work therapeutically, and the impact of the client's experience of intrusion.

5	Storage and security	The *Act*: Reasonable security of storage and against misuse is required, and reasonable steps are taken when information is shared when that is necessary. The *Code*: Similar, with the addition that documents containing information are disposed of so as to preserve privacy, and making clear that IPP5 (above) applies to information obtained prior to the *Code* becoming effective.	That you have secure storage of information, and some protocol about sharing information. That you make use of secure processes for deleting information. That you have considered how this applies to information collected recently and prior to the new *Code* becoming operative.
6	Access by the person	The *Act*: An "agency" must confirm whether it holds information about a person and how to access and correct it, though subject to various good reasons to refuse. The *Code*: Similar, and confirming that it applies to information obtained prior to the *Code* becoming effective.	If you hold such information about clients (and supervisees), that you have a process for confirming this, and for them to request, access, receive and, if necessary, to correct it; and criteria for refusal to share this information with them. That you have considered how this applies to information collected recently and prior to the new *Code* becoming operative.
7	Correction	The *Act*: A person may ask for information to be corrected, and an "agency" must take reasonable steps to ensure that information is accurate, up to date, complete and not misleading; and if a request to correct is refused, the request must be attached to the information. This is subject to various good reasons to refuse. The *Code*: Similar, and confirming that it applies to information obtained prior to the *Code* becoming effective.	See 6 above.
8	Checking accuracy before use or disclosure	The *Act*: Before using or disclosing information, an "agency" must take reasonable steps to ensure it is "accurate, up to date, complete, relevant, and not misleading". The *Code*: Similar, and confirming that it applies to information obtained prior to the *Code* becoming effective.	What process do you have for reviewing and checking the information you have, whenever obtained, before you make use of it or pass it on?
9	Retention	The *Act*: Personal information can only be kept for as long as needed for any lawful purposes. The *Code*: Similar, and confirming that it applies to information obtained prior to the *Code* becoming effective.	What process do you have for removing redundant personal information, whenever it was obtained? How often do you review older files?

10	Limits on use	The *Act*: Personal information can only be used for the purpose for which it was obtained (with various exceptions, including for research purposes if a person cannot be identified, and based on necessity). The *Code*: Similar, but with a proviso for health information obtained before 1 July 1993.	Note the link with Principle 8. What process do you have to ensure that you use information only for the purpose for which you sought it?
11	Limits on disclosure	The *Act*: Disclosure of personal information must be directly linked to the purpose for which it was obtained, authorised by the person concerned, or necessary for various reasons. The *Code*: Similar, and giving instances of what might be proper, such as disclosing to a caregiver that someone has been detained under the *Mental Health Act 1992*, or for professional accreditation or risk management purposes, or reporting by health practitioners to a Medical Officer of Health.	Note the link with Principles 8 and 10. What process do you have to pause and check before disclosure that it is lawful?
12	Limits on disclosure outside New Zealand	The *Act* and The *Code*: Supplements Principle 11 and requires consideration of whether there are equivalent protections or whether the person concerned has been informed that the protections may be less strict.	What process do you have for investigating whether disclosure may be to someone not governed by New Zealand law and whether there is similar protection or not and what to do if not?
13	Assigning unique identifiers	The *Act*: Unique identifiers can be used only if necessary (and cannot be the same as one used by another agency only in limited circumstances). The *Code*: Similar, but with provisions for the use of the National Health Index number.	What checks do you have for this requirement, particularly if you work with other agencies?
* In terms of working with other health professionals, it is useful — and, in an emergency, essential — to have your client's full name, date of birth, and NHI (national health index) number.			

Health and Disability Commissioner Act 1994

The *Health and Disability Commissioner Act 1994* provides an additional element of the framework for those providing health services (widely defined and expressly including psychotherapy and counselling services). A central function of the Commissioner is to prepare and enforce a *Code of Health and Disability Services Consumers' Rights* (Health & Disability Commissioner, 1996); this is contained in secondary legislation, emphasising its status. Right 1(1) sets out the right of every consumer "to be treated with respect", and Right 1(2) is the "right to have his or her privacy respected". This means that there is an additional

method of enforcing privacy, though this turns on an assumption that the reference to "privacy" here indicates the rights as defined in the *Privacy Act 2020*.

