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Te Rōpū Whakaora Hinengaro

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Editorial

Paul Solomon

I am very happy to introduce the 2010 issue of 'Forum: The Journal of the New Zealand Association of Psychotherapists'. We open with Paraire Huata's keynote address from the 2009 conference, which was hosted in partnership between NZAP and Te Puna Wānaka, Christchurch. Paraire invited us to enter Te Ao Māori; and that was the conference that saw us vote members of Waka Oranga onto Council. I hope that Māori psychotherapists will feel encouraged to contribute to future issues of the Forum.

Paraire spoke of the challenge of encountering borders, places where we experience different customs, language, smells and tastes that are strange to us, where we touch beyond the physical realm. In editing the articles for this issue of the journal, I was struck by similarities between the challenges of crossing borders that separate Pakeha and Māori cultures, and the challenge, when reading each article, of entering the worldview, way of thinking and feeling, and ways of working, of each contributor. They are diverse in their theoretical affinities, yet all share a passionate commitment to the possibility of healing through dialogue, through kōrero. All the writers, in one way or another, address what it is to cross the borders that divide each therapist from his or her clients; and Keith Tudor's article "Bridges across troubled water" discusses the wisdom of humanistic and psychodynamic psychotherapies seeking common ground.

Some of Keith's recommendations about conditions needed to build a solid bridge between psychotherapy modalities are, it seems to me, applicable to how Pakeha might approach learning about Māori: for example, acceptance, curiosity, empathy, and lack of defensiveness. But, as Vamik Volkan (2002) observes, dialogues between 'opposing' groups (Serbs and Croats, Arabs and Israelis, Germans and Jews, etcetera) are initially limited by the defensive relegation to unconsciousness of all awareness of a need for dialogue, and any sense that issues remain unresolved for present generations. In the New Zealand context, some Pakeha dismiss or do not feel any need to think about Te Tiriti ō Waitangi or Māori grievances and experiences: no bridge, then.

Ashleigh Phoenix's paper, which she presented at our conference in Nelson in 2010, is entitled "The hijacked mind: An examination of the trauma of sexual abuse, using the events of September 11, 2001 as a metaphor". Ashleigh, too, refers to gulfs and attempts to bridge them: as she so poignantly observes, there is a gulf between the state of mind of the person who has experienced catastrophic trauma, and the listener; and she links this to one of the consequences of 9/11, that we in the West have lost our previous sense of safety, of going-on-being, and are left confused.

Other contributors have also written accounts of clinical work with their patients: Itay Lahav has contributed a paper, "The adolescent", in which he outlines ideas about assessment of adolescents for suitability for therapy; and shares a case history from his practice. Papers on child and adolescent therapy have appeared all too rarely in the Journal, and this one is very welcome (as is Sandra Winton's paper, mentioned later). Carol Worthington's paper, "Fragment of a therapy: Experiences with psychosis", describes in some detail ten sessions of psychoanalytic psychotherapy with a patient who struggled with psychotic processes, and I feel privileged to have read this intimate account. It is perhaps redundant to say so, but again, the metaphors of 'gulf' and 'bridge' seem relevant: Carol describes how in their work together this patient was able, to some extent, to melt the harsh grip of her paranoid-schizoid defences, and eventually find a bridge to a more functional 'reality'. Margaret Bowater's paper, "Dreams at the edge of death", is based on her conference presentation and workshop in Nelson (2010). Margaret offers a distillation of many years experiences of hearing workshop participants and psychotherapy clients' accounts of dreams and near-death experiences; and she contextualises these by quoting dream accounts from antiquity, and from other cultures.

We are fortunate to have Nancy McWilliams' commentary, "Individuality: A threatened concern in the era of evidence-based practice?" Many of us know Professor McWilliams as the author of books on which we found our practice of psychoanalytic psychotherapy, and as an editor of the Psychodynamic Diagnostic Manual; we know her work so well that when she came to address us in Auckland last year it was hard not to think of her as 'Nancy'. Professor McWilliams addresses the gulf between current conceptualisations of psychotherapy as a collection of techniques, targeting discrete disorders; and the ways in which many practitioners attend to individual differences in their patients, and indeed in their own personalities. Sean Manning's contribution "Is psychotherapy any good?" addresses similar themes. It is what Sean calls a "summary of summaries", reviewing some of the research around evidence-based practice, and inviting readers to take up the conversation regarding the validity and effectiveness of psychodynamic therapy.

Chris Milton offers an invitation into the territory of a Jungian analyst with his paper, "Towards individuation: A Jungian view of being a body and being together." He begins with a discussion, which he calls a 'thumbnail sketch', of the theory of analytical psychology; and he offers his reflections on how Jung's thinking anticipated that of later psychoanalytic theoreticians. Chris includes a case vignette from his own practice, followed by a "constructed, fictionalised case" that embodies elements of his clinical experiences with several patients. He invites us to enter a world that may be unfamiliar to the majority of NZAP members, and he uses some of the language of phenomenology, that has not (as far as I recall)

hitherto found a place in the Forum. Sandra Winton's article, "Paul Russell and repetition" introduces Russell's reworking of Freud's thought about the repetition compulsion, and Russell's very vivid 'theory of the crunch'; and Sandra uses these ideas to elucidate her work with two patients, an adult and a child.

Finally, Victoria Grace's review of Ian Parker's book "Lacanian psychoanalysis: Revolutions in subjectivity", introduces yet another territory: one that is unfamiliar to me and, I imagine, some other readers of the Journal. Parker, in her view, delineates the socio-political and historical dimensions that are implicit in Lacan's thought. I identified with Victoria's suggestion that the book would be interesting to those psychotherapists who have Lacanian psychoanalysis 'in the periphery of their vision, and would like to learn more'.

I hope you enjoy this issue of the Journal, and will be inspired to contribute to a future issue. I acknowledge all the contributors to this issue, and thank them for their generosity and hard work in sharing their experiences in written form.

Reference

Volkan, V., Ast, G., Greer, W.F. (2002). The Third Reich in the unconscious: Transgenerational transmission and its consequences. New York, NY: Brunner-Routledge.

Māori Psychotherapy – A cultural oxymoron

Paraire Huata

More than 18 months ago I was asked to write something for the NZAP journal. I remember saying yes, and then forgetting all about it. Over that time, the requests have continued. Only today in May 2010, have I actually done something about it. I'm not sure what I said back then, so this is what I wrote to present at the Christchurch gathering.

I begin, however, with a story, a remembering now coloured by time and recited with a different awareness.

It's about two Susans at a time when they were beginning their careers as psychotherapists. I had the good fortune to spend a little time with both of them. Susan one shared her fears and wondering about working with a group of Maori men all incarcerated in 'A' Block at Paremoremo Prison. Here's this white chick dressed in vibrant colours enquiring about those unspoken things with hardcore criminals. "What can I do better, she asks me?"

I only know she finally got them to take their shades off and one memorable night they played a kids' game. She dared to be different and embraced their difference. Susan two shared her new world with some of my Counselling students. She gave them licence to ask all sorts of questions. When she shared that she was in a loving relationship a student dared to ask her did that include having sex. Susan smiled from her wheelchair and noted that although she had broken her back and had lost all physical sensation from the neck down, she was doing very nicely thanks and they were both very happy. She dared to be different and embraced her normality
Every country in the world has what is called border control or "Customs".
The word for "Customs" in Māori is Tikanga.

When we encounter these borders, we are questioned, challenged.
"Have you anything to declare?" is the most common.

So, have you anything meaningful to offer, to declare in wanting to step into my world, my land, my being?

Before you cross my border, let me give you some glimpses of what you will encounter.

You will hear a different language. You will see a group, a community. You will smell a different aroma, you will taste food for the mind and spirit. You will touch beyond the constraints of the physical realm. In fact you will be bombarded with a

cacophony of sounds and images that may tell you that you are in a foreign land. Perhaps you are.
Thank you for the opportunity to present. As you know it's termed a 'keynote address'. In the way I think, that means that I've been given the freedom to enter your citadel of knowledge and parade through it with all the pomp and glory I can muster.

So I've brought an army with me, a barbaric horde, a collection of togetherness. I've also brought a healthy curiosity.

In terms of the charter that this wānaka sits with, those I bring are students and role models of that Charter. The term we use is tauira - He tauira, hei tauira. It's kind of like a live powerpoint.

So that's the geographical area of this place and Te Puna Wānaka sits at the centre of it.
This is a house of learning and remembering. It's our gallery, come visit it with us.
Whakaahua, poupou (pictures and carvings of those departed).
We are the recipients of their knowledge their dreams, their wisdom.
The words we utter are music to them. They need be rich in imagery, allegory and beauty.

The term Māori psychotherapy is an oxymoron. As we know an oxymoron is a figure of speech that combines two normally contradictory terms. It's often used for rhetorical effect. Its first cousin is paradox.

To continue the grammar lesson, an oxymoron is normally an adjective/noun combination. Thank goodness for English Grammar, that in our language the word Māori can be either an adjective or a noun. Only one problem: none of us in this group identifies as Māori. We give voice to our mountain, our river, our lands, our tribes.

Psychotherapy in many ways represents the clinical expressions of a Eurocentric modality best understood as being of the predominant culture. Is psychotherapy a noun or an adjective, I'm unsure.

Under the notion of biculturalism then we are often forced into an oxymoron. To allow us to be bicultural, one of the contradictions must be weakened.
To paraphrase a Zen saying: "Now that we've burnt your house down, at least you get a better view of the sunset." Those who are hosting this gathering are doing this "in partnership." They are doing this within the tenets of judicial law "In good faith and with due diligence." I commend the Association and those they partner with, for their commitment and courage. Whatever will develop also with Te Roopu Oranga, will keep on testing that resolve.

In traditional lore, the saying goes … "I whanau mai he whetu, a te matenga he whetu, maha ana a Purapura whetu." - "Born a star, transformed by death, countless are the seeds of light."
'In partnership' then has many configurations and may often extend beyond our lifetime.

We are a poetic nation and have a love of a good turn of phrase. Oratory is truly an art form. "ko te kai a te rangatira he kōrero." The food for chiefs is oratory. In accessing the minds and dilemmas of others we use kōrero as the chief healing tool. We want to demonstrate how use of waiata, moteatea and pū rākau can be used to surmount the barriers to wellness.

In this the 150th year of the Kingitanga we will take a waiata belonging to those people, to unpack some of the practices and philosophies of Te Ao Māori. We start by quoting Te Arikinui Te Atairangikaahu:

> For each is a lifestyle to a person of another creed and race, an ordinary person who, while engaged in the everyday problems of living and life, finds among his or her own, a community of close interest. Each race is as a tribe. Each has its own ways. Each has an "in-ness" that binds the tribe together and an "other-ness" that slows the footsteps of a stranger who would enter and yet be accommodated.

On the common ground of eating together, sleeping together, talking together we may eventually contribute to a togetherness. That increases the potency of all in this community of interest.

Here's the waiata: I offer the words here, and if you should have the good fortune to sit beside an elder of Tainui, of the Kingitanga then I'm sure the time would be well spent listening to the song and perhaps all of its hidden meanings. I trust then that the journey you have as an association embracing all of your differences and struggling to not talk past each other will bear fruit that your grandchildren will gladly consume together.

Timatangia Te Puea

Te kupu tuatahi e, me wehi ki a Ihowa

Koia nei hoki te timatanga me te whakamutunga e!

Timatangia Te Puea e, i te pou o Mangatāwhiri

Ki te waha nga iwi, ki te waha te tikanga me te rangimarie e

Na Turongo i hanga e, te whare Pare Waikato

E tomo atu ai ki te Tairāwhiti ko Mahinarangi e

Mahi ake nei aue, i tōku nei whare e

Ngā pou o roto he māhoe he patatē, he hīnau noa e
Wai hopuapua e, e mimiti ai koa e
Ko te wai a Rona he manawa a whenua e kore e mimiti e

E huri to kanohi e, ki te hau tūārangi e
Te Tiriti o Waitangi e tū moke mai rā i waho te moana e
Nō te ariki te aroha, hurihia nuitia e
Ki runga ki nga iwi hei kākahu rā, mō te iti mō te rahi e
Kaati nei e te iwi e, tō kumekume roa e
Kei mau tātou, i te rā whakawā, i te rā whakawā a te Atua
Kō Paneiraira e, kō Paneiraira hoki
Ko Paneiraira he tangata rawerawe, nō roto Waikato e.

Building Bridges over Troubled Waters: Regarding Humanistic and Psychodynamic Psychotherapies

Keith Tudor

Abstract

This paper considers the relationship between humanistic and psychodynamic psychotherapies. It argues that these two "forces" or traditions are closer than they sometimes appear, and demonstrates this with regard to ideas about wellbeing and social instincts. Drawing on the metaphor of a bridge, the paper explores a number of options with regard to the relationship between these traditions.

Introduction

For 21 years (1987 to 2009) I described myself as a humanistic psychotherapist (and still can outside Aotearoa New Zealand) as I have trained in gestalt therapy and transactional analysis, and I have undertaken further study of and professional development in the person-centred approach, its psychology and applications. As a client both before and during training and, at times, since qualification, I have had experience of different humanistic therapies, in different forms including group therapy and couples therapy, as well as of Jungian analysis and, most recently, psychoanalytic psychotherapy. As someone who is interested in ideas and in the history and context of those ideas, I have read not only within humanistic, "third force" psychology and therapy, but also within psychoanalytic and psychodynamic literature. Most if not all humanistic psychotherapies have their origins and roots in psychoanalysis and/or psychodynamic thinking, and, as we cannot understand the present without knowing the past (history), it is worth knowing our intellectual genealogy or whakapapa, what Traue (1990/2001) has referred to as "ancestors of the mind". For example, one of the founders of humanistic therapy, Carl Rogers, having studied with and been influenced by Otto Rank, is only two degrees of separation or handshakes away from Sigmund Freud; and, whilst Rogers' (1942) "newer psychotherapy" is a long way from Freud's psychoanalysis, there are elements of psychodynamic thinking in Rogers' theory, especially his concepts of defences i.e. denial and distortion. Lest there be any doubt about the relationship between these forces or traditions, it is worth noting that Maslow (1962) who coined the phrase "third force" psychology, described humanistic psychology as "epi-behavioural" and "epi-Freudian" (epi meaning building upon).

A study of the history of psychotherapy, however, reveals more breaks, splits and divisions than building within as well as between these "forces" and "schools". This history is compounded by the fact that, in terms of professional associations and accrediting bodies, psychotherapists have organised themselves predominantly according to theoretical orientation. Whilst this has had some benefit, it has created further separation and distance between different approaches, which, when fuelled

by misunderstandings, misrepresentation, ignorance, and prejudice, often results in a kind of psychological sectarianism.

This paper considers the relationship between the second and third of these forces: the psychodynamic and the humanistic and, in doing so, challenges the common polarisation of the two. I have, elsewhere, considered the relationship between two therapies representing the first and third forces i.e. cognitive behavioural therapy and person-centred therapy (Tudor, 2008a). The invitation to give a talk on the subject of this paper to The Hallam Institute in Sheffield, UK, an organisation which accredits psychodynamic psychotherapists, perhaps represented a certain rapprochement between the psychodynamic and the humanistic worlds, a rapprochement reflected in the title of my talk there and at AUT University (AUT) in Auckland. It also symbolised a personal and particular journey for me as I delivered the talk in Sheffield, where I lived and worked for some seventeen years, on the eve of emigrating to Aotearoa New Zealand.

In addition to my work as a psychotherapist and a supervisor in Sheffield, I co-founded and established a training institute, Temenos, which promoted – and still promotes – person-centred education (see www.temenos.ac.uk). Here in Aotearoa New Zealand, in addition to being an Associate Professor in the Department of Psychotherapy at AUT, I am the Programme Leader for courses and a professional training which is predominantly, although not exclusively, psychodynamic in its influence and its thinking about psychotherapy. In many ways, delivering a second version of the original talk to The Psychotherapy Forum at AUT represented walking a bridge between – or, perhaps, myself bridging – two theoretical traditions, two countries, and two cultures.

This article (a further revised, third version of the first two talks and papers) begins with some reflections on certain terms and images: field, territory, water, and bridge. This is followed by some thoughts about humanism and humanistic psychology and psychotherapy. The third part comprises two discussions – on wellbeing and social instincts – which identifies some common ground between humanism and the psychodynamic tradition. The fourth part comments on the possibilities of four different bridges between these traditions, and the paper concludes with some thoughts about bridge-building as well as some referernce to other "rivers" which the profession needs to cross.

Terms and Images: Field, Territory, Water, and Bridge – and a Caution

The image of a bridge over troubled waters identifies two elements – the bridge and the waters – but also implies two other elements, that is, the land on either side of the bridge, separated but also linked by water.

By "field" or fields I refer to the respective areas of humanistic and psychodynamic psychotherapies. My use of the term derives from field theory (Lewin, 1952) in

which "field" refers to the totality of existing facts, which are mutually interdependent. For Lewin, the "field" represents the complete environment of the individual or, in this case, the individual or particular theory – and hence the importance and significance of context, history, environment, and culture.

The term "territory" acknowledges that the definition and ownership of fields, whether geographical or intellectual, is often disputed. One example of this is cognitive behavioural therapy which, in its name at least, implies that it – and only it – is concerned with cognition and behaviour (for a critique of which see Tudor, 2008a); and, indeed, one of the themes of this paper is a questioning of the territorialism and polarisation of the "humanistic" and the "psychodynamic".

In every culture water is suffused with social/political, environmental, cultural, spiritual, and psychological meaning, and it influences, if not determines, social, spatial, and environmental relations (see, for example, Strang, 2004); and there is an argument that water holds memory (see Chaplin, 2007). In this paper I use the image of water to refer to a "troubled" relationship between two fields, although it is perhaps significant that the water, which separates different land masses and territories, also connects them.
As far as the image and symbolism of the bridge is concerned, I consider and develop this in the fourth part of this paper.

My caution is to do with knowledge and comparison, in other words: epistemology and methodology. I am very aware of the dangers of misunderstanding between – and even within – theoretical orientations to therapy, based often on ignorance of the richness, diversity, and developments within and currency of a particular approach. It is all too easy to characterise and caricature another approach in terms which simply would not be recognised by its proponents or, to put it another way, to project onto the other/Other attributes or qualities which, for the most part, do not belong to the subject. A classic example of this in my own field is the ubiquitous reference to Rogers' "core conditions" (of congruence, unconditional positive regard, and empathic understanding), a phrase Rogers never used and a framework which omits three other therapeutic conditions (Rogers, 1957, 1959), for further discussion of which see Tudor (2000, in press – a).

A little knowledge – or assumed knowledge – is, indeed, a dangerous thing. This situation is exacerbated by the fact that most psychotherapy training is based on a – and usually one – core theoretical model. Indeed, in the UK, it is a requirement of accredited courses that they have a "core theoretical model". Whilst this has certain advantages in terms of familiarity with, and rigour and consistency in a particular theoretical orientation, this approach to and requirement of training creates a separation and, at times, separatism between different schools and forces. So, in this paper, I write more from a humanistic perspective and leave the reader to draw their own comparisons and connections, which, hopefully, will inform present and future dialogue. When we compare two or more things, with each other we do so

from a particular perspective. If we compare "a" with "b", we are, in effect, prioritising "a", as we are placing it before "b", and suggesting that "b" is considered in the light of "a". In this scheme there is an implicit directionality to the comparison: a → b. In order to avoid the bias of such unidirectional comparison, with the inherent danger of assessing deficiencies in "b" in the light of "a", we also need to compare "a" with "b", that is "a" in the context of "b" or b → a. We only have to substitute western world-view or psychology for a, and māori world-view or psychology for b to appreciate the significance of this point for how we compare and understand different world-views, psychologies, and approaches.

Humanism and Humanistic Psychology and Psychotherapy

In her anthology of humanist writings, Knight (1961, p. xiii) suggested that the term humanist implies a view: "that man must face his problems with his own intellectual and moral resources, without invoking supernatural aid; and that authority, supernatural or otherwise, should not be allowed to obstruct inquiry in any field of thought." This echoes similar sentiments in a speech made in 1878 by Sir Robert Stout, then Attorney General (and later a Prime Minister) of New Zealand:

> A freethinker is one who sought to learn what man is and what is his relation to the universe – who claimed the right to consider these questions unfettered by any State, any Church, any Society or any individual and who must be guided in his inquiry by those canons of evidence which will enable him to follow his analysis to the bottom.

There are, of course, many forms of humanism which include: literary and, more broadly, cultural humanism; religious and, specifically, Christian humanism; secular humanism, and modern humanism, for a review of which see Edwords (1989).

Knight (1961) identified two corollaries of humanism: that virtue is a matter of promoting human well-being; and that the mainsprings of moral action are what Darwin called the social instincts, that is, those altruistic, co-operative tendencies that are as much a part of our biological equipment as our tendencies towards aggression and cruelty.

My own humanism was forged in a liberal education and upbringing influenced by my father's pacifism and conscientious objection during the Second World War; by my parents' non conformist Unitarian faith; by my own education in the Litterae Humaniores (Advanced Studies or Liberal Education) and, specifically, philosophy and theology; and, later, by my political activism. Given this background, it is perhaps no accident that my first book was on the subject of positive mental health promotion (Tudor, 1996); that, for the past ten years, I have been interested in the concept of homonomy (Angyal, 1941) that is, the trend to belonging, which, as a concept, is underrated and underdeveloped in Western psychology and psychotherapy (see Tudor & Worrall, 2006; Tudor, 2008b).

As far as organised humanism in Aotearoa New Zealand is concerned, this can be traced back to 1878 when Sir Robert Stout, a leading member of the rationalist movement, laid the foundation stone of Freethought Hall in Dunedin. In 1927 the Auckland Rationalist Association was formed, and in 1967 another society, the Humanistic Society of New Zealand, (see www.humanist.org.nz/pamphlethumanism.html; Facer, 1967/2006). These organisations subsequently amalgamated into the New Zealand Association of Rationalists and Humanists (see www.nzarh.org.nz), which publishes a quarterly journal *The Open Society* (see Cooke, 1998).

In terms of humanistic psychology and psychotherapy, a number of traditions within this "third force" of psychology are represented in Aotearoa New Zealand and, currently, it is possible to train to qualification and registration in bioenergetics, gestalt therapy, psychodrama, psychosynthesis, and transactional analysis.

Here I discuss these two corollaries of humanism – well-being, and social instincts – and, in doing so, demonstrate that humanistic and psychodynamic theorists and practitioners may hold more of these fields in common, although we may cultivate them differently.

Well-being

From a review of the history of what different schools of psychotherapy have had to say about the human psyche, it is clear that, in general, we have more to say about illness, abnormality, pathogenesis, defences, and psychopathology than we do about health, "normality", salutogenesis (Antonovsky, 1979), growth, and psychosanology. As Winnicott observed: "Health is more difficult to deal with than illness."

Although Freud (1937) himself was sceptical about "normality in general", which he viewed as an "ideal fiction" (p. 235), a number of other psychoanalytic and psychodynamic thinkers have written about health: Jones (1931/1942) considered that definitions of normality are based on criteria of happiness, efficiency and adaptation to (psychological) reality.

Reich argued that, as the primary life force is genital sexuality, a force which is repressed in patriarchal-authoritarian systems – and hence his interest in the mass psychology of fascism – mental health, including sexual health, is achieved through personal and political consciousness and change.

Fromm (1956) took up Freud's basic requirements of love and work and wrote that:

> Mental health is characterised by the ability to love and to create ... by a sense of identity based on one's experience of self as the subject and agent of one's powers, by the grasp of reality inside and outside of ourselves, that is, by the development of objectivity and reason. (p. 69, original emphasis)

Klein (1960) suggested that a well-integrated personality is the foundation for mental health and that the elements of such a personality include: "emotional maturity, strength of character, capacity to deal with conflicting emotions, a balance between internal and adaptation to reality, and a successful welding into the whole of the different parts of the personality" (p. 16).

Guntrip (1964) viewed mental health as: "the capacity to live life to the full in ways that enable us to realize our own natural potentialities, and that unite us with rather than divide us from all the other human beings who make up our world" (p. 25, original emphasis).

Fairbairn talked about the fundamental dynamic wholeness of human beings, and that the preservation and growth of this wholeness constitutes mental health.

Winnicott (1988) considered that "the doctor's assumption that health is a relative absence of disease is not good enough" (p. 1) and, in what is in effect a critique of the World Health Organisation's (1946) definition of health, that "the word health has its own meaning in a positive way, so that the absence of disease is no more than a starting point for healthy life". He went on to suggest that "the health of the psyche is to be assessed in terms of emotional growth, and is a matter of maturity ... [and that] Maturity gradually involves the individual in responsibility for environment" (p. 12).

Central to humanistic thinking about health is the concept of actualisation. Maslow, one of the founders of humanistic psychology, wrote a lot about this subject, and specifically, about self-actualisation, which he defined in terms of: experiencing fully, vividly; choosing growth; letting the self emerge; being honest and courageous; using one's intelligence; being open to peak experiences; and identifying defences (Maslow, 1961/1993). He also recognised self-actualising people who he identified as having certain "being values" i.e. truth, goodness, beauty, wholeness and dichotomy-transcendence, aliveness, uniqueness, perfection and necessity, completion, justice and order, simplicity, richness, effortlessness, playfulness and self-sufficiency. From his initial research on personal adjustment in children, published in 1931, Rogers developed an interest in health, adjustment and maturity, terms with which he elaborated the concept of authenticity, which, elsewhere (Tudor, 2008b), I have argued characterises the person-centred approach to the state – or process – of health. This encompasses congruence, openness to experience, psychological adjustment, extensionality, and maturity.

From even this brief review, it is clear that both psychoanalysis and humanism have contributed to our understanding of health, and that there is considerable overlap between the contributions and understandings from these different traditions. However, both traditions stand accused of promoting a somewhat individualistic, self-centred view of individual health, as a counterpoint to which we need to consider the concept of social instincts.

Social instincts

Whilst it is clear that man(kind) is a social/political animal, it is less clear whether psychotherapists hold this in mind, let alone base their practice on it.

Of all the early leading figures in psychotherapy, Adler was the first to promote an explicitly holistic and social view of the individual and one which is specifically identified with mental health. Writing about Adlerian therapy, Clifford (1996) has commented that:

> mental health can be measured by the amount of social interest a person has. Mentally healthy people are assured of their place and contribute to the tasks of the groups to which they belong; they co-operate with their fellow human beings and are part of a community. (p. 106)

Reich argued that neurosis is rooted in physical, sexual, economic and social conditions – and hence his interest in bodywork, about which he developed character analysis and the theory of character structure (Reich, 1933a); in sexual (orgone) energy (he established and worked in the first sex education clinics); and in the analysis of the economic/social system, which he analysed in what is perhaps his most famous work, The Mass Psychology of Fascism (Reich, 1933b). For Reich a healthy person is someone who is liberated economically and socially and physically and sexually i.e. that he or she has "orgiastic potency".

Like a number of organismic psychologists who were working and writing in the early and mid 20th century, Rogers was alive to the interdependence of organism and environment, especially in his thinking about the therapeutic relationship – and, indeed, as early as 1942 had, following Taft's (1933) work, referred to his therapy as "relationship therapy", a development which predates the current interest in "the relationship", and the "relational turn" in psychotherapy by over half a century (see Tudor, 2010). Rogers, however, did not always emphasise interdependence in his work or theory. In order to reclaim this emphasis, I and a colleague (Tudor & Worrall, 2006) have gone back to the work of Angyal (1941) (whose ideas influenced Rogers, and each of whom cited the other), who viewed the organism as having two related trends: one towards increased autonomy or self-determination, and the other one towards homonomy or a sense of belonging. Angyal's contribution shifts our thinking about actualisation from a self-centred or ego-centric view to an other-centred or socio-centric one. Whilst the human organism, as all other organisms, still tends to actualise, it is this other trend which expresses our need for relationship and to relate, for kinship and to belong, for society and to congregate and organise (for further discussion of which see Tudor, 2008c).

In a separate strand of development, some psychologists and researchers have been moving forward the mental health agenda through studies of subjective well-being. Notable amongst these is Keyes (2003) who has developed a perspective on mental health which he refers to as flourishing, and on mental ill-health and illness which

he refers to as languishing. Keyes (2007) has identified thirteen dimensions of subjective well-being which he has divided between those which are hedonic (as in hedonistic) which are concerned with pleasure and positive emotions, and those which are eudaimonic, the word Aristotle used to describe a state of being happy, which are to do with self-fulfilment and positive functioning, including positive social well-being:
Social Acceptance – defined as holding positive attitudes towards, acknowledging, and being acceptant of human differences.
Social Actualisation – whereby people, groups, and society have potential and can evolve or grow positively.
Social Contribution – in which the individual sees her/his own daily activities as useful to and valued by society and others.
Social Coherence – whereby the person has an interest in society and social life, and finds them meaningful and intelligible.
Social Integration – or a sense of belonging to, and gaining comfort and support from, a community.

Again, it is clear that some practitioners, theorists, and researchers from across both psychodynamic and humanistic traditions have a clear interest in and analysis of social instincts and, more broadly, the social world. There are radical, social and even socialist thinkers and activists in both traditions – as there are conservatives. Just as research suggests that there are more "common factors" between different approaches than techniques which divide them (see, for instance, Lambert, Shapiro & Bergin, 1986), so we might consider that psychodynamic and humanistic psychotherapists have more in common than we may like to acknowledge – and that differences between psychotherapy practitioners might be more to do with "extra therapeutic factors" such as culture, personality, upbringing, values, and politics.

There are, of course, differences between the two traditions which, generally, centre on different thinking and approaches to the nature of human beings; attitudes to health, illness, growth, development, deficit, and dynamics; and the nature and use of transference and countertransference: differences which find expression in the different metaphors used to describe the client/patient, the therapist/analyst, the therapy/analysis, and the therapeutic relationship. Some practitioners and colleagues hold these differences lightly; others more tightly – a position which, historically, has at times led to what has been described as "turf wars" between competing theoretical orientations, and has had an impact on training, the organisation of psychotherapy, and access to employment.

Bridges: Differences, similarities, commonalities, and common cause

In seeking to understand the relationship between humanistic and psychodynamic psychotherapies and the sometimes troubled waters between them, and drawing on

the image and metaphor of the bridge, I consider four positions or possibilities: no bridge, one (temporary) bridge, two bridges, or a bridge with a café on it.

Interestingly, in the discussion that followed the two talks, the audience in Sheffield picked up on and discussed and developed their associations with the image of the café, whereas more of the audience in Auckland focused on the image of the bridge and the significance of territory.

No bridge

We can, of course, simply claim our different territories, refuse to build any bridges, and, if anything, shout at each other across the water. (To a certain extent and in some areas this describes the current state of relationship between psychodynamic and humanistic psychotherapies.) The content of what we might shout is all too familiar: psychodynamic psychotherapists are too analytic, cold, and rigid; humanistic therapists are too "nice", warm and friendly, and don't have or hold boundaries. Although maintaining such prejudices is an option, it is no solution. It is self-referential and self-indulgent, and serves only to maintain prejudice and sectarianism rather than openness, dialogue, learning, and research.

One bridge

The image of one bridge overarching the two territories appears attractive. Some people would see the enterprise of "integrative psychotherapy" as an attempt to build a bridge between or over two or more approaches. However, I see this as problematic for two reasons: Integration suggests an adding together or combining of parts. The problem with this is that some parts, e.g. conflicting views about the unconscious, or the directivity or interventiveness of the therapist, simply do not add up or combine. Too many training courses which advertise integration actually deliver little more than a "pick 'n' mix" of different approaches; and, as a basic and first level training, such integrative courses can offer no more than a brief and necessarily superficial overview of the whole field of psychotherapy. With rare exceptions, "integrative" is the new eclecticism, a term which Hutterer (1991) viewed as representing an identity crisis.

A second problem of integration or integrative is that of branding. It is not user-friendly as a) it begs further description i.e. what a practitioner means by integrative; and b) it does not indicate the basis of the integration i.e. whether the practitioner is psychodynamic/integrative, humanistic integrative, or "humanistic and integrative" (as is one of the Colleges of the United Kingdom Council for Psychotherapy [UKCP]).

In this sense, most forms of integrative or integration, I suggest, offer us no more than a very shaky or temporary bridge. However, if we raise the standard (and, perhaps, the bridge) and define integration as meta-theoretical then it would – or should – provide an overview of approaches. This, however, would the practitioner to have: a) comprehensive knowledge and thorough understanding of at least two

and preferably more approaches, and, arguably, approaches which themselves represent a range of psychologies; and b) a meta-theoretical framework by which s/he could analyse, synthesise and evaluate all the elements of the theories at her/his disposal. In this context, Pine's (1990) work on four psychologies: drive, ego, object and self, is a useful framework for such a meta-analysis; and, as Pine argues, for clinical synthesis (although I would add to his taxonomy the concepts and psychologies of organism and person). This option is intellectually robust, although it probably requires a lifetime of training: in effect, a minimum of two postgraduate trainings, as well as a post postgraduate genuinely integrative training.

Whilst such training, at least formally, is rare, personal integration over the course of a career is something to which many would hope to aspire. In this sense, as Olli Anttila (24th September, 2009) put it (at the talk in Auckland), perhaps the psychotherapist is the bridge. This view of the person as the or a bridge echoes Simon and Garfunkel's (1969) lyrics to "Bridge over Troubled Water" in which the singer/protagonist says: "Like a bridge over troubled water | I will lay me down" and, later, "I will ease your mind". It is perhaps not insignificant that Anttila and I both are immigrants, a status and position which necessarily embodies some bridging (see also Anttila, 1995).

Two bridges

Two separate bridges is, by and large, the situation we have at present. In many ways psychodynamic and humanistic psychotherapists occupy and are interested in the same territory that is the human psyche and human society, but all too often we appear and often are divided and divisive. In many ways the old categorisation of three "forces" of psychology – i.e. behavioural, analytic, and humanistic – sets up a kind of identity through division and opposition, especially from the standpoint of the third force, humanistic psychologies. With one bridge for psychoanalytic and psychodynamic practitioners and another for humanistic practitioners, we end up perpetuating a kind of psychological apartheid, fuelled (in my experience) by a sometimes vicious sectarianism, based on a quasi-religious fundamentalism – and I draw these analogies advisedly. I would also extend this critique of divisions to what I see as the common ground of psychotherapy, counselling, psychology, and counselling psychology. Here I give two examples.

