A Response to Philip Culbertson's Presentation

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Thank you for inviting me to respond to your paper, Philip. I have enjoyed the opportunity to play with some of the ideas and questions you have raised.

In this response I want to address some of the issues that Philip has raised and, in particular, my thoughts on the clinical implications of the radical separation of sex, gender, and sexuality and the exploration of narratives in relation to this.

I would concur with Philip's statement that there is little dialogue between psychoanalysts and narrative therapists in this country. I find this fascinating, particularly because I first came to psychotherapy following a workshop in family therapy, the birthplace of narrative therapies, run by two women from New York. I was terribly impressed with the videos they shared of their work. Now I am immersed in exploring the psychoanalytic world and practising as a psychodynamic psychotherapist, and I write from that position.

On reflection I wondered if the lack of dialogue might be the effect of the social constructionist story that Philip presented. I think the conceptual origins from which each school of therapy was created have not always been considered an important part of training new therapists. The philosophical arguments of history have become practice arguments today. As such, like those people in the story, we have an almost religious belief in the validity of practice theories and techniques that underpin our various therapeutic endeavours.

Both schools critique each other's approaches. These critiques include different ideas about the roles of reality, fantasy, truth, consciousness and unconsciousness, discovering vs creating the mind, and the place of narrative and language in the healing process—not to mention the role of the therapist in the therapeutic relationship.

The concept of reality

How do these differences help in thinking about the questions that Philip raises, i.e., the usefulness of separating genitals, sexuality, and gender in working with our clients?

We might look, for example, at the arguments over the existence of an external, objective, and verifiable reality. This idea is at the heart of the positivist movement out of which psychoanalysis arose. However, it was not long before the role of subjectivity, memory, and Freud's proposal of the unconscious began to disrupt or interact with this assumption. The subjective nature of memory and experience was problematic to Freud and psychoanalysis. In the 1880s, Nietzsche anticipated Freud's observations: "'*I did that*,' says my memory. '*I could not have done that*,' says my pride, and remains inexorable. Eventually the memory yields." (Brown, 1991, p. 7)

Freud framed and reframed his understanding of psychoanalysis and human experience to try and accommodate this, among other subjects, and I have heard psychoanalysis described as the study of human subjectivity. The task of rewriting foundational theory in response to clinical evidence and philosophical movements continues.

The difficulty of subjective reality is manifest when we sit with clients. I am sure a number of you will have had the experience of working with transgender clients who want to understand why they are having their particular experience of gender. Some want a clear, single explanation, and for a few, it would be preferable that it be a physical one. This would allow them a socially acceptable understanding, i.e., it is not their fault that they are not having what society determines a "normal" gender experience; it is biological. The idea that there is perhaps a single external truth that will ease the internal distress is comforting. This stands in contrast to the idea that the "why" may be irrelevant and perhaps unknowable in direct cause-and-effect terms. The suggestion that the focus of the therapy is on the "how" and "what", and the multiple truths inherent in their individual "lived" gender experience, can be less comforting, even disconcerting. The idea of external or verifiable truth lingers and haunts us, both as therapists and as clients.

Another area to challenge is the idea that somehow both narrative therapy and psychoanalysis are interested in mental health in its broadest sense. How we conceive of and relate to that seems important. Where psychoanalysis has located itself, I believe, has an impact on the way it has incorporated these ideas into its theory and practice. To some extent, psychotherapy has an uneasy alliance with medicine, often going along with a "consensual standard of mental health based on conscious clarity about objective reality" (Moore, 1999). From a constructivist perspective, this clearly needs to be re-thought. However, it appears that while psychoanalysis has engaged with constructivism from its earliest conception, there is "no articulated consensually

agreed upon standard [to define mental health] within the current framework of constructivist psychoanalysis" (Moore, 1999, p. 155).

Perhaps a single agreed-upon definition is a contradiction in terms. Partially this is because the idea of a single definition brings us back into a circular argument over the competing truth-claims of objective reality, individual subjective reality, consensual reality (in the sense of Habermas's "converging horizons"), and socially constructed reality.

In Philip's presentation, he makes the observation that "my experience with clients is that they often struggle with the task of evaluating their own psychosexual story with any sense of objectivity." This clearly demonstrates how difficult it is to work with these concepts. Does he mean that they struggle with their relationship to an external "objective" reality, believing that there might be one? Or does he mean that the client has no observing ego, and therefore can only really be "in the experience," and therefore only give descriptive accounts and certainly not move to articulate and evaluate the meanings of their behaviour? These two different experiences may necessitate differing clinical approaches.