There are other aspects of the *Code* that might have implications for notes, reflecting how notes might be drafted and what should feature in notes:

- Right 1(3) sets out a right to have services that reflect cultural and social beliefs and values: a professional approach to meeting this requirement will note what was considered, what was concluded, and why (including what discussion was held with the client and perhaps with others if appropriate — and without breaching privacy rights — to determine how to meet this right).
- Right 3 is the right to respect for dignity and independence; see above as to how this was ensured.
- Right 5 is the right to effective communication, which may include interpreters; again, notes about the process of deciding that there was no need for support in communication or what was contemplated and ultimately decided on will ensure that this right is respected.
- Right 6 is the right to be fully informed, including making informed choices and having relevant information provided, including a written summary of information provided; Right 7 is the express right to informed choice and consent (including issues of capacity to consent and steps to take if there is no capacity). Evidencing that these rights have been met without having adequate notes of the steps taken may be a significant hurdle.
- Right 10 is the right to complain and have a fair and speedy process of resolution; adequate notes, made contemporaneously, will play a central role in this.

There are also rights that ensure that the standard of care is of an appropriate standard (Right 4), non-discriminatory, exploitative or otherwise problematic (Right 2), and with support persons present, unless there are good reasons (Right 9).

Naturally, there is a need to ensure that this does not become a tick-box exercise; nor should there be the move to unnecessarily defensive practices whereby treatment is rendered ineffective because of the concern that rights have been accorded. At the same time, a reminder of issues that arise in the context of compliance with rights, in the form of a template, cannot be problematic: and the provision of treatment should be in accordance with the right to treatment, and these various subsidiary rights can be seen as designed to secure this primary right.

Pae Ora (Healthy Futures) Act 2022 (The Act)

The Guide to He Korowai Oranga: Māori Health Strategy (Ministry of Health, 2014), notes that:

> Pae ora is a holistic concept and includes three interconnected elements: mauri ora — healthy individuals; whānau ora — healthy families; and wai ora — healthy environments. All three elements of pae ora are interconnected and mutually reinforcing, and further strengthen the strategic direction for Māori health for the future. (p. 3)

The *Act* itself sets out certain principles by which the health sector will operate, the implications of which for psychotherapy we plan to discuss in a separate article. With regard to notes and records, we suggest that the following principles are relevant to psychotherapy practice:

- engagement with Māori and other population groups in a way that reflects their needs and aspirations (Section 1b);
- providing opportunities for Māori to exercise decision-making on matters of importance (Section 1c);
- providing services that are culturally safe and responsive (Section 1d(ii)); and
- providing services that reflect mātauranga Māori (Section 1d(vi)).

Health Practitioners Competence Assurance Act 2003 (HPCA Act)

The *HPCA Act* does not refer to notes and, although it refers to records and clinical records, it does not define them. However, the various references to clinical records (Sections 40(3e), 41(3d(iii)), 42, and 44) suggests that there is an expectation that a health practitioner has, and maintains, such records, and can make them available should they be required, for instance by a professional conduct committee (Section 77), or a Disciplinary Tribunal (Schedule 1 Sections 7, 8, 11(1), and 12). In this, such notes may be useful for justifying a course of action. Also, as Section 16 ("Fitness for registration") refers to the practitioner being able to communicate effectively, this may also imply the presence of notes or records on which the practitioner can base their communication. That said, with regard to compliance with the requirement to provide information or document(s), the *Act* also states that:

> No person is required to produce to a committee any papers, records, documents, or things if compliance with that requirement would be in breach of an obligation of secrecy or non-disclosure imposed on the person by an enactment (other than the Official Information Act 1982 or the Privacy Act 2020). (Section 78(3))

The PBANZ

The PBANZ has information sheets on health records (PBANZ, n.d.b) and on clinical notes (PBANZ, n.d.a), and also refers to records and information in its *Psychotherapist Standards of Ethical Conduct* (PBANZ, 2022) in a section (8) on respecting privacy. This includes the imperatives to:

- keep appropriate records that are accessible and legible;
- take all reasonable steps to ensure that the client's personal information is collected, stored, used and disposed of in a manner that protects the information;
- take all reasonable steps to ensure that information remains retrievable for at least 10 years from the date of the last provision of services to the client;
- make adequate plans for access to and disposal of records in the event of retirement, serious illness, or death of the psychotherapist; and
- take all reasonable steps to maintain the anonymity of clients, colleagues, supervisees or trainees when clinical material is used in education and training, or in research and publications, unless consent to disclosure has been obtained. (pp. 7–8)

Implications

From our reading of the literature, law, policies, and guidelines regarding notes, note-taking, records, and record-keeping, we conclude the following:

