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THE NEW ZEALAND
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CONTENTS

Editorial 4
Margot Solomon
References 5

Speaking from the body 6
Paul Solomon
Abstract 6
References 19

Response to the speaking body 20
Josie Goulding
Abstract 20
References 24

Echoes from the east 26
Paul Bailey
Abstract 26
References 29

Immigrant Psychotherapists and New Zealand clients 30
Mark Thorpe & Miranda Thorpe
Abstract 30
References 43

We cannot imagine without the other. 46
Keith Tudor
Abstract 46
Conclusion 57
References 57

Psychotherapy training in a therapeutic community. 62
Ann Speirs
Abstract 62
References 72

Martha: Finding oneself in the other. 73
Sandra Buchanan
Abstract 73
References 86
Endnotes 88

Imagining the Other: Some hallucinations from a therapy 89
Grant Dillon
Abstract 89
References 101

Conservative, Liberal and Radical Psychotherapy 103
Jonathan Fay
Abstract 103
References 110

Book Review 111
John O'Connor

Contributors 114

Guidelines for contributors 117

Editorial

Margot Solomon

> I don't have nothing only words to put down on paper. Its so hard. Some times theres mor in the emty paper nor there is when you get the writing down on it. You try to word the big things and they tern ther backs on you. (Hoban, 1980. P. 161.)

This quote is from a novel called Riddley Walker, set two thousand years after a nuclear war, "the one big one." It "looks to the moment in the postholocaust future when humanity, well into its second Iron Age, begins once again to pursue knowledge that will destroy it" (Cowart, 2009). The novel addresses problems of being human, those which we approach every day in our work as psychotherapists – and in this quote, the problem of expressing ineffable experience in a language that is inadequate.

I have never considered myself a writer, which is one reason for liking the quote from Riddley. New Zealand psychotherapists are reluctant writers. I want to thank all those who have been willing to show yourselves through your writing and also those who have participated in the process, the peer reviewers and the subeditors.

As I approach writing my last editorial for the NZAP journal I reflect on my role as editor. I have learnt a great deal about the process and hope to pass my learning on to the new team. The 2008 journal has been slow to come to print. This is due to the editor's struggle with ill health and workload. I apologise to those who have been waiting. The journal is packed full of tasty morsels, and each paper brings a perspective from the experience of the psychotherapist-writer that enriches the reader's reflection on their own practice. The subjectivity of the psychotherapist and the intersubjective process are central to the papers.

Four of the papers in the journal were presented at the conference in Waitangi, which had the theme "Imagining the other: initial contact in the psychotherapy relationship".

We start with a new departure: a paper is presented and then discussed by two writers. Paul Solomon's paper introduces the use of vipassana meditation as a resource for psychotherapists to enable a greater awareness of countertransference responses, especially body countertransference. The respondents are Josie Goulding and Paul Bailey.

Mark and Miranda Thorpe explore the ways immigrant psychotherapists induct themselves into the new culture. Immigrants have much to offer us if we can bear to listen. Each new person brings a fresh perspective to the culture that we take for granted. At the same time immigrants travel their own journey of mourning and discovery.

Keith Tudor, who is coming from the U.K. to join us in 2009 in Auckland. He offers the conceptual framework of organismic psychology to engage with the encounter with other. He uses the language of the arts and the psychotherapy language of humanism.

Ann Speirs, Sandra Buchanan and Grant Dillon all invite us to journey with them as they reflect on their clinical work. Ann takes us inside the process of training to be a psychotherapist with a specialist focus on the therapeutic community, although her ideas are applicable to any training experience. Sandra does a rare thing: she brings us the essence of an NZAP case-study. Grant's honest and deep reflections on his bi-cultural experience with his client Aria offers us the chance to reflect on our own assumptions and deeply held theories and practices.

Jonathan Fay considers conservative, liberal and radical orientations to psychotherapy, and recognises the dialectical potential of encompassing all three. Jonathan's paper has the potential to help us clarify our thinking as our psychotherapy association faces the changes that registration is bringing.

Finally, the theme of meeting the other is continued in John O'Connor's review of "Penina Uliuli". I hope you enjoy reading the journal and perhaps may even be inspired to contribute to a future issue.

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The speaking body: Psychotherapists who meditate

Paul Solomon

Abstract

Psychotherapists who practice Buddhist meditation can develop a heightened awareness of their own body sensations. Some psychotherapists develop the skill of using their body awareness inter-subjectively: their bodies can become sensitive instruments that resonate with the unconscious emotional and physical experiences of their patients and clients, in a form of body-based counter-transference. This article discusses two clinical vignettes from a study of the work of six psychotherapists who meditate, in Auckland, London, New York, and Boston (Solomon, 2008).

The author suggests that the practice of insight meditation (vipassana), and other forms of meditation, may enable therapists to achieve "evenly-suspended attention" (Freud, 1912), develop their sensitivity to body sensations and body counter-transferences, and temporarily suspend psychic boundaries between self and other.

Evenly suspended attention and reverie

I propose that the ability to achieve a meditative state of awareness helps psychotherapists to develop an orientation of their attention which Freud (1912, 1958) called "evenly suspended attention." Freud does not describe a specific method for achieving this; he merely refers to what he calls "a very simple technique" (p. 112), of not directing the attention to anything in particular, with the aim of attuning the unconscious of the analyst to that of the patient. Beginning meditators, and many psychotherapists, do not find this so simple. No doubt Freud's genius enabled him, apparently by a simple act of will, to refrain from attending to details so as to achieve a state of awareness that can elude practitioners of meditation, and of psychotherapy.

Bion's (1967) recommendation to "renounce memory, desire, and understanding" (p. 272) and enter a state of "negative capability," echoes Freud, and Ogden (1997) developed a related idea in his descriptions of the analyst's reverie. Ogden's account of free-floating attention emphasizes the mental and emotional aspects of experience rather than the physical. He describes states of reverie in which the analyst's fantasies and apparently random thoughts are found, on closer examination, to reflect patients' unconscious experience. In the following vignettes, therapists describe not counter-transferential thoughts, emotions, or inferences about patients' self-states, but rather distinct body sensations that on examination are found to register their patients' emotional experience.

Linking vipassana meditation with psychotherapy

Some of the elements of vipassana, re-branded "mindfulness," have entered the field of cognitive-behavioural psychology in the form of Mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1990) and Mindfulness-based cognitive therapy (MBCT; Segal, Williams, and Teasdale, 2002). These empirically-based, positivist interventions are not a focus of this article: the following account of vipassana is included to suggest links between meditation and descriptions of some states of mind experienced by psychotherapists engaged in psychodynamic therapeutic work.

The Pali word vipassana means insight; this form of meditation was described by the Buddha 2500 years ago in the Mahasatipatthana Sutta (great discourse on establishing awareness), handed down orally, then written down around 30 B.C.E. in the Pali canon. Pali was an ancient Indian literary language. This is not a religious or esoteric text, and a Buddha is regarded as a human being who has fully developed the quality of Buddhi, insight. According to Solé-Leris (1986), the discourse is a primary source for the practice as taught by the Buddha Gautama, who described a method for developing insight into the nature of human experience.

In this form of meditation, the object of attention is the body. Body sensations are observed with an increasingly concentrated and trained mind. The Buddha's advice was to work at developing insight into the true nature of reality by refining our awareness of that portion of reality which is most readily available for experiential study, namely, our own physical, emotional, and mental being and their inter-related nature. The Buddha's discoveries were made within his own mind and body. Hence he said:

> It is within this fathom-long carcass, with its mind and its notions, that I declare there are the world, the origin of the world, the cessation of the world, and the path leading to the cessation of the world. (Samyutta Nikaya cited in Carrithers, 2001, p. 3).

The "cessation of the world" is taken by meditators to mean not a literal ending of the world or the death of an observer, but the cessation of habitual ways of understanding, distorted by a consciousness that has not been refined and developed in meditation.

In several respects, the Mahasatipattana Sutta anticipates the findings of the psychologists Lambie and Marcel (2002), and of the psychoanalysts Stolorow and Attwood (1994) and engages with the interface between experience and thought. For example, there is the idea that body sensations

and emotion experience are filtered through an unconscious evaluating faculty, before becoming available to introspection. By the time we become aware of sensations, we have unconsciously evaluated them as desirable or undesirable—craving or aversion in Buddhist terminology; Lambie and Marcel (2002) write of "desirable or aversive" primary process stimuli. In vipassana (as in zen and other Buddhist meditation practices, and in psychoanalysis), one trains one's awareness towards choice-less observation, free of craving or aversion, which Buddhists view as the roots of suffering.

The concept that all emotion is first experienced through body sensation, as asserted by Stolorow and Attwood (1994), Damasio (1999), and Schore (2003), is also found in Buddhist psychology. In vipassana meditation, the primary object of attention is body sensation; when discursive thoughts arise, meditators return their attention to the sensations, training themselves to stay in the experience rather than thinking about it. It is understood that with sufficient practice one can, to some extent, collapse the subjective separation between observer and observed, mind and body, and between affect and cognition, with a concomitant increase in sensitivity to body sensations and affects, even very subtle ones. The effects of this are powerful, especially when practiced in meditation retreats that involve twelve hours of daily meditation for ten or twenty days, or longer.

Describing the enterprise of training the meditative mind to remain centred in body experience, rather than in conceptual thinking about experience, the meditation teacher S. N. Goenka (1999) comments: "You must have direct experience. The observation must be without any separation of observer and observed" (p. 52). As Goenka explains:

> If you try to understand body just by taking the attention, say, to the head and asserting that 'this is my head', it is only an intellectual truth, that of recognition. To experience reality you must feel it. Therefore there must be a sensation, and body and sensation go together in this exploration.(p.26)

The theme here is the intentional control and training of one's awareness in such a manner as to transcend separation between the observing mind and the body sensations that it is observing.

The meditative experience of dissolution

I will very briefly outline the meditative experience of impermanence, of dissolution of the body-mind (Pali: bhanga) as it relates to the term "interbeing" (Thich Nat Hanh, 1999). It is an important stage on the path

of vipassana to reach the ability, with a concentrated and focused mind, to become aware of subtle sensations throughout the body. This is described by Goenka (1999) in this way:

> Initially it is very gross, solidified, intensified, but as you keep practicing patiently, persistently, remaining equanimous with every experience, the whole body dissolves into subtle vibrations, and you reach the stage of bhanga, total dissolution (p. 29).

In this stage the whole body is experienced as a network of tiny wavelets of energy or sub-atomic particles, arising and passing away with enormous rapidity. Meditators are thus able to experience the materiality of their bodies in a way that is consonant with both Buddhist psychology and particle physics. As Capra, a physicist who has worked at C.E.R.N. (Centre Européene de Recherches Nucléaire) puts it:

> Modern physics, then, pictures matter not at all as passive and inert, but being in a continuous dancing and vibrating motion whose rhythmic patterns are determined by the molecular, atomic and nuclear structures. This is also the way in which the Eastern mystics see the material world. They all emphasise that the universe has to be grasped dynamically, as it moves, vibrates and dances; that nature is not a static but dynamic equilibrium (1975, p. 216).

From the perspective of modern physics, Capra also comments on the illusory nature of the perception of the separateness of each human individual.

Once the stage of bhanga has been attained, it is the author's experience that one can maintain a fine and focused awareness of one's own body for extended periods of time; and this brings with it an ability to feel, in one's own body, sensations that reflect the experience of another person who is in close proximity. The boundaries between self and other are temporarily suspended. In the therapy setting, I have felt the pattern of my own body sensations change to reflect the emotions of patients. For example, I have felt a patient's grief as an ache in my sternum, as if the flesh were melting like an over-ripe fruit; and a patient's rage as a tingling in my arms. Sometimes I become aware of subtle feelings of connectedness or distance, aliveness or deadness, love and hate.

As mentioned above, all psychological states seem to have their physical correlates, however tenuous; and a non-reactive meditative focus on the

sensations defuses the psychic energy attached to traumatic memories, whether these are physical, mental or emotional. However, vipassana meditation differs from psychotherapy, according to Solé-Leris (1992), in this way:

> In vipassana one does not need to know what particular mental content is being cleared, nor is there a specificity of physical correlates: an accumulation of psychic energy (which would otherwise remain active as a source of future psychological or psychosomatic conditions) is simply dispersed as it becomes conscious in the form of sensation and is not reacted to. (p. 151)

Here Solé-Leris states the Buddhist understanding that cognitive, conscious awareness of trauma, and understanding of its etiology and expression in present emotional relationships and life patterns, are not preconditions for the healing that results from meditation practice of itself; mere sustained, non-evaluative attention to one's physical sensations is sufficient. Behavioural therapists employ variants of mindfulness in therapeutic work focused on specific goals (e.g., Segal, Williams, and Teasdale, 2002); cognitive-behavioural interventions are not a focus of this article.

Psychotherapists' experiences

I will now quote two vignettes from transcripts of interviews with psychotherapists who meditate, and whose body sensations reflect the emotion experience of their patients. Here the focus will not be on the healing effects of meditation, but rather on therapists' experience of their own physical sensations as they reflect the psychic and somatic experience of patients when self-other boundaries are suspended.

First vignette

One participant reported physical discomforts of various kinds with a number of her clients. An example is this:

> *Sometimes I have very uncomfortable physical experiences that are quite hard to sit with. For example, I had one client where I had quite a consistent pain in my jaw, and my jaw wouldn't be able to move very well; and he'd had major surgery on his jaw when he was younger.*

The therapist had jaw pain only when she was with this client, whom she saw over some years. There was nothing physically wrong with her own jaw, and she understood her pain as a reflection of her client's experience:

> *Somehow we worked it out between us. It was a part of, I think, me entering into his reality somehow, to have that physical discomfort and pain, somehow I was mirroring him. Don't ask me to explain how it happens, but it happens to me a lot. There are clients where I get physical sensations.*

The client's pain had a physical cause, but the therapist's pain had no physical cause. The explanation she offers is that what happened was "me entering into his reality somehow" and "mirroring him." Listening to the therapist's account, I felt belief in her sincerity, and a "phenomenological nod," (van Manen 2000), the feeling that, yes, this could have happened. The word "mirroring" recalls studies of mirror neurons (e.g., Rizzolati and Craighero, 2004): specialised neuron systems in the pre-frontal cortex of monkeys and humans were found to be activated when the subject either performed actions, or observed actions (including mouth, hand, arm, foot, and leg) performed by another. This work is recent, but promises to identify a neuro-physiological basis for human empathy (Ramachandran, 2002) and language (Rizzolati and Craighero, op. cit.).

The client had been fully aware of having had "major surgery" on his jaw when younger, and the therapist understood her own consistent jaw pain and inability to move her jaw as "entering his reality somehow" and "mirroring him," and explained that she believed the client's jaw immobility, as well as being the result of physical trauma, acted as an expressive metaphor in the sense that it paralleled the client's inability to speak about emotional realities that could not be spoken within his rigid and controlling family. She understood her ability to be receptive in this way as "surrender" to her emotional experience, and quoted Ghent's (1990) paper on surrender versus submission. Ghent writes:

> The meaning I will give to the term "surrender" has nothing to do with hoisting a white flag; in fact, rather than carrying a connotation of defeat, the term will convey a quality of liberation and expansion of the self as a corollary to the letting down of defensive barriers. (p. 108)

Ghent (1990) proposes that this kind of surrender requires a creative act, one of willingly entering a domain of transitional experiencing like that of an infant who "lives through a faith that is prior to a clear realization of self and other differences" (p. 108-109). To maintain defensive barriers requires an investment of psychic energy, and it follows that letting the barriers down frees that energy for more constructive uses. The participant's use of the term implies that she enters the client's reality just as a mother participates

in the experience of her infant, by an act of empathic immersion which, in the example quoted here, involves the registration of physical sensations and muscular tensions as well as emotions. The therapist mentioned that the client in his ten-year therapy made some progress in speaking out, but was never able to speak with complete freedom; and she felt a progressive relaxation of her jaw as work with the client progressed. But right up to the termination of the therapy, she felt "occasional twinges" in her jaw, probably indicating that her physical and empathic attunement continued to accurately respond to changes in the client's self-experience.

Second vignette

The therapist said:

> *I am surprised at the synchronicity between what the client is talking about and what I'm experiencing. There's one very powerful one that happened over a period of months, which started with a discomfort in my legs, you know I've had this before with other clients, and at first of course I just notice it and do nothing because I'm not sure if it's just me.*

"Just notice and do nothing" is quite a clear statement of one of the foundations of mindfulness meditation. One just observes one's sensations, abstaining from the habitual reactions of liking or disliking. The therapist indicates the tentative nature of her consideration about the possibility of having body sensations that reproduce something reflecting her client's experience: "I'm not sure if it's just me."

She continued:

> *Eventually it was so powerful I could barely stay still, my legs were so uncomfortable, so shaky...Eventually it felt like she was quite stuck and frozen, and I asked her how she was feeling, and she said she couldn't feel her body at all; this was over a whole lot of sessions. So at one time I asked her how her legs were, and she couldn't feel them. And it was almost like over a period of months she gradually came to begin to feel in her body.*

In this example, the therapist again reports feeling physical pain in response to a client, who in this case felt nothing. It seems remarkable that the therapist silently tolerated the pain over many psychotherapy sessions, just noticing it and holding in her mind the question about whether it belonged to her client or herself. At last the therapist told her client about the pain, and the therapy moved on:

This happened over more than one session, and she remembered that when she was quite little, I've forgotten the story, she had something wrong, she had to have her legs in plaster and they waited until she could walk. And the moment she could walk they operated on her and so she spent three months with her legs in plaster from her waist down to her knees, and she couldn't move, and it [the therapy] was like this unravelling of her operation; and she started to feel and I stopped feeling. It changed and she started to feel, and it was very painful and very emotional.

It appears that, somehow, therapist and client had entered into a relationship where the therapist felt in her body something corresponding to the experience of the client, who at first was unable to "feel in her body." The therapist contained her body sensations, wondering and thinking about them but refraining from speaking, while the client continued to feel nothing. After some months, the therapist, unable to tolerate the pain any longer and intuitively sensing that the moment had arrived, spoke to the client about her physical pain: the client then began to feel in her body; the therapist stopped feeling pain. The therapist's understanding of what had happened to the client who had been immobilized in the plaster cast was this:

She somehow took everything into her head so that all her learning was in her mind, and not through her emotions or her body; and somehow through our experience together, and my holding of that physical pain, she made some connections, started to notice her body.

The therapist feels sure that her "holding of that physical pain" helped the client to make some connections she had hitherto been unable to make. She uses the word "somehow" to capture the mysterious or non-cognitive quality of the process—tacit experience (Polanyi, 1966) which can be felt and to some extent described, but not easily or logically explained without recourse to clinical inferences about the patient's inner states. I did not press the therapist for any analytic elaboration of the psychic movement that clearly had occurred, but it seems likely she would have been able to supply this if asked.

This sort of phenomenon might be what Schore (2003) had in mind when he described the therapist's task of containing raw emotions until a suitable emotionally engaged moment arrives for communicating "the patient's affectively charged but now regulated right-brain experience" (p. 54) to the patient's linguistic left brain for further processing. In the above example, holding and eventual verbal expression by the therapist were precursors to

emergence in the client of affective connections with her body sensations and affects, that had previously been absent or out of her awareness.

The therapist elaborated her theoretical understanding of her interaction with her patient in this way:

> *It feels like what I do is, in a way, that I let go the boundary between myself and the other. I'm willing to open, open the boundary between us, so that's part of it I suppose. I surrender; I don't hold on, but I suppose I open myself up somehow and it's like an osmotic experience. We influence: some of me goes into them, and some of them comes into me, and I suppose that's what happens. But it's not just that, I suppose one thing that I experience is I begin to notice things that are not me, that are part of them.*

In this description, the language used by the therapist is simple and tentative ("it feels like; I suppose"); she uses mostly short, Anglo-Saxon words (rather than Latinate polysyllables), and I suggest that this may indicate the experience-near quality of her verbal account.

This therapist noted that the process of surrendering some of her boundaries sometimes became disorienting, and at these times she needed to feel her separateness:

> *[T]o feel myself moving backwards, away from them; I get a bit of distance, regroup. Yes, regroup, feel my own self, it's like the thread gets a bit thin, I get lost in their stuff. And sometimes I need to be able to do that to help, to be useful.*

In this account, it is as if the therapist, when she fully surrenders and immerses herself in her experience of the non-separation of self and other, cannot always maintain her awareness of being a separate self. She needs to "regroup" and feel her separate self again in order to regain some sense of executive ability in the therapy.

Emotion and neuro-science

Discussing the physiological basis of emotional experience, Schore (2003), in an integration of the literatures of psychoanalysis, attachment theory, and psychoneurobiology, describes some differences between right brain hemisphere, emotional and attachment processing, and left brain linguistic and intellectual thinking (pp. 70-75). The right hemisphere and its emotional and attachment functions develop in the first eighteen months of life, and provide a matrix for the mother-infant bond and, Schore proposes, the emotional aspect of the therapist-patient bond. The linguistic, conceptually oriented left

hemisphere, according to Schore, develops later and becomes dominant; but communication between the hemispheres is incomplete, and constitutes a barrier between emotional experience and linguistic processing.

Psychotherapists work with this partial barrier between emotional and cognitive experience, between feelings and thoughts, between conscious and unconscious. We attune our emotional right-brain to our patient's right-brain, we contain and regulate emotion experience that may at first be out of awareness, and as a result of this regulation we are eventually able to communicate "the patient's affectively charged but now regulated right-brain experience" (Schore, 2003, p. 54) to both the patient's and our own linguistic left brain for further processing.

Schore (1992) mentions that Stolorow and Atwood have observed that this sort of left to right brain feedback allows for a linking between non-verbal and verbal representational domains, and facilitates "evolution of affects from their early form, in which they are experienced as bodily sensations, into subjective states that can gradually be articulated" (p. 54).

Psychologists share the view that emotional states are first experienced as body sensations. Proposing a theoretical framework for emotion experience, Lambie and Marcel (2002) develop a "two-level view of consciousness in which phenomenology (1st order) is distinguished from awareness (2nd order)" (p. 1). They argue from an extensive review of psychological literature that occurrence of a "1st order emotion" in most cases is signalled by "phenomenal awareness of autonomic and bodily changes" (p. 3). These bodily and neurological responses result from an evaluative activity of the mind, (sometimes conscious, and sometimes unconscious and automatic), in which events or circumstances (actual, remembered or imagined) are appraised "in terms of relevance to or implication for one or more of the organism's concerns" (p. 23). Events are judged suitable and desirable or unsuitable and aversive; and objects of awareness and appraisal may include experiences of self, of other, or of the world; and this activity gives rise to "evaluative descriptions and action attitudes" (ibid.) that constitute the individual's emotional response to the life-world; the life-world includes orientation to oneself, to others, and to the world. In this schema, a "2nd order emotion" is produced when one adopts an analytic observational response to one's emotion, usually after it has been experienced, but sometimes during the experience.

Lambie and Marcel (2002) comment on the difficulty inherent in describing emotion experience:

> There would seem to be a problem in accurately characterizing first-order phenomenology, given our general position that we can only know it via second-order awareness, which usually transforms it. When we deliberately attend to it, we tend to adopt an analytic observational attitude, which disintegrates its first-order holistic nature (p. 34).