The UK Association of Humanistic Psychology Practitioners (AHPP) has suggested that humanist practitioners share certain fundamental core beliefs about:

The theory of human nature and of self – that the individual is unique, truth-seeking, an integrated and self-regulating whole, with a right to autonomy with responsibility.

The aims of therapy and of growth – which is self-awareness and actualisation, which, in turn, includes: wholeness and completion, authenticity, emotional competence, the furtherance of creativity, respect for difference, and integrity and autonomy whilst acknowledging interdependence.

The nature of the therapeutic relationship – as the primary agent of change, and founded on the therapist's genuineness, empathy, openness, honesty, and non-judgemental acceptance of the client (see AHPP, 1998/2009).

In a more detailed contribution Cain (2001) identified a number of characteristics which define humanistic psychotherapies. He suggested that in terms of views of the person, these are:
That she or he is self-aware, free to choose, and responsible.
That she or he is holistic – "The person is viewed holistically, as an indivisible, interrelated organism who cannot be reduced to the sum of his or her parts" (ibid., p. 5) – and as embodied, and contextual beings.
That she or he needs to make sense and find meaning, and to construe her or his realities.
That she or he has a capacity for creativity.
That, as primarily social beings, we have a powerful need to belong.
Cain also discusses the importance in humanistic psychotherapies of: the actualising tendency, a relational emphasis, phenomenology, empathy, the concept of "the self" (or the "Self"), and anxiety.

Both the AHPP and Cain have, in effect, drawn up these definitions and lists in order to distinguish humanistic psychotherapies from other forms of therapy and, specifically, from psychodynamic psychotherapy. However, I think that there is much in the above in which psychodynamic colleagues are interested and with which they would agree. As Gomez (2004), in her excellent article on this theme, put it: "I don't think I would find a psychoanalytic approach that would declare that it only tries to work with only part of the person" (p. 8). She continued: "It might not define 'person' in the same terms; but then, nor do many humanistic approaches." In our postmodern and interdisciplinary world, some of the old divisions between and within disciplines, professions and territories are breaking down. In this context, it seems both irrelevant and unsustainable to maintain two bridges alongside each other.

This being the case, it seems more useful to propose a fourth option which is one, robust bridge, with a meeting-house and a café on it.

One bridge, many people

A bridge is a structure which carries a road or which affords a passage. Either way, it needs to be fit for purpose, and if our purpose is to meet, pause, talk, and engage, then we need one bridge which can accommodate many people, and, as John O'Connor pointed out (24th September, 2009, at the talk in Auckland), the bridge

needs to big enough for a wharenui – a meeting-house, in which people from the same and/or different cultures can meet and talk.

For two years in my early thirties I lived in Italy, from which time I have fond memories of drinking wine and coffee in cafés (and hence the importance of the café on my bridge). I also have memories of a small Southern Italian village where two men of diametrically opposed politics would sit in one of the cafés and, to mix my cultures, enjoy what the Irish refer to as the craic. They were old sparring partners who met and argued – but, importantly, still met. My image of this fourth bridge is one where many people of diverse theoretical orientations and cultures can walk and talk, and where there is a both a meeting-house and a café in both of which we can dispute our differences and recognise our commonalities and common cause.

I see three arguments which promoting such meeting: Humanistic psychology and psychotherapy builds on psychoanalysis and psychodynamic psychotherapy. Despite some differences with the first two forces of psychology, humanistic psychology builds upon (à la Maslow, 1962), and includes rather than excludes or necessarily opposes these other traditions. Examples include: The fact that many humanistic therapists find concepts from the first two forces useful such as the unconscious, transference, and countertransference (from psychoanalysis), and modelling and feedback (from behaviourism).
The fact that humanistic practitioners and theorists have contributed to the development of such ideas, perhaps most notably, about empathy (Rogers), for a summary of which see Tudor (in press – b), and, for instance, about co-transference (Sapriel, 1998) and co-transferential relating (Summers & Tudor, 2000).

Psychoanalysis, and psychodynamic and humanistic psychotherapies and psychotherapists have certain common ground. Examples of this include: With regard to definitions – Gomez (2004), who has described herself as a humanistic and psychoanalytic psychotherapist, has reviewed the respective flag statements of the Analytic Psychology, Psychoanalytic & Psychodynamic (APPP), and the Humanistic & Integrative (HIP) (then) Sections of the UKCP and found little to which practitioners from either Section would object: "Most humanistic psychotherapies do not rule out either transference or unconscious levels of experience ... and while they might hope for more than the resolving of old conflicts. This would certainly be one of their aims" (p. 8).

With regard to the importance of personal therapy during training – Within the UKCP, the analytic and humanistic Sections are the only two Sections which both require that trainees undertake personal therapy for the duration of the training. With regard to groups – The analytic interest in the large group experience is, in a number of ways, similar to the emphasis in the person-centred approach on the large group, community meetings, and encounter. In a fascinating article Sturdevant (1995) compared what she refers to as the three democratic contexts of

the Classical Greek koinonia, the psychoanalytic median group, and the large person-centred community group, and draws a number of conclusions including that the psychoanalytic concept of outsight was similar to that of the person-centred view of empathy. With regard to social, cultural, and political analysis or understanding – Thinkers within both psychodynamic and humanistic traditions have been at the forefront of applying our different theories to the social world (see, for example and respectively, Clarke, Hahn & Hoggett, 2008; and Rogers, 1978). Practitioners from both traditions were involved in the launch of Psychotherapists and Counsellors for Social Responsibility (see www.pcsr.org.uk), and are involved in the journals Critical Psychology, Counselling and Psychotherapy, and Psychotherapy and Politics International, and in the opposition and alternatives to the state regulation of psychotherapy and the state registration of psychotherapists (see House and Totton, 2011; Tudor, 2011). With regard to radical and critical theory and practice – There is a long history in both psychodynamic and humanistic traditions of radical thinking and practice (see, for instance, Robinson, 1969). This finds current expression in the critique of the UK government's proposals about regulation in the Alliance for Counselling and Psychotherapy Against State Regulation (see www.allianceforcandp.org/pages/) which also was founded by and encompasses practitioners from both traditions.

Humanistic therapies differ from each other.

Humanistic psychology is a "broad church" with as many divisions and splits as within the church. Humanistic therapies differ from each other more than they do from psychodynamic and behavioural therapies, for instance, with regard to non-directivity (see Levitt, 2005), levels of interventiveness (see Warner, 2000), and ideas about the power of the therapist (see Mearns & Thorne, 2000) and of the client. This suggests that the attribution of distinctions between the three – or, if we include the transpersonal, four – "forces" is inaccurate, and that this categorisation is all but useless. All this suggests the benefit and even necessity of us meeting, thinking, linking – and even drinking – on one bridge.

Conclusion: Bridge-building

Whatever form the bridge between psychotherapists takes the crucial issue is the structure and quality (or qualities) of the bridge. When a colleague and friend of mine in Sheffield heard about the timing of my talk in the UK, she observed that, in terms of an analogy with the therapeutic hour, my talk there could be viewed as representing my last few minutes, and thus something of a door handle confession. When I shared a draft of this paper with a colleague here in Aotearoa New Zealand, he commented that they could be taken as something of a manifesto. So, mixing my metaphors, and taking the door handle firmly in my grasp, whilst also nailing my manifesto to the door, I conclude with some final thoughts about what I consider to be the qualities or conditions needed to build a solid bridge across what historically have often been troubled waters:

More contact between different traditions and approaches both during and after training – which will lead to less sectarianism in psychotherapy.

Less defensiveness about our own approaches – and less hostility towards others'. More critical reflection on the limits and limitations of our own particular approach/es – which, I hope, will challenge defensiveness, fundamentalism, and closed systems, and lead to greater openness, and 'philosophical congruence' (see Tudor & Worrall, 2006), as well as genuine and informed critique about different approaches.
More acceptance of and curiosity about other approaches – which will lead to greater learning.
More knowledge and understanding of and more empathy for different theories – as well as more humility that we probably don't know so much about other theories as we may think we do.
More openness to and reception of the other and their field or territory – which, hopefully, will lead to greater co-operation and alliance. After all, in the context of our bicultural society in Aotearoa New Zealand, the differences between psychodynamic and humanistic psychotherapies may be seen as a local argument between two colonial and colonising theories. In this context, both forces or traditions need to be open to critique, deconstruction, and the "Southerning" of the western (and northern) theory on which they are both built (see Cornell, 2008).

Clearly there are other troubled waters, including those swirling around regarding the statutory regulation of the profession and the state registration of psychotherapists; the differences and similarities between psychotherapy and counselling; and the number of practitioners who identify as psychotherapists (or with psychotherapy) who are not members of NZAP – and thus, as Jimmy Cliff put it, "Many rivers to cross". In this context, and in the face of certain dogmatic, sectarian and monocultural thinking and practice, it is even more important that we build bridges to encourage autonomy and pluralism in the practice and organisation of psychotherapy.

This paper is an edited and further version of two talks on the same subject delivered at The Hallam Institute, Sheffield, UK (on 1st July 2009), and the AUT University Psychotherapy Forum (on 24th September 2009). I am grateful to both institutions for their invitations; to both audiences for discussions which have further stimulated my ideas; to Margaret Morice for her welcome; and, specifically, to Louise Embleton Tudor, John O'Connor, and Paul Solomon for their specific comments on earlier versions of the talks and this paper.

References

American Psychology Association Division 32 (Humanistic Psychology) Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services. (2005). Recommended principles and practices for the provision of humanistic psychosocial services: Alternatives to mandated practice and treatment guidelines. Document available online at: www.apa.org.divisions/div32/pdfs/taskfrev.pdf

Angyal, A. (1941). *Foundations for a science of personality.* New York, NY: Commonwealth Fund.

Anttila, O. (1995). Some thoughts on the process of immigration. *Forum: The Journal of the New Zealand Association of Psychotherapists,* 1, 77-85.

Antonovsky, A. (1979). *Health, stress and coping: New perspectives on mental and physical well-being.* San Francisco, CA: Jossey-Bass.

Association of Humanistic Psychology Practitioners. (2009). UKAHPP core beliefs statement. Document available online at: www.ahpp.org/about/core.htm. (Original work published 1998)

Cain, D. J. (2001). Defining characteristics, history, and evolution of humanistic psychotherapies. In D. J. Cain & J. Seeman (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (pp. 3-54). Washington, DC: American Psychological Association.

Chaplin, M. (Ed.), (2007). The memory of water [Special issue]. *Homeopathy*, 96(3).

Clarke, S., Hahn, H., & Hoggett, P. (2008). *Object relations and social relations: The implications of the relational turn in psychoanalysis.* London, UK: Karnac.

Clifford, J. (1996). Adlerian therapy In: W. Dryden (Ed.), *Handbook of individual therapy.* (pp. 103-120). London, UK: Sage.

Cooke, B. (1998). *Heathen in godzone: Seventy years of rationalism in New Zealand. Auckland, Aotearoa New Zealand.* New Zealand Association of Rationalists and Humanists.

Connell, R. (2008). *Southern theory: The global dynamics of knowledge in social sciences.* Crows Nest, NSW, Australia: Allen & Unwin.

Edwords, F. (1989). *What is humanism?* Paper available online at: www.jcn.com/humanism.html.

Facer, W. (2006). Humanism. In: *Honest to goodness.* Wellington, Aotearoa New Zealand: The Humanist Society of New Zealand. (Original work broadcast 1967) Article also available at: www.humanist.org.nz/literature/humanism.html.

Freud, S. (1937). *Analysis terminable and interminable.* The standard edition of the complete psychological works of Sigmund Freud. Vol. 23 (J. Strachey Ed. & Trans.) (pp. 209-253). London, UK: The Hogarth Press/Institute of Psycho-Analysis.

House, R., & Totton, N. (Eds.), (2011). *Implausible professions: Arguments for pluralism and autonomy in psychotherapy and counselling (2nd Ed.).* Ross-on-Wye, UK: PCCS Books.

Gomez, L. (2004). Humanistic or psychodynamic: What is the difference and do we have to make a choice? *Self & Society,* 31(6), 5-19.

Guntrip, H. (1964). *Healing the sick mind.* London, UK: Allen & Unwin.

Hutterer, R. (1991). *Eclecticism as identity crisis of person-centred therapists.* Paper presented at the Second International Conference on Client-Centered and Experiential Psychotherapy, Stirling, Scotland.

Jones, E. (1942). The concept of normality. *International Journal of Psychoanalysis,* 23, 1-8. (Original work published 1931)

Keyes, C. L. M. (2003). Complete mental health: An agenda for the 21st century. In C. L. M. Keyes & J. Haidt (Eds.). *Flourishing: Positive psychology and the life well-lived* (pp. 293-312). Washington, DC: American Psychological Association Press.

Keyes, C. L. M. (2007). Promoting and protecting mental health as flourishing: A complementary strategy for improving national mental health. *American Psychologist,* 62(2), 95-108.

Klein, M. (1960). On mental health. *British Journal of Medical Psychology,* 33, 237-241.

Knight, M. (1961). *Humanist anthology.* London, UK: Barrie & Rockliff.

Lambert, M. J., Shapiro, D. A., & Bergin, A. E. (1986). The effectiveness of psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.). *Handbook of psychotherapy and behaviour change.* (3rd ed., pp. 157-212). New York, NY: Wiley.

Levitt, B. (Ed.), (2005). *Embracing non-directivity: Embracing person-centered theory and practice in the 21st century.* Ross-on-Wye, UK: PCCS Books.

Lewin, K. (1952). *Field theory in social science.* (D. Cartwright, Ed.). New York, NY: Harper & Row.

Lomas, P. (2001). *The limits of interpretation.* Harmondsworth, UK: Penguin. (Original work published 1978).

Maslow, A. H. (1962). *Towards a psychology of being.* New York, NY: Van Nostrand.

Maslow, A. H. (1993). Self-actualizing and beyond. In: *The farther reaches of human nature* (pp. 40-51). Harmondsworth, UK: Penguin Arkana. (Original work published 1961)

Mearns, D., & Thorne, B. (2000). *Person-centred therapy today: New frontiers in theory and practice.* London, UK: Sage.

Pine, F. (1990). *Drive, ego, object and self: A synthesis for clinical work.* New York: Basic Books.

Reich, W. (1969). *The mass psychology of fascism.* Harmondsworth, UK: Penguin. (Original work published 1933)

Reich, W. (1972). *Character analysis.* New York, NY: Farrar, Straus & Giroux. (Original work published 1933)

Robinson, P. A. (1969). *The sexual radicals: Wilhelm Reich, Geza Roheim, Herbert Marcuse.* London, UK: Paladin.

Rogers, C. R. (1931). *Measuring personality adjustment in children nine to thirteen.* New York: Teachers College, Columbia University, Bureau of Publications.

Rogers, C. R. (1942). *Counseling and psychotherapy: Newer concepts in practice.* Boston, MA: Houghton Mifflin.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology,* 21, 95-103.

Rogers, C. R. (1959). A theory of therapy, personality and interpersonal relationships, as developed in the client-centred framework. In S. Koch (Ed.), *Psychology: A study of a science. Vol. 3: Formulation of the person and the social context,* (pp. 184-256). New York, NY: McGraw-Hill.

Rogers, C. R. (1978). *Carl Rogers on personal power*. London: Constable.

Sapriel, L. (1998). Can gestalt therapy, self-psychology and intersubjectivity theory be integrated? *The British Gestalt Journal,* 7(1), 33-44.

Simon, P., & Garfunkel, A. (1969). Bridge over troubled water. On: *Bridge over troubled water* [Album]. New York, NY: Columbia Records.

Strang, V. (2004). *The meaning of water.* Oxford, UK: Berg.

Sturdevant, K. (1995). Classical Greek "koinonia": The psychoanalytic median group, and the large person-centered community group: Dialogue in three democratic contexts. *The Person-Centered Journal,* 2(2), 64-71.

Summers, G., & Tudor, K. (2000). Cocreative transactional analysis. *Transactional Analysis Journal,* 30 (1), 23-40.

Taft, J. (1933). *The dynamics of therapy in a controlled relationship.* New York, NY: Macmillan.

Traue, J. E. (2001). Ancestors of the mind: A pakeha whakapapa. In R. Brown (Ed.), *The great New Zealand argument: Ideas about ourselves* (pp. 137-147). Auckland, Aotearoa New Zealand: Activity Press. (Original work published 1990)

Tudor, K. (1996). *Mental health promotion: Paradigms and practice*. London, UK: Routledge.

Tudor, K. (2000). The case of the lost conditions. *Counselling,* 11(1), 33-37.

Tudor, K. (2008a). Person-centred therapy, a cognitive behavioural therapy. In R. House & D. Loewenthal (Eds.). *Against and for CBT: Towards a constructive dialogue?* (pp. 118-136). Ross-on-Wye, UK: PCCS Books.

Tudor, K. (2008b). Psychological health: Autonomy and homonomy. In B. Levitt (Ed.). *Reflections on human potential: Bridging the person-centered approach and positive psychology (pp. 161-174).* Ross-on-Wye, UK: PCCS Books.

Tudor, K. (2008c). We cannot imagine without the other: Contact and difference in psychotherapeutic relating. *Forum [The Journal of the New Zealand Association of Psychotherapists],* 14, 46-61.

Tudor, K. (in press – a). *Rogers' therapeutic conditions. Person-Centered & Experiential Psychotherapies.*

Tudor, K. (in press – b). Understanding empathy. *Transactional Analysis Journal.*

Tudor, K. (2010). Commentary: Turning over "the relational". *European Journal of Psychotherapy & Counselling, 12*(3), 257-267.

Tudor, K. (Ed.), (2011). *The turning tide: Pluralism and partnership in psychotherapy in Aotearoa New Zealand.* Auckland, Aotearoa New Zealand: LC Publications.

Tudor, K., & Lewin, P. (2006). Fit for purpose: The organisation of psychotherapy training. *Self & Society*, 34(1), 33-40.

Tudor, K., & Worrall, M. (2006). *Person-centred therapy: A clinical philosophy*. London, UK: Routledge.

Warner, M. S. (2000). Person-centered psychotherapy: One nation, many tribes. *The Person-Centered Journal*, 7(1), 28-39.

Winnicott, D. W. (1988). *Human nature*. London, UK: Free Associations.

World Health Organisation. (1946). *Constitution of the World Health Organisation*. New York, NY: Author.

The hijacked mind: an examination of the trauma of sexual abuse using the events of September 11th 2001 as a metaphor.

Ashleigh Phoenix

Abstract

This paper considers the traumas suffered by those who have been habitually sexually abused by a parent living within the family home. The cumulative events of the '9/11 terrorist attacks' are used as a metaphor. This metaphor has helped the author to think and to imagine the scale of the damage to the child's internal world and to appreciate more fully the extent of the losses which are incurred by the victims of abuse. Throughout the paper the impact of annihilation anxiety on the personality development and symptomatic presentation of those who have been hurt by a parent in this way, is highlighted.

One can never fully close the gulf that exists between those who have experienced massive trauma and those who listen. Nor is it desirable, for the essence of the help is contained within the separateness, as much, if not more than, in the listener's ability to imagine and identify with the traumatized.

Laub and Auerhahn (1993) discerned that there is a paradox in understanding severe trauma. They write "while those who have not experienced catastrophic trauma ultimately cannot imagine its reality, those who have cannot imaginatively know it either". They suggest that this is because "knowing in the form of elaborative play requires a capacity for metaphor which cannot withstand atrocity" (p.289). However, I hold that metaphors can be useful for the therapist's thinking, in providing a bridge towards understanding.

A shaken world

9/11 has caught the world's involvement and imagination as we try to grapple with the fundamental confusions and reverberations of catastrophic betrayal, the fear that the West's protective shield is a mere illusion and the consequent loss of our previous 'sense' of safety, our " going-on-being" or "continuity of being" as Winnicott described (1965, p. 60-61).

Sexual abuse is a trauma that similarly involves catastrophic betrayal, the failure of the parental protective shield and the loss of ordinary "going-on-being", leaving the victim in a state of fundamental, even critical, confusion.

Winnicott's concept describes a primitive mental state of relaxed unintegration, which occurs in conditions of trust, based on the reliability of positive environmental experience. The first such experiences are internalized at the breast (Winnicott, 1949).

Then again in 1965 Winnicott wrote:

> Good-enough ego-coverage by the mother (in respect of the unthinkable anxieties) enables the new human person to build up a personality on the pattern of a continuity of going-on-being. All failures (that could produce unthinkable anxiety) bring about a reaction of the infant, and this reaction cuts across the going-on-being. If reacting...recurs persistently it sets going a pattern of fragmentation of being. (1965, p. 60)

This paper focuses upon one particular patient's experience of being abused sexually, emotionally and physically by her biological father. I shall refer to my patient as Jessie. She attended thrice weekly psychotherapy with me between 1997-2006. By comparing Jessie's experience to that of New York's inhabitants, we can attempt to imaginatively know about her trauma of having to live with a form of terrorism at home.

Primitive symbolism

Sexual abuse, when committed by a parent does not occur in a political vacuum but, rather like the 9/11 terrorist attacks, it occurs in the context of a highly charged, primitive object relationship, i.e. within a volatile and menacing political climate.

Hanna Segal (2002) wrote: "I think September 11 was highly symbolic" (p. 35). She suggested that the American message in building the Twin Towers and the Pentagon was: "We are all-powerful with our weapons, finance, high-tech; we can dominate you completely". She goes on to say, "the suicide bombers sent an equally omnipotent statement: 'I with my little knife, can puncture your high-flying balloons and annihilate you' " (p.33). One has to agree with Segal; the 9/11 terrorist attacks were littered with menacing symbolic messages, which were delivered in a concrete way. Sexual abuse is similarly highly symbolic: father delivers messages, sometimes consciously and sometimes unconsciously, via his abusive acts. The child receives these messages and is terribly afraid and damaged by them.

From Jessie's account, her father's messages seem to have been like the following:

> I will puncture your omnipotent idea that you can have the breast, which you have stolen from me. I will stop you imagining that you hold the seat of power in this family and that you can bask in the protective shield of the breast. I will destroy your infant sense of "going-on-being" just as mine was destroyed. Now that I am father and no longer the abused child, I hold the power: both mother and you are my possessions and I will repeatedly remind you of this.

I believe that both the 9/11 attacks, and familial sexual abuse, exhibit a form of primitive symbolism and I offer other striking parallels:

Firstly, before the attacks, Al Qaida began a grooming process, lulling America out of 'stranger anxiety' and into a state of relaxed inattention. To effect this grooming it seems that the hijackers spent months living peaceably amongst their victims and taking many dummy flights to acclimatize and familiarize the airline companies and the F.B.I to their presence. This build up of innocuous intimacy allowed them to slip beneath America's protective shield and in so doing to become all the more powerful and overwhelming by attacking from within it. I think this is the core of the agony of betrayal-someone attacking from within the protective shield.

The penetrative attacks, which followed this grooming process, led to the collapse of the Twin Towers and to the perverse creation of a Ground Zero situation. I will use these events as an analogy for the damage done to the abused child's internal world through familial incest. By comparing Jessie's 'internal landscape' to the New York landscape, and by comparing her experience to that of those caught up in the hijackings, I shall depict the destructive transformation of a child's developing internal world from a state of 'going-on-being' to trauma site. In addition I will show that the damage to the defence headquarters (The Pentagon or ego of the victim) led to fundamental confusion and to the scrambled marshalling of primitive defences (the beginnings of a hijacked mentality) displayed by my patient and indeed by the Americans as they oscillate between different forms of knowing and not knowing about their trauma. Throughout I hope to highlight the impact of annihilation anxiety on the symptomatic presentation of those who have been abused by a parent.

In "Beyond the Pleasure Principle," Freud (1920) described traumatic neurosis as "a consequence of an extensive breach being made in the protective shield against stimuli" (p. 31). Freud (op. cit.) attributed importance to the element of severe fright, suggesting that it is:

> [C]aused by lack of any preparedness for anxiety, including lack of hypercathexis of the systems that would be the first to receive the stimulus. Owing to their low cathexis those systems are not in a good position for binding the inflowing amounts of excitation and the consequences of the breach in the protective shield follow all the more easily" (p. 31).

Terrorists and abusers usually strike when their victims' defense systems are in "low cathexis". It seems evident that they tend to choose victims who have relaxed into a state of "going-on- being". Also most abusers and terrorists have considerable skills in activating this state of non-alertness, and build up of trust. This technique may simply be an act of seeking the safest opportunity to perpetrate their crime; however the work with Jessie has prompted me to wonder whether there is envious intent behind the shattering of their victims' inner sense of relaxation at 'the breast'. In this way of thinking, their criminal act is the sexualized expression of an envious wish to reduce their victim's inner world to the shocked, collapsed, state of their own.

The following is a quote from The Guardian newspaper's first edition of October 17 2001, the day after the Black Box recording of Flight 11 was released to the press. It contained the chilling actual words spoken by the hijackers of Flight 11. Notice that the journalist tried to convey the pre-trauma sense of "going-on-being" in the ground control room:

> It was 7.45 am at Logan airport in Boston and ground control was going through the perfunctory business of talking the pilot of American Airlines Flight 11 through the manoeuvres towards take off....Five weeks after the attacks, transcripts of what went on between the pilots of the hijacked planes and air traffic controllers trace the air paths from banality to doom... At 8.14 a.m. two controllers are recorded discussing the fact that the pilot is out of contact. There is silence for 10 minutes until a hijacker's voice is heard. "We have some planes," it says, "just stay quiet and you will be OK. We are returning to the airport. Nobody move, everything will be OK. If you try to make any moves you'll endanger yourself and the airplane. Just stay quiet".

Twenty-three minutes later, at 8.47 a.m. the same plane was steered into the North Tower of the World Trade Centre in New York. This assault was the first in a chain of air crashes that would leave approx 3,000 dead in the U.S.A. This would seismically alter American lives, for their sense of personal safety within a national protective shield was now ruptured and, I contend, due to the loss of fundamental boundaries, their development and 'personality' as a nation has now been hijacked by trauma, threat and survival anxiety.

Compare this with Jessie's account of the day of her father's first sexual assault upon her: Jessie reported that she was still 3 years old, and at that point in her life, although her father had begun to hit her when chastising her, she thought she was loved. Her father would tell her that she was "the apple of his eye". Tragically she was indeed the apple of his eye but in the same perverse way that New York was the 'big apple' of Osama bin Laden's eye. Jessie's brother had just been born and her mother seemed 'wrapped up' in the baby, causing Jessie (and perhaps her father) to feel out of contact with her. The family were at their caravan for the weekend. They all went to the park and she and her father were playing 'chase and tickle', a now familiar game, when he announced that he would take Jessie back to the caravan for tea. Jessie was taken up on his shoulders and they left, leaving her mother feeding the new baby in the park.

This is a flashback from Jessie. Notice that she moves between past and present tense. Unresolved trauma cannot fully be consigned to the past:

> I run from room to room playing chase. He lifts me onto the kitchen bench and tickles me. I still thought it was a game – until he made me do things to him, things I didn't want to do. He got angry with me. He told me to be quiet. He told me not to move and I'd be alright. *(Note the similarity to the words of the hijacker on Flight 11).* He pushed my head down. I remember seeing something close up to my face. Next I feel I am choking. I want to be

> sick and I cannot breathe. Then I am lying on the floor, crying; my ankle is bleeding.

Jessie reported that when she looked up from the floor she did not recognize her father; but despite her confusion, the incident registered in her mind as a real threat to her life.

This violent sexual assault on Jessie was the first in a chain of many such assaults which would affect her development and personality, for Jessie's life had lost its boundaries, she had been betrayed by one of her primary objects, and her sense of a personal protective shield had been ruptured.

I think that massive trauma causes structural change to the minds of its victims and witnesses (perhaps also to its perpetrators). I think this is because the previously held 'parameters of the possible' collapse, as unconscious phantasy becomes actual experience. Psychic paradigms are permanently altered. An inner atmosphere of "going-on-being" is replaced by a constant sense of foreboding: a feeling that 'anything bad could happen at any time'.

Living with the threat of annihilation is traumatic in itself. Any break in the protective shield is equated with the loss of the good object and exposure to the bad object (O'Shaunessey, 1964). Our inherited reaction to a threat of trauma is a 'startle response'. This prompts the 'fight/flight' defensive posture, designed to eliminate the bad object in one way or another. When humans are actually hurt, we sense the failure of our ability to protect ourselves and others; the inadequacy of our protective shield. At these times we don't just feel exposed to the bad object, we feel caught in its grip.

Whilst I think there is hope that the surviving New Yorkers' startle response may return to normal, as most could run, scream and behave as their minds dictated; this is not the case for the child whose father abuses her. These children are caged, emotionally trapped, and perhaps physically pinned down. This is more like the experiences of the passengers on Flight 11, who (we can only imagine) sat rigidly, obeying their captors, hoping to be returned to safe ground and the airport (mother's breast), as the hijackers promised, whilst waiting helplessly for their nightmare to end. In such circumstances, obedience seems paramount to survival, as escape from the bad object does not seem possible.

The impact of cumulative trauma

T.V. channels transmitted the terrorist attacks live and repeatedly. This diminished the 'great Atlantic divide', and pulled most viewers out of their own "going-on-being" and into identification with the panic-stricken citizens on the run from the bad object. However, I recall seeing one man, appearing out of the dust cloud, standing on the sidewalk, completely grey, covered in dust. He stood unblinking, staring into space, petrified, like a stone statue, his dust-covered briefcase in his hand; he seemed to be like a monument, unveiled in the dreadful space of Ground

Zero, depicting both what was once America and what it had now become. He appeared to me to be overwhelmed, with all instincts to flee the bad object gone.

Compare this with Jessie's state of mind, three years after the cumulative traumas of her abuse began:

> I'm told to go home for lunch, he has made me chicken soup. Afterwards I don't want to go back to school, I want my mother. He walks me back to school. I cry. I feel sore. A button had popped off my blouse and this upsets me. I sit at the back of the class and sob. A teacher questions me and all I can say is 'my button's missing'. The teacher sends me home.

When Jessie got home her father beat her for missing school. She poignantly added, "I stare out of the window. No one comes. They never do, but I stare anyway". Like the man on the New York sidewalk, Jessie too just stared like someone petrified. With all defences over-powered by their aggressors, they both displayed the nullification and stupefication effects of cumulative traumas which have overwhelmed both body and spirit.

An internal Ground Zero situation: the fate of the internal objects

Laub and Auerhahn (1993) agree that in trauma "the internal mother always watches, allowing the attack to occur, or at least failing to prevent it" (p. 287). In the situation of sexual abuse, this is particularly shaming and destabilizing because Jessie felt that her internal mother had seen the abuse. As a child, she carried a painful contradiction inside her mind: Whilst her external mother appeared to 'see nothing and know nothing' her internal mother appeared to be frighteningly 'all seeing and all knowing' - a terrifying omnipresence. This was very confusing for Jessie. Her conscious mind thought she was keeping the secret of abuse from her mother, as her fathered ordered her to, but her unconscious mind believed she was keeping the secret *for* her mother. With these realizations her internal landscape changed irrevocably. The impact of primary betrayal, and failure of her protective shield induced part of Jessie's internal world to collapse. Like the fall of the Twin Towers, it was as if both of the previously built up, inner parental objects crumbled as their structure became unraveled: they, who had been associated with life-sustaining properties, ceased to exist.

Laub and Auerhahn (1993) suggest that "the essential experience of trauma (is) an unravelling of the relationship between the self and nurturing other; the very fabric of psychic life" (p. 287). As Jessie put it: "My insides are in tatters".

Melancholia is most commonly described by sufferers as "a pit in the stomach…as if someone died." Ground Zero hauntingly depicts the feeling of loss and internal collapse which is experienced in depression. I think that Jessie felt this to be the case and in her therapy it was as if she searched amongst the rubble of her own internal Ground Zero, for her lost loved ones and the lost parts of herself. The search continued (and for some the search may never end) as she tried to restore the collapsed imagoes of nurturing parents. Those who come for therapy don't

necessarily come to tell you how it is: they come hoping you will say, "Here they are look, safe in an air pocket after all these years".

Jessie lost a unified self in the abuse trauma. This can feel irreparable. As a child Jessie unconsciously recognized this when she cried over her lost button.

Jessie's button can be understood as a symbol of her protective shield (her early mother's nipple), the object which had held her together as an infant and which 'flew off' in the assault, but, in its absence, reminded her of what had been lost. The gaping hole left by the missing button could be thought of as representing a "psychic hole" (Freud, 1887-1904 p.104) that Jessie feared she was pouring through and suffering annihilation (Symington, 1985). I also think that the fright of her button flying off was unconsciously linked to her experience of being suddenly and perversely weaned (from mother's nipple to father's penis) at a point when Jessie was still reeling from the shock of her brother's arrival.

The truth as a bad object

How does a child survive this state? What is a child to do? Often they deny the truth. Dissociation and omnipotence take over in the flattened space and the truth, in its awfulness, is perceived to be the actual bad object that they need to resist (Klein, 1946 p. 102; Laub and Auerhahn 1993 p. 288).

To defend herself from the devastating truth of her private Ground Zero, Jessie needed to divest herself of the remnants of her traumatized self and her persecutory inner objects. Thus she began to run away from knowledge as a way of eliminating the bad object.

The presence of annihilation anxiety in a climate of helplessness can prompt the mind to flee from unbearable realities. On the streets of New York, on September 11, a dawning realization began that the planes used as missiles were 'domestic flights' carrying Americans. The nation was horror struck. Similarly Jessie's father used Jessie's own body, her sexuality and her trust, in a domestic crime against her own family. Such things are hard to withstand.

The mirage self

I suggest that in situations of horror some abused children install a mirage inside; a beautifully made up illusion of what once was or what they wish there to be. This is akin to the initial American proposal to build two replacement Twin Towers, bigger and more prominent than the first, in the place of ground Zero.