1. That, whilst there is no legal mandate that health care providers must make notes and/or keep records, it may be considered unprofessional not to so do, especially if your notes are subsequently required in a legal or disciplinary process. Moreover, if you are a psychotherapist, you have an ethical obligation to keep records (PBANZ, 2022).
2. That there are no legal definitions of what constitutes appropriate notes or records, although the context in which you work may determine this and may, for example, require you to obtain and record certain information about clients. Whilst you may question this, any failure to do so, could lead to sanctions under your terms and conditions of employment.
3. That there is some ambiguity about the distinction between clinical notes and psychotherapy notes, which warrants further research, in the context of which, it may be prudent to separate them. It appears that, in practice, most therapists do make a distinction but the origin and effect of such a distinction is not clear and also warrants further research. However, subject to the clarification as to whether there is a legal distinction between clinical notes and psychotherapy notes, and as the PBANZ (n.d.a) state that health records include "a record of the therapeutic process and clinical thinking" (p. 1), this may be problematic for some psychotherapists. An alternative is to make only those notes that you are willing to share with clients; and, indeed, we know one colleague who writes up notes on each session and emails them to their clients.
4. That, assuming you do keep notes and records, there are clear guidelines about all aspects and phases of the practice: from the purpose of collection, and the source of information, through to the disposal of notes and records (as we have detailed and referenced above), and that these have implications not only for the education/training of psychotherapists, but also for the time involved for practitioners to follow and apply these in their practice.
5. That, ultimately, and as Freud himself acknowledges, the nature of such notes and records are as much if not more to do with the individual constitution and character of the practitioner.

Public statutes

Accident Compensation Act 2001
Health and Disability Commissioner Act 1994
Health Practitioners Competence Assurance Act 2003
Health Practitioners Competence Assurance Amendment Act 2019
Mental Health Act 1992
New Zealand Bill of Rights Act 1990
Pae Ora (Healthy Futures) Act 2022
Privacy Act 2020

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Kris Gledhill spent the first part of his career as a lawyer; as a barrister in London, his main work was representing detained people, including those subject to mental health legislation. He always maintained an academic side, publishing articles and books, and lecturing both in academic settings and in continuing professional development settings. In 2006, he moved to Aotearoa New Zealand and academia became the forefront of his work. He is currently a Professor of Law at AUT's Law School. He has published several further books in

the areas of human rights law, mental health law and criminal law, and a large number of academic articles and op-ed pieces; he edits two journals and a book series. His teaching, in the areas of criminal law, human rights law, clinical legal education and prison law, has included numerous courses taught as a visiting professor at various overseas universities. Kris remains grounded outside academia, working with lawyers and governmental bodies, lecturing in various continuing professional development settings for various professions, and serving on various committees. His particular interest is in developing arguments based on the Human Rights Framework that allow social progress to be made, whether through legislation, policy development or litigation. This has led to his involvement in several cross-disciplinary research projects. See his profile and links at: https://academics.aut.ac.nz/kris.gledhill

My journey toward becoming a psychotherapist: Reflections on a long career

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Abstract

As the New Zealand Association of Psychotherapists (NZAP) celebrates 75 years as an association, the author, a psychotherapist of long-standing and considerable experience as a practitioner in Aotearoa New Zealand, reflects upon her journey to becoming a psychotherapist. She considers the influences that have impacted upon her in this journey, and the qualities essential, in the author's view, to the practice of psychotherapy. The article is a reflection on lessons learnt throughout her career, in the hope that this may be of benefit to other practitioners, whether beginning or well-seasoned.

Whakarāpopotonga

I tēnei te wā e whakanui nei te Rōpū Kaiwhakaora Hinengaro o Aotearoa (RKHA) i te whitu tekau mā rima tau tūnga hei rōpū, ka tahuri ake ki te whakahoki whakaaro mō te hīkoi i hīkoia e tētahi kaiwhakaora hinengaro kua roa nei e mahi ana i te mahi whai mātauranga kaimahitanga i Aotearoa nei. Ka aro ake ia ki ngā pānga me ngā kōunga, e ai ki tāna tirohanga, tau mai ki runga i a ia. He tuhinga tēnei o ngā mātauranga i mau mai i te wā e mahi ana ia, ā, ko te whāinga kia whai hua ētahi atu e mahi ana i tēnei tūmomo mahi, ahakoa he kaimahi hou he kaimahi kua roa kē e mahi ana.

Keywords: psychotherapist; psychoanalysis; NZAP; analyst.

I worked for many decades as a psychotherapist, before retiring some time ago. As our Association celebrates 75 years, I was invited by the Editors to offer my reflections on my career as a psychotherapist, and the many lessons this work has offered me. The following are these reflections.