This goes to the heart of the problem with verbally describing experience: when we are deliberately attending to phenomenological experiences such as body sensations and emotions, by observing or remembering, they are transformed from experience (left brain) into thought (right brain), and thus changed and distorted. If this formulation were accepted, we would need to remain sceptical of any description of experience, including of course the clinical vignettes (above). Nevertheless, I suggest that, in psychotherapy, some speech is closer to body-emotion experience than it is to left-brain, intellectual speaking. There can be clues in therapists' use of language: this was mentioned (above) in connection with one therapist's use of simple language and short words (e.g. "Some of them comes into me, and some of me goes into them").

Daniel Stern (2004) suggests that the disjunction between experience and the verbal expression of it may serve to protect the integrity of our lived experience:

> Something is gained and something is lost when experience is put into words. The loss is wholeness, felt truth, richness and honesty. Is there some kind of resistance operating to counter this loss—a resistance that keeps some experiences protected in their richly complex, non-verbal non-reflectively conscious state? Perhaps it is an aesthetic and moral true-to-self resistance, an existential resistance against the impoverishment of lived experience (pp. 144-145).

Stern's conjecture that something is lost when we put our experience into words has resonance for psychotherapists when we begin to practice Buddhist meditation; our psychotherapy trainings have privileged verbal expression of subtle feelings, and in learning to meditate we are enjoined to stay in the experience and abstain from conceptual thinking.

The context of body psychotherapies

Although Freud (1923) originally described the ego as "first and foremost a body ego" (p. 364), it is my impression that in psychoanalytic writings the body has to a large extent been ignored in the first two thirds of the 20th Century. A notable exception was the work of Wilhelm Reich (1945, 1972),

which inspired Alexander Lowen's bio-energetic therapy (1958). In England David Boadella (1987, 1997), with whom the author studied in the 1970's, drew on these foundations for his biosynthesis therapy, and Gerda Boyesen developed her biodynamic therapy.

In Chicago, Gendlin (1978, 1996) together with Carl Rogers, noted that patients who were able to attend to unclear bodily felt senses experienced the most benefit from psychotherapy. This marked the beginning of focusing-oriented psychotherapy. Many other theorists and practitioners have made significant contributions to the literature on body psychotherapy in a range of modalities, some of which include touch. Most theorists acknowledge the need for therapists to attend to their own body counter-transference. The author regrets that there is not space in this article to do more than acknowledge his debt to them. Their work is embedded in my thinking, and enriches my psychotherapy whakapapa.

Discussion

Although psychoanalytic authors frequently refer to the importance of noting body experience, few have offered specific case examples of the clinical use of the therapist's body. An exception is Concetta Alfano (2005), a psychoanalyst and zen meditator, who describes a practice which she terms "transcendent attunement," in which she intentionally opens the somato-psychic boundary between self and other:

> [A] disciplined, yet unselfconscious attentive process within the analyst, which has a counterpart within the analysand, in which boundaries between self and other and between somatic and psychic perception are temporarily dissolved (p. 227).

With highly evocative case examples, Alfano explains that in the course of her work with a patient she found that her "normal self-conscious subjectivity was temporarily suspended" (p. 224), and that she "experienced her body as a resonating, containing space, an echo chamber, to that of her analysand's unconscious communications" (p. 223). She notes "It is not until after such a dissolution of boundaries has occurred that we can reflect on the experience, recognizing its component elements and phases" (p. 226).

Alfano's account of her work is more detailed in its conceptual elaboration than the vignettes from the work of the anonymous therapists whom I have quoted above; yet there are striking similarities. Both Alfano and the above therapists mentioned the dissolution of self-other boundaries; and found their bodies resonating with psychic and somatic aspects of their patients'

experience. All connect their meditation experience with their ability to attend in a free-floating, choiceless way to the various aspects of their experience, and in this way to transcend self-other boundaries. All mention that their experiences in therapy relationships come before conceptual thinking. And finally, all mention holding their psycho-somatic experiences, and reflecting on their meaning, before eventually finding a way to share them with their patients.

All the therapists quoted above have said or implied that in their experience, there is sometimes no clear boundary between psychic and somatic modes of experience. For them, body and mind can be experienced as a unified field. However, in the study on which this article is based, only three of the six psychotherapists and psychoanalysts interviewed, described attending to body sensations in the manner discussed above. It is the experience of the author, and of the anonymous therapists, and of Alfano (2005) that Buddhist meditation is potentially one of the foundations of this sort of suspension of self-other boundaries; and that training in meditation enhances the ability to allow one's attention to float freely and to notice psychosomatic sensations that are sometimes ephemeral and subtle.

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Response to The speaking body: Psychotherapists who meditate

Josie Goulding

First my thanks to Paul Solomon for writing this great article and to the editorial team for giving me the opportunity to read and respond to it.

This article was, for me, a delicious dive into ideas and questions that have long held my interest. Vipassana meditation as a lens to look at these questions was refreshing and stimulating.

The familiar questions are about the nature and practice of psychotherapy and the role of the body and language. Psychotherapy is, minimally, a two-person endeavour and, by intent, an intersubjective process that requires interaction/communication of some sort. There is an acknowledgement of the role of unconscious communication, right back to Freud: "It is a very remarkable thing that the Unconscious of one human being can react upon that of another without passing through the Conscious" (Freud, 1915, p. 194). The method of "classical psychoanalysis" was defined by Freud as "the act of following the chain of ideas presented by the analysand" (Bollas, 2007; Freud, 1932). This was done through free association on the part of the analysand, and the analyst who needs to hold a stance of free-floating attention, as was mentioned in Paul's article. While this was primarily seen as a verbal endeavour in which the analyst was expected to listen, follow, and ultimately interpret, the listening certainly seemed to include listening to the patients' enactments and their bodies as communication. However, as the article suggests, the body of the therapist was, historically, largely ignored and was seen primarily as the site of perception, and not of unconscious process. With increasing attention placed on the role of transference, countertransference, projection, identification, and projective identification, and, as indicated in the article, the constructive nature of the intersubjective relationship on the brain, psychotherapists, among others, have been investigating the implications for the healing and communication that occurs in the therapeutic relationship. In these investigations, the idea that the body of the therapist can be the site of complex and creative exchange of unconscious material has been of increasing interest and acknowledgement. Therefore the question of accessing or noticing our bodies as therapists becomes important.

In the article, it is suggested that "evenly held attention" and reverie were the most commonly articulated methods of attending to unconscious (interpersonal and intrapsychic) communication in psychoanalysis. In

vipassana, attending takes place through meditation. The article points to the idea that these methods are at least minimally similar, particularly in the way they are used to gain some sort of access to the often unspoken, but responded-to and enacted or embodied, aspects of one's own or the client's experience.

As stated, Freud talks about evenly-held attention as though it was easy to attain, but it may not be so easy, particularly for beginning practitioners. The article identifies the specific advantages of vipassana meditation and Buddhist philosophy as a gateway to unconscious experiences through its particular focus on the therapists'/mediatators' awareness of their bodies. In part, its advantage is that vipassana has a clear method of practice that is taught. This clarity of method is not my experience of psychoanalysis. The practice of, for example, free floating attention as described above can seem mysterious. The teaching of psychotherapy and its practice is generally come to through retrospective analysis and reflection. Often much of the teaching has been a largely cerebral endeavour, with verbal language the most attended to form of communication. Often the method, if achieved, first creates this slightly woolly experience. This rightly could be put down to the individuality of experience, the need to allow space for not knowing, the personality of the therapist, and one's capacity to think in this way as something that can only emerge with experience. However, I did wonder about the rather refreshing clarity of method for vipassana. Alongside this was my own research, in which practitioners identified that they could use a variety of methods to practice this sort of openness, connectivity, or dissolving of boundaries, both within and outside the therapy room, that seemed to allow them access to these experiences (Goulding, 2002).

The idea of the dissolving of interpersonal boundaries is one that is written about by a number of authors—for example Orange (2000, 2002) and Zeddies (2000)—from an intersubjective perspective. The idea that inside and outside are a dualistic creation of the mind to enable a sense of integrity of the self, in the same way we divide body and mind, is reinforced by the experiences described in the article. The article provides examples of where this division appears to break down in relation to the therapist's experience of their body and the client's body. It is well articulated by the practitioner in the second vignette. What was particularly interesting in the article was vipassana's clear method for developing this capacity to notice. It would seem that the effect of developing an acute sensitivity and capacity to stay present to the practitioner's own body experience allows the meditator to be aware of others' experiences through their own body, and thereby participate in this particular form of communication.

This, for me, raises the question that if we accept that the body is a site of unconscious processes, and unconscious to unconscious communication, what do we do once we have noticed it? Do we need to move to articulate these experiences, or are they healing in themselves?

As stated in the article, there is agreement amongst some authors in both psychotherapy and philosophy that all experience is embodied (Aron, 1998; Damasio, 2000; McDougall, 1989; Merleau-Ponty, 1962; Schore, 2001; Stern, 1985). But, if the client's experience is generated by unconscious conflict and distress, for example, can it be resolved without a move to conscious verbal awareness? As the article states, much of our early crucial learning occurs before we attain verbal fluency. From a developmental perspective the sequence is experience first, words later; however, human beings, it would seem, are hardwired for symbolisation (Anzieu, 1989; Damasio, 2000; Schore, 2001; Stern, 1985). The argument is that if our embodied experience remains locked in the primordial (those non-reflective places of our soul), we may simply become enslaved to "be" our embodied experience repeatedly (Krystal, 1988). If this is the case, our embodied experience lowers our ability for self-determination or self-agency and, as part of that lessened capacity, our ability to move toward identifying what we hold as "motivating, inspiring and defining of self" becomes restricted (Zeddies, 2002, p. 8). Even Merleau-Ponty (1964), who supports the primacy of body and perception as locating one's self in the world, says:

> Left to itself, perception forgets itself and is ignorant of its own accomplishments. Far from thinking that philosophy is a useless repetition of life, I think on the contrary, that without reflection, life would probably dissipate itself in ignorance of itself or in chaos. But this does not mean that reflection should be carried away with itself or pretend to be ignorant of its origins (p. 19).

The article provides an interesting counterbalance to the dichotomy of experience and understanding in the way it describes the vipassana meditator as not requiring what we therapists traditionally see as the separate observing self. Instead, it suggests the collapsing of the two positions: the experiencing self and the reflective observing self. This is hard for me to hold on to, even though I have experience with holding this paradox. My question clinically is, if we do reach this position experientially, what does this give us, and how do we use it? In vipassana, it would seem, the method of resolution is through the continued focus on the body. My understanding from reading the article is that it is moving away from the attachment to the emotional or

valenced element of the experience, through a continual return to noticing the body, that some form of resolution occurs. This has not been the model in psychotherapy.

It is within the intersubjective process, and through the communication of the internal experience to the self by the self through the use of the other, that resolution is seen to occur. In other words, being able to use the other (Winnicott, 1969).

Can the form of resolution reached in vipassana be useful intersubjectively? While I can see the way that a deep acceptance of one's experience without, as Krystal (1988) would suggest, an over-investment in the emotional element could change the experience in itself and not require a conscious understanding of what has happened; I can also see that learning could occur over time through the repeated use of this method without reflective understanding. However, if this method was only held experientially, it would seem to me to be a very long commitment to the meditation process—or, in fact, the "use of the other"—in order to generate the incorporation of unrecognised or difficult experience, and therefore resolution. Developmentally, we gain the capacity for language, and if we can use this creatively, it enhances our aliveness, our ability to know ourselves and others, and to learn from and manipulate our experiences. It seems to me those moments of embodied connectedness described above and in the vignettes are most useful if they can be articulated in some way, eventually, as indeed they are in the vignettes. I think this is so even if language always remains inadequate to fully describe the experience. This would seem, in the article, to be where there is some disagreement between psychotherapy and vipassana, but also perhaps where they intersect with one another. Or, perhaps it is where I become, or psychotherapy becomes, a coloniser, picking only the perceived usefulness of the Eastern concept in further developing a Western one.

So how do we use these experiences in psychotherapy? It seems to me that, in the article, the therapists treat the communication in the same way they treat other unconscious communication. There is an acknowledgement that there is a complexity and creativity in unconscious communication that both obscures and articulates our experiences (Bollas, 2007; Winnicott, 1966).

The body exists somewhere in the paradox between the concrete reality of the physical and a more dreamlike metaphoric, symbolic, "meaning-making" state (Broom, 1997). Bollas writes, "enactment is a form of thought" (2007, p. 25). I think that by using this concept, I could say the body can also "think". Being able to be used in this way by the client can lead to accessing this mode of thinking. I suspect the body operates like a kind of dream and, therefore,

that immersing oneself in the body experience, then bringing the body to mind, noticing the details of it, free associating to it, and having it as part of our reverie, is the way, it would seem, that the psychotherapist can use her or his body experiences. While using vipassana techniques to access this may be a "colonising" act, and not in the spirit of the Eastern tradition, the advantage of the training that vipassana offers in this process seems clear. Perhaps it should be part of psychotherapy education.

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Echoes from the East: A response to Paul Solomon

Paul Bailey

As I sit down to respond to Paul Solomon's article, I am reminded of how many jokes begin with an opening line such as "Did you hear the one about the Jew, the Catholic and the Buddhist?—except that by 1978, I was no longer a Catholic and, instead, was in training in Igatpuri with a Burmese Buddhist from Bombay, now Mumbai, who is referred to in Paul's writing. I want to acknowledge my indebtedness to this inspiring teacher, S. N. Goenka, and his lineage, in my poem:

Dissolvable

The women of Igatpuri
scoop up fresh ox dung from
dawn's dusty streets.

Already I have emerged from
my grass hut. Gently trod
the cobra's path

to the meditation hall. I
drink from the deep well while
Goenka and

all the other chanting ancients
teach me to sweep away
solidity. (03-05-08)

Neuroscience and trauma studies have brought the body back into psychotherapy. Maybe now, modern physics, with encouragement from Buddhist psychology and writers such as Paul, will awhi the profession further into the positive possibilities of transcendent attunement.

However, there is a shadow side in moving in the direction that Paul is exploring and it is this that I want to address. Some heed is needed before rushing prematurely into any form of liminal unboundedness. The most obvious caution is summarised by Engler, who writes, "you have to be somebody before you can be nobody" (1984, p. 17).

Writers such as Engler, Epstein, Kornfield, and Wilber have been invaluable catalysts in the interweaving of the insights of Buddhist psychology with psychoanalytic theory. Each in his own way has elaborated the benefits of meditation and learning to dissolve the boundaries between self and other. At the same time, none of them is unaware of the risks involved in this adventure, and the preparation that may be needed to take up the challenge of moving towards transcendent attunement. Thus, I am fully in agreement with Concetta Alfano's addition of the word "disciplined" into her statement quoted on page ten of Paul's article. Both meditation, the operational arm of Buddhist psychology, and psychodynamic psychotherapy are disciplines, with designated schools, texts, teachers, and lineages. In my training in vipassana meditation, Goenka often reminded students of how he and we were being carried by over 2000 years of rich tradition. He initiated us into a rigorous and structured practice of concentration before we were invited into destructuring practices. So, too, is psychotherapy a discipline, with clear contractual containment, a code of ethics, and a rigorous assessment using a tradition known as psychodynamic formulation.

Both disciplines use uncovering techniques in order to work more directly with what is below the surface of ordinary consciousness. These techniques involve the practitioner's becoming a neutral observer as well as an active participant. There is an encouragement in each tradition to work towards eliminating censorship, and to avoid "acting out." Both utilise mindfulness. Another strong similarity that both share is the understanding that ego or personality belief is an internalised construct, formed in relation to experiences with the world of others. Each acknowledges how this construct appears to possess a consistent and continuous identity. However, it is here that these two paths move apart. Psychodynamic psychotherapy understands that the lack of a sense of self is the problem. Being deprived of developmental cohesion, the person describes feeling unreal, inauthentic, and the psychotherapeutic relationship becomes a reparative identity-formation hothouse. In Buddhist psychology, through the practice of meditation, the opposite happens. The intention is to dissolve the illusion of a sense of self.

A way through this seeming impasse has been hypothesised by Wilber. He writes of the development from the pre-personal to the transpersonal

stages of consciousness. Thus, for him and a growing number of theorists and practitioners, transpersonal experiences are no longer seen necessarily as evidence of pre-egoic states, although both have obvious similarities. They argue that traditions such as vipassana meditation are able to assist human beings to progress towards transcendence, rather than towards a regressed arrest into more primitive experiences. What is important here, though, is that the human being is integrated sufficiently into a stable sense of self. Only then can there be sufficient assurance that the individual has the capacity to surrender safely to the guidelines of any lineage that encourages the attending to and the experiencing of all the thoughts and sensations and feelings as they arise, without desire or judgement. This is especially so when surrender involves unstructuring previously-intact psychic structures. If individuals are already fragmented, or have a borderline personality style or other relatively unformed selves, then, of course, the goal needs to be exactly the opposite. As Engler explains, "meditation is designed for a different type of problem and a different level of ego structure" (1984, p. 39).

Yet, once psychotherapists are cognisant of the dangers for themselves of inappropriate use of meditative techniques, the benefits of this tradition can be identified. And this is what Paul has done in his article, outlining one such benefit, a way towards what he calls transcendent attunement. I believe that Buddhism, either in itself or through commentators such as Engler, Epstein, Kornfield, Solomon, and Wilber, has much to offer psychotherapy. Both Buddhist teaching and the insights of modern physics may assist us to wake up to the possibility that psychotherapy's traditional attachment to the goal of assisting the development of a stable intact self may be simply another stage of arrested development that, in time and with discipline, we may grow out of, as we do from the schzoid phase. From the Buddhist point of view, an adherence to an enduring sense of self is none other than the prime source of human suffering. We gain a self in order to transcend the self.

So, thank you, Paul, for writing this article. I will finish with another of my recent poems:

The Sun.

I was the sun pulsating, light
undulating and love's
vibration till

birth earthed me, made me as solid
as an Easter Island
statue. Question

now is, after adapting to
this still dense form, do I
move on or back?

All I want is I am you are
me are we are us all
again the sun. (01-05-08).

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Immigrant Psychotherapists and New Zealand Clients

Mark Thorpe and Miranda Thorpe

Abstract

There has been a gradual increase in the number of overseas born and trained mental health professionals practicing in New Zealand. This paper, based on an interactive workshop, looks at those factors which shape the therapeutic relationship between immigrant psychotherapists and New Zealand clients. Variables discussed include: a) the therapist's attachment style and resultant ability to tolerate, process and mourn the multiple losses including friends, family and clients; b) the therapist's phase appropriate use of defences; c) the complementary attitudes and projections of the host country, colleagues and clients; and d) the degree of perceived difference between client and therapist.

Introduction

The migration of people from one country to another is as old as human history. However, it is only in the last few decades that there has been such a significant increase in international migration of highly qualified professionals including mental health practitioners. Akhtar (2006) points out that there has been an "an increase in the number of culturally diverse trainees in psychology, social work, psychiatry and psychoanalysis" (p. 23).

There was a noticeable absence of early psychoanalytic literature on the subject of immigration, despite so many of the early analysts being immigrants or refugees themselves. It is important to differentiate between the emotional aspects of immigrants and refugees: the former have choice – they are 'pulled' by opportunity, adventure and curiosity, whereas refugees are trapped with no choice and are 'pushed' out. Despite two significant migrations during his lifetime, Freud made little reference to them. When he left Vienna for London at age eighty-two, Freud noted that "the feeling of triumph at liberation is mingled too strongly with mourning, for one had still very much loved the prison from which one has been released" (Gay 1998, p. 9). Possibly the early analysts were more concerned with intrapsychic processes rather than the social context and its effects on internal worlds? Or was it simply a denial of loss and mourning with an over-adaptive need to belong to their newly chosen group?

The fact that these European analysts were not actually immigrants, but exiles, might also have contributed to their silence on this issue. Wanting to forget their traumatic departures from their countries of origin, to deny cultural differences between themselves and their patients, and to become rapidly assimilated at a professional level, they had no desire to draw others' (and their own) attention to their ethnic and national origins. Hence, they wrote little about their experiences in practicing analysis as "foreigners" (Akhtar, 2006, p.23). Over the past twenty years more attention has been given to the process of immigration with some significant contributions from Grinberg and Grinberg (1989), Volkan (1999), Mann (2004) and Akhtar (1999).

New Zealand is a relatively young country populated by many immigrants. A significant percentage of the health professionals practicing in New Zealand were born or trained abroad. Compared to other OECD countries, New Zealand had the highest ratio of foreign-born doctors (52% in 2005-2006) and among the highest for nurses (29%) (Zurn & Dumont, 2008). Anecdotally these rates climb significantly amongst psychiatric nurses, particularly those working in crisis teams, and to an even greater extent amongst psychiatrists. Some psychiatric registrar programmes contain more than 90% of foreign candidates.

A significant percentage of psychotherapists working in New Zealand identify as immigrants. For example at the opening of the 2006 NZAP conference in Wellington, when asked with which part of the world they identified, less than 10% of the delegates placed themselves in the Māori or Pākehā group. Even though these were subjective responses in a particular context, the implications are significant. Similarly a large percentage of psychologists working as psychodynamic or depth psychotherapists are trained abroad.

This paper focuses on the process of immigration and the resulting interaction between the immigrant psychotherapist and the New Zealand client.

Immigration

Stress is caused by 'too much change, too quickly, with insufficient preparation'. The process of immigration brings multiple layers of change in its wake. In addition to the loss of parents and family, some of the more predictable stressors are the change in friends, colleagues, social and financial status, housing, culture, educational systems, politics, geography, climate, food, dress, language and identity. Calvo (1977) points out how immigrants need to endure the devastating feelings of loss, while at the same time making intense efforts to adapt to the new environment.

Striking a positive chord, Grinberg and Grinberg (1989) discuss the psychological advantages of immigration. They point to the possibility of true growth and development if the immigrant is able to tolerate the disorganization, pain and frustration and to work through and overcome the losses and conflicts.

Emigrating therapists leave their clients behind in the old country. The process of mourning lost clients is influenced by the different strengths of sadness, anger, guilt and relief as well as duration and depth of the relationship. Therapeutic relationships characterised by conflict and ambivalence, which may escalate after the therapist's declaration about emigrating, are more difficult to mourn. This extremely stressful termination period is characterised by endeavouring to balance respectful due notice to clients and colleagues without jeopardising referrals and income. Frequently all of the therapies are terminated within the space of a few weeks, at a time in which the therapist is chaotically packing, planning and saying farewell to everyone else. Therapeutic endings are confidential and there are no public acknowledgements or rituals to facilitate the process. The consequence is that the way therapists relate to clients in the new country will be determined by how they have worked through and mourned the loss of those in the old.

Some of the complexities specific to psychotherapists immigrating to Aoreatoa/New Zealand include:

1. The infantilizing and narcissistically injuring process of 'jumping through the hoops' of professional re-registration. This is particularly bewildering for therapists arriving from countries with larger and more established analytic traditions.
2. The public confusion between counseling and psychotherapy and the lower status accorded to psychotherapy than in other OECD countries.
3. The different cultural values reflected in the 'doing rather than being', 'number eight wire', and the 'tall poppy' syndromes.
4. The Treaty of Waitangi and the divergent ways Maori and Pakeha view psychotherapy.
5. The domination of the behavioural model and antipathy towards depth therapy found in many universities and District Health Boards. For example psychotherapy was not mentioned in the Ministry of Health funded document on 'Talking Therapies' (Peters 2007).
6. Development of new professional and referral networks.

7. Learning about and adapting to different implicit therapeutic styles and psychotherapy politics, i.e. the splits between psychotherapy and clinical psychology, and the complicated role of the Accident Compensation Corporation (ACC).
8. Recognizing the subtly different ways in which New Zealand clients present, their expectations and their styles of interpersonal relating.