The acceptance of multiple truths, even within the same person, does not necessarily negate the presence of an external reality. The impact of the world on us engenders our subjective reality; Moore (1999, p. 140) would say that "construction cannot occur without it." We have to have something to be subjective about. In the example we are using, it is the lived experience of the body genitals we are born with, their relation to our experience of our gender identifications, and the development of our gender identity in a gendered society. These discussions are classically poignant in the area of the body, particularly in the discussions on the link between genitals and gender. Freud's (1923) statement that the ego is "first and foremost a body ego" (p. 26) speaks to the way psychoanalysis has tried to understand the process of the ego's emergence as being an embodied dialectical process. It occurs at the intersection of what the constructivists would call the "potential reality" of what is outside consciousness, and then is presented to consciousness in the moment-to-moment of living or "going-on-being." Creating a narrative about discrete experiences can be part of that.

What is inside and outside consciousness reflects another difference between narrative therapy and psychoanalysis. The former holds consciousness as the central focus of therapy. Unconscious experience or thought is either not considered, or considered only as it emerges into the conscious field. Psychoanalysis, on the other hand, is very interested in unconscious material.

Conscious and unconscious material or experience is an example of a range of concepts—for example, inside and outside, experience and narrative, objective reality and subjective reality, mind and body—which can be conceptually argued as opposites. Alternatively they can be seen as dialectics that continually construct each other. Trying to separate them as a way of understanding experience does not work, in my opinion.

The embodied nature of being

In his presentation, Philip cites Judith Butler's suggestion that "we do not have genitals, we enact them." This clearly holds some experiential truth, but this position separates the body from the mind. That is, if I am enacting my genitals, there is an "I" that is separate from my genitals. Clearly this is not the whole story. Partially this is a perceptual artefact of the way our brain works, e.g., language is a second-order representation; it is always re-presenting some thing to the self (Burmudez, Marcel, & Eilan, 1998). I think Butler's statement somehow ignores the fact that perceptually and experientially we are our bodies. Everything we experience, we experience through our bodies. Merleau-Ponty is useful here in that he understood the body to be central.

> *Merleau-Ponty inherited the soul as Being and as Nothingness and set out alone to do what none before him—or since him—could think to do; first, he made the soul a thing, a body, and then, he incarnated all things into the Flesh. His successors have yet to appear. Those who follow him in time are still resisting incarnation; they are still trying to make the Flesh become word; they are still seeking to obtain release from the world by transforming it and themselves into a text.*
>
> (Dillon, as cited in Grosz, 1994, p. 219)

This is one of the problems if we unpick the weaving of the mat in Philip's presentation. The whole is more than the parts, but the parts are necessary for the whole. Radically separating the narrative from the embodied experience is useful for exploration and healing for some people, but I do not believe it is where we live.

This is a problem for those who experience their gender—a social construction—as different from their sex, a visible and invisible but effecting total-body experience. No matter whether we perceive ourselves as female or male, or how we enact our gender experience, or even how we alter our bodies through hormones, drugs, and surgery, many defining experiences for both genders have to be grieved in the disjunctions between the body, and an individual's socially and psychologically constructed gender experience.

This also raises the issue of congruence. Congruence is the idea that multiple facets of oneself are available in response to social or environmental settings, but are linked in a way that provides us with a sense of "going-on-being." This experience contrasts with discrete separate selves or parts. My daughter asked me a while ago, "Mum, which character in *Sex and the City* do you think you are?" I wasn't sure whether to be flattered or offended by her question! I was more interested in her own answer so, typically therapist, I said, "I will have to think about that; who do you think you are?" "Well, I think I am all of them in some way at some times." Clever girl, I thought! Yes, the show does provide an overview of a range of somewhat caricatured but typical, or maybe archetypal, "narratives" about what it is to be a professional white middle-class woman. Some of these narratives are contradictory. Having some flexibility to engage and recognise the way in which each is useful and restrictive allows malleability, but also allows some sense of consistency of self-experience.

This contrasts starkly with a client story. This client knew she could be librarian-like or vamp-like, but that these two personae were not consciously connected with any triggering events or circumstances, so that she felt her experience as being random. She said, "I just don't know which one I am going to be at any time." Or alternatively, another client who had such a rigid attachment to what, for example, it meant to be a man, to the degree that there was no flexibility to move and compassionately, or even passionately, embrace other narratives or constructions he had been exposed to. As Philip has indicated, rigidity around sexuality and gender is often the difficulty, and we can question whether these are trauma-based splits or dissociations.

Clinical application

So what about the role of narrative in psychodynamic practice, and in particular, how does it relate to my practice?

The concept of narrative is used in a number of ways, so a definition could be helpful. Polkinghorne's (1988) definition of a narrative is

> *a scheme by means of which human beings give meaning to their experience of temporality and personal actions. Narrative meaning functions to give form to the understanding of a purpose to life and to join everyday actions and events into episodic units. It provides a framework for understanding the past events of one's life and for planning future actions. It is the primary scheme by means of which human existence is rendered meaningful.*
>
> (Cited in Moore, 1999, p. 144)

Using that definition, I want to raise a couple of examples of how I have found that a focus on articulating narratives can be both useful and not so useful, and why I think that is the case.