Being a psychotherapist was never on the horizon when I was growing up, as it was assumed I'd become a concert pianist. I was certainly precocious, but this idea faded when I was at college. Everyone in the family was a pianist and Mum taught the piano. It's of interest

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that Ella Freeman Sharpe, a psychoanalyst from way back, thought that enjoyment in listening to music was similar to listening to patients in analysis. Looking back, I can see several strands that later cohered into psychotherapy and "mending". All my teddy bears were operated on when I was quite a young child, with neat little scars carefully stitched. I wanted to be a surgeon, involving the same hands that coaxed the piano into performing at its best.

My parents had friends, the Stewarts; Catherine Stewart became a Labour MP in 1938, and when I was nine years old she developed asthma and was hospitalised. I remember Mum taking me to visit. While there, I clearly heard a voice say, "This is where you belong." I wanted to be a doctor.

My twelve-years-older brother had a bookcase of The Best American Plays, including *Death of a Salesman*, *Cat on a Hot Tin Roof*, *A Long Day's Journey into Night*, and *The Iceman Cometh* (by Arthur Miller, Tennessee Williams and Eugene O'Neil respectively), and although my parents had left school at 14 they were very intelligent and the house was always buzzing with conversations about psychology, philosophy, war, literature, music, and Labour Party politics, and I think such a rich background made me very aware of world issues and the psychology of people.

I was put into almost the lowest class at college because I didn't attempt much of the entry IQ test, so I had a low opinion of my abilities. I could not do even the simplest of mathematics, and finally I was exempted from any future maths classes, with a note sent home to my parents: "The child is mentally defective." Walking home from college one day I heard footsteps running after me; it was Jocelyn, the class genius! I was astounded that she talked to me until we reached the bus, and concluded there must be something of value in me if Jocelyn thought so. So I started to study and eventually qualified for university, which I began in 1950. I studied psychology simply because my brother had taken it for his MA. To my surprise I did quite well, getting top marks in my final two years and being awarded the Hunter Memorial prize which I shared with the professor's daughter, getting my MA in 1957.

My brother had Freud's I*nterpretation of Dreams* and after reading this I was hooked on psychoanalysis and becoming a psychiatrist like Freud, but after a visit to a psychiatrist to ask him how one achieved this I was shocked by his verdict that I was mentally unstable — delivered after I had answered his hushed question, "Do you ever touch yourself?" with a "Yes, all the time!" thinking it was a trick question: how could one bathe and dress without touching oneself! A very naive 18-year-old, who promptly gave up the idea of psychiatry. In any case I'd have needed to win a scholarship to enter medical school and I didn't consider this likely, so I thought about becoming a veterinary surgeon, but the only schools were in Australia and again I'd need a scholarship. Ironically, my daughter has become the veterinary surgeon I'd wanted to be.

The real problem I had to confront was: could I leave my mother? She'd assumed we'd be with her always and she needed us. Her background exuded loss: she'd lost two fathers, one to pneumonia and the other in WW1, and had seen her mother miscarry with twins, her younger sister choke to death on an apple and her younger brother die from hydrocephaly. There were the horrors of living in London during WW1, and her first baby, Joyce, was premature and died from pneumonia aged six weeks. When she and Dad emigrated to Aotearoa New Zealand in 1921 they also lost all their friends. She could not tolerate the loss

of my brother and me, and I now know I could never have left her anyway, due to my own unresolved issues with separation. Mum had been so terrified of the Plunket Nurse's injunction that I be fed every four hours and not when I was hungry, that I screamed all day and night for the first six weeks of life, my brother has told me, till Mum finally gave in and fed me every two hours. These experiences can drive a baby mad, leading it to forcibly split the good mother who does finally feed from the bad, abandoning mother who left it to starve.

This early trauma led to my seeking an analyst but he was unable to help. At that point I met my husband, so any idea of medical school was abandoned. It was while bringing up the children and realising I had major problems that I sought another analyst. I was so fortunate in my choice: I needed someone who could tolerate madness, bend the rules by sitting on the floor with me and holding my hand, and allowing himself to be used in the full Winnicottian sense, including being whacked occasionally. I became very identified with my analyst and yearned to become one myself. During this time I also enrolled for a Ph.D. on *Alcoholism in New Zealand*, finishing this in 1977.

Armed with my new Ph.D. I visited the psychiatric unit in Wellington Hospital and asked if they needed a psychologist, and they employed me in Outpatients until 1984. This exposed me to a huge variety of patients, and I was expected to make diagnoses — useful when I went into private practice. So, at the age of 47, I finally became a psychotherapist, a doctor/psychiatrist of sorts. I do recall walking around the hospital corridors and thinking of that voice, "This is where you belong," the only thing missing being the longed-for stethoscope round the neck.