Giovanni Liotti (1999) in describing Pierre Janet's (1907) thinking relayed that for Janet "consciousness is a creative act of meaning making – an activity of personal synthesis" (p.758). Experiences that are too horror-filled or bizarre are encoded in a separate system of "fixed ideas". Janet suggested this was an attempt to encapsulate the trauma. There can be no synthesis or meaning making, as these are dynamic activities, which cannot occur in a paralyzed or fixed mind.

The installation of idealized parental false objects is akin to Janet's "fixed ideas". Jessie's mirage of 'wonderful parents' imprisoned both her knowledge of the trauma and her ignorance of it, rendering her mind fixed in the trauma moment, throughout her development into adulthood.

The abused child uses dissociation and idealization to help the mirage withstand inspection by the self and by others. She relates to her abusive parents as if they are ideal. In this way of thinking, the attachment one sees, in a child, to the abusive parent is not an attachment to a bad object, but a desperate clinging to their defensive mirage of 'ideal nurturing parents' that they think will hide the truth of their shameful circumstances. Jessie told me she "adored" her father's smile. Perhaps when one inhabits the bleakest of landscapes, the simplest of primroses can mean so much.

In a letter, Jessie told me about her mirage:

> As a child I had a fantasy where I was a pretty, confident and happy girl. A girl who had a perfect life, loving parents who protected her, who took time out to play with her, showered her with kisses and bought her presents because they loved her. ...To enable me to cope during an attack, I would concentrate very hard on my fantasy and wrap myself up in a 'bubble', my own little protective world where no-one could hurt me.

Here we see the installation of fake parents and a fake self, as well as the mirage of a protective shield: her "bubble". These things were grasped and held onto as if her psychic life depended upon it, especially at the moment that her father, by his intrusion, threatened to reveal the truth again of her private Ground Zero.

Perverse twists

When one is trying to run from the truth as a bad object, lies and secrets can come to be perceived as places of safety, like good objects, seeming to offer shelter at times of need. It is interesting that the protective shield Jessie was able to form was an exact copy of the misshapen, perverse, shield that her mother demonstrated to her: silence, denial and falsities.

Jessie kept her abuse secret for the first year of therapy, requesting help for bulimia nervosa. She was also an alcoholic, having used vodka from the age of nine to nullify her experiencing and thinking self.

The act of keeping the abuse secret is like a child running into a cupboard to lock herself away from 'the bogey man', only to find that he is already in the cupboard. This is because the secret trapped Jessie with her external abuser and with her shaming 'internal mother' who was made all the more powerful by being the only witness. The following dream of Jessie's and other similar dreams of hers prompted this understanding:

> A little girl is trapped in a small room or cupboard. Someone tells her that her family has left her all alone, that no one wants her. She is terrified but can't get out of the cupboard. Everything appears dark.

Americans feel that Ground Zero is the epicenter of their national rage, their grief, and their family bond. For an abused child their Ground Zero is the epicenter of their shame and their aloneness: the fissure in her family's bond. They too have rage, but it is directed at the self who has internalized the imagoes.

Splitting and Multiple Personality formation as a form of encapsulation of traumata

With embarrassment and a fear that I would have her sectioned, Jessie eventually freed herself from another secret. She told me that her 'mirage-self' had a name: "Debbie". This is a name she had borrowed from her favorite film "The Sound of Music". (It was the real name of a child actress in the film whom Jessie liked). One way of thinking about "The Sound of Music" is that it is a film about the restoration and emotional re-habilitation of a father. Jessie watched the film obsessively as a child and I think of this obsession as her way of escaping her 'cupboard'.

My patient also had "Little Jessie" who contained all the experiences. "Little Jessie" was hated.

Like a complementary pair of "fixed ideas" these two characters persisted throughout her development until the loosening process of therapy. It was "Little Jessie" who internalized it all and who was felt to possess the images, now felt to be torturing objects. 'Debbie' on the other hand was adored for her non-experiencing. Jessie interacted with her real parents as 'Debbie', supporting her own mirage and the 'mirage' her parents created of themselves. One can see how her rage was kept away from the fragile mirage, the real parents and the real world. Abused children usually tell no one and end up in a very isolated place where the experiencing self is the hated object.

In one session Jessie said:

> After an attack, I was always left alone, rejected and unloved. Everything hurt inside and out, physically and emotionally. I would sit on my bed crying, staring at myself in the mirror (note that she no longer stares out of the window looking for her mother). I hated myself, I hated my face, I hated my body and I hated my life. I was a shy, weak, worthless and unlovable child. The anger I felt towards myself was incredible.

And:

> I wish I could explode and get all the shit out, once and for all. I have an image inside my head where I burst and little Jessie comes shooting out in pieces. First her legs come out, followed by her arms, then her body and finally her head. Out. Out. Out. She's gone and I don't ever have to deal with her anger, pain and sadness again. I want rid of her, I hate her.

On several occasions Jessie cut her wrists and thus repeated the cluster of wrongs: primary betrayal; the self used to abuse the self; a wrongful penetration; and the

break in her protective shield (her skin). This time the projectile was not a penis, but a knife held in her own hand guided by omnipotent rage.

The hijacked mind

The traumatized person whose external good objects are perceived to have collapsed by their utter failure to function, experiences herself as having killed off her internal good objects. In everyday life this had terrible consequences for Jessie. She felt guilty every day for her refusal to have contact with her parents, feeling sure that they were "dead or dying." She also worried that she would harm or abuse her own daughters (both were conceived and born during the course of her therapy, after 8 years of previous infertility was corrected by a new abstinence from alcohol). Indeed she was terrified of her own unconscious, fearing anything she might momentarily imagine or wish for would materialize. This was the consequence of her 'fundamentalist' father transforming her ordinary oedipal wishes and fantasies into awful, concrete reality. Jessie reacted to her unconscious as if it was a terrorist part of herself; she could not allow herself to relax; and generally she avoided all men. She was unable to enjoy sex with her husband and she felt ashamed at her occasional capacity to have an orgasm.

Due to the damage caused to Jessie's developing ego (her Pentagon or Defence Headquarters) the marshalling of her defences was scrambled, confused and haphazardly over-reactive or under-reactive. She found it very difficult to distinguish between good and bad external objects. This frequentlyled her to leap to wrong conclusions about where the actual threats lay, like the American and British Governments post 9/11. This fundamental confusion also made her prey to paedophiles outside of the home as a child. At the same time her damaged ego was unable to enlist the help of good objects, like her teacher, because of her fear of encountering the 'perverse object' who 'flips' from good into bad, as traumatically experienced with her parents.

In addition to this fundamental confusion, Jessie's mind was constantly hijacked by flashbacks of abuse, which were felt as persecutory and were a central feature of her presentation. Jessie described a sense of relaxed "going-on-being" which would be violently disrupted by seemingly insignificant sensory data.

For example, Jessie clipped her car in a supermarket car park because she was disturbed by seeing someone wearing a coat with a button missing. The image hijacked her mind to the moment she lost her button.

Importantly, as a child Jessie began to equate feelings of relaxation, to trauma. In response to this reaction she began to deprive herself of any feelings of security or trust in others. In this way, what was once an inter-personal dynamic between Jessie and her father became an intra-psychic dynamic, compulsively repeated. As soon as a part of her relaxed, another part of her adopted the role of father and destroyed the moment, by intruding flashbacks, which, to Jessie, appeared to be current rather than historical. This resulted in a daily rush of 'startle responses', which took on the menacing quality of father's presence. (Her inability to relax

meant that she could not shift to the couch until she had already had 4 years therapy). The 'Terrorist' was now resident within her own mind. She perceived the whole world to be full of abusers, and she feared she might be one of them.

This state of partial inner collapse, hidden by a constructed mirage of fixed ideas and secrecy, as I have described, was the condition of Jessie's inner landscape when she presented for treatment; but I did not know that.

Treatment

The experience of working with Jessie and other patients who have a 'Ground Zero' situation is analogous to the New York Fire Department's gradual, reluctant realization that they were involved in a recovery operation, not a rescue mission.

Jessie often engendered 'rescue' urges in me. I found these omnipotent ideas unsettling. One needs to be prepared to stand with the patient on their 'Ground Zero' and help them face their truth. However one needs to do this in full awareness that the space, now occupied by omnipotence, can act like a 'Black Hole' drawing everything that is too near into annihilation. On 9/11, the firemens' sense of emergency, confusion and identification with the victims, was lethally combined with instinctive urges to rescue, and a belief that their expertise would act as a protection against harm. I think the same elements can pull therapists towards danger.

At the beginning of Jessie's therapy, she used my consulting room as "The Cupboard" of her dreams, which she ran into to escape her situation. However, once the transference relationship developed, she experienced me as 'the Bogey Man' in the cupboard, pointing out that she had no one who loved her. In the transference, it was as if I held the awful truth, and she did not. I had become the bad object who could pop her mirage and reduce her to 'Ground Zero' again by speaking.

When she began to reclaim the truth for herself Jessie became very anxious and depressed. She brought many dreams about structures collapsing, and about falling, or being trapped. Here is an example:

> I am on the top floor of a high building. I get into the lift and suddenly it races down at a forceful speed. As I go down I see faces of people staring at me on each floor. I am terrified; I am all alone and have no control of the lift. I am afraid as I know when the lift hits the ground I will die.

With immeasurable sadness I also report that very late in treatment, when her memories shifted from being somatically held to being held in her mind and when she began to trust that I would not reject her or abuse her, Jessie likened these 'lift dreams' to her father's sexual act upon her and her fear of dying, as the pace of his rape quickened.

Sometimes it felt as if she placed intense pressure upon me to abandon my separateness of mind so that, once seduced away from my boundaries, I would join

her, metaphorically, in the 'lift' of her nightmares. We would then both fall forever, as Jessie and her father did 30 years in the past.

Jessie often perceived me to be too distant or unfeeling. For example, the waiting room had a glass partition. She often arrived very early and sat watching for me, turning me into the mother who never seemed to come. Silences and breaks had a similar quality, as did gaps in my empathic attunement to her (of which there were many). She would mostly begin each session by telling me of something dangerous or distressing which had happened to her in the gap. After a while I lost some empathy and thought: "She's so dramatic," but later I began to think of this as a wish to tell the mother therapist: "Look what terrors happen to me when you've forgotten about me and focus on the baby!"

At such times I would experience such a painful countertransference that I would feel a pressure to be extra attentive and giving, hence losing my separateness at a stroke.

Sometimes Jessie experienced my quiet thinking to be like two people whispering behind her back, hatching plans. She reacted to me as if my mind contained a murderous couple. This was simply natural given her inner circumstances. She began to be interrogative as soon as she perceived that I was thinking and not just passively listening. At these moments of perceived separateness, of differentiation between us, she began to be abusive towards me. The atmosphere would suddenly change, as she grilled me over something I had said or done (or not said or done) and scrutinized it for signs of coldness, betrayal, seduction, disbelief, failure to protect her or hold boundaries. I would often feel shocked, pinned down and momentarily afraid of the possibility of professional annihilation. With my own "going-on-being" vaporized by her, I would wonder what I had done to upset her so much and be really quite keen to avoid it happening again. I felt a push to keep *my* bad object at bay by being nice to it. I began to understand more about Jessie's need to appease her menacing father.

On another occasion Jessie reported having kicked and destroyed her faulty vacuum cleaner, in a blind rage. It seemed clear that the faulty machine was a stand-in for the therapist who was not making it all go away. It became obvious that Jessie could become identified with her abusive father. On such occasions her children's expectations that she assist their own "going-on-being" stimulated her envy of them. This temporary envy, of 'the child who has a protective shield', would prompt her to startle them out of their self-absorption by shouting at them. Gradually Jessie began to recognise their fear, seeing "Little Jessie" in their eyes, and her father in her own behavior. In the last year of therapy, instead of her more usual paranoid fear that I would inappropriately ring Social Services about her care of the children, she became tearfully regretful. Her distress, caused by this fresh more reflective view of herself as an active agent, gave me hope that Jessie was moving towards a capacity for empathy with her children and maybe even with "little Jessie".

Endings and the importance of mourning

My chosen metaphor has helped me to hold in mind Jessie's multiple losses and fear of being killed. I began to see her difficult transference behavior in a more empathic light. This empathy has, in turn, helped my patient to think about her experiences and to mourn losses which had previously been unappreciated by her conscious mind. I should say that the work of grieving for these losses might only arise very late in treatment. However, I think the concepts of catastrophic loss and of annihilation anxiety need to be held somewhere in the therapist's mind, informing her or his thinking, when working with those who have been abused by a parent, particularly a parent who controls by menace.

As the dust settled, and the years passed we made real, Jessie's Ground Zero, and accepted it as our work site. In the process we found Jessie's drive to work hard, like the New York recovery personnel, to find and reclaim and sometimes to memorialize each part of her inner world.

I began to see Jessie's own impulse to create after destruction; to be a protective shield for her children, and to go forward towards mourning her own lost childhood: In particular the loss of "going-on-being" which tragically occurred so shortly after she first experienced it as a baby at the breast. The truth was slowly re-instated as a good thing. This has enabled Jessie to gradually own what she once only wished to flee from. Although occasionally sad, she can allow herself good times of true "continuity" that are not interrupted by flashback intrusions, and she is a good mother to her girls. I appreciate that the work was long and arduous and initially costly to the health service, but the need for more costly medication and hospital admissions were averted, as was the need for multi-professional involvement such as the alcohol services and crisis response teams; and I believe that the trans-generational benefits are evident. Jessie's children, whom I have met, are happy individuals. To date Jessie has claimed an enjoyable life as a teacher, for which she trained upon her discharge; she had previously survived on a disability living allowance. Jessie has a solid and intimate relationship with her husband, and she has a small group of friends who know her story and who have replaced me as her confidants (although she writes to me occasionally). She is now not just a survivor, but a liver, and a lover, of life.

I would like to end with Winnicott's (1970) observation on children who have experienced a high degree of environmental failure:

> They know what it is to be in a state of acute confusion or the agony of disintegration. They know what it is like to be dropped, to fall forever, or to become split into psychosomatic disunion. In other words, they have experienced trauma, and their personalities have to be built round the organisation of defences following trauma. (p. 260)

References

Freud, S. (1920). Beyond the Pleasure Principle. In *The Standard Edition of the Complete Works of Sigmund Freud* (trans. J. Strachey) Vol. 18: 4, p.31

Masson, J.M. (1985). Draft G. Melancholia 1. *The Complete Letters of Sigmund Freud to Wilhelm Fliess, 1887-1904.* p.104 Cambridge, MA: Belknap Press.

The Guardian. Wednesday 17 October 2001. Michael Ellison New York. Special Report: Attack on America

Janet, P. (1907) *The major symptoms of hysteria.* New York: Macmillan.

Janet, P. (1894). Histoire d'une idée fixe, *Revue Philosophique*, xxxvii (1), 121-168.

Klein, M. (1946) Notes on Some Schizoid Mechanisms *The International Journal of Psycho-Analysis* 27: 99-110.

Laub, D. & Auerhahn, N.C. (1993). Knowing and Not Knowing Massive Psychic Trauma: Forms of Traumatic Memory. *The International Journal of Psychoanalysis, 74*: 287-302.

Liotti, G. (1999) Understanding the Dissociative Processes: The Contribution of Attachment Theory. *Psychoanalytic Inquiry* 1999 19: 757-783.

O'Shaunessey, E. (1964) The Absent Object. *The Journal of Child Psychotherapy* 1 (2): 34-43

Segal, H. (summer 2002). Not learning from experience: Hiroshima, the Gulf War and 11th September. *The International Journal of Psychoanalysis*, vol *11:* 1.

Symington, J. (1985). The Survival Function of Primitive Omnipotence. *The International Journal of Psychoanalysis, 66*: 481-487.

Winnicott, D.W. (1949). Birth Memories, Birth Trauma and Anxiety. Re-printed In *Through Paediatrics to Psychoanalysis .1975 Collected Papers* (p. 185). London: Karnac Books.

Winnicott, D.W. (1965). The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development. (p.60-61) *The International Psycho-Analytical Library,* 64:1-276. London: The Hogarth Press and the Institute of Psycho-Analysis

Winnicott, D.W., (1970). The mother-infant experience of mutuality. In E.J. Anthony & T. Benedek.(Eds.) *Parenthood,* (p. 255) Boston, MA: Little Brown.

The Adolescent

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Abstract

In this article I attempt to address some core questions about psychoanalytic psychotherapy for adolescents. Is adolescent turmoil inevitable? Some think it is, and generate their understanding from psychoanalytic investigation in the therapeutic relationship. Others disagree, and base their argument on psychological research. Why is it that different conclusions are reached, and what do each mean by adolescent turmoil? In this context, what are the implications of psychotherapy in the adolescent period, and what factors need to be considered in deciding on psychotherapy? Finally, what might adolescent psychotherapy look like?

Is Adolescent Turmoil Inevitable?

Psychoanalytic theory describes adolescence as a period of transition that involves inherent struggle and turmoil (Blos, 1978; Freud, 1958). There are physical changes, change in the parental relationship and cognitive changes. Physical change brings about an increase in sexual and aggressive drive at a time when ego strength is not yet sufficient. Adolescence thus includes a struggle between new emerging desires and phantasies of the id, and the repressive forces of the ego (Freud, 1958; Jureidini, 1991; Klein, 1922). A change in relating to parents also occurs. Preadolescent sexual instinct is predominantly autoerotic, but that of adolescence is in new sexual objects outside the family. This necessitates disengaging from external and internal parents, a process of dramatic change that entails rejecting parental ego support, and accepting a degree of ego weakness (Blos, 1978; Freud, 1958; Freud, 1905).

There are also cognitive changes in adolescence, involving a move towards formal operational thinking, which can cause discomfort and anxiety. This rapid development in cognitive ability can overwhelm an adolescent, and coping may include denial and eliciting strong reactions from adults (Jureidini, 1991). Adolescence involves reworking early frustrations and fixations, meeting threatening phantasies head on, and is a period of psychic restructuring and secondary individuation (Klein, 1922; Blos, 1978). All in all the period of change is described as a stressful time. Some even go as far as saying that not experiencing some sort of turmoil could signify a delay in development and should be taken seriously (Freud, 1958). On the other hand psychological research describes adolescence as an adaptive phase of growth characterised by integrational harmony and emotional stability, without disabling crisis. Turmoil is seen as the exception not the rule (Weiner, 1992).

Why are there such differences of opinion? Perhaps different methods are used to study the adolescent group, and what is gained is understood through different

theoretical eyes? In general, psychological research seems to focus on what is expressed, including thoughts, feelings and symptoms; in other words, on what is more or less conscious or preconscious. In comparison, psychoanalytic theory investigates deeper strata of the mind, and looks to the unconscious to explain adolescent processes. While research is gathered from the general population, psychoanalytic findings are often based on those who are unwell, rather than the norm. Research may be based on surveying attitudes. As adolescents are in a stage where they are particularly vulnerable to anxiety about normality, acknowledging that something is wrong could significantly threaten narcissistic omnipotence, and asking about turmoil could see an adolescent reporting that there is nothing wrong with them. This attitude can be seen in normative adolescent reluctance to seek help, and in a rationalising attitude that problems experienced are simply the fault of school, parents, friends and their changing body. Adolescents avoid being seen as different and are strongly influenced by their peer group, which could translate into a reluctance to share difficulties or in normalising them (Laufer, 1975).

Perhaps a central issue in understanding the debate is the definition of turmoil. Psychoanalytic investigation is based on seeing turmoil, and the associated discomfort and anxiety, as part of normal development. It acknowledges that only a minority experience neurosis or psychosis because of an existing vulnerability in the psychic structure, and that this makes dealing with adolescent tasks difficult (Blos, 1978; Freud, 1958; Klein, 1922; Martin, 1963). In comparison, some research seems to define turmoil in a more pathological light (Weiner, 1992). The definition of turmoil varies so it is understandable why it appears that different conclusions are reached. But each approach makes valid contributions and yields relevant findings. Perhaps a theory is needed to account for and explain the validity of both psychological and psychoanalytic approaches?

To assume that all adolescents experience turmoil and that turmoil is pathological, could lead to difficulty in identifying those in real need of therapeutic help and signifies a risk of a self-fulfilling prophecy. On the other hand, some abnormality may be characteristic of this stage, and formal assessment should not take place too quickly. This does not mean that assessment and intervention may not be necessary, as turmoil that is in excess of normal adolescent functioning can significantly affect future emotional wellbeing and may compromise the psyche (Bronstein & Flanders, 1998). Psychotherapy may be of assistance in locating early frustration and fixation and removing obstacles to ongoing development. A successful therapy outcome means freedom to resume individual development (Slaff, 1979).

There are some differences regarding the type of therapy that is suitable in adolescence. Some call attention to the relative weakness of the ego during this stage, and adolescent reluctance to engage in therapy, and believe adolescents should treat themselves and find their own solutions to difficulties. Others believe therapy should only deal with preconscious and conscious material, with the aim of strengthening the ego through suggestion and support (Anthony, 1974). Yet others

support in-depth psychoanalytic work, and describe the aim as discovering the cause of the problem and bringing this into consciousness, which assists in adjusting the demands of the conscious and unconscious (Klein, 1922). In recent evidence-based research psychodynamic therapy has been shown to be of at least equal value to other popular therapies like cognitive behaviour therapy. However, what has also been found is that while approaches like the latter have positive effects which decay over time, gains from psychodynamic processes not only endure, but increase with time (Shedler, 2010).

I believe that most adolescents go through some sort of change and turmoil, and that most do so without harm. Some experience great difficulty, and even pathology, and are in need of help. It seems that the line between being psychologically healthy and unwell is less easy to define in adolescence. It is the latter group that is in need of assistance, and even psychotherapy. I believe that adolescence can be a good time for psychoanalytic psychotherapy because it is defined by the personality structure not being stable. It is a time of regression, progression, reworking of early conflict, introspection and awareness of internal conflict. But, such therapy may not always be the answer, and may even be contra-indicated in some circumstances.

Psychotherapy or Not Psychotherapy, that is the Question

In the following section I look more closely at such issues and how to assess an adolescent's suitability for psychotherapy. It is divided into three parts. The first focuses on the adolescent's external reality or environment, the second on factors of the adolescent and the third on examples of where psychotherapy is contraindicated.

The psychological health of the adolescent is dependent on the balance between body needs, drives, and the demands of the external reality. The symptoms presented in assessment represent poor solutions and compromises in attempts to defend against anxiety. Defence mechanisms are activated, and in some cases result in symptoms and maladaptive behaviour (Freud, 1966). The described balance can be disturbed by internal processes, normal development or harsh demands of the external reality. It is for this reason that psychotherapy will not be fruitful unless the objective threatening aspect of the external reality is reduced. It is only once this has occurred that greater adaptation and balance is possible between the individual and the environment, which results in a reduction of symptoms (Freud, 1965).

A number of areas need to be considered when assessing the environment of an adolescent for psychotherapy. A suitable psychotherapist needs to be available (Connor and Fischer, 1997), and the length of treatment needs to be considered. The longer the therapy the more resources are needed from both the institution that offers the psychotherapy, and from the parents. In the health system of today cost effective treatment is important. Parents, carers or the adolescent need to have transport resources to attend therapy on a regular basis. The environmental

expectations of the outcome of therapy are also important. This expectation may differ from the adolescent expectation and may not necessarily be reality based and could hinder healing, as well as pressurise the assessor to adopt an inappropriate treatment plan (Dyke, 1987). For example, an adolescent could be referred for emotional and behaviour problems, but during the assessment process it is revealed that custody issues, parental divorce or drug and alcohol abuse by one or both parents are affecting the situation. In such an instance where the adolescent environment is not stable, psychotherapy may not be the answer. Rather, intervention could be aimed at stabilising the environment, and perhaps reassessing for psychotherapy at a later stage.

The external reality includes not only society, but also the family. This necessitates asking some of the following questions: Is the adolescent's family in harmony with their environment, and how does this affect the adolescent (Simmons, 1987)? For example, an adolescent of a family that has recently immigrated can be expected to have cultural adjustment difficulties, and psychotherapy may not necessarily be indicated. The adolescent does not live in isolation, but in a family system that is affected by the environment. It is therefore necessary to assess the relationship between the young person, their family and the environment in order to decide if the adolescent needs psychotherapy or if intervention should involve the external reality, including the family and school. It is necessary to ask specific questions to untangle the complicated relationship between the young person and the external reality.

Can the family collaborate in agreeing on a treatment plan or is there a possibility of it being hindered by, for example, their own mental health? Furthermore, how does that which hinders this process affect the adolescent and how is it envisaged that the process of psychotherapy will impact on this (Simmons, 1987)? It will be of benefit, if resources allow, to work with the adolescent and family concurrently. In the absence of this, community support may be necessary. At times a family may need or expect one of its members to be sick. For example, if an adolescent has emotional problems the parents may occupy themselves with this so that they do not need to look as closely at their own difficulties (Simmons, 1987). An adolescent's problem could also be influenced by family expectations. For example, it may be expected that the adolescent will be similar to his or her father or brother who has a criminal history.

Part of the normal process at the start of therapy is experiencing an exaggeration of symptoms at times. This means that we have to ask questions about the parents' ability to contain their own anxiety and that of their adolescent child. You would not want the therapy to result in the family falling apart, or in the family's resistance significantly affecting the adolescent's therapy. You would also not want the family to terminate the therapy process prematurely (McDonald, 1965). When assessing an adolescent for psychotherapy it is important to consider to what extent the parents' experience of their own childhood influences their relationship with their child. Maybe it is not the adolescent that is in need of therapy (Fraiberg,

Adelson and Shapiro, 1975; Lyons-Ruth and Zeanah, 1993). Finally, the parents need to understand the problem and collaborate in the treatment plan, for example by providing a reliable setting for work with their child. The therapeutic process will flow more smoothly if everyone is on board and doing their part; this may include the parents, the school and others who are significantly involved with the young person (Rustin, 1982).

There are also a number of factors of the young person that influence saying 'yes' to adolescent psychotherapy. First, the general health of the adolescent needs to be assessed. Perhaps the problem is of organic origin and the adolescent needs physical or neurological assessment and intervention (Broder and Hood, 1983). The quality of the adolescent's object relations should also be considered, as a certain basic object relating ability is necessary for successful therapeutic intervention. Is the adolescent able to have meaningful relationships, and will he or she be able to experience identification with the therapist? Can the therapist be used in the transference (McDonald, 1965; Meeks, 1971)? In extreme cases the quality of an adolescent's early relationships is not sufficient to exploit the transference (Winnicott, 1949).

The severity of the problem is also important. Is the disturbance transitory, as in normal development? If so, psychotherapy may not necessarily be indicated. Alternately, is the adolescent at risk of developing more serious concerns at a later stage of development if therapy does not take place (Laufer, 1965; Simmons, 1987)? It is of benefit that the adolescent wants to change, has insight into the problem, and is able to sufficiently communicate the problem through speech. If psychotherapy is the treatment of choice, how the client may get along with the therapist needs to be considered. For example, the adolescent may have a rejecting, punitive father and may refuse to attend therapy with a male therapist. Other cultural and social factors may also contribute to such a situation. It should also be considered how the therapist will be affected by the client and to what extent countertransference will be bearable and therapeutic. For example, it may not be in a client's best interest to explore their sexual abuse with a therapist who has been affected by sexual abuse and has not sufficiently resolved this.

There are some instances where psychotherapy is contraindicated. It has been found that psychotherapy can be relatively ineffective in treating adolescents with severe pathology (Reisman, 1973). Psychotherapy is also not indicated for adolescents who have experienced recent trauma, including loss of a parent or sexual abuse. In such cases therapy can be experienced as traumatic, and should be considered only after the adolescent has worked through the trauma. Phantasies can only be safely explored once the adolescent perceives his or her reality as safe (Dyke, 1987; Jernberg, 1979).

Psychotherapy is also largely ineffective as a treatment of psychopathic adolescents. In such a case therapy can only be effective if the young person is pre-adolescent, if the parents are agreeable with not accepting the delinquent

behaviour, and if they are prepared to work at their own problems. Unfortunately, parents of delinquent children all too often have resistance. Caution should also be exercised in choosing treatment options for adolescents who are emotionally fragile. Such adolescents may react with anxiety and panic to structured or directed psychotherapy. It may be preferable to refer such adolescents for non-directive work, where they can experience feeling safe and able to influence others (Jernberg, 1979).

Therefore, when deciding on saying 'yes' to psychotherapy, a question is being asked about treatment. As psychotherapy is often but one of many treatment options, the first area that needs to be explored in agreeing to psychotherapy might include, "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, under *which* set of circumstances?" (Paul, 1967, p. 111).

What adolescent therapy might look like

I have chosen a young man, who for reasons of anonymity I have called Chad, as an example of a psychoanalytic therapy process with an adolescent. At the time of Chad's referral for psychotherapy I worked at a family support organisation that deals with children and adolescents with behavioural and emotional problems. We accepted referrals for psychotherapy only from the local child and adolescent psychiatric service. This included those who had been diagnosed with moderate mental health difficulty or who were at risk of developing personality disorder. My therapy with Chad, which took place in our playroom, was accompanied by work with Chad's Mother that took place with one of our social workers. The aim of the latter was to support Chad's family while he was in therapy, and work on parenting issues relevant to the referral question. Chad had already gone through a formal process of psychiatric assessment and review, so I did not replicate this. However, I did meet with his mother for a couple of sessions before starting therapy for purposes of my own history taking, and to gain a more specific understanding of the relevant phantasies, anxieties and general family interaction patterns.

Chad presented as a 13 year-old boy of high average intellectual ability. He had been diagnosed with Attention-Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD). He had also been diagnosed with a congenital eye condition, called Cone-Rod Dystrophy, which meant that he had progressively lost his sight. Chad first starting speaking at the age of eleven months and his mother reports that he was toilet trained by twelve months. At twelve months he also suffered from severe asthma and showed motor clumsiness. By the time he was three he had become quite clingy, and this was described as becoming worse with age. He was first recognised as having degenerative vision problems at the age of five. The origin and prognosis of this condition was not clear, and had caused much confusion for the family and Chad. At the age of five Chad was also first prescribed stimulant medication. His start at school was troublesome, and saw him described as challenging, competitive, aggressive and controlling. He had trouble making friends. By the age of seven Chad had developed a fascination with fire lighting and spoke about burning down houses. He did not allow such

phantasies to be challenged. Chad threatened to kill himself, his parents and others. On one occasion he ran after his sister threatening her with a hammer, and also got into a severe fight with a boy that landed the boy in hospital. By age nine his behaviour had got worse and his parents made arrangements to send him to a specialised school for the blind, very far away from home. But, Chad was expelled at the point of one of numerous oppositional episodes requiring calling out the police to secure the school. He was referred for therapy soon after returning home.

Chad's parents could be described as competitive. In particular, his father was significantly occupied by and well known in the sporting world. Chad's mother described a strained marital relationship influenced by her husband being uninvolved in family life, and his having engaged in an extra-marital relationship. At the time of entering therapy Chad made use of a walking cane and read Braille. However, he completely denied not being able to see, and would become angry if mention was made of this, to the point of becoming aggressive. I met with Chad once a week, over a period of a year, in total for about 40 sessions.

Before starting the therapy process I generated hypotheses about presenting symptoms, anxieties and defences, based on the information I had gathered. During the actual therapy process these were continually tested for confirmation, and revised. My first hypothesis concerned how Chad being blind affected his parent's relationship, and conversely how their estrangement further increased his anxiety, something he had difficulty tolerating in the first instance. It seemed that the parents did not provide sufficient containment for their children or for themselves for that matter. I wondered how the family members were feeding off each other's anxiety, and how their anxiety gathered momentum.

My second hypothesis concerned Chad being an adolescent in the process of secondary individuation and psychic restructuring. I wondered if he had difficulty in the withdrawal of libidinal cathexis and disengagement from external and early identification with internalised objects (Blos, 1978; Freud, 1958). His progressive loss of sight would mean needing to be more dependent on his mother. This had manifested throughout his development as clinginess, and may have delayed development.

My third hypothesis concerned the affects of the libido being directed towards the body. This investment in the body would raise more anxiety than it would in normal circumstances, as Chad's body had in reality failed him. The extent of his anxiety and the persecutory nature of this were to a large extent dependant on the developmental stage at which his sight had first started to deteriorate. Early frustration, anxieties and phantasies could result in a persecutory superego and a division between the real ego and ego ideal. I wondered to what extent his oppositional behaviour related to an excessively harsh superego. This harshness could also have resulted in negative narcissism and vulnerability to depression (Holmes, 2001; Klein, 1963).

My fourth hypothesis concerned Chad's phantasy about burning down houses, and his denial of being blind. His escaping into a world of omnipotent phantasy could be a defence. To what extent did this result in poor reality testing and deficient ego functioning? I was concerned that he had already had problems with his aggressive drive during latency, a period of relative calm under normal circumstances. What would happen during adolescence, a period of elevation of aggressive and sexual drive (Freud, 1905; Freud, 1958)?

In summary, I thought that Chad was delayed in his developmental line, as the result of a significant stressor and inappropriate resolution and fixation in the early stages. At the time of initiating therapy Chad had difficulty tolerating and facing these anxieties and phantasies, as well as those applicable to the adolescent stage. I doubted that he could navigate his way through adolescence without the help of psychotherapy.

The first time I met Chad was at our initial psychotherapy appointment. His mother made the introductions. Chad was a tall, slim boy, with short brown hair and a smattering of freckles on his face. He seemed confident and sure of himself, and interacted in a friendly manner, with a good sense of humour. His clothing was appropriate, but perhaps not as fashionable as that of some boys. It was only when I spoke directly to him that I could tell he was blind. Chad did not speak about his friends, school, wanting independence or any other topics that adolescents usually speak about. Instead, he told me about his extraordinary abilities, including his superior ability to hear things. He asked if I was jealous of this ability. In general, our interaction was not what I had expected. His behaviour was more that of a child in the Oedipal stage. It was surprising how quickly this transference was re-enacted and how clear it was to identify.