Splitting

Deep sorrow about the multiple losses, coupled with excessive needs for adaptation, leave immigrants vulnerable with weakened ego resources. The most frequently used defence in the 'honeymoon phase' of the first few months is a manic one. The over activity and manic energy fuels the immigrant's idealized aspirations and hopes of the new country. Fantasies of a land with greener grass, milk and honey are amplified by the omnipotently tinged marketing slogans such as "Godzone". The idealization is frequently followed by a sudden crash into devaluation when confronted by a xenophobic reaction as the one described by Kafka (1958):

> Your ignorance of the local situation is so appalling that it makes my head go round to listen to you and compare your ideas and opinions with the real state of things. It's a kind of ignorance that can't be enlightened at one attempt, and perhaps never can be. Never forget that you are the most ignorant person in the village, and be cautious (p.62).

In order to reduce the chaos and pain, and slow down the internal psychic process in order for the ego to be able to marshal its resources, the immigrant starts regressing and makes prudent use of splitting. A similar process is evident in children after families have separated and are adapting to new environments and people. The defence takes the form of retrospectively idealizing and overvaluing the lost country and devaluing the new (Lijtmaer 2001, Akhtar 1999). This is the most evident when immigrants indulge in a "when we" style of nostalgia while at the same time complaining about the new culture.

Authors such as Marlin (1977) and Volkan (1999) conceptualize nostalgia as a fantasy-based return to that which the person never had. However, if used judiciously, nostalgia creatively slows down and assists the process of mourning. As Wernan (1977) states,

> The failure of mourning leads to a continuing search for the idealized lost object, an inability to love new objects, a depreciation of objects

> in one's current life, and an endless pursuit of nostalgic memories for themselves at the expense of an inhibition in many areas of existence (p.396).

In some immigrants the direction of the idealization and devaluation is reversed. The new country is counterphobically idealized while the old is spoiled and devalued. A third style consists of alternating shifts in the direction of splitting. These shifts are triggered when the immigrant moves between reference groups with varying biases towards the immigrant's country of origin. According to Ogden (1985) the shifting from one pole of the dialectic to another is part of the later phases of integration leading to a synthesis and emotional resolution.

In addition to the usual forms of splitting immigrant therapists also split along the lines of therapeutic worldview and style. These 'therapy specific' idealizations and devaluations are emotionally fused with the process of mourning and adaptation. Characteristically therapists devalue the 'new' theoretical orientations, views on confidentiality and the frame, frequency of therapy and supervision, mental health organizational structures and support, the mental health act and ACC, professional organizations and their membership criteria, interpersonal therapeutic style etc. Indigenous therapists feel their hackles rising when they continuously hear statements such as "but it worked much better in Shangri-La".

The 50-minute hour takes place behind closed doors within the therapist's domain. Only the supervisor is privy to a filtered version of this private and confidential process. The immigrant therapist may follow a pattern of professional ethnocentric withdrawal by choosing a like-minded immigrant supervisor and developing a peer group with an aligned therapeutic worldview. The analytic ego then becomes resistant to cultural adaptation and may be the last aspect of the immigrant's personality to change.

Grinberg and Grinberg (1989) coined the term 'postponed depression syndrome' to describe how some seemingly well adapted immigrants paradoxically fall into a state of profound sadness and apathy, often accompanied by psychosomatic symptoms, at the point at which they could enjoy the fruits of their hard won adaptation. They suggest three years is the danger point. Walsh & Shuman (2007) attempted to empirically validate the idea that premature adaptation gives rise to later symptom formation. They interviewed 68 emerging adult immigrants around their sense of self, immigration experience and level of psychological and physical symptoms. Subjects were reassessed one year later. Results indicated that attempts to resolve splits early after immigration led initially to a lower

level of psychological symptoms followed by an increase one year later. Conversely those who took longer to adapt, initially exhibited higher levels of symptomatology but were healthier a year later. Walsh and Shuman (ibid) concluded that splits in the sense of self, following immigration, are an adaptive defence, allowing time to adapt and adjust to a new reality, rather than a pathological reaction to the trauma of migration.

The implications are that those immigrants who initially idealize their country of origin, devalue the host country and experience greater levels of mental and physical illness end up being healthier and more integrated than those who used less splitting and appeared to have adapted in the first few years. Paradoxically the 'when we' immigrants who irritate the natives with their devaluing whingeing turn out to be better citizens in the long run than those who initially 'shut up and blend'.

Attachment

Klein (1937) was one of the first psychoanalysts to link the immigrant's sense of mourning to the loss of the original maternal object:

> Thus we speak of our own country as the 'motherland' because in the unconscious mind our country may come to stand for our mother … In psycho-analytic work it has been found that phantasies of exploring the mother's body, which arise out of the child's aggressive sexual desires, greed, curiosity and love, contribute to the man's interest in exploring new countries … In the explorer's unconscious mind, a new territory stands for the new mother, one that will replace the loss of the real mother. He is seeking the 'promised land' – the 'land flowing with milk and honey'. We have already seen that fear of death of the most loved person leads to the child's turning away from her to some extent; but at the same time it also drives him to re-create her and to find her again in whatever he undertakes. Here both the escape from her and the original attachment to her find full expression (1937, p. 333).

Recent neuroscientific evidence (Schore, 2001) built upon the work of Bowlby, Winnicott, Main and others, has confirmed that the quality of childhood attachment is intimately linked with patterns of interpersonal relatedness throughout life. Immigration is all about attachment, separation, loss, and re-attachment. The authors propose that this even influences the choice of country for immigration.

Based on Ainsworth's Strange Situation Test and the resultant Adult Attachment Interview we can see adult styles of relating to primary

attachment figures parallel the attachment styles identified in the early maternal relationships. Hazan and Shaver's (1987) research showed childhood attachment styles are evident in adult romantic relationships:

> ...attachment styles of couples can be viewed in terms of the answer to the question "Can I count on this person to be there for me if I need them?" If the answer is "Yes" in a positive and secure way, the partners feel confident that they may rely on each other, have open communication and experience flexible co-operative relationship. If the answer is "Maybe" partners tend to have an insecure-ambivalent style with vigilance about loss, and alternating clinging and angry demands for reassurance. If the answer is "No"... in the resulting insecure-avoidant attachment style, the partner avoids closeness or dependency, denies the need for attachment, and views others with mistrust (Goldstein and Thau, p. 268).

The way in which the immigrant responds to the host country may be similar in style to how he or she relates to the other in a partner relationship. The authors postulate that immigrants' attachment styles influence their process of leaving and arriving in the new environment. Being separating from the 'motherland' re-activates early attachment issues and affects the immigrant's ability to settle in the host country. These re-activated early patterns will be mirrored in relationships with partners and clients. The way in which the mourning and integrating into the new country is managed may be dependent on the original attachment process in early life. How was the first rapprochement phase handled, as well as the adolescent process? Akhtar (1995) refers to immigration as the third separation-individuation phase.

Just as relationship with the self often becomes adversely affected by immigration, so do other significant relationships i.e. with partners, family members, colleagues and clients. The stressed immigrants are forced to turn to those closest, frequently with detrimental effects imploding within these relationships within the first few years after arrival. Often splitting, melancholia, resentment, somatising and mourning symptoms are experienced within partner and family relationships. Relationships that were under strain before immigration, often crack, break down and fall apart with the extra pressure. The resulting loss of the significant intimate relationship adds to the difficulties of settling into the new country and maintaining a cohesive sense of self.

It is suggested that the original attachment style affects the immigrant therapist's decision to emigrate, the ability to process the difficulties, and

may affect the ability to work productively in the new country. In addition, how effective is the new country at providing a secure base for this newly arrived therapist? As Winnicott said "there is no baby without a mother"; so there is also no partner without the other, no immigrant without a host environment and no therapist without a client. Can immigrants count on the new environment to be there for their needs so that they in turn can provide sufficient holding for their clients? How does an environment of ignorance, neglect or even xenophobic rejection affect the newly arrived therapist? The way in which each attachment style may play itself out in the immigrant therapist is discussed below.

Secure attachment

Securely attached infants in the Strange Situation sought their mothers when distressed, seemed confident of her availability, were upset when she left, eagerly greeted her upon her return and were readily comforted by her embrace. Mothers of secure infants responded more promptly to their babies, offering affectionate joyful holding. The babies returned to excited or contented play.

It is proposed that securely attached immigrant therapists seem confident of their nationality, are upset and mournful on emigrating, eagerly greet the new motherland upon arrival, are comforted in their mourning by her warm responsive holding, and are able to continue with creative playful practice.

Insecure-Avoidant

Avoidantly attached children depended less on their mother as a secure base, sometimes attacked her aggressively, were far more clingy and demanding than the secure children in the home environment and despite often being just as openly upset by the mother's departure, showed no interest upon her return. Mothers tended to interact less with their babies and in a more functional way. These children remained watchful of mother and inhibited in their play.

Insecure-avoidantly attached immigrant therapists depend less on the motherland as a secure base, sometimes attack her aggressively, and are more clingy and demanding in the home country. Despite being just as openly upset and distressed on emigrating, these immigrants show no interest in transitional phenomena, or in returning for visits. The new country feels unresponsive and they remain watchful and inhibited in their therapeutic practice.

Insecure-Ambivalent

Insecure-Ambivalently attached children tended to be the most overtly anxious, and the most clingy and demanding at home. Upset when abandoned, they sought contact when reunited, but resisted by arching away, or remaining limp, in the mother's embrace. Unsoothed, they continued to alternate between anger and clingness. Mothers of these children tended to ignore their babies' signals for attention and be unpredictable in their responsiveness. Exploratory play was inhibited.

Insecure-ambivalently attached immigrant therapists are the most overtly anxious and demanding in the home country. Distressed at the time of emigration, and although seeming to seek contact when arriving in the new country, they resist by turning away from a dismissive environment and remain apathetic and uninterested. These immigrant therapists cannot be soothed, and continue to be angry and complaining. Creative and exploratory therapy practice is unsettled and inhibited.

Insecure-disorganised

Insecure-disorganised children showed a diverse range of confused behaviours when reunited. The children appeared to be both drawn to and fearful of their mothers, who had unpredictable and detached responses to their babies. Instability of attachment or oscillations between dependency and detachment were typical in both mother and baby. Play was confused, inhibited and erratic.

Insecure-disorganized immigrant therapists show a range of confused and unpredictable responses to the home country prior to leaving, are distressed at emigrating as well as on arrival in the new environment that is viewed with suspicion and hope. They display ambivalence about returning for visits to the homeland. There is a possibility of disintegration, psychic collapse or even psychotic breakdown. Therapy practice may have to be adjourned to facilitate recovery.

Language

As part of attachment, language is the most important of the cultural transitional phenomena that keeps the new settler linked to the original motherland. Food, folklore, religious rites, music etc are all linked to language. In addressing the process of splitting in immigrants and bilingual persons, Marcos, Eisma and Guimon (1977) emphasized how they experience a dual sense of self, depending on the language that they speak.

On the positive side bilingualism provides an ability to stand in another's shoes, to experience another's culture from the inside, and early in life possibly helps in the process of mentalisation.

Akhtar (2006) suggests that words with the same denotive meanings in two languages are often capable of stirring up different associations and affects. One of the authors observed a client who tended to alternate between her mother tongue and her second language. The issues brought to therapy and the affect displayed was markedly different depending in which language the client was immersed. Similarly, Javier and Munoz (1993) point out that memories recalled in the actual language of an experience are more affectively charged and vivid than if they are recalled in a different language.

Language is strongly linked to our sense of identity, and when an immigrant's sense of self is already under threat, the additional difficulty of having to manage living and working with a second language adds to potential destabilization. As Mirsky (1991) points out:

> The loss of the mother tongue in immigration is accompanied by a deep sense of loss of self-identity and of internal objects. Learning a new language involves an internalization of new objects and self-representations and reactivates the internal process of separation (p.620).

How does this affect an immigrant therapist in transition, already struggling with a transforming and possibly fragmenting sense of self, to have to translate into a second language? Akhtar (2006) puts it like this:

> The bilingual analyst's own language-related inner experience has remained unexplored in the literature. This is surprising, since an immigrant analyst often conducts treatment in a language other than his mother tongue, and this must, from time to time, impact his analytic capacities…(he) might occasionally miss puns, double-entendres, metaphors, or allusions (p. 31).

This is problematic when patients arrive in our rooms wanting to be understood, and wanting to understand without the added effort of trying to decipher the therapist's pronunciation or cultural peculiarities. If the immigrant is a 'hidden' immigrant there may be little to indicate this to the patient – the therapist may speak the native tongue of the country, and look ethnically similar, but hide a vast difference of experience and culture.

Degree of perceived difference between client and immigrant therapist

The degree of difference between the therapist and client influences the therapeutic relationship. In order to provide an estimate of the perceived degrees of difference between the immigrant therapist and client, the authors constructed the following rudimentary scale. It has proved to be a useful tool in stimulating discussion in workshops and discussion groups. The items chosen appeared most frequently in the therapy conducted by the authors as well as in conversations they had with colleagues and the public.

Client and Immigrant Therapist Degrees of Difference Scale

Skin colour

0 1 2 3 4 5 6 7 8 9 10

Language (accent)

0 1 2 3 4 5 6 7 8 9 10

Worldview/culture

0 1 2 3 4 5 6 7 8 9 10

Distance from "home"

0 1 2 3 4 5 6 7 8 9 10

Time self and/or family has lived in Aotearoa/New Zealand

0 1 2 3 4 5 6 7 8 9 10

Total degrees of difference (average)

0 1 2 3 4 5 6 7 8 9 10

This raises the perennial question of optimal therapeutic difference, distance and flexibility. For argument's sake the scale could be divided into three levels of difference. At lowest level of perceived difference, the therapist can easily identify and empathize with the client. Their shared scotoma keeps the work at the level of simple counseling and precludes interpretive work on the unconscious. At the middle level the optimal difference provided by the immigrant therapist facilitates the client's ability to break free of their invisible social and cultural defences. The client can alternate between identifying with the therapist and using them as a different object. At highest level, the differences outweigh the empathic common ground. The gap is too wide and the therapy may falter at the initial interaction. In New Zealand many

immigrant psychologists and psychiatrists, who would fall into level three, work for government organizations providing free or subsidized therapy. The disjunction is at its height with these therapists consulting clients often on the lower socioeconomic end of the spectrum who are less well traveled and au fait with foreign values and cultures.

Gedo and Gehrie (1993) describe difficulties faced by therapists at the extreme end of the scale:

> The deck is stacked against an analyst's treating someone from an entirely different cultural background with no knowledge of that background. An analyst relies heavily on shared cultural meanings in any analysis, as in any sort of intimate communication. Possibilities for misunderstanding are so broad as to be endless and not correctable solely on empathy (p. 5).

Work as a psychotherapist

In a recent paper Akhtar (2006) evocatively describes some of the technical challenges faced by the immigrant therapists. These are: a) maintaining cultural neutrality by remaining equidistant from their own and the client's cultural patterns of thought and moral dictates; b) curiosity and 'gentle scepticism' regarding the client's unconscious choice of an immigrant therapist with its accompanying projections; c) inter-ethnic clues to deeper transferences; d) conducting therapy in a different language to their mother tongue; and e) avoiding shared projections, acculturation gaps and nostalgic collusions when working with clients from similar ethnic backgrounds.

A career provides the worker and their family with money, status, security, and a sense of belonging. The more time, money and energy invested, and the fewer outside satisfactions and interests, the greater sense of identify is fused with the career. Similarly, practicing as a competent and useful psychotherapist in the new country provides the immigrant with a sense of identity, purpose, and 'going-on-being'. When an individual loses his or her capacity or opportunity to work, he or she also loses an important experience vital to the maintenance of a "cohesive, energetic, and balanced self" (Wolf, 1997, pp.77-73).

It may be argued that doing therapy with clients plays an important role in stabilizing immigrant therapists and helping them adapt. To what extent do clients function as a 'therapist to their analyst' Searles (1960), a transitional object (Winnicott 1953), or the container for unmetabolized trauma (Bion 1962)? This is a subtle process because therapists tend to deny their own

emotional neediness and project it onto willing recipients, i.e. the helping profession syndrome (Malan, 2004). Immigrant therapists may specifically use their clients to repair the anguish and guilt felt at deserting their friends, parents and patients. These tendencies may be eased if the immigrant initially works in an agency that can provide firm containing and a supportive collegial network, as opposed to the loneliness of private practice.

Workshop responses

Following a 50-minute presentation by both authors, they moved the audience into a circle. They then facilitated a 40-minute group discussion. It was hoped to elicit ideas and experiences about how immigrant therapists worked with local clients.

We were intrigued by the group's general responses to the presentation. Many acknowledged they felt 'triggered' and had strong personal responses to the issues. The themes of loss, mourning, and guilt predominated. Some of the content was personally conveyed to us only days and weeks later. Despite our facilitation attempts, it seemed premature and forced for the participants to talk about the therapeutic relationship, when the fundamental issue of identity, language, family and personal fragmentation was foreground. The issue of intergenerational grief due to the trauma of immigration, displacement and asylum was a recurrent theme amongst the group members. That the group seemed not to be able to get past grief, is in the authors' opinion indicative and representative of the very issue that keeps many immigrants stuck in melancholia versus the process of mourning.

The group agreed with the suggestion that, despite often being in a difficult financial position, additional supervision and personal psychotherapy is recommended for any new immigrant therapist to facilitate this potentially traumatic process. The group also suggested a longer workshop as well as ongoing support groups for immigrant therapists.

Conclusion

The quality of the therapeutic relationship developed between the immigrant psychotherapist and the New Zealand client is influenced by a variety of factors. Some of these discussed in this paper include: a) the therapist's specific attachment style which is amplified by the stress of migration; b) the success with which the therapist is able to tolerate, process and mourn the multiple losses, particularly those of friends, family and clients; c) the judicious and phase appropriate use of splitting i.e. idealization and devaluation; d) the complementary attitudes and projections of the host

country, professional associations and clients; and e) the degree of perceived difference between therapist and client. Due to the increasing numbers of immigrant psychiatrists, psychologists and psychotherapists this critical issue merits further discussion and research.

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We cannot imagine without the other: Contact and difference in psychotherapeutic relating

Keith Tudor

Abstract

Human beings are interdependent: we can only say 'I am' because 'we are'. We are therefore intersubjective, and cannot imagine without the other. Thus, in any helping or therapeutic relationship, it is crucial to reflect on, process, understand and evaluate how we relate, one with another and with others. This is especially and particularly important when we are relating across differences. This paper, which is an edited version of one given at the NZAP Conference held in Waitangi in April 2008, draws on the tradition of organismic psychology. The view that the human being is an organism connects the individual to his or her environment and to the significance of others, without which the individual cannot be understood. More recent research in neuroscience has confirmed that this psychological and, ultimately, political perspective has neurobiological foundations. On this basis, the contact between client and therapist is crucial: from the initial contact before meeting, to the first face-to-face meeting, and throughout the therapeutic encounter. Drawing on the work of both Rogers and Stern, the paper critiques the concept of 'the therapeutic relationship' as a fixed construct, and offers some ideas about the importance of contactful 'ways-of-being' in therapeutic relating.

Interdependence, intersubjectivity, and imagining

Human beings are interdependent. The human infant is one of the most dependent born mammals and, of all mammals, has the longest period of dependency; hence the importance both of attachment and of social and psychological support for the mother or primary carer. However, when we look at this more closely, and particularly with the benefit of insights gained from recent research in the fields of developmental psychology and neuroscience, we see that the relationship between baby and mother is in fact one of mutual synchrony. Winnicott encapsulated this when he said that: 'There's no such thing as a baby, only a mothering pair.' Most obviously, the baby is dependent on the mother. However, the mother is also 'dependent' on her baby, for instance, to stimulate oxytocin, one of the hormones, which are produced when mother and baby are interacting in a mutually pleasurable way. Winnicott refers to the gleam in the new mother's eye, a perception that is supported by research that demonstrates the increase in the percentage of light in the mother's eye when she looks or gazes at her baby (see Schore,

1994). Also, if we consider the importance of regulation, we can think about ways in which the baby/infant/child both regulates – and dysregulates – the parents or carers, which is why it is so important that parents have space and support to reflect on what gets evoked by their children and by their own parenting.

There are wider, social understandings of interdependence. Marx and Engels use the term in the Manifesto of the Communist Party (1848/1971) when they describe the universal interdependence of nations, in comparison to the old systems based on local and national seclusion, isolationism and self-sufficiency. Gandhi (1929) echoes this comparison:

> Interdependence is and ought to be as much the ideal of man as self-sufficiency. Man is a social being. Without interrelation with society he cannot realize his oneness with the universe or suppress his egotism. His social interdependence enables him to test his faith and to prove himself on the touchstone of reality.

In 1945 the American philosopher, Will Durant, drafted a Declaration of Interdependence, which aimed to promote human tolerance and fellowship through mutual consideration and respect (see Weyler, undated). Since then a number of other such declarations have been drafted, most emphasising an ecological perspective (see the David Suzuki Foundation, 1992), one of which formed the basis and inspiration for a Symphony (no. 6 Interdependence) by the Finnish composer Pehr Henrik Nordgren (2001).

Interdependence is a biological, neurological, developmental, relational, social, political and environmental fact of life. It encapsulates a dynamic of being mutually responsible to and sharing a common set of principles with others. Some people, cultures, and societies advocate independence and freedom as an ultimate and abstract good; others advocate kinship, attachment and loyalty to one's family, group, tribe, community, society, land and earth. Interdependence recognises the reality of each trend. This is encapsulated in the Nguni word Ubuntu which carries the sense that 'I am because we are'. In a similar vein, Lévinas argues that the self cannot exist, cannot have a concept of itself as self, without the other (Kearney, 1984): "I am defined as a subjectivity, as a singular person, as an 'I' precisely because I am exposed to the other. It is my inescapable and incontrovertible answerability to the other that makes me an individual 'I'" (p. 62). I think this is interesting in three respects.

The first is linguistic. We often think of 'I' as the starting point of the individual and of identity. In fact, as infants, we say 'me' before 'I'. This

personal pronoun represents the social self, that is, a self defined by others, and which we internalise in some way ("me want", "me do", etc.). In terms of human development and the development of language, 'I' comes later, and represents a personal self. Language, of course, comes relatively late in an infant's development and, developmentally, before 'me' is, at least conceptually, 'us', a pronoun which represents the co-regulating 'mothering pair'. I suggest that 'us' is the fundamental life position on and from which we develop, through attachment and separation to individuation – but an individuation based in relationship and in connectedness.

The second point of interest is Lévinas's use of the word 'exposed': we expose ourselves to the other, we put ourselves out, we lay ourselves open, we make ourselves vulnerable and known. Put in these terms, being ourselves may sound risky. On the other hand, to live is to risk. As Ward (undated) puts it in his poem (entitled 'To risk'):

> But risks must be taken because the greatest hazard in life is to risk nothing.
> The person who risks nothing, does nothing, has nothing, is nothing.
> He may avoid suffering and sorrow,
> But he cannot learn, feel, change, grow or live
> ....
> Only a person who risks is free.

The third important point Lévinas makes is that we are individuals only because of the other or others, to whom we are answerable. That is to say, we have to answer to others in order to be ourselves. This makes sense to me. For example, at an interpersonal, social level, there is a sense that as an author I am answerable to the reader for this article. Moreover, at an existential level, we need an answer from another. The lack of an answer is the tragedy of Echo who, according to Greek mythology, could only repeat what the other said, and of Narcissus who was punished for not accepting Echo's love by being condemned to fall in love with himself. Here there was – and is – no interdependence, no answerability, and no intersubjectivity. I refer to Narcissus as I think that one of the major psychological problems in Western society and, in some aspects, of the profession of psychotherapy is, as the American social commentator Christopher Lasch (1979) puts it, The Culture of Narcissism.