As Philip has suggested, trying to elicit clients' narratives about the separate parts of their experiences around sexuality in its broad sense is very enlightening, and can be useful in helping them gain insight into how these may or may not form an integrated or generally coherent experience of themselves. In my early training, a large component in TA and Gestalt therapy got me interested in separating out, for example through two-chair work, varying parts of the self and body. Some clients found this very easy and helpful, and they shared rich conversations and descriptions of their respective gender roles, sexual practices, and parts of the body. They were able to use these processes to integrate, grow, develop, and heal—creating, or I would suggest, co-creating, narratives that expressed or gave rise to meaning in their lives.

Other clients were not able to create verbal narratives. Their descriptions were impoverished, concrete, and linear, and there was a general failure of symbolisation. This meant they could not manipulate their experiences in an abstract way. Chiozza (1999) suggests:

> *A chronological biography presented with a time sequence almost never contains the meaning that we seek; what we seek, no matter how surprising it sounds, is literature!*
>
> (p. 118)

For example, hearing a client with vaginismus describe her vagina as "… about the size of a pencil … a tube … no I don't imagine it could change shape … I don't really think about it except I want to have a baby … I think my husband should just force me to have sex, that might solve the problem" is not literature!

My experience of working with this woman was very much a reflection of the apparent dissociation and lack of descriptive, alive language shown in the above verbatim. Her apparent lack of ability to create a living, rich narrative did not just relate to her vagina. One cannot make people think or mentalise. Real thinking and creativity emerges both developmentally and in the space that can be created by "a facilitating environment" (Winnicott, 1960, p. 43).

In this situation, I could imagine all sorts of narratives that may have been associated with her statements, but she could not. Her history and the restrictions that it engendered were, however, enacted in the therapeutic relationship.

We lived her reality in our relationship through processes of enactment and embodiment. These seemed to be the only access points in working with her. Creating a narrative to some extent is a "doing" activity. For her—and this is a psychoanalytic construct—I felt we needed to go back to "being." My idea was that she might need a containing space, created relationally, in which the capacity to play could be allowed and developed. I believe that this capacity to play is needed before narratives as tools to healing can be useful.

Conclusion

Clinically, narratives are clearly useful. We are hardwired for symbolisation and relationship. Verbal language is the form of symbolisation that gives us the most specificity. It allows us to create meaning or, as Krystal (1988, p. 67) says, to "own our own soul." Language is, however, by its nature restrictive. Whenever we verbalise anything, something is lost. Language is the symbol, not the thing in itself. Ironically, we could therefore say that language is not the whole story in either life or therapy.

Narratives are one way that we can engage in play and meaning-making with our clients. This requires that the client, and the therapist for that matter, can both enter that transitional space where play occurs. Winnicott first locates this creative space between the mother and baby (Winnicott, 1971); perhaps it could also be located "between the reflective and pre-reflective spheres of the life world" (van Mannen, 1997, p. 345). The capacity to use this space is a developmental achievement in which some clients are not able to fully participate, due to past trauma or developmental deficit. I believe that growing that capacity requires another sort of activity which precedes the use and exploration of narratives.

Finally, to quote one of my favourite philosophers, Leonard Cohen: "Poetry is just the evidence of life; if your life is burning well, poetry is just the ash" (Lunson, 2006).

References

Brown, D. P. J. (1991). *Introduction to psychotherapy: An outline of psychodynamic principles and practice.* London: Routledge.

Burmudez, J. L., Marcel, A., & Eilan, N. (Eds.). (1998). *The body and the self.* Cambridge, MA: MIT Press.

Chiozza, L. A. (1999). *Why do we fall ill? The story hiding in the body.* Madison, CT: Psychosocial Press.

Freud, S. (1923). The Ego and the Id. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 19, pp. 12–60). London: Hogarth.

Grosz, E. (1994). *Volatile bodies: Towards a corporeal feminism*. Bloomington: Indiana University Press.

Krystal, H. (1988). *Integration and self-healing*. Hillsdale, NJ: The Analytic Press.

Lunson, L. (2006). *Leonard Cohen: I'm your man* (DVD). Vancouver: Lionsgate.

Moore, R. (1999). *The creation of reality in psychoanalysis: A view of the contributions of Donald Spence, Roy Schafer, Robert Stolorow, Irwin Z. Hoffman and beyond*. London: The Analytic Press.

van Mannen, M. (1997). From meaning to method. *Qualitative Health Research, 7*(3), 345–369.

Winnicott, D. W. (1960). The theory of the parent-infant relationship. In *The maturational processes and the facilitating environment* (pp. 37–55). London: Karnac.

Winnicott, D. W. (1971). *Playing and reality*. London: Tavistock.