Therapy continued to develop along lines that are not typical of adolescent therapy. Chad preferred communicating through the use of toys, and projecting into these his extensive and rich phantasy world. This was a unique process. His unconscious seemed to have easy access to the conscious mind. They appeared to be unusually fused, perhaps the result of failed repression.

There were a number of therapeutic themes and a variety of processes that we worked through. An initial one concerned his wish and phantasy of being a vampire. As a vampire he could fly, was very quick in his movements and had great powers. I was also aware of how vampires live in the dark, like Chad. He often referred to the sharp teeth he had, a weapon of the oral sadistic and oral cannibalistic stage (Klein, 1963). I thought this was where the fixation had likely occurred. Maybe this was due to his severe asthma and his deterioration in eyesight, both evidencing a failing body. The fixation occurred at a stage when sadism becomes active and reaches its height. In normal circumstances this is threatening to the ego (Klein, 1927 & 1933). For Chad this may have been further complicated as the ego, with its introjected psychic representation of the body, is first of all a body ego (Brenner, 1973). Chad's difficulty with breathing and taking

life into himself would, in this case, be an experience of an increase in threatening stimuli. As this occurred at a stage of incomplete development it would be more likely to have a traumatic effect. In order to escape this Chad may have treated the stimuli as if they were originating from the outside (Freud, 1920; Freud, 1966).

The consequence of this early projection taking place at the same time as introjection, was two-fold. First, the threatening qualities would be identified as belonging to the external object. Second, the persecutory object would come to reside inside self (Klein, 1933). Chad likely felt that he was being assaulted from both the outside and the inside by persecutory part objects, which may have resulted in him turning away from the reality principle during this period of infancy, towards the pleasure principle and the omnipotence of phantasy. In doing so he could deny the external reality and his vulnerability to it. Chad experienced the external world as a blind bat. But in his phantasy this blind bat went through a metamorphosis into an all-powerful vampire, who could suck the life force out of others. This meant that he would no longer have to be afraid of not being able to take life into himself, as he had been in infancy.

One of the things that I struggled with in the therapy process related to my countertransference feeling of being frustrated by my own tendency of continuously needing to escape into my own phantasy world. Many times, I felt as though the reality and our interactions were too slippery to hold onto. I continually had to battle with myself to bring my attention back into the room, to our interaction. This was partly resolved in supervision, where I came to understand these feelings as the result of projective identification. I had identified with Chad's frustration and his difficulty in choosing and maintaining the external objective reality. Therefore, I was able to see projective identification, not only as a defence, but as an object relation and a means of communication (Ivey, 1990). I also struggled to understand the complex transference, the part object that was being identified with, and what identity I assumed in his phantasy (Casement, 1985).

In any one session I was invested with different identifications of part objects. I could be the original pre-Oedipal castrating mother who had removed faeces, which were perceived as part of self during this stage of infancy (Klein, 1928). I think this related to Chad's phantasy of his mother having filed down his teeth, which he spoke about in therapy. I also soon assumed the identity of the castrating Oedipal father, who was threatening and experienced as a rival. I believe that because of my wish to understand him, we were able to progress in therapy, and in doing so I became a good-enough object that allowed Chad to resolve some of his early frustrations. In turn, this ushered in the more appropriate developmental period of adolescence.

Chad's working through the many anxieties relating to early object relations resulted in a toning down of his libidinal cathexis, which freed him to seek and pursue love interests outside the family. In therapy he started speaking about male friends at school and his experiences with consecutive girlfriends. His mother

confirmed that he actually had started to engage in such experiences. In therapy Chad started presenting with anxieties relating to sexuality. The de-cathexis of his early love objects not only resulted in his directing his libidinal energy towards other objects, but also in it becoming attached to his own body. This gave rise to his viewing his body as a source of potential danger. In reality his eyesight had indeed failed him. In phantasy he imagined passing on terrible diseases to sexual partners, and spoke of this in therapy. His guilt resulted in him moving from one girlfriend to the next in his real social interactions, albeit that such interactions were defined by innocent non-physical contact. Unfortunately, I did not have the opportunity to see the resolution of such anxieties, as my moving to another city resulted in termination of the therapy process. But, on a positive note there was no longer a significant delay in his developmental line. He had resolved some of the pathogenic origin of his excessive anxiety, which had manifested in the triad symptoms of inattention, impulsivity and hyperactivity.

As a result of constitutional factors, his body failing him and insufficient parental responsiveness, Chad failed to master the early developmental stages. This failure complicated each successive stage of development, which became increasingly distorted and delayed. In this context it is understandable why he needed to play rather than converse in therapy. I believe this is also the reason why he presented with neurotic phantasies about monsters, derivative of the oral and anal stages. In therapy he was developmentally delayed rather than emotionally regressed, which would be a more normal part of pre-adolescence. For these reasons, I believed that the exploration of psychodynamic issues, rather than the remediation of the neurophysiological or cognitive problems was appropriate (Smith, 1986). At the end of the therapy process Chad was functioning well, both at home and at school. He had successfully stopped his stimulant medication. In therapy I had become a whole object that existed in reality, an object that was both satisfying and frustrating.

Conclusion

In conclusion, the question of whether or not to accept an adolescent for psychotherapy is not an easy one. This process requires bearing in mind many aspects that could influence the success or failure of therapy. I have tried to outline some main points in this regard. I hope I have also illustrated that while psychotherapy may be of benefit to some adolescents, in certain circumstances, it could also be contraindicated in others. If nothing else, I hope that I was able to convey that while we spend much time assessing the mental health of the adolescent, we should be careful not to short-change the process of assessing for psychotherapy, especially in light of inevitable restrictions of resources. If therapy is an option, I think it is important to make sure that the adolescent will be able to maintain a therapeutic relationship and be able to benefit from the process.

References

Anthony, J. E. (1974). Psychotherapy of adolescence. *The American Handbook of Psychiatry, vol 2*, (pp. 234-249). New York: Basic Books.

Blos, P. (1978). The second individuation process of adolescence. *The adolescent passage* (pp. 141-170). New York: International Universities.

Brenner, C. (1973). *An elementary textbook of psychoanalysis* (revised ed.). New York: International Universities Press.

Broder, A., & Hood, E. (1983). A guide to the assessment of child and family, In , P., & Rae-Grant, Q, *Psychological problems of the child and the family*, Chapter 7, pp. 130-149. New York: Basic Books.

Bronstein, C., & Flanders, S. (1998). The development of a therapeutic space in a first contact with adolescents. *Journal of Child Psychotherapy, 24*(1), 5-35.

Casement, P. (1985). Forms of interactive communication (Chapter 4), In: *On learning from the patient*. London: Tavistock.

Connor, D. F., & Fischer, S. G. (1997). An interactional model of child and adolescent mental health clinical case formulation. *Clinical Child Psychology and Psychiatry*, 2(3), 353-368.

Dyke, S. (1987). Saying 'no' to psychotherapy: Consultation and assessment in a case of sexual abuse. *Journal of Child Psychotherapy*, 13(2), 65-79.

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery. A psychoanalytical approach to the problems of impaired infant mother relationships. *American journal of child psychiatry,* 14(3), 387-421.

Freud, A. (1958). Adolescence. *The psychoanalytic study of the child, Vol 13* (pp. 255-278).

Freud, A. (1965). *The writings of Anna Freud, Volume VI: Normality and pathology in childhood: Assessments of development.* New York: International Universities Press.

Freud, A. (1966). Orientation of the process of defence according to the source of anxiety and danger. In *The writings of Anna Freud, Volume II: The Ego and the mechanisms of defense,* Chapter 5, pp. 54-60, Revised edition. New York: International Universities Press.

Freud, S. (1905). Three essays on the theory of sexuality, In S. Freud (1986), *The essentials of psycho-analysis*. London: Penguin Books.

Freud, S. (1920). Beyond the pleasure principle, In: S. Freud (1986), *The essentials of psycho-analysis*. London: Penguin Books.

Freud, S. (1966). The paths to the formation of symptoms. In S. Freud, *The complete introductory lectures on psychoanalysis* (pp. 358-377). New York: W.W. Norton.

Holmes, J. (2001). *Ideas in psychoanalysis: Narcissism.* UK: Icon Books.

Ivey, G. (1990). *An introduction to object relations theory.* Unpublished work, University of Natal, Durban, South Africa.

Jernberg, A. M. (1979). *Theraplay: A new treatment using structured play for problem children and their families.* San Francisco: Jossey-Bass.

Jureidini, J. (1991). Adolescent development. In R. J. Kosky, H. S. Eshkevari, & V. J. Carr (Eds.). *Mental health and illness* (pp. 49-56). Sydney: Butterworth-Heinemann.

Klein, M. (1922). Inhibitions and difficulties at puberty (pp. 54-59). In M. Klein *Love, guilt and reparation and other works (1921-1945).* UK: Vintage Books.

Klein, M. (1927). Criminal tendencies in normal children (pp. 170-185). In M. Klein *Love, guilt and reparation and other works (1921-1945).* UK: Vintage Books.

Klein, M. (1928). Early stages of the Oedipus conflict (pp. 186-198). In M. Klein *Love, guilt and reparation and other works (1921-1945).* UK: Vintage Books.

Klein, M. (1933). The early development of conscience in the child (pp. 248-257). In M. Klein *Love, guilt and reparation and other works (1921-1945).* UK: Vintage Books.

Klein, M. (1963). *The psycho-analysis of children.* London: The Hogarth Press.

Laufer, M. (1965). Assessment of adolescent disturbance. *Psychoanalytic Study of the Child,* 20, 99-123.

Laufer, M. (1975). Danger signs in adolescence. *Adolescence, disturbance and breakdown* (pp. 34-51). Harmonsworth, UK: Penguin Books.

Lyons-Ruth, K., & Zeanah, C. H. (1993). The family context of infant mental health: I. Affecting development in the primary caregiving relationship, In Zeanah, C. H., (Editor) *Handbook of Infant Mental Health,* chapter 2, pp. 14-17. New York: Guilford Press.

McDonald, M. (1965). The psychiatric evaluation of children. *Journal of American Academy of Child Psychiatry,* 4, 569-612.

Martin, F. (1963). Technical problems in the treatment of adolescents: Beginning Psychotherapy. *Journal of Psychology and Psychiatry, 4,* 109-124.

Meeks, J. E. (1971). The diagnostic evaluation of the adolescent patient, In *The fragile alliance,* Chapter 3, pp. 48-87. Baltimore: The Williams & Wilkins Company.

Paul, G. L. (1967). Outcome research in psychotherapy. *Journal of Counselling Psychology,* 31, 109-118.

Reisman, J. M. (1973). *Principles of psychotherapy with children.* USA: John Wiley & Sons.

Rustin, M. (1982). Finding a way to the child. *Journal of Child Psychotherapy,* 145-150.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist,* 65, 98-109.

Simmons, J. E. (1987). *Psychiatric examination of children* (4th ed.). Philadelphia: Lea & Febiger.

Slaff, B. (1979). Adolescents. In J. D. Noshpitz (Editor in chief), & S. I. Harrison (Ed., vol 3) *Basic handbook of child psychiatry: Therapeutic interventions* (pp. 504-518). New York: Basic Books.

Smith, H. F. (1986). The elephant on the fence: Approaches to the psychotherapy of Attention Deficit Disorder. *American Journal of Psychotherapy, 40* (2), 252-264.

Weiner, I. B. (1992). Normality and abnormality in adolescence. *Psychological disturbance in adolescence* (2nd ed, pp. 1-26). New York: John Wiley & Sons.

Winnicott, D. W. (1949). Hate in the countertransference, In *Through paediatrics to psych-analysis,* Chapter 15, pp. 194-203. London: Hogarth Press.

Fragment of a therapy: Experiences with psychosis

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Abstract

Ten sessions of the therapy of a psychotic patient are presented, illustrating the effectiveness of psychoanalytically-oriented psychotherapy for some aspects of psychotic processes. The seven-year therapy of this patient, while not wholly successful, at least enabled her to become able to live and work more or less independently.

The continuing debate over genetics versus environmental failures in the genesis of psychosis (Breggin, 1993, pp.1-22, 113-144) prompted me to present the case of Abby (all names are fictitious), referred from Ashburn Hall hospital in the 1990s with a diagnosis of atypical psychosis. My supervisor, a psychiatrist, commented, "What's 'atypical' about it!" and prescribed small doses of Haloperidol, an antipsychotic drug, after seeing Abby. (She always reduced the dosage after any improvement as she hated its deadening effects, and at one point was taking only a "homeopathic" dose of five mg. My feeling was that the medication played no role in improvements or regressions). As I came to know Abby better, I thought that "atypical" psychosis was the correct diagnosis.

Abby had a huge loading of what some would call genetic factors. The father was a manic-depressive on lithium, and the mother and Abby's younger brother had temporal lobe epilepsy with mood swings and violent temper outbursts. My preference was to follow Winnicott (1965, pp. 48-52, p.135, p. 256), who regarded psychotic illness as resulting from an "environmental" failure caused by premature disruption of the mother-infant unit, and I conceptualised Abby's difficulties in terms of the effects on her of parental behaviour accompanying their conditions.

Background

Abby, aged thirty-four, had been committed to a London psychiatric hospital and was sent back to New Zealand and into Ashburn Hall where she had a year's therapy with medication. The Hall felt she could benefit from further psychotherapy and referred her to me. This was her third or fourth major psychotic episode but she was never completely well, always having delusions, hypomanic outbursts, suicidal ideation, and exceedingly odd behaviour. She had a degree in nursing and another important diploma, but any attempt at working was soon followed by a breakdown. In her delusions Satan was making love to her; God would punish her for this by killing her in her sleep; she was pregnant and about to give birth to the child; she was a spy for Interpol, but as a double agent she risked being killed by both sides; she was a queen driven underground from where she directed a surface war; she had terrifying orders to destroy the world. The delusions seemed to express sexual and aggressive impulses and punishment for these. In at least one session she had an auditory hallucination. In most sessions she

masturbated by pressing her thighs together, presumably to soothe herself. My initial countertransference problem arose from the intense boredom provoked by Abby's long silences and very slow speech, and her detached hostility, as if parts of her personality were simply not there. For this reason I took notes to keep myself listening and focussed. I do not usually take notes during a session.

The parents gave me background details when they heard I was taking over Abby's care. After an induced birth Abby spent the first month alone in hospital in what she called the prem. room. When she was two years old her brother Michael was born, and he screamed day and night until epilepsy was diagnosed and treated. Mother went into a psychotic depression and ignored Abby completely, attending only to Michael's needs, while the father rejected Abby and verbally abused her, blaming her for the mother's illness. The parents reported that Abby had become very withdrawn at this time.

Theoretical Formulations

Winnicott (1965) developed the concept of the mother as "environment" for her newborn. By providing a "holding" environment the mother allows maturational processes to proceed unhindered. The newborn is not differentiated from this environment-mother and must not experience this prematurely. Ogden has elaborated on this, using the term "matrix" to describe the mother-infant unit, which is eventually internalised as the matrix of the mind (Ogden, 1992, pp. 167-201). He and Winnicott (1965, pp. 48-52, pp. 135-6, p. 256) see psychotic processes as arising from the mother's failure to prevent premature disruption of this primitive connectedness to her, with consequent defences against fears of annihilation. Ogden (1992, p. 43) thought Klein's (1952, pp. 292-320) paranoid-schizoid position could be seen as a defensive reaction to the mother's inability to prevent disruption.

In Abby's case her experience of the prem. room could have been the first disruption (she often referred to a feeling of "intense aloneness as if in the prem. room"), followed by the mother's withdrawal when Abby was two years old. This could be linked with Abby's delusion that she had "orders" (impulses) to destroy the world (mother). This disruption also occurred at the age when a child is practising separateness and independence (Mahler, 1968, Mahler et al 1975), negating these strivings. Additionally, the father's rejection occurred at a time when oedipal feelings of love are stirring, and Ogden (1992, p. 197) has emphasised that the father's healthy positive acceptance of this love is vital. Winnicott (1971, pp. 111-118) has written of the mother's face as the child's first mirror, and one can only speculate that Abby would have experienced herself as a very bad person when seeing herself reflected in the mother's withdrawn face and the father's angry face. With all these factors converging, the stage was set for severe psychopathology, leaving Abby experiencing attraction to her father as extremely dangerous in provoking both father's rejection and hostility, and "disappearance" of the mother. Both Khan (1986) and Ogden (1992, p.215) refer to

cumulative traumas as being especially disruptive. With these considerations in mind we can now look at the therapy process.

The Therapy Process

Abby's sessions were often full of oedipal sexuality material, but with my background of eclectic psychotherapy more in the tradition of the British Independent School of psychotherapy and analysis (Balint, 1965, 1968; Kohon, 1986; Symington, 2007; Winnicott, 1965) rather than the more Freudian (Freud, 1949, pp. 144-174) tradition, I tended to ignore the oedipal stuff and to focus on the disruption to the mother-child unit, though these strands were always interwoven in any session.

In our first year together Abby was often delusional, and after I took an overseas trip she became resolutely psychotic, even though I had phoned her almost every day to maintain contact. Periodically she tried to work in various jobs but always failed. I persevered at interpreting her defences against psychological growth, to no avail. Gradually it dawned on me that I was not paying close attention to what she was actually saying in each session but was screening out the unwelcome oedipal material, and I realised she needed to work through this before the deeper problem of disruption of her early connectedness to mother became meaningful to her.

This paper describes ten sessions in which a psychotic episode was resolved, and dates from my return from the Christmas break in the fourth year of her therapy. Not all sessions are consecutive. Abby was struggling with an office job she had begun at Christmas.

Session I. Abby glared at me balefully as usual, and lay deathly still on the couch as usual, each sentence followed by long silences. "Lost my job … couldn't cope … went psychotic … head all mushy, too slow…got fired. If you hadn't gone away this wouldn't have happened. I want to go back to Ashburn Hall." I said Ashburn Hall seemed to have become the good mother and I the bad one who left her to cope alone with her anxieties (I was thinking of how she was emotionally abandoned at age two). She agreed and added, "Well, I can't have money anyway; as soon as I earn it I deprive myself by spending it." After a long pause she asked, "Does money mean I could have a home of my own?" I said it did and that this must have some negative connotation for her. She immediately replied, "Yes, I'd lose Mum" (meaning she'd lose her feeling of connectedness with her mother). She asked to see me more frequently and we agreed on three times weekly, after which she said, "I'd like to be the therapist who makes money, not have all mine taken by you." It was clear that money of her own was equated with independence and loss, but there was also the first hint of rivalry with me. It was also the first hint – in her question about the meaning of money – that she was beginning to think about her predicament. Ogden (1982, pp. 190-192) refers to difficulties developing in thought processes if the mother fails as a container for her infant's "meaningful" projections. This may be a reason why therapists often feel there is little

therapeutic alliance and that they are doing all the patient's thinking for him or her, while the patient carries on ignoring reality.

Session 2. "I did a merge this morning" (meaning that she had become more integrated). Abby used splitting mechanisms of the kind Klein has documented. Parts of her personality would be split off, or would later merge with other parts - she sometimes said something in the back of her head had gone to the front - or get projected into others, and when destructive parts of herself were "killed off" I sensed detached hostility. Klein (1952, pp. 292-320) has written at length about these mechanisms used by patients who operate from a predominantly paranoid-schizoid position.

Abby then told me the real problem at work. She had needed to open the mail and she had become unable to do so in case there was a letter bomb. This could be personal as she was a spy for Interpol, or impersonal, somebody just angry about the Maori land claims. (I thought this sounded like oedipal material: two people rivalrous over the same bit of "land", which caused bomb-like rage). She rambled on about snakes under her bed and dying in her sleep, but suddenly thought of herself as a baby in the prem. room and burst into tears. "I know why I over-eat; it's to give the fragile baby substance. Being slim terrifies me, I go psychotic. And it could also make me attractive to men." I took up this idea of attractiveness and asked if she was afraid of being attractive to her father, pointing out that in not working she was able to have him to herself all day while the mother worked. Her reaction showed this to be correct: she became confused and hazy and projected her phantasies onto her father. "He watches me sexually. I can't bear to be physically close to him."

She'd awakened from a dream in which a voice said, "Stab your mother," and she'd been afraid to get out of bed in case she saw a knife. After a long silence she said, "I thought I gave birth to Christ this morning." I asked why Christ and she replied that He was pure goodness and it meant she was a good person. I thought the delusion might be a reaction to wanting to stab mother and have father's baby – she is good and pure instead. She became very disturbed by this and asked me to help her head, as it had "gone all mushy". I suggested that all these sexual and aggressive phantasies had frightened her so much that she had to kill them off and this made her head feel blocked and mushy. She said, "That's exactly how it feels. If I wasn't mushy and let myself go, I might go psychotic or kill someone. I might even call Mum a bitch." It would seem that going psychotic was an alternative to killing someone.

Session 3. A lot of thinly veiled hostility emerged, about my deserting Abby at Christmas and making her lose her job. I am successful, have a home and career, while she is a failure. She would like to kick me. I thought my desertion of her at Christmas would have felt like her mother deserting her when Michael was born, and her father rejecting her also at that time. She did not respond, but after a long silence she said she had had lots of ideas about breaking away from "Mum" and

having a home of her own, but then Abby got tearful. "I've got the idea that if I work, something awful will happen to Mum or the family, we'll die." We could see that independence was equated with extreme loss. However, in spite of this she said she felt better. She got progressively quieter and then said she'd had a dream of getting married. I interpreted this as a retreat from independent breaking away and a going back to phantasies of merging with Mum. This suggestion evidently reversed the regressive trend because she said, after a silence, "I suddenly feel much more grown up. I think I'll cook tea for the family tonight."

Session 4. Abby arrived next day looking ghastly and lay like a log. She had been awake all night, convinced she would die in her sleep. Satan wanted her to destroy the world. I suggested that this might be a reaction to feeling that in cooking tea she was destroying her mother by taking her place and being more grown up. She finally admitted that while cooking tea she had had to be physically close to her father and she could not bear it. Abby knew that on two or three occasions the father had come to see me to talk about his enormous guilt over his daughter, and she had consented to these interviews. She suddenly yelled, "I wish my father had never come to see you. You're mine, not his. He's charmed the pants off you."

I said she was implying he took my pants off and we had sex, and she agreed she had occasionally thought this happened here. She said that he came between her and Mum. I thought it more likely that Mum came between her and him, and that maybe she felt excluded from their sexual life, just as she felt he and I excluded her. She said, "Mum works, we three just lie around," to which I replied that maybe she felt there was room for only one professional working person in the family, her Mum, and that giving up being competent and successful got rid of the anxiety over competing with Mum. This evidently helped because after a thoughtful silence she said, "You won't ever retire, will you?" At the door she gave me a huge hug and said, "You're very skinny but you're really quite strong. I don't think you will break in half" (which gives some idea of her fear of destroying me with her rage)

Session 5. "My cousin visited last night. She used to be a prostitute. Her boyfriend came with her. I felt angry about their sex life. I felt the same anger about you when you came back after Christmas." After a silence she said her parents went to bed every afternoon (the mother had just retired from work) and she wondered if they were having sex. After another long silence she said through gritted teeth, "Volcanoes erupted recently." I commented that she probably felt like erupting with all that sex going on around her, and she asked if she really had to erupt or could the bomb be defused? I agreed it would be better to find a constructive way of dealing with her rage, rather than killing off the angry parts of herself and then feeling all mushy. She replied, "I think that's what my suicidal feelings are all about. I'm trying to kill off my angry parts by killing me." She then thought of a delusion at Ashburn Hall when she'd felt a penis thrusting inside her and thought it was Satan's. When I asked why Satan, she said "who else could it be!" I reminded her that while masturbating she had occasionally thought of her

father's penis thrusting inside her, so could it be his penis? She dismissed that idea. However, later that night the family rang, to say that Abby was crouched in terror in a corner, muttering incoherently about her father's terrifying eyebrows. The father supplied the clue when he said his eyebrows were bushy and Mephistophelian, which linked him with Satan. I spoke with Abby on the phone, telling her I would see her the next day and we would try to understand this terror of the eyebrows.

Session 6. Abby was dreamy and delusional, and mumbled about her father and his eyebrows and how he used to get so angry with them that they had to treat him like God. After a longish silence she started to wonder what it might be like if he touched her, and this led to wanting to masturbate on the couch and she got very excited and made pelvic movements and said she would like her father to touch her, and she wanted me to touch her also. I said, "No you don't, you're just frightened to exclude me in case I get angry that you are taking your father away from me." She replied, "In bed last night I thought, of course Carol isn't having sex with my father, it isn't real … and then I had this wicked thought: now I can have my father all to myself."

Session 7. Abby told me she'd joined a Grow group and a womens' anger management group; so clearly the work on her feelings about wanting father and her fear of retaliation had reduced her anxiety over functioning generally.

Session 8. It is difficult to convey how intensely real this following session felt to Abby. She had arrived about a week later in an appalling state. Her "head [was] mushy" and for ages she could not think or speak coherently. Finally she managed to tell me that her father had given her and her sister $50 each to spend in Waikanae and they had spent the night at the family's cottage there. Abby had decided to sleep in the parents' double bed. She had lain on mother's side of the bed and stretched one foot tentatively over to father's side of it, but that felt a terrible trespass. She progressively became more incoherent and disrupted while telling me this. She wanted to get up, stand in a corner and not move. She felt her breathing was stopping and that she was choking to death. Something terrible was happening inside her head and she begged me to help her. I said, trying to sound calm, that the idea of taking Mum's place in the bed must have been a really scary one. She started flinging herself around on the couch, almost falling off, screaming at me, "You've got to help me, my head is disintegrating; I want to cuddle you." I said the cuddle would simply reassure her that I wasn't angry about her taking her mother's place in the bed (though it could also be seen as her need for "holding" and containment). However, I did hold her hand and she calmed down a little. She lay in very odd almost catatonic stances, punctuated by floods of tears. She finally admitted the worst: "I had the idea of kissing Dad in that bed." Then she felt like going to sleep. I said that would send the scary ideas to sleep! After a long silence Abby said, "There's my mother in my head and she's saying we shouldn't have taken that money from Dad, we're too poor." I thought this mother in her head sounded very punitive and depriving, and that the mother outside her would want

her to be attractive and successful and to have good things. (Reassurance never really reassures, but at this point I couldn't think of anything more useful to say). She gradually calmed down, and this climactic session proved to be a turning point.

Session 9. The following day I went to a weekend conference. In the next session Abby was much more verbal. The buzz word was "attention." She couldn't go back nursing because she hated giving attention to her patients, she wanted to be the nursed one who got the attention. Father didn't pay her enough attention. Mother and father gave each other all the attention, except when Michael came and then he got it all. Father read the newspaper aloud to get attention. Mother used to get attention by talking about her "special needs" children at school. At this point I intervened, saying that at last I thought we'd reached Abby's experiences when she was two years old and her mother withdrew from her and gave all her attention to Michael's "special needs." She went quite rigid: "I didn't like it when you said that." I wondered if my going to conferences had anything to do with this attention business, since she'd always gone psychotic when I'd taken a holiday. She said, "Yes, you take your attention from me and give it to all those others and they all crowd around you, hanging on every word you utter," (as if I were "feeding" others, the way she would have seen her mother feeding Michael). She perked up quite a bit as the session went on, saying a lot more about attention and how this was a really big issue. At the door she looked at me intently and said, "It's nice to see you again!" I said it was nice to see her also. I wondered afterwards if the interpretation about "special needs" had got in touch with a part of Abby that had been dissociated - possibly what Tustin (1986) refers to as an "autistic capsule" that could be her pre-two-year-old self - and that this part was able to recognise me and feel it had found something familiar: perhaps the good mother before the tragic events surrounding Michael's birth.

Session 10. The next day she was dramatically different, almost normal. She was full of memories of her past, weeping copiously. She'd been able to cuddle her father and cry on his shoulder without any sexual thoughts or worries. She said, "I suddenly feel very young and alone with my parents," and I said, "Like before Michael was born?" and there were floods of tears over this. She spoke of the "golden wonderful magical years" when there was just her and her parents and no brother and sister. She ended the session by saying insightfully, "This is why I can't work. It means giving up being two years old and having them both to myself, just the three of us in the house all day." It seemed that she had finally got in touch with some of her traumatic infantile experiences, but also the good times before that, and was able to be insightful about how these had affected her ability to separate from the family.

Conclusion:

The ten sessions seem to reveal a gradual build-up to the mutative experience in Session 8, in which Abby faced her worst fears of catastrophe if she were attracted to her father. My role was to "hold" her during this experience, and contain the

psychotic terror of the mother's retaliation for the foot on father's side of the bed and the phantasy of kissing him. My acceptance of this enabled her to bear it as something to be thought about and no longer disowned. Also crucial was that she experienced me as "surviving" her destructive impulses at a deep level. Winnicott (1965, pp. 102-3, 1971, pp. 84-96) describes the need to experience the mother as being destroyed but paradoxically as also surviving, and I think my "survival" helped Abby into the more reality-oriented state she achieved in sessions nine and ten. Stopping session eight, or suggesting hospitalisation or more medication, would be examples of my not surviving. Session nine also opened the way for a reaching of the good time before Michael's birth and her infant self that had been split off after his birth.

Abby stayed in therapy for a further three years, and our work dealt mainly with her anger over relinquishing all her unsatisfied infantile needs and developing a life of her own. She complained of a "grumpy opposition" to any independent activity because "all my 'success things' have to be done on my own." She went nursing but felt very alone doing this and would take my phone number and stare at it, to have a feeling of contact, often wishing her mother could go to work with her, so that they could feel blended. She achieved this blended feeling by "standing still and binding my thoughts." There was much material about her mother "not being there" for her, which we continued to link with the two-year-old's experiences and with the prem. room. She felt "aware of being on the verge of a sense of identity but it's too much to bear." She also said that "some very nasty parts of me" were still shut away. Sadly we never did manage to integrate those, though I think the psychotic defences were considerably weakened. Importantly, she did manage to break away from the family and get a flat of her own, and so far as I know she was able to carry on with her nursing career. However, I suspect that she remained an angry and unhappy person, and she terminated therapy long before I wanted her to.

I lost touch with the family, so I do not really know how much further progress she continued to make. My only not very welcome clue came from Abby's sister, whom I had in therapy some years later. She one day said, in transferential awe and fear, "Whatever did you do to Abby! She's so angry, because she tries to go psychotic and she can't."

References

Balint, M. (1965). *Primary Love and Psycho-analytic Technique.* London, UK: Tavistock Publications.

Balint, M. (1968). *The Basic Fault.* London, UK: Tavistock Publications.

Breggin, P. (1993). *Toxic Psychiatry.* London, UK: Harper Collins.

Freud, S. (1949). *New Introductory Lectures on Psychoanalysis.* London, UK: Hogarth Press.

Khan, M.M.R. (1986). The concept of cumulative trauma. In G.Kohon (Ed.) *The British School of Psychoanalysis: the Independent Tradition* (pp. 117-135). London, UK: Free Association Books.

Klein, M. (1952). Notes on Some Schizoid Mechanisms. In Klein, M, Heimann, P, Isaacs, S. and Riviere, J. (1952). *Developments in Psychoanalysis* (pp. 292-320). London, UK: Hogarth Press.

Kohon, G. (1986). *The British School; of Psychoanalysis:Tthe Independent Tradition.* London, UK: Free Association Books.

Mahler, M.S. (1968). *On Human Symbiosis and the Vicissitudes of Individuation.* New York, NY: International Universities Press.

Mahler, M.S., Pine, R. and Bergman, A. (1975). *The Psychological Birth of the Human Infant.* New York, NY: Basic Books.

Ogden, T.H. (1982). *Projective Identification and Psychotherapeutic Technique.* New York, NY: Jason Aronson.

Ogden, T.H. (1992). *The Matrix of the Mind.* London, UK: Maresfield Library.

Symington, N. (2007). *Becoming a Person through Psychoanalysis.* London, UK: Karnac Books.

Tustin, F. (1986). *Autistic Barriers in Neurotic Patients*. London, UK: Karnac Books.

Winnicott, D.W. (1965). *The Maturational Processes and the Facilitating Environment.* New York, NY: International Universities Press.

Winnicott, D.W. (1971) *Playing and Reality*. New York, NY: Basic Books.

Dreams at the edge of death

Margaret Bowater

Abstract

Death is the great unknown that lies ahead for all of us, shaping the way we choose to live our lives. Is it the end of our being, or a transition to something different? Many people facing death, from Socrates to the present day, have had visionary dreams hinting at another level of reality beyond death, after which they lose all fear of death. This article presents a selection of visions from the edge of death, including some from New Zealanders, to invite consideration of how this perspective can make a difference to clinical practice. This topic was presented at the NZAP Conference in Nelson, 2010, as a basis for discussion with a group of practitioners, who all contributed thoughts and examples from their own experience, thus greatly expanding the range of material. Here is the skeleton for others to hold a similar discussion.

Socrates' dream

Since ancient times some records have survived of powerful dreams and visionary experiences around the time of death. One such is that of Socrates, 500 years before Christ, as recorded by his disciple Plato, and quoted by Kelly Bulkeley (2008), a modern scholar of dream literature:

> The dialogue known as the Crito opened with Socrates sleeping in his prison cell, while the Athenian authorities awaited the arrival of a religiously ceremonial boat that would signal the time for his execution. His friend Crito was sitting there when Socrates awoke just before dawn, and Socrates immediately declared that the boat in question would not arrive that day:
>
> Crito: What makes you think that?
>
> Socrates: I am going by a dream that I had in the night, only a little while ago.
>
> Crito: What was the dream about?
>
> Socrates: I thought I saw a gloriously beautiful woman dressed in white robes, who came up to me and addressed me in these words, 'Socrates, to the pleasant land of Phthia on the third day thou shalt come...'
>
> Crito: Your dream makes no sense, Socrates.
>
> Socrates: To my mind, Crito, it is perfectly clear (Bulkeley, 2008, pp. 147 – 148).