I became a member of NZAP in 1983. All one had to do then was to present an original paper at Conference and the judges would then decide on potential membership. Over the years I've written several articles for *Forum* (now *Ata*) and presented a few papers at branch meetings. NZAP was helpful in arranging for me to attend Psychoanalytic Psychotherapy Association conferences in Australia in the 1990s. These were very intensive live-in events with usually 6-8 papers given daily over three days. I made many friends amongst that group and was actually offered a position in a private clinic, but after sharing an evening meal with my new-found colleagues I saw a financial side to them that was alien to me and I did not take the job. (This is why I refer to "patients" rather than "clients" as the latter implies business and financial contracts while the former implies someone needing a bit of help. No hospital ever has "Inclient" and "Outclient" signs.)

I attended many weekend seminars at Ashburn Hall in Dunedin in the 1990s-2000s, where psychoanalysts from Australia would provide intensive supervision. I recall being torn to shreds by one very austere analyst (with whom I later became friends) but also being significantly helped by others there. I also enjoyed the happy contacts with Dunedin therapists while there.

Several "happenings along the way" have influenced me in becoming a psychotherapist. Finding my brother's book by Freud, my need to be something medical — in the sense of being a helper — and my identification with my analyst, stand out. So much seems to have been serendipitous: finding that book and wanting to be like Freud (and intrigued by the theories he had), Jocelyn talking to me, the "voice" in the hospital when I was nine, the rich conversations when I was growing up, finding the analyst who fitted me. I stumbled across

Klein and Winnicott while browsing in a book shop and was again hooked. Much later, I came to understand how Klein's defences (Klein et al, 1952) had played a major role in my illness and how Winnicottian "holding" (Winnicott, 1960, 1986) had been vital in the analysis, plus the importance of attachment theory (Bowlby, 1969, 1988; Mahler, 1969).

I have many memories of working over 45 years. When a senior psychiatrist retired, she bequeathed to me her suicidal patient. He considerably improved and developed a coterie of good friends. This gave me the courage to work with psychotics, which I did with some success. I learned some bitter lessons along the way, such as that one can be so "clever" as to analyse away all the patient's defences so that psychosis is no longer possible, but sometimes be left with someone who is deeply unhappy. But I have also had some intensely rewarding experiences, such as a very withdrawn patient who eventually asked me to come closer, and later generated a dream image gesturing towards the gradual development of her true self.

Thinking about the ingredients that prepare someone for working as a psychotherapist made me reflect on the stimulating environment I was brought up in, and I think being well-read is a huge advantage. Enough liking for one's fellows to be able to establish good working relationships, even with those who can be unlikeable, also applies. My personal view is that analysis is essential. I was dragged kicking and screaming into the depressive position and my perception of everything became more whole and realistic, accompanied by an ability to tolerate loss. Stumbling across the "right" authors certainly helped me, and it pays to have studied those authors intensively, as well as much reading of authors with differing views. A therapist needs a good knowledge of *all* relevant theories plus the ability to extract from each what seems crucial to one's own work and applies to any particular patient, without resorting to the "Gospels of St. Freud, St. Klein, or St. Relational Therapy". Access to good supervision is also vital, i.e. having a supervisor who gently encourages one to think about the problems, not one who barges in with ideas of their own, intrusively. Currently, I belong to a group of six therapists meeting monthly, of whom four are NZAP members. It's particularly useful that we all practise slightly different forms of psychotherapy, which makes for stimulating meetings and helps me keep in touch.

The therapist needs to develop a body of knowledge that best fits, and for me that was Klein with her two fluid developmental positions, the paranoid-schizoid and the depressive position, attachment theories as exemplified by Bowlby (1969, 1988), the crucial importance of the mother-infant relationship as revealed by Winnicott (1960), and Mahler's (1969) separation-individuation continuum. (I cannot accept Klein's theories of infantile aggression directed at the breast as the basis for "normal" development, nor her concept of a death instinct.) I have read much about intersubjectivity and the analytic "third", but am not sure these are not a re-inventing of the wheel. Brodie (2020) has discussed this thoroughly, but when trying to define intersubjectivity he has come up with "wholeness" and "the ability to see the other as autonomous and separate", which has already been seen to arise from the depressive position, and from the separation-individuation continuum studied by Mahler.

Qualities that a good therapist should embody would be, as well as the liking for and listening to people, a strong desire to help and a determination to "see it through" no matter what. Maybe one should also enjoy being a detective, ferreting out mental mechanisms that are not immediately obvious. Some of my favourite TV programs are detective ones,

including plane crash investigations where experts have to deduce the cause from shattered bits remaining on the ground. (In parenthesis I must admit I also watch medical programs, and a recent highlight for me was my surgeon allowing me to watch his surgery on my arm.)