If we are interdependent and we define ourselves as 'a subjectivity', then it makes sense to think in terms of intersubjectivity. Atwood and Stolorow (1996) describe as this as 'reciprocal mutual influence'. They go on to describe the implications of such reciprocity:

> from this perspective, the observer and his or her language are grasped as intrinsic to the observed, and the impact of the analyst and his or her organising activity on the unfolding of the therapeutic relationship itself becomes the focus of ... investigation and reflection (p. 181).

Rather than asking 'What's happening to you?' or 'What's happening to me?' we will, if we focus on the intersubjective world and the domain of intersubjective relatedness, tend to ask 'what is happening here between us?'. Parlett (1991) suggests that: "when two people converse or engage with one another in some way, something comes into existence which is a product of neither of them exclusively ... there is a shared field, a common communicative home, which is mutually constructed" (p.75). Thus, intersubjectivity supports what Stark (2000) refers to as a 'two person' mode of therapeutic action. This perspective has its roots in psychoanalysis and its developments, such as Sullivan's (1953/1997) interpersonal theory of psychiatry and therapy. Whilst these origins of intersubjective and interpersonal, relational perspectives may be familiar to readers of the Forum, what may be less familiar is that these perspectives also have their roots in humanistic psychotherapy, notably in Rogers' (1942) 'relationship therapy' and, more generally, in organismic psychology (see section below).

From a developmental perspective Stern (1985, 2000) writes about the interpersonal world of the infant, and suggests that, from nine months, along with other senses of self (emergent and core), the infant develops the sense of an intersubjective self. As he puts it:

> [This] quantum leap in the sense of self occurs when the infant discovers that he or she has a mind and that other people have minds as well. Between the seventh and ninth month of life, infants gradually come upon the momentous realization that inner subjective experiences, the 'subject matter' of the mind, are potentially shareable with someone else ... This discovery amounts to the acquisition of a 'theory' of separate minds (p.124).

Fonagy and his colleagues (2002) refer to this as mentalisation, a preconscious or ego function that transforms basic somatic sensations and motor patterns through a linking activity. Assuming that others have minds enables us to work together. This is important both developmentally and in the present moment. It is also important for us as social/political beings; elsewhere I and a colleague have described the development of an active and engaged citizenship as involving the necessary movement from being 'a subject' to being an 'intersubject' by means of intersubjectivity (see Tudor & Hargaden, 2002).

So, how do we get to sharing? I think we do this through imagining and empathising. Developmentally, the mutual synchrony and co-regulation of the mothering or caring pair is the basis for imagination and imagining: we cannot imagine – that is, to form and symbolise an image – without another, as we need another to reflect back our reflections, to regulate us, and to help us make meaning of our world. The development of imagination is, thus, also a co-creative process. To live, love and work is to risk contact and, thereby, both attachment and loss. To risk contact is to risk exposing one's own subjectivity and to risk exposure to another's. To risk such intersubjectivity is to risk both imagining what it is to be that other, and to risk relating to the other. Before discussing these aspects of life and of psychotherapeutic practice, I turn to organismic psychology, the theory which, for me, supports this view of interdependence and intersubjectivity.

Organismic psychology

The view that the human being is an organism connects the individual to his or her environment and to the significance of others, without which the individual cannot be understood. The biological entity that is the human organism, and its qualities, offer us a theoretical base for the interdependent life. It is central to organismic, gestalt, and person-centred psychology. Rogers was one of a number of psychologists who have expounded organismic theory. Others include Kantor (1924a, 1924b), Brunswik (Tolman & Brunswik, 1935), Wheeler (1940), Murphy (1947), Werner (1948) and, more recently, Brown (1990). Rogers himself acknowledges his debt to Goldstein's (1934/1995) work on The Organism and to Angyal's (1941) Foundations for a Science of Personality. Thirty years ago, Hall and Lindzey (1978) recognised that Rogers adopted an organismic orientation in his theory and practice, a view also explored by Fernald (2000) who claims Rogers as a body-oriented counsellor. Organismic psychology is, in my view, the lost tradition of the 20th century. In his excellent book on the conceptual domains of psychoanalysis Pine (1990) discusses the domains of drive, ego, object and self, a taxonomy which, I think, represents the development of psychotherapy in general. Pine, however, omits the domain of the organism. Drawing on this lost tradition, Tudor and Worrall (2006) elaborate the centrality of the organism specifically to person-centred approaches to therapy.

According to Angyal (1941) the organism (from 'organ' meaning tool) refers to "a system in which the parts are the instruments, the tools, of the whole" (p. 99). Feldenkrais (1981), the founder of a form and method of bodywork, defines it as consisting of "the skeleton, the muscles, the nervous

system, and all that goes to nourish, warm, activate, and rest the whole of it" (pp. 21-2). In his forward to the re-publication of Goldstein's work in 1995, Sacks traces a brief history of neurology, seeing Goldstein and others, including gestalt psychologists, as important in rebutting more modular and atomistic views of neural organisation and the human organism. Damasio (1994/1996) defines living organisms as "changing continuously, assuming a succession of 'states,' each defined by varied patterns of ongoing activity in all its components" (p.87). This understanding, as well as other more recent developments in neuroscience, supports the premise that the experiencing human organism tends to actualise, maintain, enhance, and reproduce itself. Tudor and Worrall (2006) elaborate this perspective: that, as human beings, we are holistic, experiential, interdependent organisms; that we are always in motion; that we construe reality according to our perception of it; that we differentiate, regulate, and behave according to need; and that we have an internal, organismic valuing process.

There are a number of implications of this organismic perspective which are relevant to our present interest:

Firstly, Rogers' use of the term organism represents an holistic and experiential view of human beings. As our mind, body and spirit are inseparable, anything and everything we do is connected. As Tom Waits puts it: "The way you do anything is the way you do everything" (reported by Kot, 1999). This was elaborated in the 1930s by Goldstein (1934/1995) and is confirmed by more recent developments in neuroscience. One of the implications of this is that we cannot separate our behaviour from who we are. Behaviour is, as Rogers (1951) puts it: "basically the goal-directed attempt of the organism to satisfy its needs as experienced, in the field, as perceived" (p. 491). Thus, we are our behaviour. This is challenging to theory and practice (predominantly cognitive and behavioural therapies) which seek to separate and compartmentalise behaviour from the person.

Secondly, as formulated in his theory of personality and behaviour, Rogers (1951) asserts that the human species, as with other species, has one basic tendency and striving: "to actualize, maintain, and enhance the experiencing organism" (p. 487). Angyal (1941), however, sees the organism as having two related tendencies or trends: one towards increased autonomy and another towards increased homonomy. He defines the organism as autonomous in the sense that it is "to a large extent, a self-governing entity" (p. 23), and homonomous in the sense that it longs "to be in harmony with superindividual units, the social group, nature, God, ethical world order, or whatever the person's formulation of it may be" (p.172). As Panksepp

(1998) puts it: "Homologies at the neural level give us solid assurance of common evolutionary origins and designs" (p.14). Human beings live autonomously and homonomously in a world that is heteronomous or other. Most practitioners trained in psychotherapeutic theories and methods which draw on Western psychology will be familiar with the concept of autonomy, for instance, as an ethical principle or a political demand. We may be less familiar with the concept of homonomy, although when the NZAP (2006) talks in terms of "the spirit of partnership" (p.13) and of psychotherapists' responsibilities to the community it is expressing a trend to homonomy.

Thirdly, as organisms, human beings are interdependent with our environment, and cannot be understood outside of that environmental context. As Perls (1947/1969) puts it: "No organism is self-sufficient. It requires the world for the gratification of its needs ... there is always an inter-dependency of the organism and its environment" (p.38). Recent research on brain development also emphasises the importance of the environment and the dynamic relationship between the environment and the mental phenomena of the organism. Damasio (1994/96) for example, suggests that:

> mental phenomena can be fully understood only in the context of an organism's interacting in an environment. That the environment is, in part, a product of the organism's activity itself, merely underscores the complexity of interactions we must take into account (p. xix).

Again Angyal (1941) provides us with a useful term, the 'biosphere', by which he means the realm or sphere of life, and by which he conveys the concept of an holistic entity which includes both individual and environment "as aspects of a single reality which can be separated only by abstraction" (p. 100). Thus, he concludes: "The subject-matter of our considerations are [sic] not organic processes and environmental influences, but biospheric occurrences in their integral reality" (ibid). This is a remarkable statement and one which supports a genuinely integral individual/environmental approach to psychotherapy (as distinct from 'integrative psychotherapy'). In this sense, it may be more accurate to talk about a people-centred, or life-oriented approach to therapy – and to life. To extend Stark's (2000) taxonomy, this makes the person-centred approach – or, in the context of Aotearoa New Zealand and Te Tiriti o Waitangi/Treaty of Waitangi, a 'partnership-centred approach' to psychotherapy – a 'two and a half person' psychology (see Tudor & Worrall, 2006).

Fourthly, as we grow and develop through differentiation, we are inherently diverse. Rogers (1959) states that "a portion of the individual's experience

becomes differentiated and symbolized in an awareness of being, awareness of functioning" (p. 223). "Such awareness", he says, "may be described as self-experience" (ibid). Recent research in the fields of neuroscience, infant development and human communication points to the fact that infants are capable of differentiating themselves, their bodies, faces and hands from those of their mothers and, therefore, in some sense, knowing themselves. This offers us an experiential basis for understanding and appreciating personal difference and diversity and, ultimately, social and cultural diversity. Angyal's (1941) reference to heteronomy is useful here: "The organism lives in a world in which things happen according to laws which are heteronomous from the point of view of the organism" (p.33). In this sense, anyone else or other is different, and thus, as human organisms, we know what it is to be different and, thereby, to relate to difference. I would argue that this is a more human and relational basis for working and struggling with difference than that which, at least in the UK, is often imposed by an 'equal opportunities' agenda.

Finally, human beings develop an organismic valuing process, which Rogers (1959) defines as: "an ongoing process in which values are never fixed or rigid, but experiences are being accurately symbolized and continually and freshly valued" (p. 210). This speaks of an open, reflective, and fluid process of being, and of a being in process with its environment. Stinckens, Lietaer and Leijssen (2002) develop this, arguing that: "Inborn, intuitive experiencing should enter into a continuous dialectical relationship with the laws of social reality for the valuing process to correspond with the social embeddedness of the individual" (p. 48). In other words a person's internal, organismic valuing process does not lead to rank individuality or individualism; rather it takes into account others, especially those in partnership, and the environment in trust. In this sense a hurt to one is a hurt to all and, perhaps more importantly, a hurt to all, especially when 'other' is a hurt to one.

It is my contention, then, that an organismic perspective transforms our view of life and of psychotherapy from an individualistic, reactionary paradigm to one which is social if not radical, and relational if not collective.

Contact/encounter, relating, and imagining

In the last part of this paper I turn to the implications of these perspectives for clinical practice and, specifically, when, as psychotherapists, we are working and struggling with difference. I discuss this with regard to contact and encounter, relating, and imagining.

Contact in encounter

For Rogers (1957, 1959), contact or psychological contact is the first condition – or pre-condition – of therapy. Others since have developed this concept and an approach to 'pre-therapy' with clients who have some impairment in their ability to make and maintain contact, for example, people with learning impairments, with people with diagnoses of schizophrenia, autism, and dementia, (see Prouty, 1976, 1994; Morton, 1999; Prouty, Van Werde & Pōrtner, 2002). Contact through greeting, seating and meeting is the beginning of genuine encounter. Rogers (1962) himself describes therapy as "relationship encounter" (p.185). The English word 'encounter' comes from the Latin contra which means 'against', and so 'encounter' carries both a sense of 'face to face' meeting and of difference. In his book "I and Thou" Buber (1923/1937) describes 'being counter' as the foundation for meeting: to be opposite to the other offers the possibility to face and to acknowledge him, her or them. As he puts it "All real life is encounter" (p.18), and encounter is where dialogue takes place. Guardini (1955) suggests that encounter means that we are touched by the essence of the opposite. Tillich (1956) goes further and argues that the person only emerges through resistance: "it is through the resistance of the other that the person is born" (p.208). This is important not only on an interpersonal level but also on a social and cultural level. On this basis, contact, certainly on the part of the therapist, becomes a much more engaged and engaging concept and activity. I think of this view and experience of contact and encounter as embodying my commonality, connectedness, and sense of community (the trend to homonomy) and, at the same time, my difference, resistance and sense of my differentiated self (the trend to autonomy).

This perspective gives us, I think, a basis for a positive approach to struggle. To contend resolutely, to resist, to make efforts to escape from constraint, to strive, to make progress with difficulty, in other words, to struggle, is not a problem; it is a developmental, relational and social necessity. Struggle is not a problem; it is the problem that we make of struggle that is the problem – and, unfortunately, the history of psychotherapy includes theories and practice which pathologise struggle, resistance, being critical and, for that matter, being radical (see, for instance, Schwartz, 1999 for several instances). I think it is important to reclaim the importance of struggle in contact/encounter and in dialogue; the importance of difference; and the importance of not knowing. As Lévinas (1983) puts it: "Encountering a human being means being kept awake by an enigma" (p. 120).

Relating

It is widely accepted in the field that the therapeutic relationship is a key factor in the outcome of therapy. The therapeutic relationship has thus become the subject of considerable study within and beyond different theoretical orientations. However, this relationship is not fixed and, in my view, is better described in the language of both Rogers (1958/1967, 1980), and, more recently, Stern (2000), as "ways of being with" or ways of relating. This verbal form – 'therapeutic relating' – emphasises therapy as an activity between two (or more), interactive and intersubjective human beings. Furthermore, if we take an intersubjective approach, we must also view these ways of relating as co-created. Thus, I think it more useful, for example, to describe transference and counter-transference (nouns) as 'co-transference', as Sapriel (1998) does or, better, as 'co-transferential relating' (Summers & Tudor, 2000). This acknowledges that the therapist is also involved, and enters into and/or maintains a present-centred or past-centred, transferential way of relating, rather than attributing her or his feelings solely to the client. I would argue that, if we have a view of people as beings in process and of psychotherapy as being itself a process, then it is more congruent to use process language to describe both the person and activity of therapy (see Tudor, 2008a, 2008b).

I say 'present-centred' as I am interested in working with the present moment (see Stern, 2004). The fact that, according to Stern (1985, 2000), our senses of self develop in parallel throughout adult life supports working therapeutically in and with the present, and supports present-centred development, with the Adult ego state or neopsyche which represents an elaborative system connected to the mental-emotional analysis of the here-and-now (see Berne, 1961/1975; Tudor, 2003). In other words, I am interested in what is happening now, between us: between therapist and client, supervisor and therapist, trainer and student, speaker or author and audience, māori and pākehā (with regard to which I use lowercase as I agree with Campbell's [2008] point that this emphasises them as words and terms in process.) If these are viewed as complementary concepts, then the relationships they describe are complementary. My focus on the present is not to say that how we relate in the present is not influenced by the past. As Ritchie (2008) puts it: "Everything that is bicultural is available to you in the present moment … all you have to do is to be open to this experience." It is to say that history and story are available to us in the present, and that we can change our history, herstory or narrative about the past. It is too late to have a happy childhood; it is not too late to acknowledge how unhappy that childhood was, and to have a different experience/perception of the present – and of the past. One

of the epigrams in King's (2003) History of New Zealand is from the French historian Ernest Renan who says that: "A nation is bound together not by the past, but by the stories of the past that we tell one another in the present."

In terms of the theme of struggle, I am interested, as I relate to another, in what, if any, struggle there is between us and how that reflects the story of the past for him or her, for me and, over time, for us: that is, the co-created and co-creative relating that is therapy. Moreover, given what I have said about contact and encounter, I am also – and perhaps particularly – interested if there is not a struggle!

Imagining

When I first saw the literature for the 2008 Conference, I was particularly struck by the elaboration of the theme on the NZAP website: "Psychotherapy aims at the development of an imaginative partnership that can acknowledge difference and replace ignorance and intolerance with recognition, reciprocity, and respect" (NZAP, 2008).

In this paper I propose ways in which that imaginative partnership is created, co-created and developed through recognising that we are interdependent and intersubjective. The expansion in the nature of his or her sensed self, and his or her capacity for relatedness, catapults the infant into the domain of intersubjective relatedness – which is the basis for and the beginning of recognition, reciprocity, and respect. This is not an easy process either for the infant and his or her parent/s, or for two adults communicating, for example, across cultures. There may be little shared framework of meaning; gestures, postures and facial expressions may be misunderstood and misinterpreted across differences of race, culture, gender, sexuality, or class. Nevertheless, Stern's theory of selves and their respective domains of relatedness does offer a framework for communication as it explains the development of empathy. It is precisely as we develop a sense of intersubjectivity that we experience the process of empathy.

Rogers (1959) says that empathic understanding means: "to perceive the internal frame of reference of another with accuracy, and with the emotional components and meanings which pertain thereto, as if one were the other person, but without ever losing the 'as if' condition" (p. 210). In this sense, empathic understanding stands in a tradition of psychology that seeks to understand rather than to explain, a distinction which underpins the concept of empathic understanding in person-centred therapy, and distinguishes this therapy from therapies which seek to analyse, interpret or explain. Extending our understanding of empathy, I would argue that the 'as if' attitude supports

I-Thou relating and can distance the relationship from the relational, which I think is better described as a 'Thou-I' encounter. Furthermore, empathy requires imagination and identification.

In terms of personality I think of imagination and imaging being a quality of the neopsyche (Tudor, 2003):

> Free from the contaminations of archaic fixated and introjected material, the mature organism/person is curious, open to contact and relationship - not only with people but also with things, through ideas, aesthetics and the arts. It/he/she is playful and sensual. Just as this is the ego state of pure Reason, it is also the location of sheer intuition ... Alongside its reflective and critical consciousness lies the state of unconsciousness, re-membered through dreams and the imagination (p. 219).

So, as psychotherapists, we need to imagine: to imagine what it is to be 'as if' another; to imagine what it is to be different from ourselves in terms of ability, education, opportunity, and privilege; to imagine what it is to struggle; to imagine what it is to be repressed and oppressed; to imagine what it is to have land, language and identity taken away – and I write as someone who comes from a country which has a history of conquest, domination, and of dispossessing the other – and to imagine what it is like for the other if we are part of or associated with that past history. I think that as psychotherapists – and as citizens – we are engaged with others in continuous and necessary struggle. It is how we approach that struggle, how we listen and learn, and how we repair the inevitable ruptures which occur when relating with others that marks us as effective psychotherapists and citizens.

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Psychotherapy training in a therapeutic community.

Ann Speirs

Abstract

This paper outlines the formal aspects, academic and clinical, of a three-year training in psychotherapy offered in a psychiatric hospital which functions as a therapeutic community. The trainee's adjustment to the community is described, with reference to the overlap and intersection with the patient's experience in the community. Consideration is given to individual and group processes within the entire community. Erikson's concept of developmental stages is used, as well as a paper by Baird Brightman, to examine how crises in the training experience are managed by the trainee.

Introduction

The Ashburn Clinic (formerly Ashburn Hall) is a small psychiatric hospital founded in 1882. In 2007 we celebrated our 125th birthday and commissioned a local historian, Dr Cameron Duder, to write the story of Ashburn. My introduction draws on this book. Dr Duder traces the consistent theme of respect for the patient which informed the original model of 'moral-treatment', through to the present day model of the therapeutic community which became fully developed by the 1970s. The term 'therapeutic community' was first used by psychiatrist Tom Main in 1946 to describe the treatment milieu used at Northfield Military Hospital in Birmingham towards the end of the second world war. David Kennard (1998) identifies a core list of therapeutic community concepts. They include:

- An informal and communal atmosphere
- The central place of group meetings in the therapeutic programme
- Sharing the work of maintaining and running the community
- The therapeutic role of patients and residents
- Sharing of authority
- Certain shared values and beliefs

The clinic is staffed by psychiatrists, psychosocial nurses, psychotherapists and occupational therapists. It draws on the services of other professionals, for example general practitioners, a dietician and a local psychologist. The clinic has two inpatient units providing 24 hour nursing care, and a day psychotherapy unit with self-care living in an on-site hostel. Our total

bed capacity is 56. The clinic provides treatment across a broad range of diagnostic categories, including psychosis, personality disorders, eating disorders, addictions, depression and post traumatic stress disorder. The age range of patients is from 17 through to 70 plus.

The hospital has many links with the University of Otago, in particular with its Medical School, which established training in child psychotherapy in the 1970's. This was the first full-time training in psychotherapy to be offered in New Zealand. The first director of training, Dr Roy Muir, served as Medical Director of Ashburn Hall from 1984-1988.

With this background it is not surprising that the clinic has itself become involved in teaching the theory and practice of psychotherapy. In 1994 we established a full–time three-year training position. To date (June 2008) eight women and four men have embarked on the training. Nine have graduated, two are currently training and one person withdrew after two years. Most of these graduates are involved in psychotherapy practice and several have since become full members of NZAP. Since 2002 the clinic has been approved by the Royal Australasian College of Psychiatry to provide a two-year specialist training in psychotherapy to senior registrars. To date three people have undertaken this training.

Selection for training

The basic entry criteria are a minimum age of 25 years and completion of a tertiary degree course, or evidence of a capacity to work at university level. In practice most trainees have been over thirty and one trainee started in his mid-forties. It is a condition of training that people undertake their own therapy at this time.

Applicants are invited to submit an autobiographical letter in which they also consider their motivations for becoming a psychotherapist. This can be a helpful tool for assessing psychological-mindedness. Two or three candidates are short-listed and each is invited to spend a day at the clinic so that they can have a comprehensive introduction to the community at work. The candidates meet with current trainees. Both staff and patients are invited to provide feedback on the candidates. At the end of the day there is a formal interview with three senior members of staff. At this time we introduce some core concepts to the candidates:

- Conscious and unconscious processes;
- The central role of relationship in the work of individual therapy;
- The therapist's use of self as her or his basic tool in the work of therapy.

Outline of training

Aspects of the training have changed over time. A basic principle has been the value of learning within a group. This is in tune with our focus on the role of the group in treatment.

The first year of theoretical teaching is now provided by fortnightly tutorials, which are open to all clinical staff. We use a series of classic papers, which are presented to the group by trainees and other staff, in particular nurses, who attend to their professional development in this way. Papers on the therapeutic community and group work lead the way, with an introduction to the ideas of Bion. Other papers cover assessment and the therapeutic context, stages of therapy, and key concepts such as transference, countertransference and defences. Discussion from different professional viewpoints enhances the learning.

During the second and third years teaching is provided via four semesters of evening seminars, held weekly. These seminars are also attended by members of the public who satisfy our study criteria. We offer four modules of advanced theory:

1. Stages of Human Development
2. Models of Psychotherapy
3. Major Theorists
4. Abnormal Psychology

At the end of each semester trainees submit a brief essay on a topic related to one or more of the seminars. At the end of the third year trainees submit a long essay in which they display understanding of theory and the capacity for independent research and thought.

There are written requirements for the clinical training. The trainee keeps a daily diary for the first six months as a record of initial adaptation to the therapeutic community. After some months the trainee submits an account of morning meetings in an inpatient unit. This 2,000 word account examines the overt and covert tasks and processes of the meeting. In the final year the trainee writes a longer account of work as a co-facilitator in a small psychotherapy group.