The words spoken by the beautiful woman (explains Bulkeley) were quoted from The Iliad, from a passionate speech given by Achilles when he was planning to abandon the Trojan War and return to his home in Phthia. As it turned out, Achilles never made it back home. He returned to the battle, fought heroically and died. Socrates was about to die for a very different cause, that of truth and spiritual freedom. His dream seemed to suggest that death would bring him to the ultimate spiritual paradise, a kind of transcendental homecoming. The philosopher would achieve what the warrior could not.

Thus Socrates drank the poison without fear, expecting to enter a new life in a "pleasant land."

Mediaeval death visions

Carol Zaleski's "Otherworld journeys" (1987) provides a comprehensive summary and discussion of Western near-death literature from ancient times to modern, observing that there are many similarities in the reports of survivors, but also significant differences between the historical periods. The accounts in mediaeval times were mainly recorded by monastic scribes, and tended to be strongly shaped by religious beliefs, such as the expectation of passing through scenes of purgatorial torment before the faithful arrive at the "ineffable Light", whereas modern accounts rarely include any scenes of punishment for sin. In this they reflect a major shift in the dominant religious and cultural understandings which underlie survivors' stories.

Compare the ancient Greek story with the account given by Pope Gregory the Great in the 6th century AD, in his fourth book of Dialogues, as quoted by Zaleski (1987). He is reporting the story of a Roman soldier who had died of the plague.

> A certain soldier in this city of ours happened to be struck down. He was drawn out of his body and lay lifeless, but he soon returned [to life] and described what befell him. At that time there were many people experiencing these things. He said that there was a bridge, under which ran a black gloomy river which breathed forth an intolerably foul-smelling vapour. But across the bridge there were delightful meadows carpeted with green grass and sweet-smelling flowers. The meadows seemed to be meeting places for people clothed in white. Such a pleasant odour filled the air that the sweet smell by itself was enough to satisfy [the hunger of] the inhabitants who were strolling there. In that place each one had his own separate dwelling, filled with magnificent light. A house of amazing capacity was being constructed there, apparently out of golden bricks, but he could not find out for whom it might be. On the bridge there was a test. If any unjust person wished to cross, he slipped and fell into the dark and stinking water. But the just, who were not blocked by guilt, freely and easily made their way across to the region of delight (pp 29-30).

Gregory understood the vision symbolically, but it was widely known by scholars of the time.

The modern near-death-experience

Compare this again with a typical modern report, taken from my own collection:

Xanthe, 60, was visiting her daughters overseas when she went to bed with a bad cold. It developed into pneumonia and she lost consciousness. Her daughters, alarmed, called an ambulance and she was taken to hospital.

Dream report: The shining light

> I am going down a long black tube that seems to go into the ground. It is very long and dark at the bottom. As I descend I see on my left a passage radiating a strong calming light, very pretty and inviting. I want to go there. The closer I get the more beautiful this magnificent light gets, and I want to know what's on the other side. I feel intrigued, happy and confident, and I start going in; it is so inviting and calming. Suddenly I get sucked back, and start going back up the tube. I don't want to go back. I want to go into the passage with the beautiful light, so I fight back, but still I keep on going up. Then I woke up, not knowing where I was. My two daughters were there; one was crying and the other was holding her hands so tight her knuckles were white. There was a man next to me and a woman dressed in white, and another man standing at the end of the bed. I slowly realized that this was a hospital bed, and I had a mask covering my mouth and nose, and I could breathe, but I was far too tired to tell my daughters about my wonderful tunnel of light.

Comparing the three reports, you can see the similarities and differences across time and culture.

Zaleski (1987) provides a convenient summary of the main modern writers in the field of near-death studies (pp. 104-112.) In 1975, Raymond Moody, a Ph.D in Philosophy, published "Life After Life", a summary of 150 reports he had collected from people who had apparently died and recovered. The foreword was an endorsement by Dr Elisabeth Kubler-Ross, the courageous woman who first turned the spotlight onto dying as a natural process to be studied. Moody listed 15 typical elements of near-death-experiences, which were later grouped by another researcher, Dr Kenneth Ring, into 5 stages:

- A sense of peace, release from struggle;
- Separation from the body, looking down at it;
- Floating through a dark void or tunnel, sometimes aware of a choice;
- Perceiving a brilliant light or "presence" emanating acceptance; and
- A sudden return to the body.

While this is the basic structure across all cultures, each experience has different details, sometimes including such elements as: a life review; meeting deceased relatives; a Being of light (named according to prior beliefs); a continuation into beautiful scenery (fields, gardens, etc); a sense of reluctance to return; and a subsequent lack of fear of death, and commitment to lives of service.

A great deal of research has followed, in a variety of settings, including hospital cardiac wards. It all verifies the basic pattern, especially the early stage in which survivors report watching resuscitation attempts on their bodies, and also their subsequent lack of fear about death. The International Association for Near-Death Studies began in 1978 and continues to collect thousands of cases for study and research.

It seems to me that there is plenty of evidence for everyone to consider, that death may not be the end of our existence, but a transition to another dimension of being, not focussed on material concerns. If we were travelling to another country, we would listen to people who had at least looked over the border, and try to prepare ourselves for the different conditions to be expected. While existence on earth requires our commitment now, what are the values that will transcend death?

Experiences in New Zealand

Over the last 25 years I have personally listened to dozens of near-death stories told by participants in my dream workshops all over New Zealand. The basic pattern is the same, while the details differ. They may even have elements of humour, as in the following account.

Report of experience: Protecting the children

Julie remembers this delightful story told to her by her grandmother Ethel about 30 years ago, who was a Christian with a firm faith in Jesus. The event would have taken place in the late 1920s, when Ethel was in her 30s, long before the availability of antibiotics in New Zealand.

> Many years ago when my children were small I was very sick. I was in hospital with double pneumonia. I was unable to breathe. I died and came out of my body. I saw my body lying there. I then went into a tunnel and quickly came out the other side, where I saw a Being of light. I believed this was Jesus, as he was a Being of light, and radiated love and compassion. Jesus said that I could stay in heaven. However, I was very concerned about my husband, as he was very quick-tempered with the children. I said to him that I was worried about my children, particularly my youngest. He said Yes, he knew what my husband was like, and that I could go back. Immediately I was back in my body. I must have been dead some time, as somebody had put the sheet over my face. I recovered, and was able to go back to look after my family.

She was totally unafraid of death from then on. Grandma lived to the ripe old age of 85, when she died of heart failure several years after a severe heart attack. But the doctor resuscitated her, and she told him off, saying she was not afraid to die! All the family heard her say it. She did die a few weeks later.

In the words of Bulkeley (2005):

> When a person experiences a pre-death dream, the benefits often extend beyond just the dreamer... dreams become part of the family lore, shared and discussed and treasured for years. Pre-death dreams also act as inspirations for others (p.139).

A Maori near-death-experience

One of the most interesting examples I have read in New Zealand, for its historical implications, is the account given by Michael King (1983) in his biography of Dame Whina Cooper. She was an active Catholic all her life. The dream happened in 1974, when she was 60 years old, and very sick. Behind the humorous style of her telling, you can catch the typical features of what sounds like a near-death-experience:

Dream Report: Your work's not completed yet

> I dreamt I went to heaven. I walked there. It turned out to be just past Panguru, behind the church and the presbytery. I knew I'd got there because all the people I knew that were dead, my cousins and other relatives, were sitting on the bank where the road goes past the church. So I said to them, "Hey! What do you eat up here in heaven?" And they said, "Puha." So that was that. Then I walked on a bit further, and at last I saw God coming towards me. He was only a short chap with a Pakeha face and a long beard, and he had these eyes that flashed and flickered. I could hardly look at Him. Anyway, He said to me in Maori, "Where are you
>
> going?" And I said, "I'm coming up here to Heaven." He said, "Oh no, you're not. Not yet. Your work's not completed." So I had to turn round and walk back. After that I thought, oh well, I'll just have to keep going (1983, pp 204-5).

And in fact it was the following year, 1975, that Whina Cooper organised and led the Land March on Parliament. You can imagine how she drew strength from her dream.

A complex near-death-experience

Finally, here is a remarkable story from a recent workshop, offering much food for thought.

Nadine was 46, a full-time mother and farmer's wife, when she felt a "heaviness" in her chest and managed to get to the local doctor.

Report of experience: My dad supported me

The doctor called an ambulance immediately, even though the test he had done showed up as normal. When the ambulance arrived there was only one person; he decided to wait and call for another person to drive so he could sit beside me in the back. Within a few minutes' driving I had a heart attack and was resuscitated. The medical report said I "flat-lined." Amazing that the ambulance guy had called for backup, otherwise I would have not made it. In A&E at the provincial hospital I remember a sort of fleeting vision of standing by my body, near my head and watching the team working frantically. I went back in to my body and felt the terrible pain and then slowly it started to lift.

After nearly 10 days in ICU and three heart attacks very late one night as I barely held on to life, the City Hospital finally had some room and dispatched a retrieval team in a helicopter to pick me up and take me there to do the procedure my heart needed. At 3am as we were flying in the helicopter I looked out at the stars in the darkness of the sky and thought that would be my last experience of my life. At the big hospital they were inserting stents into my heart arteries. It was supposed to be a regular procedure of 20 minutes or so.

You have to be awake for this procedure so that you can indicate when the pressure is released. The pain was so sharp, intense and horrific I left my body. I was exhausted from the weeks of pain and could not resist the pull toward a light that was flooding from a doorway similar to the end of a long hallway. I was motionlessly floating toward it, then my Dad came towards me, from the doorway. I couldn't move or speak. He spoke to me and said he knew how bad I felt and that he would carry me, carry my pain for me as it was not my time to leave. He was Dad at his very best, in good shape and wearing his favorite blue shirt with his brown trousers, the ones Mum always told him off about. She didn't like him to wear brown and blue, funny now it has become so fashionable.

Anyway, Dad grabbed hold of me and carried me across his arms. I could smell him and feel his warmth. I was glad to be with him and feel all his love and protection. I wish I could have talked to him but I did not have the strength. He just spoke to me gently, "Just rest, just rest, you're nearly there, I've got you, sweetheart." Then like a jolt, I heard the familiar voice of the specialist, who was strongly calling me: "Mrs X, Mrs X!" and somehow in a flash I felt the heaviness of my body and I was back in it. I was breathing in my body. Later, I told the doctor of my experience and he explained to me that, during the procedure, when they were inserting the second stent, my artery split open. "That's when you would have seen the light," he said. I had three stents inserted and am healing slowly. Life is very different for me now and I am struggling in various ways, for various reasons. However, I would have to say that I have peace about when your time to die is. It seemed from my experience that unknown to me someone was in charge and someone was saying it was not my time.

> This is a very mystical, faith-full experience, as within the process of near-death I have gathered more sincerity in the process of life. I feel more intensely now about the question of 'What is my life purpose?' I mean, I have survived, so how do I repay the gift? Is it the chance to be true to my self and just be free from justification or expectation? I don't know why I survived, but I did, so I will try to honor the gift of time I have been given.

Conclusion

Stories like this are life-changing. They are told in many of the workshops I lead, and have a powerful impact on all the listeners, but they are not often told in ordinary conversation, for fear of being ridiculed. I think that we as therapists can not only listen respectfully to such experiences, but also explore them seriously, and be ready to pass the storyline on to others who are struggling with questions of grief, death and meaning.

References

Bulkeley, K. (2008), *Dreaming in the World's Religions*. NY University Press.

Bulkeley, K. and Bulkley, P. (2005), *Dreaming Beyond Death – A Guide to Pre-Death Dreams and Visions.* Boston: Beacon Press.

King, M. (1983), *Whina.* London: Hodder and Stoughton.

Moody, R. (1975). *Life After Life.* NewYork, Bantam Bks.

Zaleski, C. (1987). *Otherworld Journeys: Accounts of Near-Death Experience in Medieval and Modern Times.* New York: Oxford University Press.

Individuality: A Threatened Concern in the Era of "Evidence-Based" Practice?

Nancy McWilliams

Despite robust clinical and empirical literatures suggesting the importance of therapists' attunement to clients' individuality, current trends in conceptualizing psychotherapy effectively minimize considerations of individual difference. The popularity of studies of specific techniques targeting discrete disorders has had the unintended side-effect of marginalizing consideration of factors such as temperament, attachment style, defence, developmental challenge, affect structure, relational pattern, implicit cognition, religious belief, cultural context, and sexual orientation that affect the health of the therapeutic alliance and the success of therapy. Current pressures may also militate against practitioners' attending carefully to their own individuality and its role in influencing therapeutic relationships. Practitioners and researchers are urged to give more consideration to this traditional area of concern.

As a therapist in practice over many years with a wide range of patients and problems, I closely follow trends in conceptualizing, researching, and funding psychotherapy. I appreciate Paul Solomon's invitation to submit a short opinion piece for this journal on the topic of the limitations and dangers of narrowing our consideration of psychotherapy to efforts to compare and contrast different technical procedures for different discrete disorders – an approach that some have termed the "horse-race" model of psychotherapy research. The opinions stated here are my own, but I think they reflect attitudes that are common among experienced practitioners, across theoretical preferences and across patient populations.

Unintended Negative Consequences of Current Conceptualizations of Psychotherapy

Therapists of all orientations ought to be worried about some possible ramifications of contemporary, well-intentioned efforts to ensure quality and accountability in psychotherapy. The current emphasis on "evidence-based" or "empirically supported" treatment, or on "best practices" and "standard of care" may bode ill for the appreciation of individual differences (in temperament, personality, learning style, culture, belief, sexual orientation, socioeconomic status, and other factors) that has traditionally, and for good reason, been a central preoccupation of the practitioner community.

As a core value and explanatory construct, individuality has historically played a starring role in our understanding of the therapy process, but it is startling how little attention to individuality characterizes most of the empirical work that medical researchers, some academic psychologists, and (perhaps most ominously) insurance and pharmaceutical companies currently consider "evidence." This is particularly disturbing in the presence of an extensive empirical literature on personality differences, attachment, emotion, development, brain function, and

other areas of individual variability to which clinicians regularly attend to craft their interventions. Despite the inclusive definition of evidence adopted by the recent American Psychological Association task force on evidence-based practice (American Psychological Association, 2005), there has been a tendency among many of our colleagues to restrict the definition of "evidence" to randomized controlled studies of therapy outcome, as defined by reduction of observable symptoms.

In the past few decades, largely as a result of the medically conceived, categorical (rather than dimensional and contextual), logical-positivist orientation of recent editions of the *Diagnostic and Statistical Manual* of the American Psychiatric Association, there has been a tendency among researchers to reify "disorder" categories and then investigate manualized treatments aimed at ameliorating those disorders. If one wants to study depression, for example, one selects research participants with DSM-specified depressive symptoms irrespective of whether their personalities are more hysterical or obsessional, whether they are more introverted or extroverted, gay or straight, Italian or Chinese, or even whether their subjective experience of depression is more introjective or anaclitic (Blatt, 2004).

If they suffer from depressed mood, endorse enough vegetative signs to meet the DSM criteria for Major Depression, and are relatively free of "comorbid" conditions, they may qualify as research participants, and the results of the study may influence what is considered the standard of care for depression. We have learned a lot from empirical work of this sort, and the technical innovations that such studies have inspired have added valuable components to our therapeutic repertoire. But I worry that if the assumptions that underlie such research become definitional of what matters in our field, we will lose a focus that is critical to therapy outcome, one that has every bit as much empirical standing as the so-called evidence-based therapies.

Because our predecessors in practice began learning at least a century ago that individuals with similar symptoms but different personalities cannot be given a "one-size-fits-all" treatment, there is a long tradition in psychotherapy of attention to individual differences in the people we try to help. Our clients experience our interventions idiosyncratically depending on, among other factors, their temperaments, their experiences with earlier caregivers, their particular attachment styles, and their individual defences, maturational issues, cognitive and emotional schemas, social and family contexts, identifications, cultural and religious sensibilities, and relational patterns. Despite psychology's vast empirical literature on individual differences, I worry that the current tendency to treat a given symptom pattern as a thing-in-itself, rather than as an expression of a client's complex and unique subjectivity, may produce a generation of therapists whose main response to suffering is "There's a manual for that."

The Redefinition of Therapy from Healing Art to Technical Procedure

With no disrespect for the many valuable therapy manuals that have been developed in recent years or for the expansion of models that have enriched our options to help our clients, I think that what philosophers call a "category mistake" (Ryle, 1949) has been made with respect to the field of clinical practice. I have no doubt that most practitioners believe that psychotherapy should be based on scientific research and not just on clinical anecdote. But therapy's being *based on* research is different from its being *like* research.

To do a certain kind of outcome research with methodological integrity, one must have a homogeneous group of patients who meet diagnostic criteria for a particular condition and yet lack comorbid problems; one must take objective measures before and after a series of interventions; and one must manualize the treatment to be sure each therapist in the research project is proceeding similarly. To reason backwards to the conclusion that therapists, in working with complexly suffering people who are often filled with shame for seeking help, should treat disorders as separable from personality and context, should manualize their work, and should take objective measures before and after a delimited treatment conflates the demands of one field (empirical research) with the demands of another (applied clinical practice). Parenthetically, I should note that it is a prevalent observation among therapists that patients with a single, discrete, non-comorbid disorder exist only in the imagination of researchers and in the context of naively interpreted self-report.

This conflation of what is good for research with what is good for treatment has contributed to a subtle but, to my mind, sinister paradigm shift. Psychotherapy used to be generally understood as a healing relationship. Recently, it seems to have been reconceived as a set of techniques to be applied to certain specifiable, discrete types of suffering. Therapists have historically seen themselves as practitioners of an art, one that is based in psychological science, but they are being increasingly pressured to define themselves as technicians in the service of the narrowest possible definition of symptomatic improvement – the kind that nonclinical researchers might use as externally observable indications of positive change.

Clinicians have traditionally defined their role as including their calling into question, with individual clients, some of the psychologically stressful or damaging assumptions of the dominant culture - especially the commercially driven pressures that a mobile, mass society generates to consume products and compete for narcissistic supplies. Increasingly, therapists are being asked to be instruments of that society, to improve people's behavior only to the point where it is no longer inconvenient to the larger community. "Behavioral health" is replacing "mental health" as an organizing concept, as if the internal aspects of experience are only incidental to an emotionally satisfying life.

Our current focus on short-term treatments for delimited disorders is at least partially driven by the realities of current academic life (in which the prompt

amassing of a list of time-limited research projects is much more conducive to tenure and promotion than longer-term, more complex scholarship), the interests of pharmaceutical companies (who have a stake in defining mental and emotional difficulties as discrete symptoms that their drugs can relieve as easily as a psychological treatment can), and the interests of insurance companies (who learned, after marketing their policies as covering "comprehensive mental health services," to exclude Axis II diagnoses from those services, given that personalities do not change after a small, inexpensive number of therapy sessions).

The Therapist's Individuality

Despite our longstanding attention to the individuality of clients, we have paid much less attention to individual differences among therapists. In fact, research on divergent personality styles among clinicians is only in its infancy (e.g., Hyde, 2009). And yet the most consistent overall empirical finding in the outcome literature is that the best predictors of change and growth in therapy are personal factors such as the warmth and genuineness of the therapist and the quality of the relationship that develops between a specific healer and a specific sufferer (Norcross, 2002; Wampold, 2006). As therapists we know intuitively - and our clinical writing reflects this understanding - that if our technical knowledge is not integrated with our idiosyncratic personal style, we will feel deadened, inauthentic, and at risk of burnout, and our clients will feel they are being treated as objects of manipulation rather than as subjects in a mutual collaboration.

In an effort to represent the perspective of experienced mental health practitioners in current debates - in which large corporations, policy wonks, and academic researchers seem to have a much louder voice - I have written on individual differences from several perspectives (e.g., McWilliams, 1994, 1999), and although my orientation is psychoanalytic, my work has resonated with clinicians of many theoretical inclinations. We therapists often characterize our professional development in terms of our progressive integration of our technical knowledge with our most genuine personal qualities. We tune our instrument, our personality, more and more sensitively as the years go by, and we find more and more internal resonances to the diverse compositions that our individual patients play for us. In view of this prevalent attitude among seasoned therapists, and in light of recent research on the importance of the therapeutic alliance to outcome (e.g., Blatt & Zuroff, 2005), I have come to believe that for psychotherapy to be effective, the individualities of both therapist and client must be honored.

A Plea to Colleagues in Both Research and Practice

In summary, I want to inject into the current conversation about scientific evidence and psychotherapy the view that a critical kind of evidence that should influence our work is the evidence for individual uniqueness. As one of my cognitive-behavioral colleagues recently asserted, we treat *people*, not artificially isolated conditions. Much good empirical work has been done on individual differences, and yet much remains to be done on the relationship between individuality and

psychotherapy. Such work that would be more relevant to patients as they actually experience themselves and present themselves to therapists than are the "horse-race" models of randomized controlled trials. I urge my academic and practitioner colleagues to consider reviving this currently underemphasized area of study.

References

American Psychological Association (2005). *Policy Statement on Evidence-Based Practice in Psychology*. At http://www.apa.org/practice/ebpreport.pdf. Retrieved 27/05/10.

Blatt, S. J. (2004). *Experiences of depression: Theoretical, clinical and research perspectives*. Washington, DC: American Psychological Association.

Blatt, S. J., & Zuroff, D. C. (2005). Empirical evaluation of the assumptions in identifying evidence based treatments in mental health. *Clinical Psychology Review*, 25, 459-486.

Hyde, J. (2009). Fragile narcissists or the guilty good. What drives the personality of the psychotherapist? Unpublished doctoral dissertation, Macquarie University, Sydney, Australia.

McWilliams, N. (1994). *Psychoanalytic diagnosis: Understanding personality structure in the clinical process*. New York: Guilford.

McWilliams, N. (1999). *Psychoanalytic case formulation*. New York: Guilford.

Norcross, J. C. (Ed.) (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. New York: Oxford University Press.

Ryle, G. (1949). *The concept of mind*. New York: Barnes & Noble, 1968.

Wampold, B. E. (2006). The psychotherapist. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 200–208). Washington, DC: American Psychological Association.

Is psychotherapy any good? A review of evidence relating to psychodynamic psychotherapy and the nature of psychodynamic assessment

Sean Manning

Abstract

This document is intended as a resource to stimulate discussion around the validity and effectiveness of psychodynamic psychotherapy and psychodynamic assessment. It is written in an atmosphere of, to this writer, unhelpfully argumentative debate between 'scientific' (symptom and behaviour oriented) clinical psychology, and the more descriptive, relationship-oriented psychotherapies, in which the latter have been criticised as unscientific and lacking evidence for their practice (Surgenor 2006).

Introduction

In 1952, Hans Eysenck published his famous critique, claiming that psychotherapy was no better than no treatment at all, which has often expressed in Raimy's (1950) quote, "Psychotherapy is an undefined technique applied to unspecified problems with unpredictable outcomes" (p. 93).

It would seem that his conclusion is still current among many 'scientific' practitioners, even after decades of research that demonstrate considerable evidence for the efficacy of psychotherapy. Despite this controversy, or maybe because of it, many psychotherapists eschew scientific investigation. Psychodynamic therapists, and in particular psychoanalysts, often seem to regard the uninitiated with as much disdain as behavioural researchers have towards them for their allegedly poor science (Fonagy 2006). One consequence of this lack of co-operation between disciplines has been a poor showing of research into psychodynamic methods, compared to behavioural, symptom-oriented treatments. Thus behavioural therapists can claim to have more scientific basis for their work.

The terms 'psychodynamic psychotherapy' and 'psychotherapy' are used interchangeably. The terms 'psychoanalysis' 'analysis' and 'analytic therapy' are also interchangeable, but indicate a particular form or forms of psychotherapy characterized by a reflective, interpretive and neutral therapist stance, and relatively long duration.

This document is a summary of summaries, using several current reviews, a few more general resources and a couple of specific articles. It is not intended to be a rigorous scientific paper, but it is, I believe, a truthful reflection of what is 'out there' at present. It makes no exaggerated claims for psychodynamic psychotherapy.

It has three parts. In the first part, the bulk of the paper, I will discuss some of the arguments and issues relating to research into psychotherapy. Doubts about the

'gold standard' of outcome research, the 'randomised controlled trial'; its applicability to psychotherapy; and the American Psychological Association's list of ESTs, empirically supported therapies, are discussed. Then such research as exists is summarised. Psychotherapy effectiveness in relation to specific disorders is reviewed, as well as evidence for long-term psychotherapy.

Part two deals with a different order of evidence. This is a brief discussion of the implicit direction indicated by the related literatures on attachment and narrative.

Finally, in part three there is a discussion of psychodynamic assessment, as distinct from clinical diagnosis, and a short discussion of the problems with diagnosis by categories.

PART 1: Research and Research Evidence

Problems with outcome research 1: The APA list of empirically supported treatments

The 'gold standard' in outcome research is the randomised controlled trial (RCT), in which subjects are randomly allocated to one of two or more conditions - 'experimental' or 'control'. The standard used by the American Psychological Association's (APA) Task Force on Promotion and Dissemination of Psychological Procedures for 'Level 1' (the best) evidence is two or more randomised controlled trials covering the same ground (Leichsenring 2005).

In 1995 the APA task force began to report on 'empirically supported treatments' - ESTs - and a list was compiled. This list, regularly updated, still defines the international standard for psychological treatments. The case for the list is that it empowers consumers, giving some protection from fringe therapies; it provides information about what works so that everyone can make better decisions, including funders; and that it improves the training and education of practitioners.

The case against, as summarised in a recent *Scientific American – Mind* article (Arkowitz and Lilienfeld 2006), gains momentum with time.

The list is not verified in the real world. As Glen Gabbard said in a *New York Times* interview: "The move to worship at the altar of these scientific treatments has been destructive to clients in practice, because the methods tell you very little about how to read the real and complex people who actually come in for therapy" (Carey, 2004). Too much is sacrificed - therapist flexibility is constrained, researchers reject up to 90% of subjects in the interests of homogeneity and the all-or-nothing nature of the list omits information, like measures of degrees of efficacy. Some treatments have quite modest effects, with many subjects not helped at all, or likely to relapse. Westen and Novotny (2001) showed how the figure of 51% of depressed patients who improved following CBT dropped to 37% 1-2 years later.

The EST list is biased in favour of cognitive-behavioural techniques. Reviews of psychoanalytic and humanistic treatments suggest equally positive effects, but there is less research on them, so less likelihood of being included.

ESTs focus on symptoms and distress to the exclusion of other factors that will be important in relapse.

The technique may not be what produces the change. The 'Dodo-Bird verdict' confounds researchers. In 'Alice in Wonderland', the Dodo Bird, judging a race, announced, 'Everybody has won and all must have prizes'. There is a tendency for all psychological or psychotherapeutic therapies to do equally well.

In response to these arguments and anomalies, in 2005 the APA issued a policy statement defining evidence-based practice as 'the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.' This amounts to recognition that regarding randomised controlled trials as the gold standard might have been an error.

Problems with outcome research 2: The difficulty with randomised controlled trials - RCTs

Randomisation in research serves to eliminate differences between groups, thus controlling potentially disturbing influences on differences caused by treatment. Randomisation is thought to ensure the internal validity of a study. In terms of believable evidence, this is certainly the case. However, there is a series of problems in applying RCTs to psychotherapy methods.

Research into therapy that is considered empirically supported tends to have three characteristics:

1. Studies address a single disorder, usually Axis I of the DSM-IV. The use of Axis I as a basis for research on treatment effectiveness has the advantage that the subject of inquiry can be treated as a discrete disorder with a measurable set of symptoms, thus producing apparently clear results for 'evidence-based' treatment.
2. The disadvantage is that the co-morbidity commonly observed in clinical practice, often involving Axis II diagnoses (personality factors) that so often affect treatment outcome, is ignored.
3. Treatments are manualised and are of brief and fixed duration, normally without flexibility related to the individual patient. Psychological disorders are treated rather like physical illness.

Outcome assessment is based on change in the target symptom.

There is a trade-off between the undoubted internal validity of controlled trials, where the sample is deliberately homogeneous and often small to minimise the effects of extraneous factors that may affect treatment, and the external validity of 'naturalistic' research on (usually) larger populations of real patients presenting at treatment facilities. In the former case, the relationship between the treatment being

studied and outcome is clearer, but the situation is artificial and less generalisable to everyday practice. In the latter, results can be more confidently generalised, but there are issues with co-morbidity (more than one diagnosis) and heterogeneity in the sample.

Westen et al. (quoted in Fonagy, 2006, p.766) have identified four poorly supported assumptions underpinning the use of this kind of outcome research:

1. psychopathology is so malleable that brief intervention can change it permanently;
2. most patients can be treated for a single disorder;
3. psychopathology can be treated with psychosocial interventions without regard to personality factors that are less likely to be responsive to brief treatments, and
4. randomised controlled trials are the best way to evaluate treatment 'packages'.

In reality, most forms of psychopathology encountered in clinical practice are treatment-resistant, co-morbid with other disorders, and exist in the context of a distinct and idiosyncratic personality structure.
A series of problems arise when the randomised research design is applied to a humanistic field like psychotherapy.

1. Emphasis on the disorder

Treatments which rely for their evidence on RCTs tend to place the emphasis on the disorder rather than the person. No matter how useful the comparison for science and medicine, people, especially in their psychological functioning, are not like machines. This introduces a series of difficulties related to the categorical diagnostic approach, such as is used in the Diagnostic and Statistical Manual (DSM) and the International Classification of Diseases (ICD), the two main international standards. This is discussed further below, under 'Assessment'. For now, let us suggest that the psychological functioning of people is best assessed along a series of dimensions, or continua. For instance, a person may be more or less anxious, impulsive, depressed or content, rather than categorically suffering from an anxiety disorder, a depressive disorder or an impulse control deficit. Because RCTs generally focus on diagnostic categories, the results often miss the idiosyncrasies of the person.

2. Artificial conditions

It is questionable whether RCTs are representative of clinical practice (Leichsenring 2005). Randomised trials tell us only one thing: that a treatment is or is not effective under the controlled conditions of the study. The trial condition often bears little resemblance to real clinical practice. If a method of psychotherapy has been shown to work under the controlled conditions of the RCT, it is assumed, based on the medical disease model, that it will work under any conditions. A drug may be assumed to work equally well under a variety of conditions, but psychotherapy is not a drug and the disease model is not adequate to describe complex psychological difficulties.

3. Co-morbidity

In normal psychotherapy practice, complex conditions with a high degree of co-morbidity are encountered. That is, a typical client may not easily fall into a single diagnostic category – they may satisfy the criteria for several diagnoses, or have co-occurring features of several, without actually meeting the conditions for any. All of these features may receive attention from the clinician at the same time. This is not typical of research conditions.

4. Manualised treatments

In an RCT, a manual or structured method will be followed as closely as possible. In real practice, manuals are tools to be used when the clinician thinks they are appropriate, often in conjunction with a series of techniques and interventions that are not in the manual.

The production of manualised therapy, a typical outcome of RCT-style research, may have a long-term effect on clinical practice by narrowing and damaging the breadth of clinical training. A well-trained clinician, even when using a standardised approach, will deviate from it according to the responses of individual patients, and according to the clinician's responses to the patient. This flexibility and empathic responsiveness is limited in graduates who have been trained to follow the manual, and who have not had training in personal reflection and empathic responsiveness.

5. Applicability to long-term treatments

RCTs are not applicable to long-term therapy (lasting several years) or to psychoanalytic therapy.

- It is not possible to carry out a manualised therapy for several years. Inevitably the therapist will stray from the strict terms of the method.
- It is not possible or ethical to assign patients to a "no treatment" or "treatment as usual" group for several years if a special treatment is available.
- Patients who opt for longer-term therapy differ in personality traits from those who choose a shorter method. Random assignment of patients would destroy the patient-therapist matching and invalidate the therapeutic approach. The results of a randomised trial for longer-term psychoanalytic therapy would not therefore be valid for the patients who normally seek such therapy (Leichsenring 2005).

6. Some people resist randomisation

Bateman and Fonagy (2004) suggest a number of problems with outcome research, pointing out that borderline clients do not take kindly to randomisation:

> Although their lives may be dominated by apparently random behaviour, their search is for stability, certainty, control. ... when they realise that their allocation to treatment appears to be dependent on the toss of a coin they are confronted with uncertainty, loss of control and anxiety about rejection. ... the result may be, at best, a feeling of demoralisation, and, at worst, rage and aggression and refusal to participate. (p. 52)

This may be a reason for observed high attrition rates in control groups – that is, randomisation is iatrogenic. Most studies of borderline patients compare a special treatment with 'treatment as usual' (TAU). One thing that such patients do not like is to be considered routine, especially if it is known that there is another treatment available. (Op. cit. p. 53)

7. Expectations

There is a literature on expectations about therapy. Trials that are incongruent with expectations are likely to produce poor outcomes.

8. Attrition

Attrition represents a serious threat to internal validity in typically small-sample controlled trials.

9. Therapist randomisation

With few exceptions, therapists are not randomised to patients, despite evidence that the personality, skills and training of the therapist have a considerable impact on outcome.

Comparisons are often made between psychodynamic psychotherapy and cognitive methods. The latter can certainly lay claim to 'evidence-based-practice', if only for the reasons set out above, that psychodynamic therapies are less amenable to randomised controlled trials. Jeremy Holmes (quoted in Fonagy, 2006) has argued convincingly in a 2002 edition of the British Medical Journal that:

- the foundations of cognitive therapy are less secure than has been claimed;
- the impact of CBT on the long-term course of psychiatric illness is not well demonstrated;
- in at least one 'real time' trial, CBT had to be discontinued because of poor patient compliance;
- the effect size of CBT is exaggerated by comparison with wait-list controls; and
- there is evidence of 'post-cognitive' behaviour therapy approaches that increasingly take psychodynamic concepts into account.

In response to these arguments it has been suggested (Nick Tarrier, also BMJ 2002, quoted in Fonagy 2006) that:

> ... [traditional psychotherapy] has been around for 100 years or so. The argument ... becomes a little less compelling when psychotherapy's late arrival at the table of science has been triggered by a threat to pull the plug on public funding because of the absence of evidence. (p. 768)

Psychodynamic clinicians are invited with some justification to

> '… do more than gripe and join in the general endeavor to acquire data.'

It is in this spirit that the following review is offered.