Ability to understand and handle one's own aggression, gained through analysis, enables the therapist to see it in patients, and to distinguish whose anger it is in the room. This leads on to handling rage in the consulting room, as when a patient took all my books from the bookcase and hurled them at me one by one, with unerring accuracy. (I had to hide my delight that she could no longer deny I mattered to her.) Knowledge of one's own defences and traumas is vital, so that these do not intrude into a patient's analysis.

Having a better than average memory I also consider vital, not using it as Bion (discussed in Grotstein, 1981) warned, to direct a session, but to be able to remember what happened in the last several sessions that may be determining what is happening in the current one, and to remember the whole flow of the analysis generally. I retired at age 88 when I was beginning to doubt that I could recall most of a session easily. Psychotherapists must also be able to function with that peculiar ability to become thoroughly involved with what is happening to the patient, but also to switch off that involvement on leaving the consulting room, or before the next patient.

A therapist also needs to be able to relate comfortably to people from backgrounds different from their own and with differing problems. Keeping up to date with any developments in the field is also necessary, while ultimately retaining faith in one's basic theoretical models and not being swayed by the latest fad.

It is generally accepted that the essence of psychotherapy is the relationship between patient and therapist, and the transference (though what transference actually may be is still hotly debated — see Brodie, 2020). My own analyst said that when it occurred he could only think of it as "awesome". Therapist and patient have to work their way through a minefield of defences and traumas as they struggle together to understand past experiences which are being enacted in the here-and-now relationship. The therapist needs to have patience, to allow a sense of "timelessness" to develop, to reach back to the early traumas (to reach the "feeling-memories" of the first six weeks, in my case). I was "fortunate" in having problems that required going back over aeons of time as it helped me deal with those who, like myself, are or have been a little mad. It does not seem necessary that patient and therapist always like each other, though usually they do, but no-one likes everything about everyone else. I certainly disliked my own analyst's superior knowledge of *everything*! He could be quite conceited about his own abilities, which included having a pilot's license to fly Catalina flying boats during WW2, and I recall on one occasion after he'd commented on the street layout of Adelaide, tartly remarking, "You seem to know more about my impending holiday than I do!" However, I also acknowledge that it was his faith in psychoanalysis and huge general knowledge of the human condition that got us through in the end.

Finally, I would like to stress my incredible good fortune — serendipity again! — in having my life changed by four remarkable fur-persons (all now deceased), without whom I would probably not be here. In 1994 I did not want a cat in my life but Tara, an unwanted stray cat, adopted me. She taught me how to love again and to accept the awful risk of loss that goes with love, after the death of my husband. Later came Rose (a Burmese) and Chaos (an SPCA moggie), whose love and antics made me laugh and showed me there has to be life

after a stroke in 2008. Finally Simba, a Burmese, who shared the last three years of his life with me as an "only" cat. He developed a series of little chirps and chatters just for me, so we had many daily "conversations". When in 2020 I fell and broke my leg, lying stranded on the floor, he came running over making worried little chirps, and tried nudging his head under my broken leg in an effort to help me stand up. What more could one ask of love and companionship than that, if family and friends cannot always be there.

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Book Review

Between the Harbour and the Mountain:
Reflections on the Ordinary and the Profound.
By Patricia Williams. (2021). Auckland, Aotearoa New Zealand: Calico.
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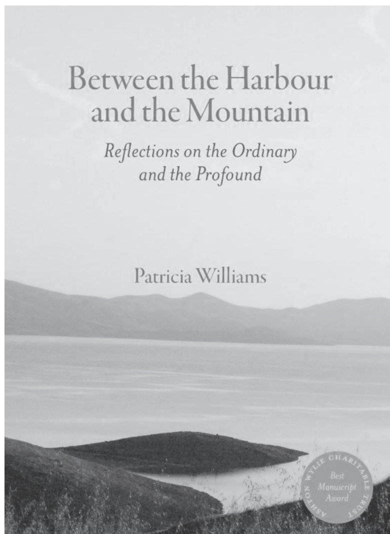

In this beautifully written and elegantly presented book the author, Patricia Williams, offers us her contemplations on the everyday world she encounters, with particular attention to the natural world and its ordinary and wondrous manifestations. Whilst many of us in today's technological age allow our attention to be distracted from the intimate detail of the natural world that enables life on this planet, Williams invites us to notice the extraordinary and sometimes frightening detail of this world within which we are all embedded, indeed intimately interconnected, as she brings her piercingly attentive gaze to the everyday. In doing so Williams reflects upon the meaning she has drawn from her rich and courageous life, allowing us not only to encounter the natural world through her eyes, but also to enter into the mind of a woman, now formally retired, who has spent her life reflecting upon and engaging with the deep questions of meaning with which we all might grapple, should we have the courage to do so.