The trainee's development is assessed via oral and written presentations of work with individual patients. A senior member of staff provides weekly supervision for each trainee. There is a weekly group supervision meeting for psychotherapists and psychiatrists in which the discipline of case presentation and formulation is practised and modelled. Once a month the

training group meets with the mentor of training (myself). This meeting has various functions: monitoring of progress, support, debrief, a place to vent feeling and express anxiety, and to address relationship issues.

Placements

The trainees spend a year in each of the three units. The year one trainee now starts in an inpatient unit – as do the vast majority of our patients. Initially he or she sits in on the full range of groups and other activities. The charge nurse for the unit decides when the trainee is ready to become a co-facilitator, working with a nurse, in a twice-weekly small psychotherapy group. The trainee also attends meetings of the multidisciplinary clinical team, which provide ongoing case discussion using psychodynamic models. Three times weekly he or she attends meetings of the whole community.

Mother-infant observation

A key component in the training is a mother-infant observation, using the Tavistock model pioneered by Esther Bick in the training of child psychotherapists. Once a week for a year, and then fortnightly until the child is eighteen months old, the trainee observes a mother and baby at home, together with the comings and goings of other family members. This observation of very early development brings to life the complex psychoanalytic theory with which the trainee is grappling. It is an observation of the baby's first relationship, the prototype for subsequent relationships.

The trainee is likely to be surprised by the powerful feelings that are evoked by proximity to a mother and baby pair. There may be pain at being excluded from an intimate relationship. Old longings may be revived. Anxiety and anger are aroused by failures of maternal empathy. Critical and judgmental attitudes may be uncovered. Two deep fantasies may be discovered: the wish to be the baby or the wish to have the baby.

The complex experience provides a form of rehearsal for the work ahead with an individual psychotherapy patient, in which personal feelings, anxieties and fantasies have to be contained, but thought about as deeply as possible. Tutorials led by myself focus on both the theoretical and experiential aspects of the study. The work is written up and evaluated.

The training experience

Joining the Community – Dislocation

The hospital comprises a set of buildings nestled together in several acres

of gardens, orchard and paddocks, framed by large old redwoods, planted over a century ago. The setting impresses the newcomer. Our present trainees have come to us from other parts of New Zealand and from beyond these shores. They appreciate the natural environment of the community and the ways in which we incorporate the setting into the therapeutic work.

The second year trainee acts as buddy to the new trainee, offering a mix of practical information and emotional support. (This practice copies a system whereby new patients are buddied by a patient in the same unit). New trainees are likely to venture some tentative but appreciative thoughts about how staff relate with patients. Despite feeling confused, overawed and maybe emotionally overloaded at this point, they tend to speak of the clinic and its staff with respect and some idealisation.

However, the opposite may also be the case. Sometimes strong negative emotions are felt and expressed, in a manner that may be raw and unrestrained. Doubt, uncertainty, vulnerability are all felt intensely. It can be a painful time. The trainee has been chosen on the basis of personal competence and perceived potential. But in the community setting, which is unsettling in all sorts of ways, the trainee is likely to feel not just a beginner, but an incompetent beginner. This is partly shaped by the trainee's unrealistic fantasies of herself or himself. Other things are at work too.

One of these is the matter of language. The language we use can include or can exclude and alienate. Unfamiliar terminology does the latter. At Ashburn we have two overlapping terminologies, that of psychiatry (including pharmacology) and that of psychotherapy. Both have to be learned by the trainee, but can only be mastered gradually. As well, there is the jargon of the therapeutic community, used with fluency by staff and patients alike. Some terms may have a short life span but pepper our dialogue until we all begin to shudder. A lot of terms and phrases endure, but seem peculiar to the outsider: pairings, exclusive relationships, the addictive mind, isolating, avoiding the group, being in relationship, sitting with your feelings. The trainee rapidly becomes aware of having joined a powerful culture, with a focus on talking about feelings and some marked conversational patterns, for example the habit of rarely answering a question directly and frequently answering by posing another question.

The pervasiveness of the language patterns may suggest a coercive belief system and may even smack of a cult. This is likely to have a particular impact on someone who feels strongly and defensively rooted in his own ideology or faith. A trainee may need to protect this faith and may fear brainwashing. There is time to brood on such matters since initially the trainee will have a

lot of unprescribed time, whereas other staff members seem relentlessly busy, rushing from one group or meeting to another. Even morning and afternoon tea breaks are used as structured meetings. The trainee can feel lonely and somewhat guilty for occupying him/herself with reading.

The trainee's interest becomes focused on the patients in their unit, whose stories are becoming familiar. They impress the trainee with their capacity to be emotionally articulate and may inspire him/her to do likewise. But here again there is a difficulty. The patient is encouraged to express distress but the trainee is expected to manage feelings internally until they can be taken to therapist, supervisor or mentor. The patient is accorded empathy, care and understanding; the trainee may wish, even long for, something similar. So at one moment the patient is an object of envy, the next moment strongly identified with by the trainee; at one moment more a sibling rival, at the next an ally in adversity.

Around this point there is often a significant event involving the trainee and a patient or patients, in which, unwittingly, the trainee is caught in a conflict or dilemma, often about a boundary matter. The event is put under the microscope and becomes an example of 'examined living'. Much comes to light: the covert agenda of the patient in which the least powerful staff member is consciously manipulated; the relative naīveté of the trainee vis-à-vis the patient; the hostile impulse hidden behind surface friendliness. In a sense this event is the initial 'blooding' of the trainee. It can cause shock and confusion. The trainee can feel duped and humiliated, or pressured. But it provides an instance in which the complex psychodynamics that are being learned about in theory suddenly become real and actual. It signals the transferential complexities ahead when trainees start individual therapy with their first patient. It requires trainees to think about the negative feelings the patient will harbour about being assigned to work with a beginning therapist.

The pain of this period is also experienced by some as a loss of innocence. Trainees hear stories of neglect, violence and abuse. In a community meeting they sit beside a woman whose arm bears the scars from being repeatedly cut, by herself. They learn about extreme and persistent forms of self-harm, which may incorporate bizarre, perverse and eroticised elements. Up close an anorectic patient may look like the images they have seen of concentration camp victims. These things are shocking. The prevalence of tales of childhood sexual abuse is likely to have an impact on the trainee's sexual self. But most powerful of all is the ever-present possibility of suicide which becomes a greater risk as patients grapple with psychological pain and conflict. Patients

often come to Ashburn with a history of multiple suicide attempts. The trainee soon becomes aware of the anxiety and vigilance carried by staff and how this can escalate in a flash. And the trainee learns about the pain carried by staff; pain about the patients who have committed suicide while at Ashburn; pain about those who take their lives after leaving. These patients are remembered for many years.

The trainee witnesses the particular awfulness of being closely connected with a patient who commits suicide. There develops a dread of one's own therapy patient taking his or her life. At least two trainees have had to deal with this.

Inside the Community – Relocation

So how does the trainee shift from mental dislocation to relocation? Recently a trainee pointed out to me that when a joint is dislocated it is relocated (ie. returned to its rightful position) as quickly as possible. This process is briefly very painful but followed by rapid relief. But the dislocation of the trainee requires relocating to a new place and there is ongoing pain and difficulty and no return. The process of becoming a psychotherapist involves even more inner learning than academic learning. It requires close examination of one's aggression and hatefulness, the shame-filled dark corners of the mind. All this is happening in the community setting and some of the trainee's most difficult moments may be witnessed by staff and/or patients. Privacy cannot be counted on.

The relocation work takes place both consciously and unconsciously. During this period the dream life of the trainee is likely to be vivid and the Ashburn experience readily identified in the dreams. It may take the work of supervision and personal therapy before unconscious anxieties become conscious. The trainee also needs help with the conscious aspects of the relocation work. Just as the patient has to be engaged in a treatment alliance the trainee has to be engaged in a training alliance. Central to this is the experience of being understood, respected and cared about – alongside the expectation that trainees manage themselves within professional limits.

The mentoring process is a common teaching modality within medical fields. It provides a mix of observing, teaching, nurturing and guiding towards a specific goal – in this case the acquisition by the trainee of knowledge, competence and confidence. In addition to the formal monthly meetings of the training group I meet as required with individual trainees. Sometimes a home situation, such as the illness of a family member, has implications for work at the clinic. More often it is a work situation that has evoked a lot of

feeling. Such feeling may be connected with another staff member, or trainee, or with myself, in particular with regard to my role. I can be at the receiving end of both positive and negative maternal transference. Part of the mentoring task is to hold and contain these experiences, sometimes to metabolise them. This can be analogous to the maternal task observed by the trainee visiting the mother and baby pairs.

The trainee group is also a natural setting for sibling rivalries. I remember this well from my own training and how unnerving it can be to experience the primitive force of such feelings. The combination of training and the community setting creates something of a hothouse experience in which either friendship or hostility can develop very quickly.

Quite early on I give trainees a copy of what is to my mind a classic paper: "Narcissistic Issues in the Training Experience of the Psychotherapist" written by Baird Brightman in 1984. He identifies the fantasies of those who enter the helping professions: to be hero, sage and healer; powerful, wise, benevolent. These aspirations make up the trainee's 'grandiose professional self'. They are severely threatened by the destabilising adjustment to the training experience. Defences are mobilised against the threats to self.

Brightman outlines these under five main headings: The obsessional defence (the trainee attempts to attain a sense of intellectual control over the experience); the hysterical adaptation (the trainee rejects an 'overly intellectual' approach, glamorises intuition and the release of affect); the acting adaptation (the trainee avoids feelings of helplessness with a high degree of 'doing something' to the patient); the paranoid adaptation (difficult feelings in the trainee are displaced on to someone else); the schizoid adaptation (the trainee uses psychological withdrawal to maintain equilibrium).

Brightman also identifies "a significant depressive experience organised around a sense of helplessness and hopelessness of achieving professional aspirations" (1984-85, p. 305). Most of our trainees have some form of depressive reaction and manage the necessary recovery. There is a developmental aspect to the training and core developmental conflicts are likely to re-emerge. Erikson's normative crises are helpful in identifying the problem (1965, pp.239-261). For one trainee the core conflict will be 'initiative versus guilt', for another 'industry versus inferiority', for a third 'identity versus role confusion' or ' autonomy versus shame and doubt'. The difficulty may emerge with the challenge of working alone with a patient (autonomy); or in supervision when trying to describe a clumsy interpretation (shame); or with guilt about finding it hard to warm to a patient. Feelings of inferiority may erupt in response to the marking of a case study. Identity

confusion can develop because of the visibility of the nursing role as a model, compared with the relative invisibility of the therapist role.

Training in a therapeutic community is a particularly demanding experience (parallel in many respects to the demands of treatment in a therapeutic community). There is considerable risk in exposing the self to change and challenge. Just as we are unable to help some patients so the training experience may be less than satisfactory for all involved. Difficulties may emerge and get no resolution. Training may be formally completed but a training alliance never really experienced, by either staff or trainee. Sometimes the difficulties for the trainee seem to belong to conflicts that are earlier in development and more entrenched than those identified above. Here Erikson's discussion regarding 'basic trust versus basic mistrust' seems relevant and helpful. In the following quotation the word 'trainee' can be substituted for the word 'child':

> A sense of trust...forms the basis in the child for a sense of identity, which will later combine a sense of being 'all right', of being oneself, and of becoming what other people trust one will become...There are...few frustrations in either this or the following stages which the growing child cannot endure if the frustration leads to the ever renewed experience of greater sameness and stronger continuity of development, towards a final integration of the individual life-cycle with some meaningful wider belongingness (1965, p. 241).

When we invite a person to start training at Ashburn I think the question of basic trust is at the heart of the matter, and fundamental to what we are trying to assess at interview. Is this person 'all right' in herself? Can she become what we trust her to become...endure frustrations...renew the self...continue in development...towards a final integration of her individual experience before Ashburn, at Ashburn and beyond?

The Insiders

This paper was originally written for the 2006 Windsor Conference, whose theme was "Outsiders and Insiders". The new trainee encounters two sets of insiders: the patients and the staff. What do we as staff members bring, both consciously and unconsciously, to our encounters with our psychotherapy trainees?

Newcomers tell us that we are more friendly, polite and interested than staff in many other institutions. This is understandable. After all, attention to welcomes and to relationship is part of what we practise every day in the

therapeutic community. However, there are also various ways in which we keep the newcomer trainee at a distance.

In the first place, we have, like any other social group, a pecking order, which is defined around length of service and established groupings. The new trainee is at the bottom of the pecking order. We expect the trainee to be visible but not too vocal and not too opinionated. (The patients have similar expectations of the trainee.)

Secondly, the new trainee occupies the most recent position in the training history. They become to some extent the repository of hopes, fears and anxieties, based on the history with their predecessors. They are aware of being watched in this community where observation is central to our understanding of each other and to working together.

Once a week we meet for an hour, with an outside therapist holding the group process. It is not a therapy group but it is the time when we 'take our pulse' with each other, both individually and collectively. The meeting can feel difficult. At such times some trainees have experienced a different kind of being looked at.

They have felt certain that there has been a projective quality to this looking and, specifically, that they are asked to carry an anxiety for other group members. The experience seems to persist for some time and then to lessen. I think that the increasing confidence and robustness in the trainee, along with growing acceptance of and attachment to him/her both play a part in its diminution.

Leaving the Community

The twin themes of arriving and leaving are a daily part of community life at Ashburn, formalised with a space in the agenda of both unit and community meetings. Movement from an inpatient unit to the day programme is treated as both a leaving and an arriving, with encouragement to the patient to say a careful goodbye to significant staff members and to think about previous separations, farewells and losses, and how they were experienced.

Some patients leave us abruptly and prematurely. When this happens the goodbye is truncated. The worst form of leaving is, of course, when a patient commits suicide and there is no goodbye.

Trainees quickly realise that we pay a great deal of attention to endings of every kind. It takes longer, I think, to gain an understanding of how central the many and various experiences of loss are to a patient's difficulties and how much the work of therapy is about unresolved and unidentified grief.

The trainee's personal therapy is likely to amplify this theme.

The major challenges for the third year of training are to complete the academic and clinical tasks, to bring therapy relationships to a close, to say goodbye to the entire community, and to manage the pressure of being farewelled, by patients and staff, over several weeks. This process is usually challenging and meaningful. There is a particular intensity in the staff group meetings where we wish to say a warm and appreciative goodbye but also to say something about what has been difficult and painful. We hope that the trainee may be able to comment on a process that is likely to have been life-changing and which is still being integrated.

Some final remarks

As the training mentor, I have a particular insider experience, which has been a large component of my motivation in writing this paper. I have come to realise that the trainees are almost always somewhere in my mind, and that I may even have them more in mind than my individual patients. This seems to me not unlike Winnicott's concept of 'primary maternal pre-occupation' which he described as the mother's 'normal illness' (Winnicott, 1975).

I have needed to think carefully about my own transferential projections on to trainees. In this I have also been helped by their responses to me, which so frequently testify to their healthy and robust training development. I feel deeply appreciative of the personal learning and growth that has resulted from the mentoring task.

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Martha – finding oneself in the other (Fonagy, 1999).

Sandra Buchanan

Abstract

This article developed from the therapeutic case study that I wrote for NZAP membership in 2006. It follows my work with Martha, an adult woman, over the course of four years of individual therapy. Issues of loss and bereavement permeated the therapy, most obviously for the client but also for me. I struggled with times when the client's life experience, as spoken in session, was very close to my own; so close that I felt my ability to remain separate and able to think was in danger of being compromised. It seems to me these are issues that all of us must struggle with at times, and merit further discussion.

Introduction

I first met Martha, a post-graduate student, when she requested counselling[1] from the Student Health Service, where I work. This was her second request for counselling, her previous counsellor having left the year before. Her main presenting issue was the same; procrastination around working on her thesis. She presented as a very obese woman of 29, dressed casually in leggings and sweatshirt, who appeared younger than her years. Martha lives an isolated life, in an enmeshed relationship with her mother, a woman with little apparent capacity for attunement or reflective function. Martha's experience of connection fills her with anxiety: on the one hand, fear of abandonment; on the other, fear of enmeshment, 'losing oneself in the other', as will be shown in this paper. In contrast, Fonagy (1999) states, regarding optimal conditions for development:

> If the caregiver's reflective capacity has enabled her accurately to picture the child's intentional stance, then he will have an opportunity to "find himself in the other" as a mentalising individual.

The therapeutic relationship provides another opportunity for one to "find himself in the other".

Client History

Martha is the second youngest of five. The youngest of her three elder siblings was born seven years before Martha; she has a sister who is four years younger. Her mother was 16 when she first became pregnant, and 'had' to marry Martha's 21-year-old father.

Her mother, a life time smoker and also very obese, suffers from chronic respiratory problems, requiring home oxygen and regular hospitalisation. At age fifty six, she can barely manage self-care, with no prospect of her health improving.

Martha was the only sibling at home until recently. Just before we started meeting, over a seemingly trivial argument between Martha and her father, her parents 'suddenly' decided to separate, after 40 years of marriage, and the family home was sold. Her mother and grandfather now live together in a flat. Martha struggles to live separately and sees her mother almost every day. It is clear that this is both to do with her mother's emotional manipulation, and Martha's isolated life and need for her mother.

When Martha and her father argued, her mother took Martha's side. This is not an isolated instance: throughout the marriage, the primary relationship has been between Martha and her mother.

Martha described being a quiet child, who, knowing that her mother was very busy with four other children, would play alone. At eight, she was overweight, and was told to reduce by her doctor, but without good dietary advice.

Making friends has always been hard for Martha and she has never had an adult intimate relationship.

She was always academically able, coming first in her class at school, but negating this by stressing how unimportant the school was. Her parents were proud, but had no real idea of her achievement. On leaving school she took a professional degree, requiring an intern year in Auckland, to gain registration; remarkably she did move there, but lasted one week only. She feels deeply ashamed about this, but the move away from home was beyond her then.

On returning to Dunedin, Martha started a further Arts degree. She felt like she "slept walked" through it, and that they awarded her a First Class degree out of pity. She was awarded a three year scholarship to write a post-graduate thesis, and started this the year before we began meeting. She also supplements her scholarship with part-time clerical work.

Dynamic formulation and diagnostic impression

Much of this history was gathered in our first session, and in my notes I see that I have written 'did not appear depressed'. Martha's bright, articulate and talkative presentation belies the huge discrepancy between her emotional/psychological/social immaturity and, to paraphrase Marvin in *The Hitchhiker's Guide to the Galaxy*, (1979), her 'brain the size of a planet'. It seems clear now that her 'non-depressed' presentation was a Winnicottian 'false self' (Winnicott, 1960), the only face she felt able to show the world and hence me.

The discrepancy noted above (between her immense cognitive capacity and emotional immaturity), can be consciously seen as a failure to achieve normal separation/individuation as an adult, specifically separation from her mother. This adult dependent state presumably replicates earlier infantile unresolved separation/individuation, one of Mahler *et al*'s (1975) key developmental tasks. Martha was her mother's 'baby' for her first four years, but on an inconsistent basis; sometimes intrusive, sometimes distancing; but always determined by her mother's needs, not Martha's. These are the conditions for creating Bowlby's (1969) 'anxiously attached/resistant' child.

Martha continues to attune herself to her mother, rather than the other way round. Her mother's alternating intrusion (but 'named' as 'support') and distancing (experienced as 'rejection') places Martha in an impossible position. Psychologically she experiences two maternal objects; a 'supportive' one and a 'rejecting' one. She internalises the rejecting object to be a bad part of herself: it is her need which is wrong and destructive. The experience of 'support' often feels like enmeshment, and becomes a terrifying precedent for relationships overall.

Eating provides a way to both be with Mum, and be like her in obesity. Intellectually however Martha is very different to her mother. Her academic abilities give her a role in the family; the 'bright one'. Ultimately though, her intellect starts to feel burdensome, as the discrepancy, between what she 'should' be doing, and what she can actually manage, increases.

This conflict becomes starkly apparent at post-graduate level. Her depression escalates; she experiences extreme anxiety to the point of panic; compulsive consumption of food no longer soothes sufficiently, so she starts to cut her own body. Psychologically she is defending against her central conflict with denial and magical thinking; she denies her unconscious knowing that the situation has become untenable: somehow, magically, the thesis will be written without her having to write it.

Denial and magical thinking are immature defences; during the first session I think I was picking this up in my sense of Martha being much younger than her years. A week seemed too long for her to wait for the next session; I was feeling both Martha's actual isolation and a more unconscious awaremess of her anxiety at not being kept in mind. I was in tune with the infant who, not having reached the stage of object constancy, worries that 'out of sight' does mean 'out of mind'.

Diagnostically, Martha fits the criteria for Dysthymic Disorder or, on Axis II, Depressive Personality. Both seem to convey the almost lifelong struggle she has had with low mood. McWilliams (1994) describes the certainty of depressive clients that they are both inherently bad, and that their anger is dangerous, as being diagnostic of Depressive Personality.

As psychotherapy has proceeded I have experienced something characterologically borderline in Martha's personality structure. Her formidable intellect often masks this, but the profound splitting, demonstrated in her idealisation of me and denigration of herself, was an early indicator. Even more strongly I am aware of powerful counter-transferential swings in myself; between a strong want to rescue, more noticeable initially, and an equally potent desire, at times, to reject Martha. McWilliams (1994) expresses how normal and diagnostic these 'internal movements' are when working with borderline clients.

Therapeutic goals

Martha's goal was clear; assistance to complete her thesis. Further goals were evident to both of us; a need to increase her capacity for intimate relationships and hence reduce her social isolation. I also thought that Martha would need to negotiate the developmental stage of separation/individuation from her family.

In order to achieve this, Martha's very limited sense of self would need to develop and mature. All of Erikson's (1951) eight stages of man seemed to apply: there are obvious difficulties with the second and third stages of autonomy and initiative, but also the later stages of industry, identity, intimacy, generativity and ego integrity. And such a limited sense of self inevitably implies failure to master the first stage of basic trust v. mistrust, with Erikson's accompanying virtues of drive and hope. He states:

> ...the amount of trust [depends] on the quality of the maternal relationship. Mothers create a sense of trust [by providing] sensitive care of the baby's individual needs....This forms ... a sense of identity

which will later combine a sense of being 'all right', of being oneself, and of becoming what other people trust one will become.

Initial phase of therapy

Areas of interpersonal difficulty for Martha, throughout our whole therapy, became apparent within the first three months. She struggled with a desire to have a psychiatric diagnosis that would 'explain' her dysfunction. If she could no longer be the 'bright one' in the family, perhaps she could be the 'sick one' and in this regressed, dependent state, get her needs met. Allied with this, there were times when she did not want to see links between her mood state and life events. Early on, she discussed a meeting with her thesis supervisors:

I hate to admit it but I'm very dependent on what [they] think of me.

Why do you hate to admit it? I asked.

Because if external events affect me, it means I can control [my mood]. And there's no reason to feel like this...I was cutting last week in advance of the meeting.

I tried to help her make the links she was reluctant to see.

It's not 'just' a meeting with your supervisors that has you cutting. It's about the whole shebang; the thesis, worrying about dropping out, are you good enough, what will you do otherwise, etc?

Martha found it hard to let people know about her difficulties and needs directly. She related her tendency to walk out of arguments and then expect to be followed. If Martha were the 12-18 months infant of Mahler *et al*'s (1975) 'rapprochement' stage of development, this behaviour would be completely appropriate; as an apparently adult woman in her 20s, it generally stimulated frustration in others. In session, I wondered if she could try to state her wants more directly, and suggested this 'passive-aggressive' communication could actually be counter-productive.