Review of evidence

A general conclusion of the Task Force of the APA on Promotion and Dissemination of Psychological Procedures is that psychotherapy is 'probably efficacious'. The caution in this statement reflects the difficulty in finding randomised trials of psychotherapy, particularly in finding two studies that replicate results.

A similarly general conclusion was reached by Gabbard, Lazar et al. (reviewed by Leichsenring, 2005) who conclude that psychotherapy is a cost-effective treatment when compared with other health costs.

Three meta-analyses have been used here to briefly summarise research into psychotherapy effectiveness.

('Effect size' is the difference in mean outcomes of the treatment and control group divided by the standard deviation of the outcomes of the control group. Essentially it is expressed as a percentage of one standard deviation. An effect size of 0.7 is substantial. 1.0 or above is exceptional. Most of this work refers to short term psychodynamic psychotherapy (STPP), meaning 20 sessions or less in USA, or 50 sessions or less in Germany).

Leichsenring (2005) sets out to describe research into psychotherapy effectiveness, and in particular to discover for which psychiatric disorders randomised controlled trials of specific models of psychodynamic psychotherapy are available. Considering the difficulties of using randomisation with psychodynamic treatments, Fonagy and others, in two major reviews (Fonagy, Roth et al. 2005; Fonagy 2006) have set out to discover:

1. Are there any disorders for which short term (20 sessions or less) psychodynamic psychotherapy can be considered evidence-based;

2. Are there any disorders for which psychotherapy is uniquely effective as either the only evidence-based treatment or as a treatment that is more effective than alternatives; and

3. Is there any evidence base for long-term psychodynamic psychotherapy?

Leichsenring (2005) details randomised trials available for:

Depressive disorders (4 trials)

Anxiety disorders (1 trial)

Post-traumatic stress disorder (1 trial)

Somatoform disorders (4 trials)

Bulimia nervosa (3 trials)

Anorexia nervosa (2 trials)

Borderline personality disorder (2 trials)

Cluster C personality disorder (1trial)

Substance-related disorders (4 trials)

Aside from RCTs, 'process research', looking at what happens in therapy, and 'effectiveness research', looking at outcomes in real clinical practice, for instance in terms of health spending and insurance company data, are also surveyed.

Depression

According to Fonagy (2006) about 20 short-term psychodynamic trials have been published in relation to depressive or anxiety disorders or symptoms. In general it has been shown to be more effective than wait-list or outpatient 'treatment as usual'.

In Fonagy's review, comparison with cognitive behaviour therapy tends to come down on the side of the behavioural methods. However, in a number of cases, therapies in these trials considered 'psychodynamic' were not actually bona fide therapies. This reveals researcher bias expressed in a lack of investment in the 'control' condition. Where there are better designed and implemented alternatives to behavioural treatment, the differences tend to disappear. There tends to be no superiority for CBT on follow-up, and differences in effect size are limited with severely depressed patients. It still seems likely that symptom-oriented behavioural treatment might produce better results in the short term, with this difference disappearing or even being reversed in the longer term.

Typical of such results is the Sheffield Psychotherapy Project, where it was found that behaviour treatment was superior to psychodynamic therapy after 8 sessions, but not so after 16. The Helsinki Psychotherapy Study suggests similarly that short-term symptomatic remission is better with a behavioural treatment – solution focused therapy – than short-term psychodynamic psychotherapy, but personality disorder factors were more affected by the latter.

The inclusion of interventions specific to a psychodynamic approach is associated with better outcomes even in therapies born of a different orientation (Fonagy 2006).

Leichsenring (op. cit.) finds four randomised trials in which psychotherapy and cognitive behavioural methods are found to be equally effective, with large effect sizes that are stable over time.

In combination with pharmacotherapy, psychotherapy improves outcome over either drug treatment or psychotherapy alone. Nevertheless, evidence for

psychodynamic therapy in depression is weak – there are few compelling demonstrations, and none for long-term approaches. As Fonagy (op. cit.) puts it:

> … the data are consistent with the assumption that a proportion of patients in any research sample will respond to therapeutic intervention of any kind. (p.781)

Anxiety

Included here are phobia, generalised anxiety disorder, panic disorder, post-traumatic stress disorder and obsessive-compulsive disorder. This field is dominated by cognitive-behavioural packages, compared with often poorly-structured control 'therapies'. Again, where the 'placebo' is an active treatment, the effect of behavioural treatments is diminished. However, the absence of studies with a well-structured psychodynamic alternative makes it difficult to state anything definitively. Where complicated grief and bereavement reactions (as opposed to exposure to trauma) are involved, psychotherapy may be more effective (Fonagy 2006).

In the single trial reviewed by Leichsenring (2005), moderate-length psychotherapy of 36 sessions proved as effective as behavioural methods for generalised social phobia.

Post-traumatic stress disorders

A single trial reviewed by both Leichsenring and Fonagy concludes that psychotherapy is as effective as trauma desensitisation. Trials reviewed by Fonagy suggest positive results for psychotherapeutic approaches that investigate the meaning of the traumatic event for the person's sense of self and place in the world. However, methodology is problematic, and results cannot be confidently quoted.

Somatoform disorders

The three trials reviewed by Leichsenring suggest that psychotherapy is more effective with about two-thirds of patients than standard medical treatment and as effective (with irritable bowel syndrome) as treatment with paroxetine. Psychotherapy (but not paroxetine) was associated with a significant reduction in healthcare costs over time.

Eating disorders

Four available trials in this area suggest that psychotherapy is as effective as other treatments. Where it is modified for a specific clinical problem, it does as well as behavioural treatments, which are similarly focused. The exception is bulimia, where behavioural treatment seems slightly more effective.

Substance misuse

In the short term, psychotherapy seems to have little impact on this group of disorders, where motivational enhancement and community support are the

treatments of choice. As with other disorders, in the longer term, psychotherapy may produce better maintenance of gains. Its place is probably as a secondary treatment, after acute problems have been overcome, and then only for some clients.

Personality disorder

There has been more research attention paid to this diagnostic group, allowing more than one meta-analysis. Substantial effect sizes of 0.7 – 1.3 have been found for psychodynamic psychotherapy, and a comparison with cognitive-behavioural treatment reveals effect sizes of 1.31 for psychotherapy, based on 8 studies, as opposed to 0.95 for cognitive behaviour therapy, based on 4 studies (Fonagy 2006). Broadly, the approaches seem equally effective.

Bateman and Fonagy (2004) review evidence for treatments in relation to borderline personality disorder. Treatments shown to be effective tend:

- to be well structured;
- to devote considerable effort to enhancing compliance (building a therapeutic relationship);
- to be clearly focused, for instance on problem behaviour such as self-harm or on problematic relationship patterns;
- to be theoretically coherent to both therapist and patient, sometimes deliberately omitting information that is incompatible with the theory;
- to be relatively long term – for example, 2 years or more;
- to encourage a powerful attachment relationship between therapist and patient, enabling the therapist to adopt a relatively active rather than passive stance; and
- to be well-integrated with other services available to the patient. (p.44)

When compared with a psychiatric treatment-as-usual group, patients with BPD treated with a psychotherapeutic approach involving partial (in-patient and day) hospitalisation tend to improve on a variety of measures, including:

- frequency of suicide attempts and self-harm;
- number and duration of in-patient admissions;
- use of psychotropic medication;
- self-report measures of depression, anxiety, general symptom distress, interpersonal function, and social adjustment. (op. cit. p. 44)

In another study, also quoted by Bateman and Fonagy, not only were these gains maintained, but patients continued to improve on most measures after the

termination of treatment. Health service costs were the same as the TAU group before and during treatment, but significantly less on follow-up.

There is evidence supporting cognitive and 'cognitive analytic' treatments in relation to BPD, but early gains tend not to be maintained, and the natural instability of the BPD diagnosis can distort results that use it as a measure of outcome. Naturalistic studies, looking at what happens in normal clinical practice, suggest that people diagnosed with BPD will not meet the criteria for the diagnosis for at least two consecutive months within the first 12 months of diagnosis. (Bateman and Fonagy, 2004: 46)

DBT (dialectic behaviour therapy), a special adaptation of CBT combined with meditation and 'mindfulness' – secular derivatives from Buddhism – designed specifically for people with BPD, appears to have better retention rates than TAU and to reduce episodes of self-harm in the short term, but seems less effective in the longer term. It may be effective in relation to certain behaviours, but not as a treatment for the personality disorder itself. More effective may be Bateman and Fonagy's mentalisation-based therapy (MBT) (sometimes referred to as "understanding misunderstanding'), which concentrates on integration of the client's thinking, feeling and intention in the moment. Transference is considered, but only as a tool to engage 'mentalisation'. (Bateman and Fonagy 2004).

Psychotherapy appears effective as a part of therapeutic community (TC) treatment for Cluster B personality disorders and substance misuse. No methodologically sound trials of psychotherapy with antisocial personality disorder are quoted in the reviews summarised here. There is some suggestion that psychotherapy may produce gains in combination with TC treatment, but research methods are too weak for confidence.

With cluster C personality disorders (anxious-avoidant), there is some evidence that psychotherapy is equivalent to cognitive therapy and possibly slightly superior. Drop-out rates are high with avoidant symptoms (sic) though better with obsessive characteristics.

Long-term psychotherapy

There are few quotable studies for long term-psychotherapy or psychoanalysis, and these are not associated with specific disorders or symptom clusters. Those that are available tend to be naturalistic, although within the constraints on this methodology, generally positive. Leichsenring is more positive than Fonagy about the validity of this methodology, concluding that naturalistic effectiveness studies, when compared with studies using randomisation, do not exaggerate the effectiveness of short-term psychotherapy, so are acceptable in relation to long-term work. For long-term psychoanalytic therapy, effect sizes greater than 0.8 and up to 1.55 are found in relation to symptoms, interpersonal problems, social adjustment, in-patient days and other outcome criteria.

There is some quite convincing evidence drawn from insurance company data, where health costs are crucial (effect size 0.78). There is some evidence that the effect continues to increase after termination of therapy (Leichsenring, op. cit.).

Psychoanalytic therapy appears to be particularly effective in relation to changes in personality, and may be more effective than shorter forms of psychotherapy for people with complex psychiatric disorders.

There are some challenging results, however. For instance, those therapists whose attitude most closely resembles the classical psychoanalytic stance (neutrality, focus on insight) tend to get the poorest results (Fonagy, 2006).

A major German study of over 400 patients in analysis for a mean 6.5 years showed considerable stable positive changes in 70%-80% of the sample, with associated savings in health costs, but there are no pre-treatment measures, so effect size is impossible to estimate. (Leichsenring 2005)

There is some evidence that children with severe emotional disorders do quite well in analysis (Leichsenring 2005)

In general, evidence on psychoanalysis favours those with milder disorders, although there are positive results for more severe disturbances. Process research suggests that outcome in psychodynamic psychotherapy is related to competent delivery of technique and the development of a therapeutic alliance.

Fonagy (op. cit.) quotes Whittle, who suggests that a likely cause of the paucity of research into the effects of psychoanalysis lies in 'fundamental incompatibilities in the world view espoused by psychoanalysis and most of current science. (p 806)

Tentative conclusions based on reviewing the research evidence

From this, we might begin to draw some tentative conclusions. Psychodynamic psychotherapy seems likely to be effective with depression, anxiety, somatoform disorders, eating disorders, Cluster C and possibly Cluster B personality disorders, and possibly as a secondary treatment with substance misuse disorders. It is likely that, where behavioural methods show initial superiority, this becomes less so with time. That is, psychotherapy takes longer to work. However, it is possible that its effects are longer-lasting and it may be more effective in the very long term at reducing health spending.

Even more tentatively, we might suggest that the benefits of long-term psychotherapy and psychoanalysis continue to improve after treatment is finished.

There is reason for caution, however. While there is considerable evidence for both behavioural (usually justified by small randomized controlled trials) and psychodynamic (more often from naturalistic studies) treatments, Bateman and Fonagy (2004) observe that we are a long way from being able to say with any

conviction which patients are best treated with psychodynamic or behavioural therapy, or in what context.

Also mentioned in the Arkowitz and Lilienfeld article in *Scientific American – Mind* are some therapies to avoid. They include 'energy' therapies, in which a client's 'energy fields' are manipulated by the therapist; recovered-memory techniques; rebirthing; 'facilitated communication' – a technique with autistic children, and crisis debriefing – there is mounting evidence that it makes PTSD symptoms worse.

PART 2: Evidence on Attachment Theory and Coherent Narrative that Supports Psychodynamic Psychotherapy

There is a strong body of evidence linking attachment style to personal functioning over a wide range of measures, including personal comfort, material success, stability and satisfaction in personal relationships. Beginning with the study of children, the extension of attachment research into adult patterns of relatedness has had profound implications for the practice of psychotherapy and other psychological treatments (Schore 1999; Siegel 1999; Fonagy 2001; Fonagy, Gergely et al. 2002). This work considers four kinds of representational systems (Bateman and Fonagy 2004, p. 57):

- expectations of early caregivers created in the first year of life and subsequently elaborated into relational expectations;
- event representations by which general and specific memories of attachment-related experiences are encoded and retrieved (a kind of 'filter' on experience and memory of relationships);
- autobiographical memories by which specific events are conceptually connected because of their relation to a continuing personal narrative and developing self-understanding; and
- understanding of the psychological characteristics of other people – inferring and attributing intention, motivation, emotion and beliefs in others, and differentiating these from those in ourselves.

Together, these constitute what we know as the 'internal working model', a template for our experience of our selves and others, closely related to the development and coherence of a 'sense of self' (Stern 1985).

This work not only gives us models for understanding psychological distress and pathology, it also defines healthy functioning in terms of concepts like the 'sense of self' (Stern 1985), the 'coherent autobiographical narrative' (Siegel 1999), 'mentalisation' and 'reflective functioning' (Fonagy, Gergely et al. 2002),

'metacognitive monitoring' (Main and Hesse 2001) and so on. Parents with a well-developed ability to reflect on their own functioning and that of others tend to pass on a secure attachment base to their children. On the other hand, there is a close relationship between intergenerational trauma and abuse and a parent's capacity, or lack of it, to reflect on her own and others' thoughts and feelings, and on her own history (Bateman and Fonagy 2004, pp. 75-79). Almost every measure of success and difficulty in life appears to be connected with the nature of a person's attachment pattern.

This work is well supported by studies of neurological development (Damasio 1999; Schore 1999; Siegel 1999; Cozolino 2002; Damasio 2003). The whole body of theory and research is supportive of the fundamental psychodynamic proposal - that there are basic processes underlying the way we function and how we produce symptoms which are best addressed in a relationally-based psychotherapy. This is not to denigrate the kind of symptom-based treatment such as is commonly provided by evidence-based practice in clinical psychology, but it is a serious error to suggest that the latter is a sufficient approach to human psychological discomfort. Not everything can be diagnosed from the history. Much of what becomes focal for therapy will emerge as the client engages with the therapist. Idiosyncratic attachment style will emerge in the dynamics of what we term *transference* and *counter-transference.* A relational therapy is essential to allow this to happen.

Since interpersonal functioning is fundamental to human contentment and distress and to success on almost any dimension, it is necessary to have a form of therapy in which interpersonal elements are central. This leads to a discussion of psychodynamic assessment, below. No matter what the symptom, it is important to understand the person who has it and what meaning they make of it, as opposed to diagnosing a condition by listing symptoms and producing a treatment out of a manual. The 'Dodo-bird verdict' mentioned above makes sense when viewed from this perspective.

PART 3: Psychodynamic Assessment

It has been mentioned above that the assessment of psychological functioning according to diagnostic categories presents some difficulties. Diagnostic categories can be used in outcome research to look at the effects of treatment on specific 'disorders', and can assist an apparently orderly process from assessment through diagnosis to treatment, much like in general medicine. This essentially mechanistic approach supposes that the human mind works in a similar way to body tissues, and that the whole resembles a piece of machinery.

The human mind, however, has few categorical disorders – developmental disorders like intellectual disabilities, autism and possibly attention deficit may with some justification be treated as discrete 'illnesses'. Psychotic conditions

sometimes behave like this, although they rarely present as clearly as their descriptions in DSM-IV and ICD-10 suggest.

In general, psychological problems fit uncomfortably into diagnostic boxes. For instance, of the nine criteria in DSM-IV-TR for borderline personality disorder, five are needed to make the diagnosis. Thus, two people with this diagnosis need share only one symptom, and in other respects may be quite different from each other. Auditory hallucinations – 'hearing voices' – especially when accompanied by fixed, false beliefs called 'delusions', along with 'inappropriate' or 'flattened' emotional states, are usually considered indicative of psychosis. Yet all of these symptoms can be caused by severe, repeated early trauma (Read 2005). A diagnosis of depression gives no indication as to the way a particular person experiences it, within their distinct personality structure. A difficulty recognising thinking and feeling patterns in others might affect many aspects of life, might be expressed in a range of symptoms and signs, and may itself be a source of anxiety, yet a diagnosis of anxiety disorder would be misleading.

As the introduction to the 2006 Psychodynamic Diagnostic Manual (PDM) observes:

> Mental health comprises more than simply the absence of symptoms. It involves a person's overall mental functioning, including relationships; emotional depth, range and regulation; coping capacities; and self-observing abilities. Any attempt to describe and classify deficiencies in mental health must therefore take into account limitations or deficits in many different mental capacities, including ones that are not necessarily the source of pain. (p. 2)

The oversimplification of mental health phenomena by reducing our problems to a series of checklists serves us ill. Reliability among clinicians is poor (PDM, p 3) compared to physical medicine, and understanding of essential developmental and self-regulating processes is not assisted by listing clusters of symptoms. Co-morbidity may be usefully considered an expression of underlying processes, but this is confused by using categorical diagnosis. Oversimplification in the interests of measurement is bad science.

For instance, Karlen Lyons-Ruth (1995), studying parental depression, remarks that categorical diagnostic thinking tends to ascribe many difficulties, for instance, marital conflict, to depression, while interpersonal difficulties are often observed to persist after the depressive episode is over.
Lyons-Ruth, pleading for a reintroduction of implicit representational systems into psychotherapy, suggests that these, along with associated interpersonal strategies (attachment patterns) and associated dysphoric affect, are less episodic and more stable, individually and intergenerationally, than is commonly supposed. In one study, relationship patterns in depressed mothers' families of origin accounted for

all of the variance in parenting behaviour associated with depression. In other words, long-term implicit relational patterns account for the problem better than the 'illness'.

In a relational-systems model (as opposed, in this case, to a mood-disorder model) relational dysfunction would be considered alongside the symptom cluster. What is required is a way of describing not just symptoms, but internal experience and a full range of mental functioning. This is the task of psychodynamic assessment.

A good example of assessment is provided by the PDM, a co-operative project of a number of psychoanalytic organisations. It uses a multi dimensional approach, with three axes. The first (the 'P Axis') tells us about personality structure, both in terms of type and degree of health or pathology, because:

> '... symptoms or problems cannot be understood, assessed or treated in the absence of an understanding of the mental life of the person who has the symptoms.' (PDM p. 80)

The second (the 'M Axis') provides detail of the person's mental capacities – regulation, intimacy, quality of experience, affective experience, defensive patterns, internal representations, integration, self-observation and standards of morality.

The third (the 'S Axis') describes symptoms and symptom clusters, emphasising the person's subjective experience, rather than considering symptoms to constitute categorical phenomena.

This approach, highly descriptive, very personal, taking into account the experience and uniqueness of the individual, complements the established diagnostic approaches. Its scientific basis is documented, and the rationale for each of the elements appears to be sound.

Final Comment

The making of meaning is central to basic functional processes. Our ability to do this is related to our attachment experience, and the whole attachment/meaning-making enterprise is fundamental to human nature (Fonagy 2006). There has been economic and political pressure from short-term, cheaper, symptom-based psychological treatments and drug regimes. However, it is not reasonable that some process resembling psychodynamic psychotherapy or psychoanalysis, with its emphasis on relationship, attachment and meaning, could ever be considered inappropriate among the range of approaches available to people with mental health problems. There always has to be a concern with the psyche as well as a monitoring of symptomatology. To turn away from the essential human (perhaps

mammalian) quality that allows us to recognise in ourselves and others the presence of a mind, of desires, emotions, intentions and beliefs:

> .. risks apocalyptic cultural and social changes .. if we mock personal experience and start to deride the feelings, thoughts, and desires of our fellow humans (Fonagy 2006, p. 774).

References

Arkowitz, H. and S. O. Lilienfeld (2006). Psychotherapy on Trial. *Scientific American Mind.* **17:** 42-49.

Bateman, A. and P. Fonagy (2004). *Psychotherapy for borderline personality disorder - mentalizaton-based treatment.* Oxford: OUP.

Carey, B. (2004, August 10th.). For Psychotherapy's Claims, Skeptics Demand Proof. *New York Times.* (p. 3)

Cozolino, L. (2002). *The Neuroscience of Psychotherapy.* London, England: Norton.

Damasio, A. (1999). *The Feeling of What Happens.* London, England: Random House.

Damasio, A. (2003). *Looking for Spinoza: Joy, Sorrow and the Feeling Brain.* San Diego, CA: Harcourt.

Fonagy, P. (2001). *Attachment Theory and Psychoanalysis.* New York, NY: Other Press.

Fonagy, P. (2006). Evidence-Based Psychodynamic Psychotherapies. *Psychodynamic Diagnostic Manual.* Silver Spring, MD: Alliance of Psychoanalytic Organisations.

Fonagy, P., G. Gergely, et al. (2002). *Affect Regulation, Mentalization and the Development of the Self.* New York, NY: Other Press.

Fonagy, P., A. Roth, et al. (2005). Psychodynamic psychotherapies: evidence-based practice and clinical wisdom. *Bulletin of the Menninger Clinic* **69**(1): 1-58.

Gabbard, G. O., S. G. Lazar, et al. (1997). The economic impact of psychotherapy: a review. *American Journal of Psychiatry* **154**: 147-55.

Leichsenring, F. (2005). Are psychodynamic and psychoanalytic therapies effective? A review of empirical data. *International Journal of Psychoanalysis* **86**: 841-68.

Lyons-Ruth, K. (1995). Broadening our conceptual frameworks: can we reintroduce relational strategies and implicit representational systems to the study of psychotherapy? *Developmental Psychology.* **31**(3): 432-436.

Main, M. and E. Hesse (2001). Attachment narratives and attachment accross the lifespan. *Journal of the Americal Psychoanalytic Association* **48.**

Raimy, V. (1950). *Training in clinical; psychology.* New York, NY: Prentice-Hall.

Read, J. E. A. (2005). Childhood trauma, psychosis and schizophrenia: a litrature review with theoretical and clinical implications. *Acta Psychiatrica Scandanavica* **112**: 330-350.

Schore, A. (1999). *Affect Regulation and the Origin of the Self: The Neurobiology of Emotional Development.* Mahwah, NJ: Lawrence Erlbaum.

Siegel, D. (1999). *The Developing Mind - How relationships and the brain interact to shape who we are.* New York, NY:Guilford

Stern, D. (1985). *The Interpersonal World of the Infant - A View from Psychoanalysis and Developmental Psychology.* New York, NY: Basic Books.

Surgenor, D. L. (2006). Consultation on the form of regulation of psychotherapy under the Health Practitioners Competency Assurance Act 2003: letter to Ryan McLean, Wellington, NZ: Government Psychologists' Board.

Towards Individuation: A Jungian view on being a body and on being together

Chris Milton

Abstract

Jungian theory and practice, more properly called analytical psychology, like psycho-analysis (Ogden, 1994, 1996, 1997), has dethroned the notion of a central conscious subject and replaced it with the notion of the centrality of a dialectic between consciousness and the unconscious. This shift away from the notion of a central conscious subject is scribed in the idea of individuation. Indeed analytical psychology is itself centred on the notion of individuation and, as Brooke (1991a, p. 88) has so forthrightly put it: 'Individuation is not "individualism"'. How then does this challenge to individualism find expression in analytical psychology and what are the implications for analytic practice?

With Brooke's assertion in mind I shall first present a thumbnail sketch of analytical psychology and the practice of analysis. I shall then extend the discussion to two particular areas of Jungian analysis (albeit ones not necessarily practiced in quite the way I will outline by all Jungian analysts) in which the challenge to individualism finds expression:

1. Presencing of the unconscious through the body.

2. Analysis as experience and activity in an interpersonal archetypal field.

The practical analytic implications of these will be highlighted by a comparison of two vignettes of analysis interleaved theoretical discussion. The theoretical discussion will be extended to include some alchemical thoughts.

("Presencing" implies bringing forth an experience in this moment rather than thinking about something).

A Thumbnail Sketch of Analytical Psychology

The theory and practice that lies within the ambit of analytical psychology is huge. It is therefore rather difficult to give more than an outline. We can understand any reference to 'analysis' as referring to dissolving, loosening, from the Greek analusis, 'a dissolving', and luein which means 'to loosen' (Makins, 1991), or untie a knot. If one's psyche is tight, tied in a knot, if one's possibilities of being are tied up then loosening or untying them leads to the freedom to be more completely who one is.

Arguably analytical psychology has its roots in the suspicion, espoused by Goethe, that the natural scientific approach to understanding humanity is too one-sided. Jung was preoccupied with the notion of one-sided psychological development that

he understood to be compensated for by a natural and progressive process. Jung became interested in the habitual attitude of the sense-of-self (or ego) and how this seemed to be compensated for by dream images, symptoms and even psychosis. Consistent with this arose the idea that whilst the ego was the centre of consciousness it was not the centre of the personality. The personality was understood to be the dynamic combination of both ego and unconscious. For Jung the unconscious comprised both a personal unconscious, into which anxiety-generating impulses, affect, images and experience are 'repressed' and a collective unconscious, which has never before been conscious and from which compensating and vitalizing possibilities of being arise to challenge the ego to change and develop, through differentiating, integrating and appropriating them. These possibilities of being mostly find expression in images or root metaphors that are based in 'archetypes'. Archetypes-as-such are living dispositions that structure our experience and behaviour. The continual process of encounter between conscious and unconscious, the challenge this generates, and, hopefully, its transcendence and integration, is called individuation (vide infra). When the capacity for directed 'thinking' of the ego is challenged by the undirected 'thinking' of the unconscious great tension and defendedness may arise. There is, it seems, no way these quite different ways of being can combine with and be appropriated to consciousness. However, they can and Jung understood that there was a capacity, shared by all human beings, to transcend and incorporate something of both the conscious and unconscious. The product of this capacity is the symbol, which we may define as the 'best possible description or formulation of a relatively unknown fact [i.e. a fact that is both conscious and unconscious]' (Jung, CW 6, para: 814).

So far we may see this rather 'metapsychological' explication of Jung's thinking as thoroughly intrapsychic and therefore individualistic (in the pejorative sense of the word). However, in the first instance Jung was profoundly suspicious of the arid individualism that may arise in western culture and he believed that there were great forces of cultural compensation active in history. For instance, he saw the alchemy as a compensation to the predominantly Christian worldview with its 'repression' of matter, evil and the feminine. In the second instance, even though Jung used the imperfect explanatory tool of projection, he saw the psyche as being out-pictured in the body, cultural artefacts and interpersonal relationships. Clinically he was committed to the notion of transference but a transference that out-pictured both the collective unconscious and the personal unconscious. Thus notions such as projection and transference serve to describe the shapes of our originary state of being-together. In other words to be is to be-with-others, that being-together is shaped through root metaphors (archetypes) and as that is an ontological given there is no escape from either the originary being-together nor its shaping.

Let us attend to some of the elements of theory in more detail and especially insofar as it involves our understanding of individualism and individuation. Individualism may defined, in psychological terms, as the belief that the

personality is centred on the sense-of-self or ego. As we have noted analytical psychology holds that whilst our sense-of-self, or ego, is the centre of our centre consciousness it is not the centre of the psyche. Jung (CW 12) states that the Self is the centre of the personality. (Note: The word 'Self' is not capitalized in the Collected Works but I shall capitalize it here. When I use the word 'self' it refers to the subject, when certain Jungian analysts use the word 'self' it refers to what I am calling the 'Self'. The context of the cited works should make this clear.) Defining the Self is a complicated matter as Jung uses the term in various, sometimes paradoxical, ways. It has been defined as:

> An archetypal image of man's fullest potential and the unity of the personality as a whole. The self as a unifying principle within the human psyche occupies the central position of authority in relation to psychological life and, therefore, the destiny of the individual" (Samuels, Shorter & Plaut, 1986, p. 135).

It may indeed be experienced as the centre of the personality (Brooke, 1991a). The Self is implicated in individuation in that it 'templates', 'sponsors' and 'directs' individuation and is indeed the ultimate Other to whom ego relates. In short the individuating total personality comprises the dynamic manifestation, centred on the Self, of the evolving relationship between sense-of-self and Other (i.e. the intrapsychic other) (Papadopoulos, 1984). The personality is always developing, we are moving towards being who we most truly are by centering on the relationship between conscious and the unconscious. Whilst this may still seem to be an essentially intrapsychic view of things this is not so, for the Other and the other mutually implicate each other.

I need to add that my personal and clinical experience leads me to develop this position further. I have come to believe that paradoxically whilst the Self is the centre of the personality so too is the relationship between sense-of-self and Other/other. I have come to understand that in living from a transcending dialectic between sense-of-self and Other/other (or we might say between ego and archetype) we live with author-ity, authenticity and an autonomy that is also relational.

The Practice of Jungian Analysis

Both clinically and theoretically these notions call forth two questions: how do conscious and unconscious relate to each other and in what way does this implicate the other? Let me start by asking what it is that Jungian analysts do, what is the practice of Jungian analysis? I will start by saying that the politics that separated Jung from psycho-analysis, and the mutual Freud and Jung bashing which has arisen from it, are very misleading. Jung and the Jungians/post-Jungians are strongly within the broad depth psychology tradition of which psycho-analysis is also part. Jung anticipated many notions that later arose in psycho-analysis of which some of the more significant are: a stress on early object-relations (e.g. Klein), innate psychic structures (e.g. Bowlby), the creative element to the

unconscious (e.g. Winnicot), stress on the clinical use of countertransference (e.g. Little), the importance of regression in analysis (e.g. Balint) and the encounter between personal sense-of-self and the Other/other (e.g. Bion) (Samuels, 1995, p. 10).

I believe that Jungian analysts use their personalities and personal knowledge and abilities to facilitate the individuatory encounter between consciousness and unconscious. Some may do this in a way close to that traditionally espoused by psycho-analysis (working with transference and resistance through the application of abstinence and interpretation), others, more classically, by 'supervising' the out-picturing of the unconscious to consciousness (in dream and active imagination) and yet others by helping the analysand presence and integrate their unappropriated possibilities of being.

Early on Freud answered the question of how conscious and unconscious relate to each other and in what way this implicates the other in his 'definition' of psycho-analysis. The relationship between conscious and unconscious finds form in resistance, and the relationship between self and other first finds form in transference. Freud came to define psychoanalysis as:

> Any line of investigation which recognizes these two facts [the phenomena of transference and resistance] and takes them as the starting point of its work has a right to call itself psycho-analysis (Freud, 1914/2001, p. 16).

We might understand that the first phase of analytic work (in both psycho-analysis and analytical psychology) is the presencing of the unconscious. I believe that, whilst Freud was disposed to a more passive presencing of the unconscious, Jung was more disposed to an active presencing of it. Freud describes presencing the unconscious as follows:

> [W]hile I am listening to the patient, I, too give myself over to the current of my unconscious thoughts (Freud,1913/2001, pp. 133).

And:

> Experience soon showed that the attitude which the analytic physician could most advantageously adopt was to surrender himself to his own unconscious mental activity, in a state of evenly suspended attention, to avoid so far as possible reflection and the construction of conscious expectations, not to try to fix on anything that he heard particularly in his memory, and by these means to catch the drift of the patients unconscious with his own unconscious. It was then found that, except under conditions that were too unfavourable, the patient's associations emerged like allusions, as it were, to one particular theme and it was only necessary for the physician to go a step further in order to guess the material which was concealed from the patient himself and to be able to communicate it to him (Freud, 1923/2001, p.239).

I shall give an example (for which I have the analysand's permission) from my own analytic practice of the kind of analysis I believe Freud might be describing but which is equally 'Jungian' in nature.

Case Vignette One

Matthew was a single man in his mid-twenties when he first consulted with me. He came three times a week on consecutive days and used the couch. The clinical material is drawn from a session in the second year of the analysis.

Matthew enters my room; he briefly looks about, crosses to the couch and lies down. I experience a settling silence fall over the room. Matthew starts to speak. I listen to his words with evenly suspended attention. My mind is simply drawn along by his words, their rhythm, his silence. His presence evokes my own thoughts and feelings, sensations and intuitions. I surrender to the drift of this material sponsored by my own unconscious. My experienced response forms a wake from the prow of his associations. I register, consider, weigh and try out the experiences presented to me and I am able to allow Matthew's presence to occupy my body-mind. From this I make some interpretation not now recalled.

Matthew says that when he was a child he enjoyed gluing model aeroplanes together. Even so, he was not very good at this and would often get into a mess. He might then ask his father for help. His father would then become engrossed in the task and take it over from Matthew. When finished his father would say something like: 'Didn't we make a nice plane?' Matthew, however, knew that he had not himself made the model. At first I find myself empathizing with Matthew as a child who felt misunderstood and unhelped, then I feel emotionally moved by his account and protective of him. I also find myself feeling as if I were a father and experiencing the difficulty of relating to a child in just the right way.

I wonder if Matthew is making an unconscious communication in which he expresses how my interpretation had interrupted and usurped his 'messy', yet creative, work, in much the same way that his father did with the model aeroplane construction. I wonder, more generally, if he is making an unconscious complaint against a figure who has usurped his creative feeling and left him feeling inadequate, if perhaps he has come to doubt his creative capacity. I wonder if I should speak but decide that there is too little evidence on which to base an interpretation. I also wonder if I should speak if I might not, again, be taking over his work. Is there a way to speak without doing this? Has the time passed to speak, has my silence shown something else? Does he experience my silence as supportive or absent or even punitive? Am I being punitive? Was I countertransferentially stung by in thinking that perhaps he was unconsciously critiquing my making an interpretation and so did I wish to remain punitively silent? My thoughts and feelings, senses and intuitions swirl in the analytic space. So the session continues.