This book began its life as journal entries. After her retirement, Williams, as she notes in her introduction to her book, "wanted to write and record my feelings and impressions, most particularly expressions of delight in the ordinary and the magic to be found in the everyday world" (p. 11). Having journalled her reflections on 'the ordinary', initially from her home in Onehunga, and more latterly her home in Mangere Bridge, she then gathered these journal entries together to form this moving and contemplative book. Her thematically organised reflections explore her encounters with the wonders, mysteries, and potentialities of her relationships to people, the natural world, and te ao Māori, and how these relationships and encounters reflect and reveal wider connections to our global context.

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I found her deeply thoughtful musings extremely moving. Every page contains intricate explorations of the microcosms of the natural world that reveal the universe, and the beauty that is before us, if we have but eyes to look, ears to listen, skin to feel, and more than anything, the heart and soul with which to receive and appreciate the wonder that is always around us. If we have the courage to bring such attention to the extraordinary that cradles us, this book reveals how such appreciation might provide us with the joy, as opposed to fear, which might more powerfully motivate us to better care for this planet which is so challenged by our contemporary climate crisis. She invites us to encounter the mysterious beauty of the universe, whether it is revealed in the great kauri tree, Tāne Mahuta, the smallest native bee, the flower of the eucalyptus tree, the delight and degradation of chewing gum, or the kindness of another's heart. Her attention is exquisite; for example,

> Yesterday — a miracle! Ambling home from the dairy... I hear a new bird call. I often take a shortcut through my neighbour's large section and, passing a flowering camellia, I hear what seems like a starling imitating a tūī. Sneaking up to the bush, what amazement and delight to see not a starling but a tūī. …
>
> Today, Tūī (note she no longer is just 'tūī' or 'the tūī' or 'it' but is now a proper noun) is cavorting in an immense oak on the same property. She persistently hounds two eastern rosellas, never letting them settle for more than a few seconds. The huge oak is always abustle with birds — sparrows, starlings, kingfishers, silvereyes and today the two persecuted rosellas — an avian condominium, in fact. (pp. 93-94)

She contrasts such natural delights with constructions of the human world,

> A supermarket is like a church built to honour consumerism: noisy, crass multiplicity of choices, a preacher over the loudspeaker telling the congregation about the latest or cheapest product they need to purchase in order to be blessed. (p. 131)

As she reveals these reflections, Williams also invites us to consider some of the core principles and beliefs that have informed her own rich and meaningful life. In particular, she emphasises her ever-growing appreciation of the depth, unity, and interconnectedness of the universe. She considers how contemporary quantum physics has proven to us all that there is no separation between us and the natural world, between each other, or amongst the many aspects of the universe that is our home. That all is intimately and inevitably interconnected, that each flap of a bee's wing reverberates around the world. She introduces us to her own philosophy and the philosophies of others, which guide us to have faith in the evolutionary possibility that we are continually moving towards recognition of this unity, wholeness, and interconnectedness, "an overall emerging pattern of grace, of wholeness and unity" (p. 33). And underpinning all of this is her faith in the capacity for love. That potent love, not a lip service love of meaningless superficiality, but love that is full of compassionate action, is our greatest hope for a planet facing potential catastrophe.

> Love is not an intangible … abstraction but finds its expression in the compassionate and just way we relate to each other; because without justice love has no meaning.

> Love/justice is a steely thing involving the will and often self-sacrifice which applies not only to my nearest and dearest but those with whom I share this land, Aotearoa New Zealand, and this planet, earth. (pp. 217-218)

Underpinning her often profound reflections is this 'steely' determination, that we will face the global catastrophes of the pandemic, of the climate crisis, of potential nuclear horror, with a steely love that seeks justice and a place for all, from the smallest of fruit flies to the largest kauri tree. And woven within the pages of her reflections, are flavours of her deeply thoughtful Christian Catholic faith. Indeed, Williams draws on a range of faith traditions, including Buddhism and Islam, as well as profoundly respectful reflections on the wisdom of te ao Māori. Her faith is not imposed upon us. It is not the faith of a "bearded person called God somewhere up in heaven" (p. 48). Rather, this is a faith, woven throughout the pages of her reflections, in which her theology reflects her conceptualisation of God as love in action.

For many psychotherapists, the concept of God and its relationship with spirituality and with psychotherapy clinical practice, is controversial and often problematic. However, Williams lives in a small community with three other women, all members of NZAP and psychotherapists, and the wisdom of psychotherapy infuses the book. Thus, her theology is both 'steely' and grounded, embracing psychotherapeutic understandings which are woven into her writing, as she offers her version of God as love in action.