Martha responded that I was wrong and became tearful. However, with me, she was able to try something different. Rather than just leaving (wanting me to follow?) she opened up more, admitting that she knew there was something childish about this communication style. She went further.

> *The final straw leading to my moving out was Dad saying that I'm a child who knows nothing of the real world.*

Martha then disclosed that she and her father have never communicated directly other than through bickering, and that "Mum always gets in the way". The pathological need of Martha's mother to keep her young, at home and therefore 'Mum's eternal child', became clearer. Martha stated that when she was happy, her mother was down and vice versa. Very tellingly she said,

> *I've never seen her so happy as when I was at EPS (Emergency Psychiatric Service); she hardly needed any oxygen.*

Part of Martha's low self esteem, and hence difficulty with being confident enough to make an independent life, has been her weight. Her obesity is the first thing that one notices. She was very aware that she comfort eats. I felt an urge to give her books about how dieting makes one fat, as if one book could fix her lifelong problem. Supervision was very helpful in managing 'my' want to do something about Martha's obesity; my supervisor spoke of how Martha would continue to use food, as long as she had nothing else.

I asked about the cutting, disclosed at assessment; Martha said she had self-harmed at about age fourteen, but not again until the recent crisis. In agreement with Favazza (1998), I understood Martha's self-harm to be 'a morbid form of self-help…[providing] rapid… relief from distressing symptoms such as mounting anxiety' and its 'effects [to be] tension release, … satisfaction from self-punishment … and relief from feelings of depression, loneliness, loss and alienation.'

Middle phase of therapy

In the initial phase of therapy the fundamental resistances and conflicts have been identified: the bulk of the therapy is the continual examination and re-examination of the identified conflicts, within the holding function of the therapeutic alliance.

Although Martha's enmeshment with her mother is always strong, her mother's hospital admissions epitomised the problem. Martha would spend hours sitting beside her mother's bedside and everything else would be jettisoned. Often I felt frustrated with Martha and her mother at these times, by this pathological 'dance' that Martha said she wanted to end but colluded with constantly.

I also had had my own experience of my mother becoming very ill and dying the previous year. The memory of the hours I spent sitting at my mother's

bedside was strongly with me, as Martha spoke. I remembered 'my' sense of helplessness in the face of my mother's pain and my want to do 'anything' to try to manage this. When Martha related her week between sessions, 'living' at the hospital, the identification felt so great that I struggled with using my irritation with Martha's 'dance' as important counter-transference information. What was mine and what was hers felt, at times, confused.

A sense of confusion was a common experience for Martha within her family where the underlying dysfunction was becoming more apparent. Perhaps, therefore, I shouldn't have been surprised when Martha disclosed, some three months on, that she had been sexually abused.

She was talking about her wish for 'everything' to be different. I responded by saying:

> *I think saying 'everything' is a defence against the pain you might feel if you get into the details. I think you need relationships, aside from your family.*

She responded with:

> *People cause pain... I'll only be hurt.*

She spoke very slowly about memories of something occurring when she was four, "an older boy". "One of your brothers?" I asked, and she agreed; Luke, seven years older than she, was the perpetrator. Martha had never told anybody before. "Perhaps it was just kids playing around." The memories, however, were clearly of masturbation and oral stimulation.

I said that at four, and eleven, this was not 'just kids playing about'. I said that Luke should not have done this, that there may be a link with her depression and it was brave of her to talk of it. Martha's need for her 'fat' as a defence against emotional intimacy became clearer now.

We also began to explore the cutting. Nobody had ever seen her cuts, and following Levenkron's (1998) model, I asked if Martha wanted to show them to me, which she did. I think there was something soothing for her in at last 'exposing' this most private behaviour to another person. This was also valuable for me as it indicated a clear demarcation between her mother, who knew nothing of her cuts, and myself. This was a 'healthy' secret between us.

Increasingly, Martha's need for human contact became apparent. In desperation, she said

Perhaps I'm just not meant to have friends, like not be an astronaut.

I challenged this and interpreted her terrible fear of relationship but her desperate longing for just that. This was obvious in our relationship where the inadequacy of meeting once weekly was clear. Although there was nothing I could do at the time about this, I commented that she needed to come more often and I wanted to meet that need.

This statement of what Martha needed (even when its provision within the Service was impossible) was important, as it counterposed Martha's certainty that she must be an unwanted burden against my declared wish to see her more often. It also modelled that needs must first be identified for there to be any possibility of them being met.

We did manage to change to twice weekly sessions, a year after starting to meet, as Martha received funding under the Accident Compensation Corporation (ACC) for sexual abuse counselling, in my private practice. Initially there seemed clear indications that attending more frquently was beneficial; but after two months, it seemed that a 'taste' of more only emphasised her sense of deprivation.

There continued to be regular crises around Martha's thesis, usually precipitated by her supervisors needing to see signs of progress. Her mother and grandfather moved into a flat together, further out of town. Initially this helped Martha spend less time with them, but she quickly reverted to old patterns.

Martha dreamed that her mother had died and there were so many obstacles she was unable to reach her. Some weeks later Martha disclosed that she had wanted to reach her mother in the dream, so that she (Martha) could kill herself. This led to her sharing her certainty that she 'would' kill herself when her mother died. I allowed this expression, much as it alarmed me, and empathised with the emptiness in her life. At the same time I proposed an alternative future, where it would undoubtedly be terrible when Mum died, but not necessarily catastrophic.

Progress fluctuated. Martha would get excited, when, for instance, she managed to find a fitting bathing suit and restarted swimming. She started using *Xenical* for weight loss and described throwing out her crisps, a symbolic act similar to a smoker discarding their cigarettes.

Her mother's role in keeping Martha fat became clear; at the same time as helping pay for the Xenical, she would encourage Martha to have fish and chips saying, "one time can't hurt". Her support for, and undermining of, any

move by Martha to make change is mirrored by the different parts of Martha also struggling with the same dilemma.

We reached our first major break. I took five weeks leave and, on my return, everything had been "fine". I later realised, that she had needed to be 'good,' so I would return. Eventually Martha disclosed that she had managed the break by resorting to cutting herself again.

The New Year also meant that two years of Martha's scholarship funding had gone. The thesis was the unspoken 'pink elephant' in the room: it became clearer that Martha wanted it done without having to actually write it. I openly challenged this magical thinking. She would talk of the impossibility of doing everything (study, work, family, exercise, diet, making friends) and eventually, with assistance in supervision, I confronted her with the paradoxical thought that perhaps the thesis was beyond her. She responded to such challenging by stating that she wanted to persist, but the difficulties continued.

In May 2005 her supervisors threatened to 'pull the plug'. After an initial collapse Martha responded well and designed an impressive plan to make progress. At the same time her 'child' face was to the fore, "it's not fair", but I had to challenge this. There was nothing unfair in her supervisors' normal expectations of progress.

Throughout this period Martha was often feeling hopeless but I was able to maintain hope; at such times I think my fantasy was that of the rescuing 'good mother', McWilliams' (1994) 'complementary counter-transference' to the unconscious belief of depressive clients, that only unconditional love will cure them. At other times I felt equally hopeless; my 'concordant counter-transference' (McWilliams, 1994) to Martha's hopelessness. Martha's projective identification of her hopelessness was so powerful at these moments, that any hope for her had to be delegated to my supervisor to hold.

There were, however, some signs of greater maturity. She began to talk of her parents in much less polarised terms, Mum no longer a 'saint', Dad not just an 'ogre'. She realised freedom from depression didn't mean continuous happiness. Counterpoised to this was Martha's want to have some actual experience of joy. These thoughts felt like indications of Martha moving towards Klein's (1946) depressive position, with more ability to tolerate ambivalent feelings.

At times, I was very moved Martha's clear appreciation of me. Once she informed me that her younger sister Ellen and her abusive boyfriend David had asked for my name for a (fraudulent) ACC claim. When their request was

put to her, Martha said she felt both possessive and protective of me. I stated clearly that I would not see either Ellen or David; Martha was my client and she came first. In my mind at the time I was thinking, "Martha is 'my' baby". I did not speak to Martha in these terms, but in demonstrating so clearly that there was no question about where my priorities lay, I think I passed a 'test' that Martha had been, at least unconsciously, setting for me.

Martha's wanting to protect me from David felt like a verification of her achieving Klein's depressive position; the stage where the infant begins to experience anxiety that the mother (therapist) has been harmed by his/her aggressive attacks. Martha's aggression was not overtly stated but certainly expressed in her constant resistance ("yes but") to any of my support towards change. This had lead to a feeling of guilt and a want to make reparation.

Such hints of greater maturity felt important because family crises in my life meant that, soon after, Martha was forced to face the inevitable disappointment of being in a relationship, when I had to cancel a session at short notice. During the following session no mention was made of this, but Martha commented that I was looking tired. I wondered if she thought I was too tired to be present with her. She said she had wanted to ask if I was all right, but wasn't sure if it was okay. I assured her that I was fine and available. Reflecting on this later, I wonder whether Martha had wanted to express anger as well as concern, at my sudden non-appearance, but was not confident to do so. I can see now that my assurance that I was "fine" limited the possibility for her to express all her feelings about the cancellation.

This was a very stressful period: my sister was critically ill in hospital and my mind was frequently elsewhere. I wonder if I was rather anxious about giving Martha the chance to explore her feelings further; unsure that I was strong enough to bear her anger, and perhaps her unconscious knowing that 'someone else' came first with me.

Events accelerated as the year progressed. Her mother's health worsened and Martha's distress became more overt. She spoke of feeling desperate, but "nobody knows it". She was cutting more often. I expressed my anxiety that she might really hurt herself and offered psychiatric care, but she declined it. Suddenly both Mum and Granddad were admitted to rest homes. Martha, 'freed' from their demands, collapsed into crisis.

This culminated in Martha's being briefly admitted to a psychiatric ward, for the first time, and she presented to her therapy session feeling suicidal. Her mother was in the Intensive Care Unit (ICU) and Martha sobbed that she thought her mother was going to die. I was very concerned about her mental

state and arranged to take her to EPS: this involved cancelling my next client and driving Martha in my car.

Reflecting later on these events, I can see that something very powerful was being communicated by Martha: another 'test' was being set for me. At the time I felt that I was the only one who could save her and that I needed to prove this with heroic measures.

Martha's mother was most present for her when Martha was ill, most obviously (as documented on page 11), in seeming to come to life when Martha was unwell enough to need EPS. Although consciously recognising this old relationship pattern, and telling Martha that she could still have me, even when well, I think that in reality, I recreated her familiar dynamic of 'clear dysfunction leading to greater attention'.

Martha had never felt that she was first with anyone. I put her first, above my other client, and momentarily passed her 'test'. Unfortunately and unsurprisingly, Martha could not truly internalise this demonstration of my regard, any more than her frantic consumption of food could really fill her up.

On reflection I feel as though I was 'forced' into actions far beyond my normal practice; that Martha, although intellectually knowing she is not an infant in her mother's care, still longs for a relationship of that degree of intensity. She projected this longing so powerfully that I found myself responding in unusual ways: this is the essence of projective identification, as Ogden (quoted in McWilliams, 1994) states:

> In projective identification, not only does the patient view the therapist in a distorted way that is determined by the patient's past object relations; in addition, pressure is exerted on the therapist to experience himself in a way that is congruent with the patient's unconscious fantasy.

The uselessness of my rescue attempt became clear at EPS, when Martha refused their help by 'running away', and I found her, at her mother's bedside in the ICU. Martha pouted and said she wasn't leaving: I could only ascertain that she was safe and reinforce our usual appointment time for the following week.

Martha did survive this crisis, and necessary further support was provided by the public mental health services. This was a relief for me: I had been feeling burdened for some time by the responsibility of being Martha's only 'functional' mother. She started attending an outpatient group programme and made the mature decision to defer her thesis.

The importance of such 'preparatory' steps became starkly clear when Martha rang me on Christmas Day to say that her mother had died. This coincided with my annual long leave. I was very anxious about Martha, but had to feel confident to leave her care to the hospital group programme.

Current progress and thoughts on termination

At the time of writing, it is over two years since the death of Martha's mother's, and recently her other main attachment figure, her grandfather, also died. Two major developments mark this later time of therapy. Martha's physical health has worsened, with the diagnosis of obesity-related complaints; high blood pressure, Type II diabetes, and renal damage. At times her only response to these serious health problems has been one of passive suicidality, and a fantasy of rejoining Mum "in heaven".

Latterly her isolation, her despair, and anxiety about ACC funding running out, has led to her dangerously overdosing on prescribed medication. This move, from suicidal thinking to acting, has been extremely worrying: the holding provided by therapy (now in once weekly sessions only) and the daily outpatient group programme has seemed inadequate.

We are still living with the anxiety about further ACC funding but after a serious crisis around Christmas, Martha seems to have found some stability within herself, although how long this will last neither she nor I know.

It is still very hard to imagine a planned termination at the right time for Martha. She worries now about getting better for fear of losing the therapeutic relationship, despite my stating that she can grow up and still keep me, for as long as she needs.

Discussion

Bowlby (1969) described the importance of the primary caregiver providing a secure base for the child, from which exploration could be made in confidence that 'safety' could be returned to. As Karen (1994) puts it, 'secure attachment' between mother and infant [is] of crucial importance to the child's psychological development and mothering [that is] warm, sensitive, responsive and dependable… [is] the key ingredient".

Martha was her mother's 'baby' until the age of four. One would assume that this was a likely foundation for focussed maternal attention, but her lifelong dysfunction suggests something other. The key words are 'sensitive and responsive'; crucial to this is the parental ability to reflect on the child's state of mind and put the child's needs first. Considering her mother's

enmeshment with Martha as an adult, it can be hypothesised that in the past she was similarly providing for her own needs, and that their attachment was at best insecure and at worst pathological. Martha's infant role is likely to have been to provide a secure base for her mother, a frightening reversal for a dependent infant/toddler. It can also be assumed that Erikson's second stage of autonomy verus shame and doubt, and Mahler et al's (1975) separation/individuation phase would be discouraged by Mum, who would feel anxiety at her toddler's attempts at independence and respond with explicit or implied disappointment, and withdrawal of love and attention.

Such an enmeshed relationship between mother and child needs to be disrupted by the father; that 'third person', so necessary to the introduction of the concept of the world containing 'others'. Martha's father's inability to 'fight' for his relationship with her, is probably a consequence of his own dysfunction. However, it was understood by Martha that she was too unimportant for him to try. The only real 'attention' she received from a male, as she was growing up, was the sexually abusive contact from her elder brother.

Fairbairn (1941) states: "development ... is essentially a *process whereby infantile dependence ... gradually gives way to mature dependence*." (italics in the original). Martha realises that her idea of friendship is similar to the infantile dependence she experienced with her mother. She knows intellectually that this is an unrealistic goal for adult relationships. In the therapeutic relationship, she has been encouraged to try something different: she has been enabled to try to 'find herself' in/through me.

Martha has become more able to manage my failures (e.g. cancelling sessions) by letting me know, rather than by totally denigrating me and the therapy. Winnicott (1955-56) says that 'The patient makes use of the analyst's failures', crucially by the analyst not defending themselves but allowing the patient to experience and express anger.

Martha's sexual trauma should be seen in the context of her lack of Winnicott's 'good enough mothering' (Winnicott, 1960), epitomised perhaps by the parents' blindness to Luke's sexualised and abusive behaviour. Mitchell and Black (1995) sum up Winnicott's view of 'trauma' as being:

> Not just… something dramatically negative, frightening and noxious (e.g. precocious sexual stimulation); it is… the failure to sustain something positive – the… conditions for healthy psychic development.

Such abuse seldom occurs in isolation but more often within the context of the 'dysfunctional family experience', well described by Alexander (1992) in her article linking attachment theory to sexual abuse.

Conclusion

Guntrip (1961) states, summarising Fairbairn, that 'the root cause of all personality disturbance ... is the unconscious persistence within the adult ... of too strong an element of infantile dependence ... The human child ... does not always grow up to be psychically adult.'

In this work with Martha I have tried to understand her inhibited development as a 'psychic adult'. The thoughts of various theorists have assisted my ongoing internal processing during the course of therapy. However, regardless of modality, we understand that it is the relationship that heals. Fairbairn (Guntrip, 1961) states it thus:

> ...the really decisive factor is the relationship of the patient to the analyst, and it is upon this relationship that the other factors depend for their very effectiveness...since in the absence of a therapeutic relationship with the analyst they simply do not occur...

I endeavour to provide a secure base from which Martha is enabled to explore the world and ' find herself'. This process is still tentative: Martha 'darts away', in Mahler *et al*'s (1975) words, and then needs to return for 'refuelling'. Often she resists the demand to become psychically adult. It is too hard: she longs to return to the 'womb' of home and Mum.

I can do little except keep being present, reliable and non-defensive; a good object for Martha to internalise, and a secure base to struggle, safely, against. In time the therapy will hopefully provide what food does not, a fullness that really satisfies, and this relationship will act as a precursor for new and different emotional experiences with others in the wider world.

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Endnotes

The service provided at Student Health is termed 'counselling' and the practitioners, regardless of training or modality, are counsellors

[1] If Martha were the infant of 12-18 months in age, of Mahler's normal developmental stage of 'rapprochement', this expectation would be completely appropriate. As an apparently adult woman in her 20s it unsurprisingly stimulated frustration in others.

[2] Levenkron regularly looks at his clients' cuts in session.

[3] A new short term person, but I can see now that I was recreating 'this' client's difficulty of always acquiescing to others' demands.

[4] I use my cellphone for contact at my private practice; hence Martha's being able to call me on Christmas Day. She has seldom abused this facility.

Imagining the Other: Some hallucinations from a therapy.

Grant Dillon

Abstract

I sit opposite my client, a 25-year-old Māori woman. It is our second session. Just in front of her face, as if projected on a screen, is the face of a middle-aged Māori man. I blink; I rub my eyes. The face of the man remains. Is this a projection of mine, a construction of who I imagine her to be? Or is it a communication from her? Or might it be a deceased relative, who needs to be prayed for and asked to leave, as my cultural advisor suggests?

It is inevitable that Pākehā therapists will translate Māori concepts into a western psychotherapeutic reading; for example, to interpret the last suggestion above as a metaphor for internal object relations. But as with any translation, something is lost, and our apparent understanding masks what we do not know. In fact, our dependence on familiar ways of understanding has many psychotherapeutic, cultural and political implications.

The story

This is not really a paper. It is a story; a story about my relationship with a client; a particular difficulty that arose in my work with her; and where that difficulty led in the direction of change, for me, for her, and for us. I am writing as a Pākehā therapist, and I am expecting to be read by other non-Māori therapists, given the small number of Māori therapists currently in NZAP. And I am writing as a pretty naïve Pākehā therapist, if a little less so than I was at the start of my work with this client. To Māori who may read this, I ask your indulgence as I find my way through this story.

I am sitting with my client, whom I will call Aria. It's our second session. Aria is a 25-year-old Māori woman who is training in social work, a mother with two young boys. She came to therapy because she has been advised to by one of her trainers, to lessen the effect of her own family issues on the work stress she will eventually face. In the session, she has been talking about what it is like coming to therapy. Then silence falls and we sit quietly for a while. Aria is looking down, pensive. As I watch her, something changes. Just in front of her face, as if projected onto a screen, there is another face – the face of a Māori man in his fifties. I blink; the face remains. I look away, look back. I rub my eyes. The face is still there. I realise I can get it to go by keeping my eyes moving round the room and looking back momentarily. But

as soon as my gaze settles on Aria for more than a moment, the face returns. It goes when Aria speaks, but returns for minutes at a time throughout the session.

Once, when I was in my twenties, I went to see a piece of performance art. The artist had taken slides of herself every day for over a decade, standing in the same pose, along with slides of people she was close to. In the performance piece, she wore a white body stocking, stood against a white wall, and had some of these slides projected onto her body and face as she talked about herself and her life. There is something similar in this experience with Aria, something close but unsettlingly different in these faces. I try to imagine whose face the man's might be – her father's? Or perhaps it might be her grandfather's? Her face and the man's are quite different. Aria's is quite triangular, unmistakably Māori to me, not exactly fair, but not dark. Her nose is almost aquiline and her skin is smooth. The man's face is a deep brown, round and lined. To me there is not an obvious family resemblance. Then it strikes me how odd it is to be trying to place this face when it should not be there at all. The face also does not seem to relate to what she's talking about; her family, and her transferential dynamics don't figure obviously in what she's saying. I wonder if this face is 'mine' - familiar to me from my life. But it does not call anyone to my mind.

The experience itself is quite neutral; I am not aware of any particular feeling, other than being in a state of reverie fairly normal to me while sitting with a client, waiting for them to speak. But the fact that I am having the experience is in itself unsettling. I know what this is – it is an hallucination. I have read about them in books. An hallucination is the "apparent perception of an external object not actually present"(OED). Freud (1949) says, "The equation 'perception=reality (external world)' no longer holds."

Hallucinations

There are two things I have learned, implicitly or explicitly, about hallucinations. One is that they happen to clients, not therapists. (My search for literature on psychotherapists' hallucinations with clients finds very little; if you know of anything, I would be glad to hear of it. Steve Appel (2000) and Linde Rosenberg (2005) have addressed it in papers they have presented at past conferences.) I know of the ubiquity of negative hallucinations – for instance, on a day when everything goes wrong and I am expecting the worst, I lose keys that magically appear in the pocket I have searched five times; or, there is a chair in my practice room that has unsettled a client with its newness, when it has been there for years. I have also experienced what I

think of as the everyday uncanny; for instance, a few times a client I have not seen or thought of for years has come to mind, and within 24 hours, they have phoned to make an appointment. (I also know the usual explanation for this – that I remember these coincidental occurrences and forget the clients who pop into my mind without then magically appearing. This seems sensible, even if it does not accord with my sense of what actually happens.) But this 'positive' kind of visual hallucination is new to me.

The other thing I know about hallucinations is that they are usually evidence of PTSD or something at least as serious. Linde Rosenberg (2005, p. 8) says that

> Experiences of seeing ... forms ... create even more worry [than apparent telepathy, or thought transference] within the psychotherapeutic community because they are associated with hallucination and psychosis. Indeed it is a serious question as to whether some of the experiences are hallucinatory or psychotic and, if they are not, how they differ.

I check myself for other symptoms; do not find any; but then, who knows? Donald Winnicott, reminds us "hallucinations are dream phenomena that have come forward into ... waking life", and that

> hallucinating is no more an illness in itself than the corresponding fact that the day's events have been drawn across the barrier into sleep and into dream-formation" (Winnicott, 1971 p 67).

But this is **my** imagining, not my client's. What is it trying to tell me?

I have also read that hallucinations are a much more common experience than we realise. A few years ago a Dutch eye specialist sent a follow-up survey to patients who had undergone a particular surgical procedure. The questions were in Dutch, but were compiled by an English assistant. One of the questions was meant to ask if the patients experienced visual distortions, and if so, what they were like. The English assistant slightly mistranslated the word 'distortion'; it came out sounding like a question about hallucinations. The specialist was astonished by the responses. He received dozens of highly detailed, dramatic 'phantom sightings'. Mostly these were of people, ordinary people, moving about the world in an ordinary way. Some were strangers, some were known. Some people reported coming across huge buildings in what they knew were empty fields; some saw crowds of people that were invisible to others. The images often persisted for hours. Many of the patients reported that they kept the experiences to themselves for fear of ridicule, and

were relieved to be asked about hallucinations because they assumed that this meant that 'seeing things' was a recognised side-effect of their condition or their surgery. It was neither. The mistake in the questionnaire revealed that hallucinations – at least among middle-aged Dutch people – are far more common than we might expect (Carter 1999).