As in psycho-analysis this vignette demonstrates a more passive form of presencing the unconscious (which was described above) and which led Freud to advocate the rule of abstinence. Jung, however, used a more active presence:

> In psychotherapy, even if the doctor is entirely detached from the emotional contents of the patient, the very fact that the patient has emotions has an effect upon him. And it is a great mistake if the doctor thinks he can lift himself out of it. He cannot do more than become conscious of the fact that he is affected. If he does not see that, he is too aloof and then he talks beside the point. It is even his duty to accept the emotions of the patient and to mirror them. That is the reason why I reject the idea of putting the patient upon a sofa and sitting behind him. I put my patients in front of me and I talk to them as one natural human being to another, and I expose myself completely and react with no restriction (Jung, 1935/1986, p.155).

This statement of Jung's brings us to the notion of actively presencing the unconscious through the body, itself one of the many possible ways in which the analytic encounter between consciousness and unconscious may be facilitated.

Presencing of the unconscious through the body

In Jung's account above the bodily presence of analyst and analysand is seen to be the palette upon which the unconscious is presenced. Whilst Jung's own understanding of the relationship between the psyche and the body can be paradoxical (Samuels, Shorter & Plaut, 1986) we gain the sense that Jung was aware of the way in which body and psyche mutually implicate each other. Near the beginning of his 1935 paper "Principles of Practical Psychotherapy" Jung makes the observation that: "One of the fundamental antinomies is is the statement that psyche depends on the body and body depends on psyche" (CW 16, para: 1). It is important to make a philosophical point about Jung's terminology. Brooke (1991b, 515) has made the argument (both terminological and philosophical) that 'the psyche is not a locality on the hither side of our being-in-the-world' but that '[f]or Jung, the psyche, like the sea in which the fish swims, is the world in which we incarnately and psychologically dwell'. He also argues that:

> Psyche is a 'place' between subject and object, and since in both the idealist and realist traditions the body-subject is abandoned to the world of things, it can be said that psyche moves between mind and body as well, or, better, includes the operations of both those traditionally conceived domains (p. 514).

So, although Jung himself at times terminologically collapses psyche and mind, properly speaking we should not collapse psyche into mind for both mind and body, self and other are 'in' psyche.

As Brooke intimates the linking of mind and body also ushers in the linking of self and other for in analysis (and indeed in everyday life) our bodies become the 'location' at which the mind of the other is registered. Plaut (1956) acknowledged this in his concept of 'incarnation'. Plaut understood that sometimes instead of

interpreting projections made in the transference the analyst may 'incarnate' them, i.e. contain or absorb them. This mostly unconscious process is dangerous in the sense that it can lead to an enactment either in over-identification or in defensive withdrawal. The process of incarnation may, for instance, have elements that are uncomfortable for the analyst (one thinks in particular of something like feeling one has 'fallen in love' with an analysand or even been sexually aroused by them).

Dieckmann (1979) discusses a case in which he felt a strong fascination, not apparently without its bodily counterpart, with a female analysand. With many struggles, Dieckmann came to understand that allowing this to become incarnated in a contained way provided the analysand with a compensatory experience of a certain type of father figure. This permitted her to move into an individuatory process. Samuels (1989) has developed the term 'embodied countertransference' to refer to the response of the analyst in which he/she embodies an emotionally experienced part of the analysand's inner world. Samuels articulates this further:

> 'Embodied' is intended to suggest a physical, actual, material, sensual expression in the analyst of something in the patient's inner world, a drawing together and solidification of this, an incarnation by the analyst of a part of the patient's psyche and . . . a 'clothing' by the analyst of the patient's soul (1989, p. 151).

Samuels takes this further and argues that self and other are implicated when the body registers psychological life:

> Using Corbin's metaphor, the analyst's body becomes less literal, a 'subtle body', a 'being in suspense', a link between soul and corporeality . . . in analysis, the analyst's body is not entirely his or her own and what it says to him or her is not a message for him or her alone (1989, p. 164).

This ambiguity in the 'possession' of the body ushers in our consideration of analysis as experience and activity in an interpersonal archetypal field.

Analysis as experience and activity in an interpersonal archetypal field

Very early on Jung (McLynn, 1997; Jung, CW 16) recognized that transference is central to the analytic endeavour. By so doing he implicitly acknowledged (as indeed did Freud) that all our theoretical and therapeutic endeavours are inextricably both interpersonal and intrapsychic. The Other within always implicates the other without. The interpersonal relationship is the field in which the unconscious manifests.

Jung effectively introduced a field concept of the transference in his long essay "The Psychology of the Transference" (CW 16). In this, and in other works drawing on it, we find the notion of the 'cross quaternio' which Jung diagramed in a rectangle with two points of consciousness above and two points of unconscious below. Later writers have subtended this rectangle with a 'deeper' archetypal point. In this diagram we can imagine two 'egos' communicating with each other at the conscious level underpinned by their respective personal complexes and archetypal

images at the unconscious level. From an intrapsychic perspective the process of individuation occurs in the facilitation of the relationship between the conscious and the unconscious, between ego and archetype, and hence between ego and Self. But this relationship is always also manifest interpersonally in the cross 'projections' between the analysand's unconscious and the ego of the analyst and also the analyst's unconscious and the ego of the analysand. This arrangement may in turn be visualized as based in an archetypal field built up around the split bi-pole of an archetype – e.g. needy child and depriving mother – which itself underlies and is constellated and made present in and through the analytic relationship. The fixity of this, the way in which the interpersonal archetypal field determines experience, behaviour and affect, is essentially an I-It relationship (Buber, 1923/1970). When there is relationship between ego and Self then this I-It can give way in the analytic work to the I-You (Jacoby, 1984).

Several analysts have utilized the diagram of the cross quaternio as a depiction of an interpersonal archetypal field between analyst and analysand. Notable amongst them are Groesbeck (1975) in his discussion of the archetypal image of the wounded healer, Dieckmann (1979) and Jacoby (1984) in their respective discussions of transference and countertransference and Spiegelman (1996) in his discussion of transference as an interactive field.

Spiegelman, (1991, 1995, 1996), in particular, has discussed the interpersonal archetypal field and the movements of change which occur within this field. As a first step when entering the interpersonal archetypal field analyst and analysand usually experience being:

> embedded in an imaginally perceived whole situation. They experience the unconscious or archetypes both 'around' and 'between' them as well as 'within' them – an encompassing, infusing, and mutually interactive field (Spiegelman, 1996, p. 186).

As a second step this then shifts into the typical analytic relationship in which analyst and analysand perform the usual activities of analysis, typically containment and interpretation. A third shift carries some analytic couples into what Spiegelman calls 'mutual process' which is characterized by each making frequent, and often intense, reference to what is occurring in the analytic relationship between them. This is a relationship characterized by the analyst being in the work as much as the analysand. A fourth and final shift shift involves all the above but also includes bodily experiences, for both analyst and analysand, and synchronistic phenomena.

With comment on the last stage of the analytic encounter as an interpersonal field phenomenon we are brought full circle with a return to presencing of the unconscious in a bodily way.
The presence of the unconscious in the body is a gestural presence and the transference filed is also a gestural field (Romanyshyn, 2007).

These arguments give us a compound theoretical and clinical vertex from which to discuss self and other in analytical psychology: the unconscious as called forth in the interpersonal archetypal field and as presenced in the bodies of the analysand and analyst.
I shall proceed to explore this through the medium of an analytic vignette that is consistent with Jung's style. I shall interleave this with theoretical discussion.

Case Vignette Two (with interleaved theoretical commentary)

The case material consists of a constructed fictionalized case in which I present a clinical experience that I have had at different times with analysands who have similar psychodynamic functioning and ways of being-in-the-world. I shall call my fictional analysand Claire. The core elements of this analytic encounter have occurred with at least four analysands.
Claire is a 45 year old woman who has had several years of psychotherapy prior to commencing her analysis with me. She came complaining of life being meaningless. At times she experiences depression. She described how she found no occupation or activity particularly interesting, how she had no sense of calling and also how she felt that she lacked imagination. Claire was evidently prone to being self-critical. She presented as a neatly turned out person who dressed in a rather covered up way. A helpful and conscientious person, she stated that she liked keeping her household neat and tidy, that there was a place for everything and that she wished that the family would return objects to these places.
We may note at this point that Claire conforms to what Freud described as an obsessional character type. He says of this type that:

> It is distinguished by the predominance of the super-ego, which is separated from the ego under great tension. People of this type are dominated by fear of their conscience instead of fear of losing love. They exhibit, as it were, an internal instead of external dependence. They develop a high degree of self-reliance; and, from the social standpoint, they are the true, pre-eminently conservative vehicles of civilization (Freud, 1931/2001, p. 218).

Claire described her previous psychotherapy with a warm but somewhat abstinent woman therapist who had worked from what was stated to be an eclectic but mostly psychodynamically informed perspective. Claire described how she would anxiously ruminate prior to sessions especially about what she would say. She found little or nothing to say and her therapist's abstinence and interpretive reflections on Claire's few apparent associations did not lead anywhere much. Claire stated that her previous therapist had worked very much in the transference but that for Claire the transference interpretations had seemed meaningless. Claire felt deeply responsible for the failure to make progress in this therapy. Furthermore she felt that she could not come up with appropriate and useful thoughts and insights. She described being mostly emotionally unmoved in her previous therapy. She was very embarrassed. Generally however she had no access to her emotional life.

This also conforms to what Freud had to say about the analysis of obsessional neurotics:

> Obsessional neurotics understand perfectly how to make the technical rule almost useless by applying their over-conscientiousness and doubts to it (Freud, 1917/2001, p. 289).

In analysis with the obsessional analysand this means that associations are mostly a product of the analysand's tendency to compliance. Furthermore, the associations are free of any real emotional valence. This is because the obsessional analysand uses a particular form of unconscious defence which Freud commented on in his seminal 1926 work Inhibitions, Symptoms and Anxiety: the defence of isolation. Isolation amounts to the conscious knowledge of events from which the emotions have been defensively stripped and rendered unconscious. This merges into both the transference and resistance, which Greenson puts very clearly:

> A typical variety [of transference resistance] is the obsessional character who has isolated all his emotions from his everyday life and who lives by thoughts and ideas alone. Such a patient has such a deep-seated resistance to all emotional reactions that he tends to interact with people only to an intellectual plan. All spontaneous emotion is felt to be a danger to be combated. Only control and thinking are reliable and virtuous (1967, p. 344).

We see this restraint in Claire. In the course of the initial sessions, whilst taking something of a history, I realized, through Claire's bodily presence, and my own bodily response to it, that she came into the room very, very anxious. On enquiry she agreed that she was anxious and that she had considerable anticipatory anxiety on the journey to her session with me. Let me describe one of these early experiences further.

I was sitting back in my chair my one hand, characteristically, to the side of my face. In this position I felt far away from her so I shifted in my chair moving forward, putting my elbows on my knees cupping my chin in my hands. Claire was speaking of her mother and her own breathing was tight and constrained. My breathing matched hers. I felt a tightness in my chest. Then I felt, in fact almost saw, a little wave of tearfulness pass across her, as if from her left to her right. I felt some emotion rise in me, something deep down in my body presence. Then she smiled and this drew me away from my own body presencing of emotion. I felt my embodied emotional response to her fade away. She spoke some more, again the tearfulness passed across her. Again the tearfulness touched me, again it faded away. I thought of holding these emotions in my own body, of helping her access these feelings of tearfulness. I waited and the wave of tearfulness came again. I tensed my muscles; sitting still I inwardly leaned further forward.
I was aware of a strange feeling that my whole body was like a living candle, all of it alive from the base where I sat on the chair right to the flickering flame. This candle resonated and caught the still but quiet resonance in Claire. My breathing

changed, I held the tearfulness in my in breath. I set my body firmly, almost stiffly, into holding the wave of tearfulness, caught in the resonating of the candle. The flame danced on the tightly held but resonating candle. Somehow my body managed to hold this feeling. Claire may have been unconscious of her emotions but the musculature of my body, of my breathing, had caught them. I somehow tuned into the feeling of tearfulness, I had caught the tears of the little girl avoided and abandoned by her mother.

We can pause to note at this point that, with respect to the role of breathing, '[i]n treating patients dominated by long-standing inhibitions, a feeling for the spontaneity in the patient is very important . . . The observer immediately "feels" whether a patient breathes freely or not' (Braatøy, 1954, pp.175-176). Braatøy, who was a psycho-analyst, argues that analysts need to cultivate a capacity to register the analysand's psychological life within their own bodies and thus help make emotions available to the analysands. In this way the body is more than a means of registration, it also becomes a vehicle for interpersonal transmission of emotion registered in the countertransference. This describes something of the process I am engaged in with Claire.

I started to speak to Claire. It is important to note that my speaking was not 'a thinking'; it was instead an answering of my being to her presence. In practical terms this meant that I allowed my body to attune to her presence and felt the muscles tightening and holding my own breath, I felt the upwelling of some as yet not quite clear emotion. I experienced this as us resonating together as if we were at the poles of some undulating and shifting interpersonal field imaged in the resonating candles opposite each other: a movement between us but also from base to flame tip – the interpersonal archetypal field.

My hands shaped something in the space before me, a literal space, but also an interpersonal space, and deep down too an archetypal space. I said to Claire that I wanted us to hold something there. I held the idea in the air between my palms and fingers, my arms were extended somewhat in front of me and I held them steady. I felt the wave of tearfulness move back and forth between us, our two candles resonating more and more.

I told her how I experienced her sitting before me tightly held in the muscles of her chest, so tightly held that she breathed with difficulty. I said I could feel a resonance in my own body to this and how somewhere in this I could feel some emotion was present, and that this emotion came and went but also resonated in her. I said that I thought this might be her as a little girl and that I wanted us to feel this little girl's feelings, I wanted her to be able to speak of how she felt. Then I fell silent. Claire too was silent. Then some sort of exchange occurred, I felt that I could let go of the tearful feelings. I started to relax my fingers, and gently withdrew my arms from the space before me. As this occurred I felt the emotions start to move more in Claire. Her eyes brimmed, first one tear and then another

gathered and slowing slid down her cheeks. These tears brought us both into the presence of the hurt and suffering little girl. Claire's own presence to her emotions built and held. The wave of feeling came and Claire started to sob. Her sobbing rose like feeling undulations running up her body from where she was seated on the chair to her face.

I relaxed my body and then felt my own waves of compassion for this sad and hurt child in front of me. After a long while I asked her what this little girl needed. She settled enough to say, through her tears, that she ached to have had her mother hold her, that was all she had needed, not mother's avoidance, not mother's absence, not mother's fear of having any feelings with and for her. I reflected on how sad it must be for her that her mother could not be with her in this way. We found ourselves in an emotionally attuned and open space. This was an encounter which fulfilled those simple suggestions that all that is needed for therapeutic effect is empathy, congruence and unconditional positive regard, an encounter which was the space of I and You.

In this encounter Claire's soulfulness, which has for so long been obstructed by arid cognition, was expressed in an embodied and interpersonal way. That embodiment was a profound dwelling with herself and a profound state of relationship with me. In my openness to her in relationship, and as an embodied other, she became present to me as an embodied other and to herself as an embodied Other. In this way she started a process of gathering her capacity for passion, that is, for her forms of thinking to become forms of feeling. This can only really happen as an expression of her bodily presence, which was also evoked in my body. We see in this what is effectively a manifestation of deeper levels of the interpersonal archetypal field: we both register her emotional life in our bodies and are able to refer to what is occurring in our bodies and in the analytic relationship. This brings me, in truly Jungian fashion, to alchemical thoughts on the case material and its links to the presencing of the unconscious through the body and the movement from emotional and interpersonal encapsulation to openness.

Alchemical thoughts

The case material introduces us to the emotional and interpersonal restriction which is so powerfully evident in the obsessional character. This ties in to certain alchemical notions. Alchemy relies on the central notion of the coniunctio, which is the conjunction between different elements within the sealed alchemical vessel. The alchemist Dorn, who Jung cites in his magnum opus Mysterium Coniunctionis (CW 14), describes three different sorts of conjunction. The first of these conjunctions is the 'unio mentalis' in which the spirit and soul combine with each other to form the mind which separates from the body. In the second conjunction the mind recombines with the body, and finally, in the third conjunction the mind/body combines with the world to form the 'unus mundus'. From an archetypal perspective the isolation of affect used by people with obsessional characters removes both their bodily and emotional reaction from the knowing of

their mind and replaces them with intellect and rationality. By this strategy the 'unio mentalis' is very successful but it also truncates the possibility of the reconjunction of the mind and the body and hence of individuation. Jung puts this quite eloquently:

> But the separation of the spiritual and the vital spheres, the subordination of the latter to the rational standpoint, is not satisfactory inasmuch as reason alone cannot do complete or even adequate justice to the irrational facts of the unconscious (CW14, para: 672).

In the Jungian alchemical formulation the mind (with its thoughts but no emotions) fails to conjoin with the body, which both bears and hides emotions. From a phenomenological perspective (strongly informed by analytical psychology) we note that:

> [T]here is a recognizable difference between an understanding which proceeds from mind and an understanding of the human heart. I can, for example, understand your grief at the loss of your friend when I know the circumstances surrounding this loss. But certainly my understanding of your grief is changed when it moves my heart. At that moment I understand you and you yourself feel understood by me (Romanyshyn, 1982, p. 101).

Heart and body are reflective one of the other, for Romanyshyn goes on to say:

> The appearance of psychological life as story suggests therefore that the recovery of the psychological body can begin with the human heart. Indeed it may even be the case that the human heart is pre-eminently the embodiment of psychological life. To be psychological it is perhaps necessary to see life and to live it through the heart (Romanyshyn, 1982, p. 101).

Thus the analytic task is the return of the body and what it carries and hides. And because 'to be' is 'to be in the world together' so my body may serve as a receptor for Claire's hidden emotions. If I can hold onto and maintain contact with these emotions in my body, these emotions that are unconsciously carried and hidden in her body, then they may become consciously available to her. They thus first become available for the conjunction of mind and body in my body and then through our shared participation in the interpersonal archetypal field the conjunction is offered to her and she can live them in her body.

The evocation and reception of Claire's embodied emotions in the interpersonal archetypal field leads to a moment in which I can understand her in and as her emotioned body. She can in turn, in that moment, feel understood by me. This provides a place of opening and reception of her own, until that time unavailable, possibilities of being. Todres (2007, p. 2) argues that the "lived body . . . grounds understanding by intimately participating in a world that can show new horizons and meanings". He goes on to say that "embodied understanding is a form of knowing that evokes its living, bodily relevant textures and meanings". This invites us to consider the third conjunction, or 'unus mundus', in which the mind/body combines with the world. Generally the 'unus mundus' is a spiritual notion that

means the highly developed transpersonal state of non-dual consciousness (Wilber, 2000) but we may also understand it, psychologically, in the context of the obsessional character, as returning the individual to the world, be that the world of nature or the world of others. This is not a regressive restoration of submersion in the collective. It is, however, an experience of compassionate attunement to the world and others. This is surely the antithesis of individualism.

The alchemical metaphor of individuation finds company with several phenomenological thinkers (e.g. Brooke, 1991a; Romanyshyn, 2007 and Todres, 2007) who are sympathetic to analytical psychology. All of these thinkers issue a call back to embodied existence together with others.

Romanyshyn (1984), in a discussion of the metabletics of the West, alerts us to how we live in a world which might be called individualistic, a world in which the individual eye looks on from a distance, a world in which the individual body is a dead mechanical device not the place of life, a world in which individuals may so easily be alienated from others and from themselves. This is the world in which the Western 'soul healer' (i.e. psychotherapist) seeks to return us to what Todres calls embodied understanding, a notion that resonates with the three conjunctions of alchemist Dorn. For in embodied understanding, one is opened to being more than cognitively aware and is involved instead in an embodied and aesthetic experience.

Embodied understanding allows one to 'increasingly experience oneself as "more than" the ways one has been objectified and defined (freedom), and therefore, more fluidly in accord with the human realm (vulnerability)'. Through embodied understanding we are opened spiritually to 'a view of human existence that lies between great freedom and great vulnerability' in a 'spirituality that integrates the personal and the transpersonal' (Todres, 2007, p.3). These words of Todres serve as a poetic articulation of individuation, the capacity to live poised between one's sense-of-self and all that which is other/Other/the other. The openness to live so poised is a freedom towards the world and others that is greater than any offered by individualism.

Conclusion

The primary aim of this paper was to present a contemporary view of Jungian theory and practice such that it met and challenged the accusation of individualism. First presenting a thumbnail sketch of analytical psychology and the practice of analysis discussion was extended to two areas of Jungian analysis - presencing the unconscious through the body and analysis as experience and activity in an interpersonal archetypal field. This was followed by a fictionalized composite case and interleaved theoretical discussion, which included some alchemical thoughts and their contemporary resonance in phenomenological thinking.

References

Braatøy, T. (1954). *Fundamentals of psychoanalytic technique.* New York: John Wiley & Sons.

Brooke, R. (1991a). *Jung and phenomenology.* London: Routledge.

Brooke, R. (1991b). Psychic Complexity and Human Existence: A Phenomenological Approach. *The Journal of Analytical Psychology, 36,* (4), 505-518.

Buber, M. (1923/1970) *I and Thou.* Trans. W. Kaufmann. Edinburgh: T &T Clark

Dieckmann, H (1979/1991). (trans. Boris Matthews). *Methods in Analytical Psychology.* Wilmette: Chiron Publications.

Freud, S. (1913/2001). On Beginning Treatment (Further recommendations on the technique of psycho-analysis I). *The Standard Edition of the Complete Psychological Works of Sigmund Freud Vol. 12* (pp. 121-144). London: Vintage/Hogarth Press and the Institute for Psycho-Analysis.

Freud, S. (1914/2001). On the History of the Psycho-Analytical Movement. *The Standard Edition of the Complete Psychological Works of Sigmund Freud Vol. 14* (pp. 7-66). London: Vintage/Hogarth Press and the Institute for Psycho-Analysis.

Freud, S. (1917/2001). Introductory Lectures on Psycho-Analysis Part III.. *The Standard Edition of the Complete Psychological Works of Sigmund Freud Vol. 16.* London: Vintage/Hogarth Press and the Institute for Psycho-Analysis.

Freud, S. (1923/2001). Two Encyclopaedia Articles. *The Standard Edition of the Complete Psychological Works of Sigmund Freud Vol. 16.* London: Vintage/Hogarth Press and the Institute for Psycho-Analysis.

Freud, S. (1931/2001). Libidinal Types. *The Standard Edition of the Complete Psychological Works of Sigmund Freud Vol. 21* (pp. 217-220). London: Vintage/Hogarth Press and the Institute for Psycho-Analysis.

Freud, S. (1925/2001). An Autobiographical Study. *The Standard Edition of the Complete Psychological Works of Sigmund Freud Vol. 20* (pp. 7-74). London: Vintage/Hogarth Press and the Institute for Psycho-Analysis.

Freud, S. (1926/2001). Inhibitions, Symptoms and Anxiety. *The Standard Edition of the Complete Psychological Works of Sigmund Freud Vol. 20* (pp. 87-174). London: Vintage/Hogarth Press and the Institute for Psycho-Analysis.

Freud, S. (1927/2001). Postscript to 'The Question of Lay Analysis'. *The Standard Edition of the Complete Psychological Works of Sigmund Freud Vol. 20* (pp. 251-258). London: Vintage/Hogarth Press and the Institute for Psycho-Analysis.

Greenson, R.R. (1967/1994). *The Technique and Practice of Psycho-Analysis.* London: Hogarth Press and the Institute of Psychoanalysis.

Groesbeck, J. (1975). The archetypal image of the wounded healer. *The Journal of Analytical Psychology, 20,* (2), 122-145.

Jung, C.G. (1928). The Therapeutic Value of Abreaction. In *The Collected Works of C.G. Jung. Vol 16.* (pp. 129-138). Trans. R Hull. Princeton: Princeton University Press 1953-1979.

Jung, C.G. (1935/1986). *Analytical Psychology Its Theory and Practice (The Tavistock Lectures).* London and New York: ARK Paperbacks.

Jung, C.G. (1944/1952). Psychology and Alchemy. *The Collected Works of C.G. Jung. Vol 12.* Trans. R Hull. Princeton: Princeton University Press 1953-1979.

Jung, C.G. (1946). The Psychology of the Transference. In *The Collected Works of C.G. Jung. Vol 16.* (pp. 163-323). Trans. R Hull. Princeton: Princeton University Press 1953-1979.

Jung, C.G. (1963). Mysterium Coniunctiones. *The Collected Works of C.G. Jung. Vol 14.* Trans. R Hull. Princeton: Princeton University Press 1953-1979.

Jung, C.G. (1971). Psychological Types. *The Collected Works of C.G. Jung. Vol 6.* Trans. R Hull. Princeton: Princeton University Press 1953-1979.

Jacoby, M. (1984). *The Analytic Encounter: Transference and the Human Relationship.* Toronto: Inner City Books.

Jung, C.G. (1963/1983). *Memories, Dreams, Reflections.* London: Fontana Paperbacks.

Makins, M. (Managing Ed.) (1991). *Collins English Dictionary 3rd Ed.* Glasgow HarperCollins Publishers.

McLynn, F. (1997). *Carl Gustav Jung.* London: Black Swan Books.

Ogden, T.H. (1994). *Subjects of Analysis.* Northvale NJ: Jason Aronson.

Ogden, T.H. (1996). Reconsidering Three Aspects of Psychoanalytic Technique. *The International Journal of Psycho-Analysis, 77,* 883-899.

Ogden, T.H. (1997). *Reverie and Interpretation.* Northvale NJ: Jason Aronson.

Papadopoulos, R.K. (1984). Jung and the Concept of the Other. In R.K. Papadopoulos, and G.S. Saayman (eds.). *Jung in Modern Perspective.* Hounslow: Wildwood House.

Plaut A. (1956/1974). The transference in analytical psychology. In M. Fordham *et al* (eds.). *Technique in Jungian analysis.* London: Heinemann.

Romanyshyn, R.D. (1982). *Psychological Life: From Science to Metaphor.* Austin: University of Texas Press.

Romanyshyn, R.D. (1984). The despotic eye. In D. Kruger (ed.). *The Changing Reality of Modern Man.* (pp. 87-109). Cape Town: Juta.

Romanyshyn, R.D. (2007). *The Wounded Researcher.* New Orleans: Spring Journal Books.

Samuels, A. (1985). *Jung and the Post-Jungians.* London: Routledge & Kegan Paul.

Samuels, A. (1989). *The Plural Psyche: Personality, Morality and the Father.* London: Routledge.

Samuels, A., Shorter, B. & Plaut, A. (1986). *A Critical Dictionary of Jungian Analysis.* London: Routledge & Kegan Paul.

Spiegelman, J.M. (1991/1996). The Interactive Field in Analysis: Agreement & Disagreement. *Psychotherapy as a Mutual Process.* (pp. 114-128). Tempe, AZ: New Falcon.

Spiegelman, J.M. (1995/1996). Transference as Mutual Process & Interactice Field. *Psychotherapy as a Mutual Process.* (pp. 164-176). Tempe, AZ: New Falcon.

Spiegelman, J.M. (1996/1996). On the Physics & Psychology of the Transference as an Interactive Field. *Psychotherapy as a Mutual Process.* (pp. 183-206). Tempe, AZ: New Falcon.

Todres, L. (2007). *Embodied Enquiry: Phenomenological Touchstones fro Research, Psychotherapy and Spirituality.* Houndmills, UK: Palgrave MacMillan.

Wilber, K. (2000). *One Taste: Daily Reflections on Integral Spirituality.* Boston: Shambhala.

Paul Russell and Repetition

Sandra Winton

Abstract

In Boston in the 1980's and 1990's Paul Russell wrote and taught about psychotherapy in a way that conveyed a lively engagement with the experience of the therapist or analyst as well as that of the patient. He foreshadowed ideas that would be elaborated by later relational thinkers. This paper seeks to introduce the reader to his thinking about the repetition compulsion and to bring it to bear on two clinical cases, one where the repetition extended over a long period and another where it was swift and pivotal. In this way I show how Russell's ideas have power to sharpen and enliven the way therapists might work with repetition – with both its difficulty and its potency.

I began this paper after attending a workshop led by Barbara and Stuart Pizer, introducing the work of Paul Russell. Both workshop presenters had been students of Paul Russell and they spoke very warmly of him as a generous teacher. Prior to his death in 1996, he used to give presentations in local programmes in the Boston area. These were very popular but almost none of these papers were published. Ten years after his death a number of his papers were gathered in the Smith College Journal of Social Work and two were printed in Contemporary Psychoanalysis. They were published 'as is' in both journals. Grounded in Freud, Russell espouses, however, Kohut's advocacy of an empathic stance and, relatively rarely for an American writer of his time, he is also influenced by Winnicott. He is valued by relational thinkers as he thinks always from the standpoint of two people in the room. He wants a therapist to feel, to be real and to be able to think about what he or she is going through in the session. He believes that the particularities of this will be a 'royal road' to understanding what the client is bringing.

Repetition

Russell speaks of repetition in the Freudian sense but we can also see him moving towards an understanding that the repetition does not belong to the client alone but comes into being between both client and therapist. Sometimes he talks of the way the therapist needs to contain the pressure under which he is placed at these times in order to be able to contain what was not originally contained (2006 a, p.76). At other times he comes very close to acknowledging what relational thinkers would come to openly embrace, that the therapist will be drawn in so that the original experience will be recreated. This is evident when, in the same paper, he presents a rare clinical vignette, showing how his feelings and those of his client captured exactly "what the reality must have been like for her" (p.79). As well as the term "repetition compulsion", he uses the word "repetition" alone, which is not quite, but near to, what relational theorists will call "enactment". I will use both terms with a degree of overlap.

Russell's most cited paper is called 'The Theory of the Crunch' (2006c). In this he considers the experience, when working with a borderline client, of being caught in a crisis. He describes something that will probably be familiar: when the therapy reaches a point where the therapy itself is under threat, when the therapy relationship is under intense strain, when both therapist and client feel confused and possibly overwhelmed:

> These crises have a way of generating so much affect and consuming so much energy that one of the major problems in the treatment situation is the disorientation of the therapist. The feeling is, that if only the storm would clear the treatment could begin. Take this point, when the confusion is at its greatest, when the therapist's anxiety, helplessness and sweat are at new levels, not before thought possible, and call it the crunch. (2006c p. 10)

This quotation gives a flavour of why Paul Russell has a particular appeal: he speaks in direct and real language of the therapist's experience. When I read this passage I felt I knew exactly what he was talking about, and that he knew precisely what I had been going through with a particular client. Realness has a central place both in his style of writing and in his theory.

In 'The Theory of the Crunch', Russell is equally direct and real about the client's experience. The borderline client, he says, has suffered trauma in the area of attachment. In the therapy, attachment arises and so the client will render into the therapy precisely what is his or her greatest difficulty:

> It is as if the patient chooses the treatment crisis - the potential rupture of the therapy relationship – to try to convey that which is most important to him. And worse yet, he does so not in words, but by recreating the anguish for which he came to treatment to begin with. (p. 10)

Russell understands this crisis as a repetition. The particular individual configuration of the early trauma, of the "primary developmental failure...in the area of the capacity to form human relationships" (op. cit. p.11) is repeated in the therapy. And both client and therapist experience it - the client as desperation, franticness or rage, the therapist, Russell says, as "urgency". In fact, he says that when therapists feel this sense of urgency, the powerful feeling that "I must do something", it is the surest indicator that we are dealing with repetition or with the crunch. Possibly one reason why this particular paper was so popular was because it offers the beleaguered therapist a thought that enables him to hold to the work. For Russell believes that the crunch can offer an opportunity for the therapist to step outside the old and offer something new - containment and a chance to experience feelings that were otherwise not available to conversation, relationship or thought. This, of course is not a single experience, but one repeated over and over, rather like a spiral staircase with each repeated turn giving a slightly higher view (2006c, pp. 14-15).

Russell wrote about the repetition compulsion more broadly than as it applied to the borderline experience. He developed his thoughts about it in a number of papers, notably one called 'Trauma, repetition and affect' which he delivered in a symposium in 1991. Repetitions occur compulsively outside therapy. Therapists will recognise this in the client who repeatedly gets herself into exactly the same sort of bother with exactly the same sort of person, for instance. But what interests Russell more are the repetitions that occur within the therapy relationship itself. These are manifested in the large scale configuration of the relationship and in the finest details of verbal exchange. They are one of the principal tools of our work.
Russell says, "The concept of the repetition compulsion I take to be the most important concept Freud left to us" (2006d, p.604). He says that in therapy repetition is experienced as unavoidable, like a fate or doom:

> ...despite the apparent wish to avoid the pain, the cost, the injury of the repetition, one finds oneself repeating nevertheless, as if drawn to some fatal flame, as if governed by some malignant attraction which one does not know and cannot comprehend or control. It has, in other words, all the external earmarks of a volitional act, and yet the person is unaware of wishing any such thing. In fact... quite the contrary; he or she would wish to avoid it. (2006d, p.605)

Russell believes that the repetition compulsion and trauma are intimately connected. The trauma may be a specific injury or it may be "the traumatising effect of a family system" (2006d, p. 602). Trauma has the effect of narrowing the range of affect available to a person:

> The more adverse the early experience, the more severe the early injury, the more limited, the more intense and more constricted is the emotional grid. (2006c, p.15)

By repeating over and over again the known path of the familiar trauma, the person, paradoxically is trying to remain safe and avoid risk. Part of the risk is of feeling affect that is outside the familiar repetitive range. The person does not know what the affect is: it is the unknown terror, and all the more terrifying because unknown. Another part of the risk involves giving up "the safety of aloneness" (2006d, p.613). Aloneness enables the person to hold on to familiar feelings, painful as they may be, and not to open to the emotion that might emerge in relationship, especially shame, sadness and grief. "The real risk", says Russell, "consists in genuinely giving up the repetition and all that this involves" (2006d, p.614).