For example, she reflects upon her experience of collaborating with one of her accomplices in the creation of a new number for her letterbox, a number six. Eventually they manage to obtain the requisite number, made, appropriately, of steel. It is of considerable size and needs to be powder coated. She and her fellow community member, Cabrini, a psychotherapist, travel off to a dingy Onehunga factory where the powder coating is being completed. When they arrive to receive their freshly minted, powder coated number six, which has taken many hours and considerable labour to prepare, Williams enquires about the cost. One of the two kind men who have done the job, replied,

> "Nothing," he says, smiling warmly. "You don't need to pay me anything". I am flabbergasted. … I feel as if Love has walked in to say, "Hello, I am here. You can find me in unlikely places". I spontaneously reach up (he is tall and I am short) and kiss his cheek. He looks surprised and touched, as am I. We drive off feeling deeply grateful and warmly affected. (p. 101)

Subsequently, Williams reflects on the possible unconscious aspects of this encounter, wondering if she may have evoked in this man,

> some positive transference from his mother which moved him to respond to me so caringly? If so, I will never know her, but her influence ripples out, touching me in an unexpected and lovely way. … my own powerful emotional response was a positive paternal transference from some very early interactions with my father, … a kindly and loving dad. (p. 102)

At times, Williams reveals how her faith is tested, her hope severely shaken by the horrors of the global terrors that we currently face. The gift of this vulnerability allows the reader to resonate with our parallel fears. Yet, throughout, her reflections are infused with hope. In her epilogue she concludes,

> So sombre, so gloomy are my thoughts as I write, and I wonder where is the optimism of the earlier journal entries? … I hope it is only a temporary absence because the natural world is a living garment enfolding our planet, and I need its comforting and constant presence. For now, whatever else is happening in our human world, the oystercatchers are still flying overhead, the godwits will still gather here in March before leaving on their vast journey to Alaska and Siberia, the magnolia will burst out in July, and in June, the banksia on our verge will again flower to become a feast for thousands of bees and singing tūī. Each morning, Zoe, our neighbour's calico cat, will check out the boundaries of our two properties and our resident blackbirds will express their usual indignation and alarm at her presence. It is assuring to know that in the world of nature, all carry on their routines, regardless.
>
> In contrast to nature, the global upheaval of the pandemic and the potential drastic effects of a changing climate can be overwhelming and drown out the song of the riroriro. This must never happen for we need hope to motivate us to act at this crucial time. (pp. 219-220)

Ultimately, Williams's writing is imbued with hope. For some readers such hope may seem futile in the face of potential devastation. But Williams's hope is steely, without being naïve. As the great Czech statesman and writer Václav Havel wrote in his 1991 book, *Disturbing the Peace*,

> Hope is not prognostication. It is an orientation of the spirit, an orientation of the heart. It transcends the world that is immediately experienced, and is anchored somewhere beyond its horizons, … The more uncompromising the situation in which we demonstrate hope, the deeper that hope is. Hope is not the same thing as optimism. It is not the conviction that something will turn out well, but the certainty that something makes sense regardless of how it turns out. In short, I think that the deepest and most important form of hope, the only one that can keep us above water and urge us to good works, and the only true source of the breath-taking dimension of the human spirit and its efforts, is something we get, as it were, from 'elsewhere'. It is also this hope, above all, that gives us the strength to live and continually to try new things, even in conditions that seem as hopeless as ours do, here and now. (pp. 181-182)

This is the kind of hope which, for me, infuses Williams's writing.

I recommend this beautiful book most highly. It is a book that can be perused one entry at a time, as a meditative prayer at day's end, or when dawn breaks. Or you may be tempted to read it all in one sitting, allowing each reflection to join the next and to provoke feelings

that stir the heart. And if ever our world needs heart as well as intellectual care and loving action, it is now. Whilst not directly a psychotherapy book, its wisdom, I suggest, would greatly benefit our psychotherapeutic work. Its hopefulness is an antidote to the despair we can so easily feel. Its realism and truth make it both pragmatic and inspiring. And Williams as a guide, allows us not only to encounter the natural world and its beauty and horrors as she encounters it, but also to enter her mind, soul and heart, to feel her subjectivity and the wisdom that might guide us all in sometimes terrifying times.

Between the Mountain and the Sea: Reflections on the Ordinary and the Profound (2021), was the winner of the Ashton Wylie Charitable Trust, Best Manuscript Award (Mind, Body, Spirit genre) (2020). It is published by Calico Publishing Ltd, and available for purchase via the publisher's website, calicopublishing.co.nz

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