At the beginning of our next session, as previously, there were long silences. In them, the face returned. I found myself wanting to get Aria to talk, to dispel the face, and my unease about it. But I did not; at least, not immediately. I waited until Aria looked a little restless before I asked her what was going on for her; and then she talked about work and study, the pressures of meeting academic requirements while being absorbed in her children. What she was saying seemed important and we spent the rest of the session on this; although I did have the impression that Aria was 'doing therapy'; in some way doing something that was expected of her, presumably by me. I wondered if there was in this some preservation of 'power distance', a deference to authority supposedly found mostly in indigenous cultures (Jackson 2006), although in my experience found just as much in our own psychotherapeutic one, and not only due to transference. The face, which seemed such a non sequitur in the context of what she was talking about, came and went as she moved between talking and silence. Once again, I had no noticeable feeling associated with the experience, apart from a sense of reverie at the beginning of the phenomenon. But it certainly left me curious.

Aria is the eldest of three children; she has two younger brothers. Her father is Māori and her mother Scottish. Her upbringing was fraught with fights with her mother, although Aria says her brothers caught the worst of it. Her mother was white, and emotionally abusive and demanding. She retreated many years ago back to her native Scotland, where she had died. Aria is in some ways close to her father. They have lived together for most of her life. She currently lived with her partner and children in her father's home. It was unclear if she liked her father, although she loved him. She found him strict and a bit cool. But she identified with him in many ways. All this had left Aria with some ambiguity about her identity. There was something about her face, not androgynous, but both feminine and masculine, both pretty and handsome. And she was staunch. I imagined that she could be formidable in a disagreement. I wondered if I had constructed an image of how I expected her father to look, mixed with some embodying on Aria's part of the father who had been such an important aspect of her identity formation, and projected it onto her.

At the next session, Aria talked about her history in intimate relationships.

She said,

> *However it starts, whatever I think or want at the start, I get lost somehow. It's like sinking in a warm bath. I can't tell where I end and the water starts. It's all about the other person. I stop noticing what I feel and think. I just lose it completely. Except it doesn't go away. It just goes under. And it builds up, and I can feel it, but I can't say it. And finally I don't have any choice. I just have to leave.*

This stood in contrast to the staunchness I was aware of last week. The face returned then. Freud's attitude to occult phenomena, according to Ernest Jones (1957),

> illustrates better than any other theme the explanation of his genius… an exquisite oscillation between skepticism and credulity so striking that it is possible to quote just as many pieces of evidence in support of his doubt concerning occult beliefs as his adherence to them (p. 375).

This is a little slanted on the part of Jones, who was a profound sceptic – Freud was a Corresponding Member of the London Society for Psychical Research, and an Honorary Fellow of the American Branch of the SPR (Katz 2005). Steve Appel (2000) has talked eloquently about different possible meanings of 'occult'– latent, hidden, and supernatural; he points out that most people are captured by the last of these. He also makes a case for relating uncanny therapeutic events in the language of the occult not because he believes in a supernatural explanation, but to maintain contact with the sense of the numinous we sometimes experience in therapy. He also makes pragmatic use of these experiences without needing to describe the exact mechanism by which they occur; specifically apparent telepathic communication, as "a phantasy projection and identification which produces a visual disturbance in the receiver of this message from beyond" (ibid p. 34). In light of this, I thought to myself during the session that perhaps in the phantom I was seeing the toughness of the father she needed within her in order to be able to face up to a partner. It was a satisfying idea; except that it did nothing dispel the face.

In a later session, during a silence, Aria was looking down and aside, and the face was there, as usual. I said,

> *You know, sometimes when I look at you, I see a different face.*

Aria looked up briefly, and the face dissolved. She said,

Hm

There was a pause.

Whose?

I said,

I don't know, an older Māori man. I was hoping you might have some idea.

She gave a tiny shrug, not uninterested, but as if it was not that much to do with her, and dropped her eyes to the floor. As she became impassive, the face returned, eyes averted. I never did see into the eyes; they were always turned away from me when the face was visible.

By now I had a complex response to the hallucination. It was as familiar, predictable and mundane as another client's fixed smile or twitching nostril might be. In fact its familiarity was one of the most unsettling aspects to it. In myself I looked for signs of paranoia, and found no more than usual – the face was a distraction, not something malevolent, nor something being done to me. I also looked for signs of omnipotent or grandiose thinking in relation to Aria, or else something histrionic in me. These are difficult things to discount. All I could say was that, quite opposed to giving me a sense of guidance or mastery, the image left me puzzled and less certain of my own ability to make sense of my experience than usual.

I also wondered if the face was a projection onto Aria of some split-off aspect of myself that Aria represented for me, possibly in her otherness to me as Māori. If so, it seemed to me that it would have to have been a major aspect of myself to manifest in this way. I held it as a possibility, although it seemed an intellectual construct without an affective kick to it.

I must admit that while I did raise it in supervision, I did not make too much of it. I was embarrassed, I think. Nothing in my training, reading, or talking with colleagues had prepared me for it. It was an experience from the margins for me; and as Adam Phillips (1995) says, one of the dilemmas psychotherapy faces is that it tries as a treatment process to address the most marginal of human experiences while wanting as a profession to claim a place in the mainstream. I was worried what my colleagues would make of me.

Cultural Supervision

It was time for cultural supervision. When I talked over this experience with Haare Williams, he suggested I take it seriously – to imagine that the man whose face I saw was a deceased relative who needed to be prayed for, and to be invited to leave Aria. If ever I could have an experience of how different cultural supervision is from psychotherapeutic supervision, this was it. Haare was suggesting this was not an hallucination at all, but a visitation. I could not act in the way requested of me, but I could not stop thinking about it either. It simply did not fit within my framework. I wanted to make space within me for an indigenous model; I just did not want it to be this one; in part because it was so far removed from my psychotherapeutic models, and from my sense of spirituality. But I respect Haare. When I am offered something by an elder, I do not reject it out of hand.

At first I tried to think about this in the context of psychotherapeutic theory. In a way, this was easy. Psychotherapy is a metaphorical activity, a way of translating apparently concrete objects into symbols unrealised by the speaker. When someone speaks or acts, we think to ourselves, "What he *really* means is…" And we think this constantly; nothing is quite what it seems. So the dead relative was some internal object, the unprocessed remnant of something or someone who haunted Aria. After all, Freud, through his work, tried "to prove that the dead really do live on with us; they haunt us and affect our daily lives" (Katz, p 146).

But had I not in a sense been thinking in this way all along? And what difference had it made, either to my experience, or to Aria's?

It is also troubling to try and translate an indigenous concept into a western one, or vice versa. There is the likelihood of a subtle colonisation, a taking over of indigenous experience. Are Taranaki and Egmont the same mountain? The associations, histories and meanings to Tangata Whenua of Taranaki and Egmont are very different from each other; Pākehā associations and meanings are different again. Conversely, western models of development and attachment are contentious to indigenous peoples with, for instance, their equations of individuation with maturity and emotional health. (Although this was getting confusing; I was trying to think/feel my way into an indigenous concept given to me by a kaumatua to understand my own (Pākehā) experience with a Māori client.)

I took Haare's suggestion to heart and decided to act as if the face was 'real' – the presence of tupuna with Aria as she sat in the room. In doing this, I was thinking of Alfred Adler and his use of Hans Vaihinger's fictionalism,

the philosophy of as if (Ansbacher, H. & Ansbacher, R., 1956). Vaihinger said that we live by fictions that, regardless of their truth, are subjectively real; and that when we act as if they are true, things turn out for the best; for instance, the idea that all people are created equal. It is demonstrably untrue in terms of abilities, tastes ... there are a million differences. And yet not treating people as created equal is a sure route, long or slow, to supremacist thinking and behaving. Vaihinger(1925) saw fictionalism as an essential element in ethical and spiritual life; we might think of it as idealism. I needed this kind of frame to allow myself as a Pākehā psychotherapist with a mostly psychodynamic way of working to make space for something that seemed radically different.

Most models of an indigenous worldview hold whanaungatanga as a core principle. For instance, Margaret Morice (2003) holds it as one of six key principles of a Māori psychotherapy. In the model te whare tapa wha, taha whānau is one of the four walls of the whare which supports and nourishes the person (Durie 2001); and whānau does not simply encompass the living. Rangimarie Rose Pere makes one of the eight arms of *Te wheke,* her model of Māori health, *ha a koro ma a kui ma* – "the breath of life that comes from male and female forbears" (1988). This holds that "good health is closely linked to a positive awareness of ancestors and their role in shaping the family." Michael Shirres, quoted in Margaret Morice (2003, p.26) says

> The persons we stand with are not only the living, but even more so the ancestors, those members of the family who have already gone before us. So basic to being a person, and to being Māori is to be whānau, family, not just with the living, but also with the dead.

Alongside treating the face as tupuna, I kept open other possibilities – that the face was a projection of mine, perhaps an imagined otherness to do with my own racial constructs; that it was a projection of Aria's of some disowned aspect of herself or her experience; or that it was an analytic third, co-created by us. I tried to find a balance between wonder and doubt, as Sue Joyce talked about at a recent NZAP Northern Branch meeting; too much wonder leading to credulousness, too much doubt leading to cynicism.

The silences in the sessions had been lengthening, especially at the beginnings of sessions. The face was most often visible at these times, when Aria was silent and looking away. At this time I was mostly mildly abstinent in sessions; I had believed that I was allowing spaciousness for something of Aria's to develop in. But our connection seemed thinner, stretched somehow, and she seemed less present to me; almost less present than the face. I was

growing concerned that I was losing Aria. Once the silence had cemented in, it was hard to shift. So I talked about it, and my concern that I was not being inviting enough. Aria agreed. She asked,

Is this how you are with people usually?

I said,

Well, yes,

and shrugged; and we both laughed a little. I said,

Perhaps I need to do something a bit different,

and again she agreed. I talked a bit about my training and my own experience of therapy, and Aria visibly relaxed. She asked about my training, and compared her own experiences in training with mine. There was something different about the session; there had been less of a familiar self-consciousness in Aria. It was not until later that it occurred to me that the face had been largely absent.

This was the start of our work becoming more conversational. In spite of the gender difference, our relationship had something of a tuākana - teina quality. With encouragement from my supervisor and especially from Aria, I gave up some of my supposed neutrality: I mostly answered her questions, sometimes without asking why she was asking them; I allowed myself to feel warmly toward her; I asked after her partner and children. The curious thing was that, the more I did this, the more complex Aria's responses to me became. On one hand, she was more talkative and warmer toward me. On the other, she was tenser at times, seeming to distrust me in my Pākehā-ness.

Whakamā

She told me about going into a café in one of the whiter Auckland suburbs, and of the stares and bristling hostility she felt from the other women there. Then she noticed her T-shirt, a tino rangatiratanga one. She felt angry and defensive, and something else – less than them, at least in their eyes. Then she said,

But then I don't really know much about you. I don't know what you think about it. Maybe you're no different.

I said,

> *Yeah, it must be hard, finding that fear and hate in most places, and expecting to find it everywhere.*

Aria began to tell me how much I reminded her of her mother, in my whiteness and the shape of my face. In one session she became quite agitated and told me that when she looked at me, all she could see was her mother's face. Waves of feeling crossed her own – fear, anger, distress, need. Her mother existed within her as a complex figure, both hated and wanted. Aria found it difficult not to split off this white, culturally strange 'Other' who was also a part of her.

Stories about her mother's behaviour alternated with stories about the behaviour of Pākehā she came across now. Her mother had made clear her feelings about Aria's darkness. And in the present, Aria talked about taking her boys to the beach. In the water, a Pākehā man had deliberately swam over the boys, knocking them aside. When Aria went in to get them and called out to the man, a Pākehā woman had shouted at her, "You don't own *this* foreshore." Alongside her rage, there was the feeling again of being seen as lesser, the deep sense of Whakamā that results in "not only outward alienation from others but also inward alienation from oneself" (Metge cited in Woodard, 2008, p.77). Farhad Dalal tells us that while the actual practice of subjugation is primary, the interiorisation of it is just as important. The sense of whakamā connected in some way to the self-consciousness I had experienced in Aria from the beginning, a subtle self-objectification.

The pain of this was at times extremely difficult to bear. In part I thought that I could understand in a concordant way what this might feel like; but as large a part was the complementary pain of being one of the 'Others' to Aria. I often wanted to tell her how sorry I was that these things had happened to her; and knew that if I did in that moment, I would be doing it to ease my vicarious guilt and shame. Mostly, the best that I could offer was a sympathetic listening. And once or twice, when I felt able to step aside from my need for absolution, I could say I was sorry that these things had happened to her. She said how guilty she felt about talking about these things to me, a Pākehā who had done her no harm.

The more deeply inside Aria went in her contact with her whakamā, the more outward her experiences of it became (Durie, 2001). I asked her once how it was talking to a Pākehā man, and she said,

> *It's such a relief. I know how to be in the Pākehā world better than in the Māori one.*

She had a hui on a marae through her work, and was filled with shame at not being able to karanga at the powhiri. She felt looked down on by the home people at her father's marae for not knowing enough kaupapa Māori, for being a city girl. It was a lost connection that pained her and that she longed to repair.

After she talked about this, as her head dropped, the face returned. I thought that Aria's loss of face was masked by the presence of this other face. I said,

Perhaps your connection isn't as distant as you think.

As she looked up, the face slipped away. I thought of the words of Hamiora Pio, in talking of the dead:

> We cannot touch them. The living come and go; they meet and greet each other; they weep for dead friends, and sympathise with each other. But the spectres of the dead are silent, and the spectres of the dead are sullen. They greet not those whom they meet; they show neither affection nor yet sympathy, no more than does a stump. They act not as do folk of the world of life (Best 1954, p.35).

Aria's ambiguous sense of me returned in the form of her father, and his father. At times she looked at me and saw her grandfather's face, saw his bitterness; or her father's disappointment and sternness. This, at a time when otherwise she talked of the warmth she felt between us. She also talked about the difficulty of her relationships with her father and grandfather, and as she did, their faces abated.

I have continued to feel challenged and quite out of my depth with Aria. At the last session before a break, she brought a small amount of food for us to eat together. How many of us have eaten with a client? Well, I have, and it was one of the most difficult things I have ever done in a session. I kept thinking of the meaning of our eating together for each of us. Perhaps for Aria it was the lifting of tapu after our kōrero, and before parting; certainly it was an expression of her manākitanga. For me, there was a struggle to overcome a powerful superego injunction against it. In eating with her I must be acting out, I thought, probably my fear of being identified as the disapproving Pākehā man; but surely the knot in my throat that made swallowing difficult was just as much an acting out, of my inhibitedness in front of a client, my fear of being seen by her, or known about by my colleagues. The next few sessions after the break were full of food talk, as we each discussed our reactions to what had happened.

Conclusion

There is no tidy ending to my story. Aria's and my work together is not finished. Some things have changed. I do not expect her experience of whakamā to ever be wholly changed; that would require bigger changes outside her than any imaginable inside her. I do believe her relationship with te ao Māori, the Māori world, to be developing and changing, becoming richer and more supportive. The transferential aspects of our relationship have shifted; I believe she sees me more clearly now, both figuratively and literally. My face is clearer to her; she no longer seems to see her mother, her father or her grandfather.

And her face to me? I have not seen the man's face for a long time now. And what do I make of it? I go back to Winnicott's statement about hallucinations being dream material that has crossed the barrier into wakeful experience. We know what it is like to be presented with the rich, allusive, surreal poetry of a dream, to be puzzled, challenged, intrigued, disturbed by it. We arrive at an interpretation of it, or more than one; and when we speak it out, it is pale and flat beside the aliveness of the dream. We know that we are fooling ourselves if we think we have arrived at a final, complete interpretation of a dream, or indeed with any experience we western-trained therapists might think of as primary process. So it is for me with the face I have experienced with Aria. I do not know what it means, frankly, and I do not see the need to believe I understand it fully. James Ritchie (1992, p 64), in discussing one of his principles of action, says, "For some strange reason Pākehā people seem to think that there is a finite body of knowledge which, once they have worked it over, will provide all they need to know... The task of understanding is never complete."

I do know that the outcome of seeing the face was to cause me to radically change how I relate to Aria and indeed to other clients in a way that is fruitful. It has struck me as odd that Aria's faces were so clearly transferential, where mine were not obviously so. It does not mean that mine were not, of course; but it is tempting to wonder if we had a transcultural exchange – that Aria had a classically western psychodynamic vision, and that mine was not. Who knows? What matters is that I have had to relate to her as a fellow subject, with her need to understand me as much as I have a need to understand her, at least as much as each of us is able. I have found that comparative transparency on my part has not destroyed transference on hers. I have had to make space for her whānau and her tupuna in my room. I have learned that an ounce of warmth and a willingness to relate is worth a pound of cleverness. I have

come to expect the unexpected. And I am grateful to the face; without it, I would not have had a clue what it was I didn't know that I didn't know.

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Conservative, Liberal and Radical Psychotherapy

Jonathan Fay

Reflecting on our daily work as practitioners of the art and science of psychotherapy, our thoughts may occasionally turn towards the 'big picture' of psychotherapy and its prospects for a long-term future. We might wonder about the limitations of psychotherapy as it is practiced today and ask what psychotherapy might become. Our enemy in this reverie is polarized thinking: right and wrong, black and white, for and against, either/or. Our friend is dialectical thinking, a willingness to value opposite points of view, and to seek synthesis and integration. The success of a dialectical conversation is determined by our ability to clearly identify differences that make a difference. First we try to identify points of maximum tension and conflict, and then we work to mediate these conflicts. In this way, we extend and strengthen our self-understanding. To help think and feel our way through and beyond some of the familiar polarities of conventional psychotherapy, I'm going to describe the basic life positions of the conservative, the liberal and the radical, and then I'm going to apply each of these to psychotherapy.

Conservative, liberal and radical choices are differences that really make a difference. The conservative resists change, the liberal allows change, and the radical requires change. The conservative is a purist, a believer in tradition and hierarchy, not particularly tolerant of difference. The liberal is a pluralist, a believer in tolerance and diversity, comfortable with the status quo but open to gradual and progressive change; evolution but not revolution. The radical speaks truth to power, and challenges the hierarchy on the grounds that it enforces an oppressive status quo, which undermines our dignity and self-determination. The conservative tends towards hierarchy and authoritarian edict. He or she seeks order, fears chaos, and supports the rule of the benevolent elite. The liberal is democratic and majoritarian, and supports governance by representatives elected from amongst the membership. The radical values self-determination and sovereignty, and would offer us consensus and cooperation in place of elite rule or majority governance. The conservative is monocultural, the liberal is multicultural, and the radical is bicultural. It is one thing to tolerate the existence of a disenfranchised minority, and quite another thing to call for partnership and power-sharing with this minority. The conservative version of justice is earned privilege. Hierarchy is fair if privilege is earned: unfair is unearned privilege. The liberal version of justice is equality. Fair means equal, and it also means the same; the same standard for everyone, no double-standards. The radical version of justice is active

support for self-development and sovereignty. What is unfair to the radical is failed or unfulfilled potential.

We can immediately see that psychotherapy is a very interesting beast; a breed all of its own, a hybrid. Firstly, psychotherapy holds a conservative tradition of expert professional knowledge and practice that sharply defines role differences between therapist and client. Secondly, psychotherapy claims a philosophy of egalitarian social relations that stands in the best liberal tradition. Thirdly, psychotherapy embraces a genuinely radical ideal of justice. If every person deserves to realize their potential, an unfulfilled life is justice denied.

How shall we bring together and synthesise all of these trends and tendencies? Perhaps the 'Holy Trinity' of psychotherapy can be described as follows: God the Father is conservative, psychoanalytic therapy, God the Son is liberal, humanistic therapy, and God the Holy Spirit is radical, socio-political empowerment therapy. Most psychotherapy practitioners hold some personal preferences among these three positions, but are fully capable of offering a critique of each and of valuing all three very highly. In marked contrast to how we position ourselves professionally, and how we speak to each other in public, I suspect most psychotherapists practice privately in all three of these modes at different times, and creatively combine many aspects of each in their daily work with clients. My hope is that psychotherapy can learn to recognize and value itself in each of these three mirrors.

Conservative psychotherapy

Very briefly, then, God the Father is a psychoanalyst, envied and emulated, sitting atop the status hierarchy, looking down upon the world of psychotherapy and seeing that all is well, save for the danger of becoming too pluralistic and namby-pamby, which is to say, liberal. Conservative psychotherapy reveres its own heritage and tradition, a tradition of purists and true believers. Conservative ideology holds that there is a right way to practice, based on time-tested methods. Individual, insight-oriented, depth therapy is far superior to any new-fangled, try-hard, do-good, merely supportive psychotherapy. Psychoanalytic practitioners (and here I include myself) have difficulty imagining a non-analytic psychotherapy we would consider adequately skilful, powerful or self-aware. One hundred years of psychotherapy tradition has built an impressive knowledge and skill base, a strong and consistent therapeutic frame, which supports our work and holds us steady in it. We prefer the frame of therapy not to be bent or broken, and certainly not to be carelessly thrown away.

Conservative psychotherapy is highly sensitive to human differences of all sorts, but fundamentally it assumes a human psyche that shares qualities and characteristics with every other human psyche. Despite all the culturally mediated differences of age, sex, race, and social position, there are universal human experiences of self-oppression. Our job as therapists is to find and free the imprisoned self, no matter what its cultural background or baggage. We are proudly saving the planet one person at a time. Conservative psychotherapy believes that the human organism, the human psyche, and human development are determined by their biological and psychological organisation. As such, they reflect a human nature that underlies and underpins cultural differences. Conservative psychotherapy can become militantly monocultural in its quest for scientific status and scientific respectability. Psychoanalysis is well known for its cultural imperialism, selectively using cross-cultural data to support the existence of a universal, 'transcultural' psyche.

Conservative psychotherapists deny both the need and the right to impose their beliefs and values on their client, and they certainly don't want their client's beliefs and values imposed on them. They distrust the projective energy of evangelistic idealism and utopian social movements, and they are quick to notice that often when psychotherapy wears its values on its sleeve, the quality of the work goes down. Conservative psychotherapists consider that naive sincerity on the part of the therapist constrains and limits the spaciousness of the therapeutic environment. The client may be forced to adapt their beliefs and values to harmonize with their therapist's beliefs and values. Anonymity and silence protect the therapist but they also protect the client from the therapist. When the therapist remains reticent and opaque, the client's transparency is backlit. Plenty of space is preserved in which to explore and make sense of the client's experience.

Liberal psychotherapy

If God the father is a psychoanalyst, God the Son is a charmingly informal and warm liberal, humanist. The basic conviction of liberal, humanistic psychotherapy is a two-fold optimism: developmentally, babies are born good, and therapeutically, it's never too late to have a happy childhood, to make up for at least some of what one missed. This positions the liberal psychotherapist in the place of a good enough parent, a primary caregiver who makes provision for and creates a set of facilitative conditions in which growth and development can resume their natural course. Most psychotherapists today embrace this liberal view. Although we are sojourners in the shadowlands, often deeply immersed in the inhumanity that is the

lesser part of our humanity, we also witness enough positive transformations to keep our faith in the basic goodness of creation, to believe in the existence of human worth and dignity, and the ultimate triumph of love over hate.