On the other hand repetition also has a "task unsolved aspect" (2006c, p.15). Russell believes that the person may reproduce the original trauma in some way or may reproduce the disruption of relationship (attachment) which is a feature of it. Either way, Russell says, "we can be sure... that what is reproduced is what the person needs to feel in order to repair the injury" (2006d, p. 614).

Let me illustrate this through considering a case. It involves a child of nine. I will call him Dylan. Dylan was brought to therapy by his grandmother with whom he was living and in whose house he was refusing to eat; he was taking breakfast at school. It soon became clear that he was making every effort to render living with grandmother untenable so that he could be returned to the care of his mother. When this occurred his behaviour would be so uncontrollable that his mother would send him back to grandmother again – and so it was going on and on. The trauma was around a failure of holding and he was repeating it over and over.

After introductions in the waiting room he came willingly with me into the playroom. It felt as if I had barely taken in his bright blue eyes, well-built body, spiked hair and sharp look before he immediately tossed the central emotional problem into the room. In the twinkling of an eye he was sitting cross-legged on top of a tall cupboard, looking down like a bright-eyes seagull at his startled therapist. Immediately there was the central issue: I was thinking with considerable urgency, one clear thought – what if he falls? A second, what if he brings the whole cupboard down? And a third, what if he is injured?

The issue was right there – falling, holding, potential calamity and collapse, potential falling to pieces of the relationship. Naturally I experienced urgency to act – and I did act, getting him safely down. This was just sensible. But on another level from 'sensible', I was from the first moment being tested in precisely the area of the trauma.

This became even clearer to me when I contacted his school. He had well intentioned teachers, genuinely concerned for his wellbeing. They were aware of the way he boomeranged between his mother's home and his grandmother's. But he was not in the classroom the day I called. He was in the next door room where he would be sent when his behaviour became intolerable. So he was going back and forth between two classrooms as he went back and forth between two homes. The teachers were doing the very last thing they would have wanted - repeating the trauma.

And in the course of therapy this determined and creative child repeated over and over the central area of difficulty. He would perch a small batman figure on the top of the curtains, door frame, any high place from which falling would be calamitous. Or I would be engaged in endless games of throw and catch, in which, despite my best efforts, I would inevitably at times drop or fail to catch the small hero being thrown at me. Being inside the repetition was inescapable and I experienced it painfully – feeling despair, failure, helplessness, what it is like to be the one who drops and the one who is dropped.

I consider that what was going on here was primarily a traumatic repetition, an endless rehearsal of the same events. For Dylan it seemed to hold an excitement,

perhaps a kind of addictive fascination. At times it was like riding a roller-coaster; the thrill lay in getting as close to terror as possible without being destroyed by it. In this repetition there was also enormous pressure on the other person to act. In his actual life the child was trying to enforce change; he was absolutely bent on getting back to his mother and his behaviour was directed to this end. There was also a mental component. As Dylan refused to eat at his grandmother's house, to accept her food, he also fought mentally to refuse her interpretation of his mother's life, her feelings towards his mother, her daughter – he was adamant in holding to his belief that he belonged with his own mother and siblings. In this mental representation of events, he was unable to hold or fit his experiences of being sent away by his mother too, or that he was causing this to happen. These experiences needed to be excluded, repressed. The truth itself was unspeakable and unhearable to him. In fact, when I attempted to put things into words, he would literally cover his ears. The original traumatic failure of holding emerged in family, at school and in his therapy, but in exact repetitions, unchanging. Relationship was excluded and replaced by repetition; I felt squeezed into acting a role in his tightly scripted drama. We were in the same room but he remained isolated. There was no place to think of past hurts – there was only the present. The range of affect was narrow: excitement, fear, rage, triumph, on his side, despair, sadness, helplessness and shame on mine.

In a paper entitled 'Our appointment in Thebes: acknowledgement by the analyst in the context of repetition and dissociation', Jessica Benjamin (2008) describes how in an enactment the therapist will find herself locked into a restricted way of experiencing the other, as freedom and flexibility of response break down into what she calls 'twoness'. In 'twoness' there is a back and forth dynamic of 'doer and done to'. In this dynamic both therapist and client can find themselves hurtling down a path that leads to a recreating of precisely the wound that both client and therapist are seeking to heal, and in a normal self state would wish above all not to repeat. They become like Oedipus, fleeing to Thebes so as not to fulfil the terrible fate prophesied for him - and running directly towards that fate. So for Dylan, I and his teachers became his abandoning mother, failing over and over again to hold him.

Russell speaks of such a repetition in one of his better-known but rather dense statements:

> The repetition compulsion represents the scar tissue of interruptions of attachment, attachments the person needed in the service of emotional growth. Interruptions, therefore, in the development of the capacity to feel. The repetition compulsion, much as does an addiction, operates in lieu of a relationship. It is its own kind of history in the subjunctive. The repetition compulsion is paradoxically both an invitation to a relationship and an invitation to repeat the interruption of some important earlier relationship. It is both adaptive and suicidal because, in this context, relatedness is what the person most needs and yet cannot feel. (2006d, p.612)

Like scar tissue, the repetitions experienced in this therapy prevented any closeness. Like thickened skin, they kept us from touching. The repetition kept away unbearable feelings and unthinkable thoughts. It rewrote the history of the past, deleting the child's loss, grief and shame, offering instead a "history in the subjunctive", a "what if", or "if only" story in which the child was in charge of his fate, his mother had not truly failed to hold him, he did not lack a father, and excitement and power replaced sadness, impotence and shame. Both inviting relationship and keeping it at bay, it was as Russell says, "both adaptive and suicidal", enabling survival and killing off real relationship.

Negotiation of Affect

How then can therapy help? Russell believes that it is through what he calls the "negotiation of affect".

Russell holds that understanding alone will not make for a giving up of the repetition compulsion. This rings true to me as I think of clients who come to understand why they do a certain thing over and over again and continue to do it, even with this understanding. At times like this the therapist can find herself repeating the same interpretation like a frozen dinner pulled out of the freezer. Giving up the repetition compulsion, Russell says, is possible only in a relationship, and a real relationship at that. The repetition compulsion is given up only in the repetition compulsion itself.

I will try to explain my understanding of this process, as described in 'Trauma, Repetition and Affect' (2006b) and in another paper called 'The Negotiation of Affect' (2006d). As the repetition is brought into the therapy, it engages both therapist and client. And it does this in such a way that the engagement is real. The therapist is feeling intensely and so is the client. The client is trying to go down the old, well-worn path with the therapist. But he or she is also, at some level, engaging in therapy, in an intimate relationship that has already survived some testing, and so has also a hope that, with this person, things might possibly be different.

Battered in the 'crunch', or repetition, the therapist, Russell believes, is first of all required to contain things – the client's feelings, but even more her own feelings and the pressure to act. What does not happen is crucial – significantly, retaliation or severance of the connection. Sometimes what occurs is primarily holding. Sometimes in the earlier stages of a therapy that is all that can occur until a degree of safety is established and affect is less overwhelming. When there is enough experience of containment to outweigh the intensity of the emotions clustered around the trauma that is enacted, something new can begin to occur.

Benjamin reminds us, however, that therapists will inevitably get caught up in the enactment – some rupture will occur. It is not only in containment but in the process of rupture and repair that safety is gradually established. She stresses the

therapeutic value of the therapist's acknowledgement of what has occurred and her own part in it.

With containment, acknowledgement and reflection, gradually there is an experience that the relationship survives. There is a gradual shift from the safety of isolation to safety within the relationship. Disavowed feelings and unthinkable thoughts are gradually allowed into the therapeutic space. Symbolisation begins to be possible. Affects can be worked with – who owns what feelings, to whom they have been passed, what feelings are there, what feelings come to be. A sense of something stereotyped is replaced by a sense of liveliness. Bit by bit safety is found less in aloneness than in a relationship. This is what I think Russell means by "the negotiation of affect". It is the therapist's affect that is negotiated as much as the client's.

Typically, Russell says, perception follows, as well as rage and then grief for how things were and "all the ways in which one has not been who one might have been" (2006d, p. 615). The repetition compulsion delivers the traumatic memory not as a conscious memory but as a present event. In the rendering of the repetition, the trauma can become a memory, Russell says, "in another part of the mind receiving the same input" (2006d, p.620). I would understand this as an implicit memory, residing in sensory and affective experience, becoming available to the processes of explicit memory, to relationship, to language.

Let me illustrate with another example. D is a woman in her late 40's, a supermarket worker, whose inner world feels fragmented and at times incoherent. She says she is dyslexic: she confuses numbers and will stumble through the syllables of a word like a child learning to read and checking, "Is that right?" She came to therapy haunted by a lifelong dream of houses that are not separate from one other and is terrified at the thought of her mother's taking over her mind. She tells me at the start that she was born to a mother who believed that she was carrying a dead baby, and who, when she delivered a live infant said she was like a pixie. She walks with a stiff-legged gait that reminds me of nothing so much as a walky-talky doll. Her doll was a nexus of childhood distress. She came to therapy like an excited and frightened child. Now she is faced with feelings that are almost impossible to bear – anger, terror, "pain".

It happens towards the end of a session where she has been feeling intensely. Suddenly she looks at me intently and asks, "Do you get affected by my pain? Are you all right?" I say that she is afraid she will damage me. I say this does not happen. I am all right. I want to help her to some understanding so after a hesitation I add, but Mum was not all right. As I add this last remark I am aware that I am showing that I am thinking about Mum. D goes with me. She talks of her mother:

> *"Her mother didn't look after her. Her father was violent to her. She would show me the scars on her legs and back where he hit her with the jug cord."*
> *"And her mother?" I ask.*
> *"She added to it. She would hit her with the hearth broom. What's a hearth broom?"*

D lapses into a failure of words and silence. Something has happened between us.

The session seems to end normally enough but I feel something of significance has happened. I record the above interaction in detail. Then D cancels the next session. I experience powerful feelings – shame, remorse, fear of having damaged my client or destroyed the therapy. It has all the hallmarks of an enactment, the emotional impact of a 'crunch'. I begin to process it in Russell's way, seeing my experience as a tracing of an earlier trauma. I negotiate to be both mother and not-mother.

This is where it takes me: When D asked if I was all right, she was bringing into the therapy the trauma, what went wrong. It was about her and Mum. In the moment I was Mum – Mum who could be destroyed by her distress. As she was afraid of damaging or destroying Mum, her therapist 'Mum' became afraid of damaging or destroying her. I stepped back. Consciously I was trying to bring calm and insight. I hoped that I could help her to begin to make some sense of what she had experienced with Mum. Unconsciously I refused to stay with her and be for the moment the Mum who could be damaged. I moved to separate myself from this fragile mother and assert my steadiness. I did exactly what Mum had done – I refused the invitation to enter the distress with her. I stepped back from her chaos and my own. She had told me how when she was distressed as a child Mum would send her to the basement to tear up boxes. I sent her back to the basement. In Russell's terms, I acted. Whatever my conscious intention, the impact of my acting was to recreate the trauma. The trauma had to do with a stepping back, a crucial failure in attachment.

I began to understand why this mother might have stepped back. This was a woman who believed that she had killed the baby inside her. The primary mother-infant interactions were infused with the feel of the dead baby being carried and terror of the murderous maternal insides. I was the mother who was trying to prevent her baby from being killed, who sent her away so as not to destroy her. I was escaping my own feelings as much as my client's.

Backing away from the destructive therapeutic moment, I took the road to Thebes. In this context Benjamin quotes Ferenczi:

> … the analyst, although he may behave as he will … take kindness … as far as he possibly can … will have to repeat with his own hands the act of murder previously perpetrated against the patient. (2008, p. 31)

Russell says something similar:

> It is as if things cannot be real, and the patient will not feel psychotherapy means anything, until the treatment situation becomes so much like a dangerous part of the patient's past, that there is in fact a real risk of a repeat of the past. (2006b, p.631)

While I am processing in this way, my client, as she later told me, is overwhelmed by her emotions. The rage is so great that she could not trust herself to come to the next session. She also feared that she will kill me or the relationship. A week later she returned.

> *She came in saying, "I haven't been to work today. I rang in and said I was sick and had my period. I know I'll get punished tomorrow for taking the day off but I am owed 137 sick days." I registered the impossibility of this number and her struggle to come to therapy.*
> *"I want to ask you something. Are you sympathetic to my mother?"*
> *I said, "I will answer your question but tell me what you are thinking. I've been thinking about what happened at the end of the last session"*
> *"I felt you got interested in Mum's story. That you were thinking more about Mum. Feeling sorry for her. I've been very, very angry. I needed to stay away last week because I was so angry with you. I had to take the time to get it straight in myself. I put you under a glass jar for a while."*

D then recounted two dreams: one which had been repeated over four nights. Both dreams were accompanied by intense affect. "I am in a car being driven through a forest. Other people are in the car. I have to get to work. That feeling is very strong in the dream. Then in the dream I have this thought- it's very clear –'This is not my dream.' In the second dream I am in a long house on my own. It's my house. I go upstairs and there is a man there eating a meal. He does not belong in my house. I get very angry and want to get him out. But he manhandles me, he throws me about. I feel very upset that I cannot use my martial arts against him. I desperately want to dial for help but cannot recall the number. In the end I ring 123 and get Telecom."

There had been times before in this therapy where the client had become enraged with me and visibly struggled in the chair not to fight with me or "rip off your face". Up until this point, I had been unable to have thoughts about why these feelings might have come about at a particular point; my response had been to hold and survive. But this time, in the enactment, the trouble was brought into the room by both of us and we were able to begin the conversation that may eventually relieve and demystify.

Brought into the therapeutic conversation, the dream of the car driving her to work might be seen as her own experience of being "driven", compelled to work when her dream was to be elsewhere – at therapy. It brings into the room the experience

that while she missed a session doing the work of mastering her anger, she also longed to be present. I felt as well that the clear assertion that this was not her dream might represent her experience of the therapeutic disjunction, and in the strength of the tone with which it was asserted, a beginning of separating from her mother. Interestingly in subsequent sessions she spoke of stepping back from Mum, a space opening up, like the space between the cushions in my room: "I can start to feel for Mum."

The second dream has been less spoken of and it seems important to let the meaning emerge between us. I wonder who will be the intruder eating in her house, what has disempowered her and throws her around like a doll. Certainly in turning my attention to the mother and my own needs to soothe or clarify I experienced being the intruder who broke into her mental "going on being". It does seem clear, however, that she was in her own house and that while help was not easy to get, it was available.

These sessions signalled a significant shift in the therapeutic relationship, in the client's relationships outside therapy and in her inner equilibrium. I believe that the reason for this lies not just in our bringing to consciousness the content of the dreams but more significantly in the fact of being able to talk about them, to stand aside from the joined houses of the maternal/therapist mind and the client's mind, to find a space for thought and conversation. In Benjamin's terms we might think of achieving the presence of a 'third'. In Russell's we might think about the affective repetition of the original trauma to attachment being replaced by a mutual remaining in relationship while the affects are negotiated: in this case, who feels destructive, who feels they could be damaged, where the fear lies and the anger. Who is being protected? What feels dead and why?

To transform the repetition, the therapist needs to be available for negotiation, says Russell, "must- negotiate to be both the person(s) with whom the initial negotiation failed, and the person with whom it might possibly be different" (2006b, p. 635).
In the processing what the client was later to call "the thing" or "the day you felt sorry for my mother", both client and therapist had to enter new territory. There was no theory for me to reproduce, no past for D to rehearse – there was only this new moment of both staying present and seeking words instead of the dyslexic. The conversation was alive. We were interacting with feeling. I think this is at least part of what Russell means when he talks of the negotiation of affect and "truth...accomplished in dialogue". The language becomes fresh, lively and metaphorical. At the end of the session the client said she felt "washed". The language was evocative. I pictured her emerging from water, from a stream or a womb, new born, alive. The affectively charged repetition made movement possible. Negotiation of those affects effected it.

When he considers repetition or enactment Russell reminds therapists of the client's desire to bring her trouble to where it might be held and understood and the

opposing pressure to repeat without giving up on the old defences or aloneness. Russell also draws attention to therapists' experience of 'urgency', a pressure to act; Benjamin underlines the way this pressure inevitably draws the therapist into the action that will repeat the trauma but is also the only place where the trauma can be healed. The repetition is healed only in the repetition. Russell highlights the way the therapist must be both affectively inside the enactment (in the city of Thebes) and outside it (on a hill looking down) so as to be able to see what it happening. The role of the theorist and therapeutic writing is to give a map, a guide to the city that enables us to recognise down what streets we are walking, when we are on a roundabout and when we stand at a crossroads. On this journey Paul Russell is a lively and engaged companion.

Conclusion

I have outlined Paul Russell's thinking in the area of repetition and used it to consider two clinical cases. I hope I have been able to share the pleasure and benefit I have taken from engaging with this writer.

References

Benjamin, J. (2008). Our appointment in Thebes: acknowledgement by the analytic in the context of repetition and dissociation. In The Self in Conversation, Vol VII, pp. 28-40. Sydney, Australia, ANZAP.

Russell, P.L. (2006a) Beyond the wish: further thoughts on containment. Smith College Studies in Social Work, 76, 71-83.

Russell, P.L. (2006b) The negotiation of affect. Contemporary Psychoanalysis, 42, 621-636.

Russell, P.L. (2006c) The theory of the crunch. Smith College Studies in Social Work, 76, 9-21.

Russell, P.L. (2006d)Trauma, repetition and affect. Contemporary Psychoanalysis,42, 601-620.

Book Review

Victoria Grace

Ian Parker. (2011). Lacanian psychoanalysis: Revolutions in subjectivity. In the series: 'Advancing theory in therapy'. Series editor: Keith Tudor. London, UK: Routledge.

The sub-title of this book suggests a focus on the dynamic nature of the relation between Lacanian psychoanalysis and the socio-political, historical conditions within which subjectivity is constructed and situated. But more than that, there is a radical and subversive connotation to the concept of 'revolutions', pointing to a concern with contradiction, resistance, change and transformation at the level of the individual as well as the social. Ian Parker, Lacanian psychoanalyst and Professor of Psychology at Manchester Metropolitan University, is a leading figure in the endeavours of contemporary social, theoretical analysis to navigate the unsettling, if not turbulent, points of juncture and disjuncture that sustain the relations between the various discourses of the 'psy complex' and the social conditions that sustain them. Parker's book pushes this agenda to the forefront, examining the way Lacanian psychoanalysis is both a product of the same socio-political milieu as psychology, psychiatry and psychotherapy, including the classification systems of the late nineteenth century, and yet at the same time tears against every aspect of these traditions, breaking with them definitively. To a large extent, Parker's book establishes the 'scene' within which the points of convergence and divergence across these fields are enacted theoretically and clinically, in both historical and ideological terms.

I think there are at least two readerships for this book, and I strongly recommend it to each of them. One group comprises those non-Lacanians practising and researching in psychotherapies, psychiatry and clinical psychology, for whom psychoanalysis, and Lacanian psychoanalysis in particular, possibly registers on the peripheral vision of their work leading to an interest to learn more. For those whose appetites have been whetted and who wish to extend their appreciation of what Lacanian psychoanalysis is all about as a clinical practice, this book provides an introduction to concepts and processes with considerable clarity, yet without compromising the complexity of the critique and challenge represented by Lacan's work. In addition, it situates Lacanian psychoanalysis in relation to other 'psy' practices, and this within the frame of a critical engagement with the ideology of a capitalist social and patriarchal order actively producing the subjectivities at stake within these interventions. A second readership would be Lacanian psychoanalysts, theorists and indeed others asking questions about psychoanalysis and revolutionary change, who are exploring the vexing issues surrounding individual and collective action to change the conditions of social, political and economic production, and relatedly – the relation between the clinic and 'outside' the clinic.

These are not easy questions, and yet in 'circling around' the main focus of this work, coming at the questions from a number of different 'vantage points', Parker does not detour away from the inherently troubling and problematic lines of inquiry they inevitably open up. Rather, he charts a course that lays out the grounds, traverses the issues in considerable depth, refusing to reconcile oppositions into harmonious wholes or to postulate the possibility of synchronised 'communications'. We learn how, within the frame of a Lacanian psychoanalysis, revolutions in subjectivity can only occur through living the disjunctions that construct the subject in his or her alienation; in doing so, the subject might glimpse, even if fleetingly, that he or she is not produced and reproduced solely through these ideological imperatives.

If there is a complicit relation between psychoanalysis and capitalism, Parker's book aims to break it, or at least challenge and trouble it (p. 89). And the point of leverage he proposes is an explicit disjunction between the space of the clinic and the space outside the clinic. In fact, the very revolution in subjectivity that Parker both points to and calls on psychoanalysis to induce, can only be engendered through the subject's 'use' of the space of the clinic if it is configured as a break from a space that is 'outside'. This disjunction is not proposed in any absolute sense. Indeed, Parker outlines the significance of Lacan's neologism 'extimacy', which is precisely a concept resulting from a deconstruction of the oppositional spatial metaphor of interiority and exteriority. Such a deconstruction, however, does not dissolve the distinction between the two terms, but rather creates a dialectical relation between the boundaries defining them. The exterior, the 'outside of the clinic', can only be realised as constitutive of the 'interior' of the subject, and similarly, that which is most intimate to the subject can only be experienced as exterior to him or her, if the process of analysis can blur these boundaries. For this to be possible, the space of the clinic must be constituted as a break from an 'outside' space, thus creating an otherwise impossible locus as vantage point.

There are numerous features of Lacanian psychoanalysis that tends to make it unpalatable for those embracing the 'good' work of the helping professions more generally, or 'holistic' psychotherapies in particular. One such feature is Lacan's insistence that his reading and practice of Freudian psychoanalysis cannot be one that adapts people to society; that makes disturbed and unhappy people content and at peace with themselves in a seamless relation of harmony with the social order. The very notion of 'happiness' in the neo-liberal consumerism of late capitalism is integral to a utilitarian philosophy, analysed by Joan Copjec (1994) for its propensity to offer the enticements of contentment and satisfaction resulting from participation in the hegemonic social process, in exchange for surrendering the agitations of desire. The psychoanalytic ethic, on the contrary, and as foregrounded in Parker's analysis, enjoins the subject to maintain its desire, and not succumb to these 'pathological' incentives (Copjec's term) that are typically grounded in the subject's perception of his or her own self-interest. This radical Lacanian move

counters any suggestion of an ethics of psychoanalysis being grounded in the 'good'. The subject is not understood as driven to seek his or her own 'good'. Psychoanalysis, therefore, is not a process that removes suffering, understood as an aberration from the 'normal' pacifying contentment of 'happiness'. If anything, psychoanalysis prolongs the subject's 'truth' as conflicted, divided from the object of its desire, and, as we see through Parker's book, alienated both through its subjection to signifiers and through the relations of labour in a capitalist economy.

Lacanian psychoanalysis runs counter-current to notions of a 'depth-psychology'. Parker explains how the psychoanalytic interpretation does not aim to garner hidden meanings that can be conceptualised as 'underlying' the surface manifestation of speech and conscious intention: 'interpretation does not treat the unconscious as a place from which hidden meanings are dragged out into the open' (p. 103). There is no sense of what a dream or symptom 'really means'. Thus in addition to breaking with the notion of 'depth' there is also a break with the idea that the analyst and the analysand are each working primarily with 'meanings'. The very idea that the subject harbours some inner meaning of life that, once revealed, will appease his or her alienation, is rather more an artefact of the capitalist ideology. Meaning construction is certainly a crucial register of subjectivity – in Lacanian terms it figures within the Imaginary – yet the focus on the analytic encounter and process is importantly within the register of the Symbolic, of language, of the structure of signifiers. Through Parker's book the reader is gradually introduced to the way this process works and how it is structurally distinct from the theoretical assumptions and practices of psychotherapies or indeed some other forms of psychoanalysis.

Lacanian psychoanalysis is not humanistic; it is not self-actualising. On the contrary, it is precisely the mis-recognition of a unified and 'actualisable' 'self' that is the focus of analysis. The notion of the unconscious is not posited to be somehow 'inside' the person. Parker makes it clear that the patient's thoughts and 'even the unconscious itself' is 'but a product of symbolic practices that, in bourgeois society, invite each subject to imagine that they are, or should be, an enclosed individual' (p. 77). The refusal of the analytic process to take up the most common understanding of the 'relational' dimension of interaction (between analyst and analysand) challenges the very notions of empathy, connection and containment that structure the way many psychotherapies understand their means of functioning. Lacanian psychoanalysis is famous, or infamous, for the apparent severing of the session that cuts across the analysand's speech. Yet Parker elaborates the crucial role of the 'cut' in analysis that works to section an interpretation rather than augment it; it breaks the identificatory gesture of relationship and 'causes an enigma to appear in the session' (p. 198). This 'cut', or 'scansion' (another term sometimes used by Lacanians), breaks the session, creating a disjunction between the space of the clinic and the outside, and it also breaks the relationship between the analyst and the analysand. Each of these effects

"introduce something of the 'real'" (p. 198); the 'Real' being the third of Lacan's registers within which subjectivity is constituted as an effect of language.

It is necessary to read Parker's book to work through his argument regarding the way Lacanian psychoanalysis can facilitate the connection between the collective political resistances of Marxism and feminism in particular, and the revolutions of subjectivity taking place through the structuring of the space of the psychoanalytic clinic. The disjunctions mentioned are crucial to this possibility. At a recent debate at the London School of Economics (1st December 2010), where Parker was one of three authors talking about their recently published books on the topic of 'psychoanalysis outside the clinic', he commented on the inevitable limit point to psychoanalysis given its formation within the construct of a social world that presumes the enclosure of the 'individual'. It cannot directly precipitate collective action, and this limit is demarcated by the very conditions of its possibility. Given this limit point, Parker is adamant in the book and also in his talk at this event, that Lacanian psychoanalysis is not, and must not be considered as, a 'world view'. It is not a complete system of thought, has no totalising injunction, and as he states, 'it desubstantialises theoretical concepts at the very moment it deploys them' (p. 13 emphasis in the original).

I wonder if Parker's repetitive use of the term 'under capitalism' possibly subsumes too much multiplicity, obscuring those contradictions that could usefully be explored in a more finely grained analysis for their intersections with the particular forms of alienation within contemporary subjectivity. Possibly this would be another book. With reference to contemporary social changes and their implications for revolutions in subjectivity, Parker cites the decline of the paternal imago in late capitalism. While the book does give gender and Lacan's theory of sexuation due attention, with reference to its patriarchal supports, the decline of the paternal imago is such a crucial phenomenon that, given the context, it could have been worthy of further analysis than Parker provides here. I also wonder, in turn, about the decline of capitalism? As the mythical supports of a capitalist economic hegemony appear to be decaying day by day in our globalised world, along with its very 'real' material infrastructure, the question of further turns in the revolutions in subjectivity will, if we take Parker at his word, inevitably be posed.

This volume is a highly significant intervention that addresses questions currently at the forefront of psychosocial and psychoanalytic theory as well as the relations between Lacanian psychoanalysis and psychotherapies. It is particularly commendable for the way Parker articulates the contemporary clinical and theoretical field of Lacanian psychoanalysis with the political economy of our times. I think we will be reading this work and using these ideas for many years.

Reference

Copjec, Joan (1994) *Read my desire: Lacan against the historicists.* Cambridge MA: The MIT Press.

Contributors

Margaret Bowater is a registered psychotherapist in private practice in Auckland. She has worked with dreams in public groups of all sorts for nearly 25 years, and sees dreamwork as an essential component of therapy. *Author of Dreams and visions: Language of the spirit,* she has had dozens of articles published in professional journals, and recently opened her own website, www.Dreamwork.co.nz. She can also be contacted on email via Margaret@dreamwork.co.nz. Margaret is New Zealand's contact person for the International Association for the Study of Dreams. Dreams from her collection are quoted with written permission, and identifying details changed.

Victoria Grace is Professor of Sociology at the University of Canterbury, New Zealand. She researches and teaches in the field of psychosocial studies. Her research interests include psychosomatics (many publications on women's pelvic pain), and a more recent interest in Lacanian psychoanalysis in relation to social and feminist theory. Her current writing includes Victims, Gender and Jouissance (forthcoming with Routledge, New York); a recent edited book with Renée Heberle Theorizing Sexual Violence (Routledge, New York, 2009). She is a member of the executive of the Centre for Lacanian Analysis in New Zealand.

Paraire Huata is of Ngati Kāhungunu descent. He is most comfortable with the term teacher in terms of his working life. For Paraire, the NZAP Conference represented opportunity to showcase Mātauranga Maori (Māori body of knowledge) as a reputable reference point when discussing practice. The partnership aspect that was demonstrated by the Christchurch branch of NZAP and Purapura Whetu, was very dear to him, and having the wananga at Te Puna Wānaka was of personal interest to him as his daughter is the Head of Māori Studies there. It was she and her students who provided the music and singing. He has a passion for education, especially for Māori, and always promotes scholarship and learning as a worthwhile endeavour. At present he is teaching on an Addictions Counselling Course with the Moana House Training Institute.

Itay Lahav is a psychoanalytic psychotherapist. He primarily works with adults in his private practice in Upper Hutt, but also works at the Youth Specialty Service at Hutt Hospital. Itay was born in Israel, and moved to South Africa in his mid-twenties. He started his training in South Africa in the field of mind-body medicine and HIV/AIDS. This included providing therapy to children in an orphanage who had been abandoned by the pandemic. Itay immigrated to New Zealand in 2002 with his wife, Natalie, who is a clinical psychologist. Itay has completed the graduate diploma in Child Psychotherapy with Monash University since being in New Zealand. He has an interest in the field of psychoanalytic psychotherapy, with particular investment in Kleinian theory and practice.

Nancy McWilliams is a Professor at Rutgers University's Graduate School of Applied & Professional Psychology and practices in Flemington, New Jersey. Author of *Psychoanalytic Diagnosis* (1994), *Psychoanalytic Case Formulation* (1999), and *Psychoanalytic Psychotherapy* (2004), and associate editor of the Psychodynamic Diagnostic Manual (2006), she is past president of Division 39 of the American Psychological Association, and is on the editorial board of *Psychoanalytic Psychology*.

Ashleigh Phoenix is a psychoanalytic psychotherapist registered with the British Psychoanalytic Council. She has worked with the sexually abused for 29 yrs and has a particular interest in treating childhood trauma. Latterly she specialises in treating enduring mental illness and is concerned to improve access to psychotherapy for these people. She has precious memories of New Zealand and she would like to thank her New Zealand colleagues for their warm and enthusiastic reception at the Nelson conference (march 2010) where she presented an earlier version of this paper. She currently runs a private practice in the Chalke Valley near Salisbury Wiltshire and also continues to work part time for the NHS.

Seán Manning is a psychotherapist in a therapeutic community in Dunedin, with a small private practice. His academic and professional background is in psychology and social work. Raised in Belfast, Northern Ireland, he has lived in Aotearoa New Zealand since 1975. A former member of the Board of the International, Transactional Analysis Association, and of the Training & Certification Council of Transactional Analysts Inc, until recently Chair of Ethics for the Western Pacific Association for Transactional Analysis and is the current president of the NZ Association of Psychotherapists. He is intensely interested in how psychotherapy works, and in what happens in the human brain as a result. He has authored a report summarizing the effectiveness of psychotherapy and a number of papers on antisocial behaviour and the unconscious.

Keith Tudor is an Associate Professor in the Department of Psychotherapy and School of Psychosocial Studies at AUT University, Auckland. He is a health care provider with a small private practice in West Auckland, and is a Teaching and Supervising Transactional Analyst. He is the author/editor of 11 books and over 200 professional papers; is the series editor of *Advancing theory in therapy* (published by Routledge, UK); sits on the editorial board of three international journals; and takes up the position of editor of the journal *Psychotherapy and politics international* later this year.

Sandra Winton is a Psychoanalytic Psychotherapist in private practice.

Carol Worthington holds an MA from Victoria University (1957) and a Ph.D. from Massey University (1977), and is a member of NZAP and NZPs.S. After

leaving Wellington Hospital's Psychiatric Unit in 1982, she went into private practice as a psychoanalytically-oriented psychotherapist in Wellington.

Dr Chris Milton is a Jungian analyst and clinical psychologist in private practice. He trained in South Africa and migrated to New Zealand in 2002. He is a Training Analyst with ANZSJA, serves on the Editorial Board of the online Indo-Pacific Journal of Phenomenology, and was appointed by the New Zealand Minister of Health as a founder member of the Psychotherapists Board of Aotearoa New Zealand. Chris has taught, examined and supervised in psychiatry, clinical psychology, psychoanalysis and analytical psychology in both institute and university settings. He currently devotes his time to adult analysis and supervision of clinicians, but he has worked psychotherapeutically with adults as well as with children, adolescents and their families in both the private and public sectors. Chris has published in the area of infant mental health and psychoanalytic processes. He also maintains an interest in integral psychology, spirituality and transpersonal psychology.

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 2011 is: **3rd June** . Changes in response to the editing process must be completed by **8th July 2011**.

The length of the paper is to be no more than 5000 words. Please send the paper as a document to the editor (to be announced) 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 not be used.

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 single 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, pp. 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, pp. 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

Please use APA6th edition (2009) format. 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**. American cities should include the abbreviation for the stat; e.g. New York, NY: Routledge. E.g. London, UK: Karnac.

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, D. C.: 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, MS: 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. At http://www.aapc.org/ethics.htm. Retrieved 7/05/06.

For further guidelines, authors should consult the *Publication manual of the American Psychological Association* (6th edition, 2009).

Changes in APA 6th Edition (2009) – DOI

The DOI is a "digital object identifier". Most academic Journal articles have one. You can find it on the PDF, or in the article record on the database, or underneath the abstract. Refer to the APA 6th edn. style guide, or other online resources. Example:

Li, S., & Seale, C. (2007). Learning to do qualitative data analysis: An observational study of doctoral work. *Qualitative Health Research, 17*, 1442-1452. doi:10.1177/1049732307306924

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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.

Māori fonts can be accessed through a Government site on the internet at: http://www.beehive.govt.nz/fonts/index.cfm.