There are some important dialectical differences between conservative and liberal. Here are three: Firstly, in contrast to the classical analytic orthodoxy that loss cannot be repaired but only grieved and resolved through the work of mourning; the liberal psychotherapist attunes to the client's inner child and works to retrieve developmental potential which is dormant but not dead. Secondly, the conservative psychotherapist holds that psychotherapy is akin to basic research: an investigation conducted by means of a method, carefully and consistently applied. The client is free to do as they please with the results of this investigation. The liberal psychotherapist regards psychotherapy as second-chance learning and second-chance growing up. Here the role of the therapist is at least as important as the method, and the therapist has role responsibilities similar to those of a parent and teacher. Good clinical outcomes depend upon the psychotherapist's ability to role model, facilitate, and teach, whatever is developmentally needed and will assist the client to grow. A diversity of methods can be employed to serve this single aim and liberal psychotherapy is often associated with an eclectic or integrative approach to practice. Thirdly, the liberal agenda represents a significant advance in the psychotherapist's sense of social responsibility. It demonstrates a commitment to include ourselves as part of the social fabric, to belong to and participate in the communities that we serve. It leads to a code of practice that aspires to be inclusive and non-discriminatory. Again we discover the dialectic between conservative and liberal psychotherapy in the tension between perfecting the art of serving those clients we serve best because they are already so familiar to us, versus risking incompetence as we learn to imagine the other in order to serve those clients who are less familiar to us and less known by us.

Radical Psychotherapy

Not surprisingly, psychotherapy appears shockingly different from a radical point of view than it does from either a conservative or a liberal perspective. From the far side of the dialectic, conventional psychotherapy has a lot to answer for. Private practice is a cozy niche market: white, urban, middleclass, Eurocentric, boutique, and bourgeois. We have had one hundred years of psychotherapy and the world is getting worse. Psychotherapy has huge potential but most of this is unrealized. To realize this potential, or even to begin to ask the right questions, we need to radically expand the frame

of psychotherapy to include all six billion people on the planet. The proper context for psychotherapy is not just our tribe, our culture, our civilization, but the fate of the earth and all its creatures. Five out of six people on the planet are not middleclass. The vast majority are not white. In Aotearoa New Zealand, for example, the majority of psychotherapists are tau iwi: English, North American and European immigrants. Many are Pākehā born here, few are non-white, and almost none are indigenous Tangata Whenua. If psychotherapy is ever to learn to serve a wider clientele, it must learn how to move beyond its cultural self-involvement and self-absorption. Longer-term, the future of psychotherapy will depend upon our ability to imagine the other beyond the orbit of our own assumptions, and to develop effective partnership relationships with the other, in their difference from, as well as in their similarity to us. We can defend the goodness of what we already do well, but we can also choose to develop understanding and enthusiasm for new possibilities.

Radical psychotherapy is values-driven, attracted to congruence with positive ego ideals that can be distinguished from the oughts and shoulds imposed by the superego. Radical psychotherapy is unashamedly partisan and pro client. It privileges the emancipatory agenda above the therapist's role or method. However, this investment in the client's liberation does not mean, as is so often supposed, that psychotherapy becomes social work or confines itself to being merely supportive. Psychotherapy continues to take place in a protected, private space, rather than in the world at large. It continues to value intimacy, acute self-observation, and in-depth exploration of past and present psychodynamics. But radical psychotherapy maintains an acute awareness of the effects of its social context and social positioning. It does not justify its working assumptions as inherent to the practice of psychotherapy, pre-determined, necessary, or necessarily beneficial. It may be steered and conducted differently from more conventional therapies, as the therapist relinquishes the comfort and safety of opaque practice and established method, in favour of genuine power sharing with the client. Sharing power is only possible when therapy is able to foreground twin subjectivities, when authenticity is required of the therapist as well as the client. In contrast to opaque conservative practice in which I wait until I can offer the right interpretation, or translucent liberal practice in which I turn profile and show my good side, radical therapy aims at, without ever reaching, full transparency.

Authenticity, being real, is the key to allowing two co-equal subjectivities to fully engage. This can be very uncomfortable. A process of two people

getting real with each other does not always work out. The preservation of the therapeutic space and the stability of the working alliance may be severely tested. But radical therapy is determined to narrow the gap between how we talk about clients, and how we talk to them. Some of my recent experiments in becoming more transparent have caused me insecurity. I fear being exposed and attacked for what I really think and feel, without the buffer of my familiar role and method. The interesting thing about this is that my clients tend to feel empowered, and more secure, at the very moment that I feel disempowered and less secure. Of course too much self-disclosure on the therapist's part is problematic, but so is defensive opacity and anonymity. Answering a question with a question is handy, often therapeutically productive, but it is also an avoidance of contact and a power play. Clients can learn to appreciate the benefits of allowing their therapist to remain anonymous, but so can therapists learn to appreciate fronting up when asked to do so by their clients. A partnership model of psychotherapy implies dual controls and the necessity of periodic negotiation with our co-pilot.

Radical developmental theory is also significantly different from the developmental assumptions of conventional psychotherapy. Again, very briefly, conservative psychotherapy holds that where id was, there ego shall be. The ideal is to develop good self-control and a strong sense of personal identity. Liberal psychotherapy holds that where superego was, there ego shall be. The guiding ideal here is self-love and self-acceptance. Radical psychotherapy holds that 'me' is also 'us' and 'I' can become 'we'. A mature alternative to individualism is the concept of 'intentional community', which is potentially a path to better functioning and greater satisfaction with life. In this way radical psychotherapy claims its pedigree as real psychotherapy and demands Trinitarian integration with its Holy Others.

Conservative psychotherapy has traditionally held its monoculturalism closely and defensively. We have something valuable to offer. Let them come to us if they want it. The problem with this assumption is that most people will never arrive in the first place and so never benefit. In place of this, liberal psychotherapy proposes an easy multiculturalism. Everyone is different, unique and special, no one group better or worse than another. We just need to come together and work through our differences and misunderstandings, retract our projections, learn respect and tolerance for each other. The problem of course is that the playing field on which this dialogue is meant to occur is desperately un-level. If 'fair' means socially sanctioned privilege or a single standard applied equally to everyone, justice is a fiction. The tyranny of the dominant culture is guaranteed by pre-existing structural inequality

and inequity, and the hegemony of dominant cultural assumptions that both consciously and unconsciously colonize us and them.

Both self-oppression and the oppression of the other, regularly follow certain structural fault lines. Psychotherapy has discovered an important fault line running through the heart of the family. Parents replicate their childhood and colonize their children despite their best efforts not to do so. Children colonize themselves out of love and loyalty to their families. As Freud taught us in The Ego and the Id and elsewhere, the child's ego, the individual 'I' self that we equate with personal identity is founded on a bedrock of self-oppression. However, acknowledging the truth of this does not require us to subscribe to tragic individualism and colonial melancholy. Rather, we need to appreciate that liberation from oppressive family dynamics, past and present, is only one category of freedom. Liberation from oppressive social and cultural dynamics, past and present, is another, and the ongoing reality of this oppression is highly relevant to the practice of psychotherapy. We do not need to limit our practice to clients from our own culture and background. Often it is extremely helpful, even liberating for clients to work with someone really different from themselves. But when the overwhelming majority of psychotherapy practitioners are white, cultural safety for non-white clients is a virtual impossibility. As long as psychotherapy continues to represent the perspectives and assumptions of the dominant, colonizing culture, good psychotherapy for indigenous people is unlikely. Nor will liberal guilt do much to remedy this. When we apologize, plead ignorance, and ask for forgiveness, we eventually feel victimized and resentful, which leads on to further aggressive assertions of our own cultural validity. A forward path out of this vicious cycle is active partnership, a commitment to acquaint ourselves with the culture and the cultural unconscious of the other and to draw closer, bring them to us, into our midst as fellow practitioners. Biculturalism is a deliberate choice for us. As members of the dominant culture, we receive plenty of encouragement to remain monocultural unless we actively choose otherwise. For Tangata Whenua, by contrast, biculturalism is normal and necessary, not even remotely a matter of choice.

Bicultural psychotherapy

The radical psychotherapist is passionately motivated by a pragmatic idealism, a powerful desire to live her or his psychotherapy values more fully in the real world and to generate better real-world outcomes for a wider range of clients. Biculturalism offers a radical critique of psychotherapy. It may threaten conventional ideas about psychotherapy, polarizing us into positions

of for and against. However, it can also offer us a valuable perspective on psychotherapy and may even help us develop new paradigms for our practice. We can predict that a new bicultural paradigm of psychotherapy will be spiritually awake and alert and will risk taking our own and our client's spiritual inventory. It will also take responsibility for its politics, its ecology, and its domain of social responsibility. Therefore, it will be critical of the profound and deleterious effects of globalism, capitalism and corporate domination, on individuals, families and communities. Bicultural psychotherapy will hold its radical ideal of justice with conviction and pride. It will commit itself to protect the wellbeing of those who cannot readily fend for themselves. It will advocate restorative rather than retributive justice. It will value and uphold what is local, native, indigenous and unique to our land, and our people. It will be an effective way of loving and honouring Aotearoa New Zealand.

These are all kaupapa Maori values, but they are kaupapa psychotherapy values as well. They assume a decentred, integrated, holographic universe in which energy flows through and binds all things, a universe in which we mutually regulate each other's physiology and psyche, a universe in which our breath is shared and our common fate and future intertwines. We can hold our values and beliefs spaciously enough to leave room for our clients to discover their own values and beliefs, but we cannot disown what we value and believe, without paying a price that is both unacceptable and unnecessary.

The challenge of radical psychotherapy offers a compelling reason to risk disquiet and discomfort. Psychotherapy fulfills itself in the moment that we find ourselves able to integrate and live our truth. The dream of psychotherapy is born in the hope that this integration is possible, and realized in the evidence that this integration is already occurring. We could not be content to embrace a lesser hope for our own profession.

References

Freud, Sigmund (1923), *Das Ich und das Es,* Leipzig, Vienna, and Zurich: Internationaler Psycho-analytischer Verlag, English translation (1927), *The Ego and the Id,* Joan Riviere (trans.), London: Hogarth Press and Institute of Psycho-analysis.

Book Review

John O'Connor

Culbertson, Philip, Nelson Agee, Margaret, & Makasiale, Cabrini 'Ofa (Eds.). (2007). *Penina Uliuli: Contemporary challenges in mental health for Pacific peoples.* Honolulu: University of Hawai'i Press.

Uliuli is a book that powerfully invites us to engage with the Pasifika nature of Aotearoa New Zealand's cultural landscape, and the implications of this for mental health work. It asks students and mental health practitioners of all persuasions to engage with the many voices of Pasifika practitioners. The contributors to this book identify primarily as Samoan, Tongan, Niuean and Hawaiian (and have identifications with a range of additional backgrounds). Their voices and the variety of perspectives they offer provide a rich opportunity for Palagi mental health professionals to enter the many worlds of the Pacific, to hear these voices and the potent lessons they offer. For Pasifika practitioners the book brings together voices that have struggled in the past to be heard, much less read, particularly in the tertiary training centres where many psychotherapists and mental health practitioners initially learn their craft.

The title of this book refers to the Pacific black pearl or penina uliuli. The opening page explains how over the course of years, layer by layer the pearl is formed within the protective barrier of the oyster. Similarly each chapter in this book builds on the one before. Multiple authors contribute to its many textures and contributions complement those that precede them. The result is a multi-layered work which leaves the reader informed, moved and assisted to engage across the many cultural divides which often inhibit cross cultural work with Pasifika communities.

As a Palagi therapist I approached this work with some apprehension, as I anticipated encountering my own ignorance. This was to prove the case, but my apprehension soon became appreciation. In the first section various authors explore their relationship to conceptualisations of Pasifika identities. Siautu Alefaio writes movingly of the challenges for contemporary Pasifika youth in New Zealand, whilst Emeline Afeaki-Mafile'o presents an overview of a mentoring model from a collective perspective for Pasifika youth. Subsequent authors deconstruct notions of the Samoan and Tongan male body, and explore the multiple challenges of "Being 'Afakasi". In each chapter, the reader is invited into the world of Pasifika from a particular standpoint. A theme throughout is the way in which the Pasifika sense of

self is embedded in the collective, an understanding very different from the individualised emphasis of the dominant western perspective.

In the second section, issues of spirituality are considered. David Lui emphasises the importance of spirituality to Samoan views of health and wellbeing and To'oa Jemaima Tiatia writes of the importance of considering spirituality when engaging in suicide prevention. One of the book's strengths is the opportunity it provides to represent both conventional and less conventional perspectives. Cabrini Makasiale critiques the tendency to deify culture, powerfully challenging from within the tendency to make culture "God" and the risks for Pasifika people of doing so. She comments, "Because we believe that God is an absolute, we have deified culture as an absolute. Rot! Culture is organic: it constantly grows and changes, responsive to the environment around it" (p. 83). In the next chapter a survivor of trauma writes of the pain experienced as a result of abuse which occurred within a church context. The moving power of these contributions is in allowing me as a Palagi reader and therapist a glimpse into worlds alongside which I have lived for many years. The authors evocatively describe the comfort and pain, joy and distress of their experience.

The section on the Pacific unconscious explores the ways in which the unconscious provides a resource for Pasifika people. Makasiale writes informatively of her use of metaphor and story telling to invite her clients' exploration of their unconscious. Other authors write of the indigenous Pasifika wisdom that underpins their work with the unconscious. They present many relevant challenges to those of us engaged in the training of mental health professionals if we are to assist our Pasifika students to embrace this wisdom rather than to leave it at the door when they enter our classrooms. Peta Pila Palalagi's poetry beautifully underlines earlier contributions.

The final section explores trauma and healing within Pasifika communities. Joseph Keawe'aimoku Kaholokula's contribution is particularly relevant. He outlines the process and impact colonisation has had on the indigenous people of Hawai'i, the Kanaka Maoli. The unspoken parallels to the experience of Māori are striking and undeniable. The book ends with a comprehensive bibliography of Pasifika mental health, a resource which provides a wealth of material for readers to continue their exploration.

This multi-layered publication is indeed a "pearl of a book" (p. xiv) gifted to our therapeutic community from Pasifika peoples. Philip Culbertson, Margaret Nelson Agee and Cabrini 'Ofa Makasiale have done a skilful and meticulous job of bringing together a wide range of Pasifika authors to contribute diverse, richly informative and extremely moving contributions

from the multiple perspectives of Pasifika peoples, about themselves and the world around them, and the implications this has for mental health work. I highly recommend this book for those of us who wish to embrace the opportunities of therapeutic work within Pasifika communities.

Contributors

Paul Bailey is a psychotherapist and has been so for 29 years and lives in Napier.

Sandra Buchanan trained as a psychodynamic psychotherapist through the three year, full time intensive internship offered at The Ashburn Clinic. Previous to this she lived and worked in London for many years where her work was varied but her life focus was in socialist activism. She is a member of NZAP and works both at the University of Otago's Student Health Service as a counsellor and in private practice. She is in a relationship with Bill, a specialist in the history of Kai Tahu in Otago, and benefits from immersion in his bicultural world.

Grant Dillon is a psychotherapist and supervisor in private practice in Auckland.

Jonathan Fay is a psychotherapist in private practice with many years experience teaching, training and supervising psychotherapists in the USA and Aotearoa New Zealand.

Josie Goulding is a psychotherapist and a nurse. She is Head of Department Psychotherapy at AUT University in Auckland and has a small private psychotherapy practice. Her special areas of interest are gender and sexuality, relational psychotherapy, and MindBody matters as they present for the client and therapist.

John O'Connor works as a lecturer with AUT University Psychotherapy Department and as a psychotherapist in private practice and with Segar House – Rauaroha, a specialist psychotherapy unit within Auckland District Health Board Mental Health Services, where he works primarily with clients with personality disorder diagnoses. John has particular interests in psychodynamic approaches to working with trauma, in exploring how cultural considerations impact on the practice of psychotherapy within the Aotearoa New Zealand context, and in the practice of group psychotherapy.

Margot Solomon is a psychoanalytic psychotherapist, a member of NZAP, NZIPP, PPAA, IARPP and a group member of GAS. She is a senior lecturer in psychotherapy at AUT University. Her teaching areas are psychoanalytic psychotherapy, group psychotherapy and clinical supervision. She has a small private practice that includes group analytic psychotherapy. Margot's email address is margotps@mac.com.

Paul Solomon trained in psychiatric social work and group-work in London in the 1970s. He also trained with David Boadella in bio-energetic therapy. After arriving in New Zealand in 1984 Paul worked in the psychosomatic pain programme at Auckland hospital, and later in the adolescent psychiatric department. In the 1990's he trained in Psychoanalytic psychotherapy with AFCP modules and IPP. Since 1999 he has taught on the AUT psychotherapy programme, and sees patients in private practice and in a weekly group. He practices psychoanalytic psychotherapy, taiji, and vipassana meditation. Paul will be the editor of the journal from 2009. His email address is paulsolomon@xtra.co.nz.

Ann Speirs completed a degree in Russian Studies at the University of Sussex, England, followed by graduate study at the University of Leningrad. She emigrated to New Zealand in 1969. After graduation from the Otago Training in Child Psychotherapy in 1985 she worked for the Department of Social Welfare and then in private practice seeing children, adolescents, families and individual adults. Since 1999 she has worked at The Ashburn Clinic.

Mark Thorpe is a registered psychotherapist and clinical psychologist. He obtained his PhD at Rhodes University in South Africa and worked as a psychologist in the hospital system and in private practice. He immigrated to New Zealand in 1994 where he worked for BOPDHB and in private practice. Presently he is head of psychology at AUT University and is involved in facilitating the first master's level counselling psychology programme at a New Zealand university. His interests include supervision and training of psychotherapists and psychologists, personality disorders, organization group consultancy, dialectics and the effects of immigration.

Miranda Thorpe is a registered psychotherapist and counsellor. She co-founded "Psychotherapy at Apollo" in Albany three years ago. She trained at AUT and has worked in private practice for ten years and at Auckland Family Counselling and Psychotherapy Centre for eight years. Miranda was born in the UK, raised in the Gambia, Uganda, UK, Portugal and subsequently lived in South Africa for 15 years before immigrating to New Zealand 14 years ago. She speaks several languages. Her interests include individual and couple psychotherapy, supervision, integrating health and psychological programmes at Apollo Health and Wellness Centre and the interface of attachment styles and immigration. She is presently undertaking an advanced training through the Institute of Psychoanalytic Psychotherapy.

Keith Tudor is a qualified social worker, a psychotherapist registered with the United Kingdom Council for Psychotherapy (UKCP), a Teaching and Supervising Transactional Analyst, and an Honorary Fellow in the School of Health, Liverpool John Moores University. At present he has an independent/ private practice in Sheffield, England, where he is also a co-director of Temenos, an independent training organising (and member organisation of the UKCP) which runs courses in person-centred psychotherapy & counselling, and supervision, including the UK's first person-centred psychotherapy programme to be validated (by Middlesex University) as a Masters in Science. He is an internationally recognised trainer and has run several training workshops in New Zealand and Australia. He is a widely published author in the field of social policy, mental health and psychotherapy including ten books and over a 100 professional papers. He is the series editor of 'Advancing Theory in Therapy' (published by Routledge), and is on the editorial advisory board of three international journals. He has recently been appointed as a Senior Lecturer at Auckland University of Technology, a post he takes up in July 2009.

Guidelines For Contributors

The notes that follow are intended to guide contributors in preparing manuscripts for submission to *Forum: The New Zealand Association of Psychotherapists*.

Submission of paper for publication

The editors welcome the submission of papers, commentaries, research notes, letters and book reviews from the Association's members and applicants, and from others outside the association with an interest in the field of psychotherapy. Along with their submission, contributors are asked to include an **abstract** and an **autobiographical** note, each no longer than 120 words.

The closing date for the submission of papers for 2009 is **30th June**. Changes in response to the editing process must be completed by **15th August**.

The length of the paper is to be no more than 5000 words. Please send the paper as a document to the editor (paulsolomon@xtra.co.nz) in word format

Required format of paper

Layout: Papers should be **single spaced** throughout on A4, with margins of at least 20mm all round. The font used should be **Times New Roman**, and the font size should be **12 point**. Use headings to structure the paper. Please do not add additional formatting styles.

Endnotes: These should be at the end of the document, and numbered consecutively throughout the text, with numbers positioned as superscripts.

Tables, drawings and photos should be attached as a separate jpeg file with a clear indication of where the table/photo/drawing is to be placed in the script. If a caption is part of this, make sure it is included.

Copyright: Authors alone are responsible for securing, when necessary, permission to use quotations or other illustrations from copyrighted materials. Any charges connected to permissions will be paid by the essay's author/s.

Quotations: These must always be acknowledged, and full references provided to identify their source. For quotations of 20 words or less, the quoted passage is enclosed in double quotation marks without a change in line spacing, e.g.,

This client's state of mind might be summed up in Phillips' conclusion that

'adulthood...is when it begins to occur to you that you may not be leading a charmed life' (1993, p. 82).

Longer quotations should be set out, without quotation marks, as a separate paragraph, with single spacing and indented 7 spaces from the left margin (not from the right), without the usual opening-paragraph indent.

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

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

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

References

These must include a full list of texts referred to, arranged with authors' names (and initials) in alphabetical order. A bibliography listing texts read but not cited in the essay is not required. The format for references is as follows. Please note that the author is responsible for providing all bibliographical material in its complete form. The place of publication for a book is always a **city** (not a state, province, or country).

A chapter in a book

Flanner, R.B., (1987). From victim to survivor: A stress management approach to the treatment of learned helplessness. In B. van der Kolk (Ed.), *Psychological trauma* (pp. 13-42). Washington, DC.: American Psychiatric Press.

A journal article

Hoffer, M.A., (1975). Studies on how maternal deprivation produces behavioural changes in young rats. *Psychosomatic Medicine, 37*(3), 43-56.

Books

Culbertson, P., & Shippee, A., (Eds.). (1990). *The pastor: Readings from the Patristic period.* Minneapolis: Fortress Press.

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

Web sites

American Association of Pastoral Counselors. (1994). *Code of ethics*. Fairfax, VA: Author. Retrieved 7/05/06 from http://www.aapc.org/ethics.htm.

For further guidelines, authors should consult the *Publication manual of the American Psychological Association* (5th edition, 2001).

Peer review process

Manuscripts will be reviewed by three people. The first peer reviewer is a member of the editorial group and is the one who works with the writer to prepare the paper for publication. The second peer reviewer is anonymous to the writer and vice versa and has expertise in the relevant subject area. The coordinating editor prepares the finished manuscripts for publication.

Māori orthographic conventions

The Journal follows the convention as written by the Māori Language Commission. Briefly this means macrons are used consistently to mark long vowels. A copy of the document on Māori orthographic conventions can be obtained from the editor or from the source at: http://www.tetaurawhiri.govt.nz/english/pub_e/conventions.shtml

> Orthographic conventions are a set of writing conventions that the Māori Language Commission recommends be observed by writers and editors of Māori language texts. The Commission believes it is essential for the survival of the language that a standardised written form be adopted by all those involved in the production of material in Māori, in order that a high quality literary base may be built up as a resource for the Māori language learners of today and of the future.

Instructions for setting up your computer to use Māori fonts can be found on the Internet. It helps to set up your keyboard.
http://orakei.co.nz/tereo/Macron is a useful site.
For a mac try http://www.stat.auckland.ac.nz/~kimihia/maori-keyboard#tiger
For a PC try http://www.tetaurawhiri.govt.nz/english/resources_e/download/keyboard.shtml

Notes: