Psyche and Academia

Papers from 21 Years of the Auckland University of Technology Psychotherapy Master's Programmes

Edited by Keith Tudor and Emma Green

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What colleagues said about this book

I am honoured to endorse this book. I have had close involvement with the Department of Psychotherapy (now & Counselling) since its birth in the late 1980s (then at the Auckland Institute of Technology). My late husband, Evan Sherrard, was deeply involved in establishing the original programme which was the Diploma of Psychotherapy. I remember those days as being very challenging. He was proud of this achievement. Then, my daughter, Susan, was an early student of the programme, and I remember her graduation very clearly and proudly. Therefore, I have quite a personal attachment to the history of this Department.

Psyche and Academia was a challenging read for me. Time has gone quickly when I think back to the early days. The passing of time has matched the academic development of the current programme. The majority of these research papers are brilliantly written, showing deep understanding and application of the relevant literature. The range of topics amongst these 21 pieces of work was also impressive.

I was delighted to read the studies which are specific to New Zealand and our culture. I was moved by the use of Māori literature and references to the history of our country. Several studies in this collection reflect the changing population of New Zealand.

Congratulations both to the Department and to Keith Tudor and the team for the rigorous and hard work which is behind this collection of student research. I look forward to the next volume!

Isabelle Sherrard, JP, QSO, MPhil, RN

Within this volume of papers, Keith Tudor and Emma Green have distilled much of the essence of 21 years of research undertaken by students of the Master's programmes in psychotherapy at AUT University. As Head of the Department of Psychotherapy & Applied Psychology, I was fortunate in the late 1990s to be involved in the oversight of the development of the psychotherapy programmes (both adult and child) as they evolved into the Master of Health Science, and I am delighted to see the fruits of the work undertaken since that time presented to a wider audience.

There is a richness in the variety of topics covered and the authors have provided unique insights into the difficulties and the challenges of the work they undertake. From exploring the impact of men's violence to the impact of colonisation; from understanding the meaning and importance of tears to exploring the complexities of love in the therapeutic relationship there is much to be learnt from this book. I highly commend it to the reader.

Dr Peter Greener
Honorary Professor, New Zealand Defence Force Command and Staff College
Senior Fellow, Centre for Strategic Studies, Victoria University of Wellington
Head, Department of Psychotherapy & Applied Psychology, Auckland Institute of Technology (1998–1999) and Auckland University of Technology (2000–2002)
Head, School of Psychotherapy, Auckland University of Technology (2003), and School of Public Health & Psychosocial Studies (2003–2008)

This book demonstrates the development of the psychotherapy programme at AUT. What a feast Professor Keith Tudor and Dr Emma Green have curated. I appreciate the care you have taken in reaching out to AUT Psychotherapy graduates to make this book possible.
In 1998, what was then Auckland Institute of Technology (which in 2000 became a university) began offering a Master's programme for practicing psychotherapists. These early theses and dissertations set the Department on a path toward becoming more academically oriented. Many who completed their Master's degree this way went on to become staff members or assisted the Department with supervision.

From 2015, I had the privilege of holding the dissertation classes. The students and I went on a journey of discovery, finding the unique piece of understanding that each one could offer the profession. While turning from a clinical to a research focus for the last piece of written work was often a wrench and a struggle, many of the students found a new and exciting integration of their learning through the process of writing their dissertation. Psychotherapy itself requires the psychotherapist to become at ease with a wider range of feelings than is expected or characteristic of everyday life. The research process requires students to integrate rigorous self-exploration, theoretical understanding, and clinical experience. These elements are contained in the framework of the methodology the student chooses.

This book of papers demonstrates a slice of what is achieved when students of psychotherapy approach the task of research, illustrating the range and depth of the interests and passions of graduates of the profession.

Margot Solomon
Head of Department, Department of Psychotherapy & Applied Mental Health (2003–2007) and Department of Psychotherapy & Counselling (2016–2017)

This is an impressive collection that rewards careful consideration both because of the thought that has gone into its curation and the span of time it encompasses. Covering 21 years of the psychotherapy Master's programmes at AUT, the collection makes a powerful statement about the philosophical heart of the programme and the desire of staff to train psychotherapists as human-centred, relational practitioners. Producing a historical catalogue of student work is a massive undertaking, and both editors—Professor Keith Tudor and Dr Emma Green—are to be congratulated on curating an informative and highly engaging collection. The 21 papers span a range of interests and clinical areas from parent–infant psychotherapy to offender violence, and show the emerging research culture within the Department. In my role as Associate Head of School (2016–2018), I came to work with the psychotherapists as an 'outsider' and was struck by the belief that psychotherapy was a fundamentally practice-led discipline. Through his love of writing craft and prodigious output Keith has done much to challenge the taken-for-granted obviousness of this belief and open psychotherapy up to myriad other ways of thinking beyond mere being. So, although this collection is heavy on the hermeneutics, it does point to a sense that students

are embracing the possibilities for thinking in new ways about their becoming. The editors deserve enormous credit for the Herculean task they undertook in curating, sourcing, and editing this wonderful collection which will surely be a taonga (a thing to be treasured) for years to come.

Professor Dave Nicholls
Professor of Physiotherapy
Associate Head, School of Public Health & Psychosocial Studies, AUT (2016–2018)

The intellectual endeavour of academic work has a number of ends. One is to extend, challenge, and deepen the thinking of the researcher and writer. For those involved in the health professional disciplines, this has the power to transform and refine practice as they interrogate questions and issues of interest. The other, critical end concerns how knowledge is shared, developed, and enabled to contribute to the practice and work of others, and their fields of expertise. Some of this essence is captured in the legislation of Aotearoa New Zealand that outlines the characteristics of educational institutions. Universities are concerned with advancing learning and being repositories of knowledge and expertise. Most importantly, they accept the role of being the critic and conscience of society. Sharing and engaging in the production of knowledge is critical to this role. Staff in the Department of Psychotherapy & Counselling and their leaders within the Faculty of Health & Environmental Sciences at AUT have a long tradition of finding ways to make such contributions. This includes supporting students, enabling research, and ensuring access to knowledge, debate, and critique. The papers in this book continue this tradition by engaging issues, debates, people, and context. They contribute to what is known and, through the process of being crafted and presented together, they speak to a wider audience than they might on their own.

Dr Susan Shaw
Principal Investigator, Health Futures—Health Professional Education, AUT
Associate Dean (Academic), Faculty of Health & Environmental Sciences, AUT (2010–2022)

As someone who has had the opportunity to see at first hand AUT's psychotherapy Master's programmes evolve, I very much welcome the publication of *Psyche and Academia*. Firstly, and foremost, it provides a wonderful array of findings from specific research projects that can benefit future generations. Secondly, it shows that getting a Master's degree need not be part of a factory production line: not only obtaining a symbol of authority, but also a journey of personal transition as well as a destination; and, in particular, a contribution to knowledge. Thirdly, it shows how the psyche of psychotherapeutic research has changed with changing notions of therapeutic knowledge. Here in *Psyche and Academia* we see over 21 years the coming and going of various research methodologies and methods: all of them potential approaches for future researchers to learn from, and who will be greatly assisted by the accompanying specific case studies and clinical vignettes. However, for me it is psychotherapy itself as research, in all the fascinating contexts provided, that shines through in this book. Congratulations to Professor Keith Tudor, Dr Margot Solomon, and Dr Emma Green, their colleagues and students for ensuring that these important works are

now in the public domain, a lead that other programmes throughout the world can hopefully follow.

Professor Del Loewenthal
Emeritus Professor of Psychotherapy and Counselling, University of Roehampton, London, UK
Chair of the Southern Association of Psychotherapy and Counselling, UK

In this book Keith Tudor and Emma Green present us with a jewel in the psychotherapy literature of Aotearoa New Zealand. The writers of these pieces have gone on to publish, to teach, to take up roles in the profession, and to practice the skill and the art represented here in work that they completed during training. This is a volume continuing the documentation of psychotherapy, its development, and its practitioners, arising out of a single school which, for decades, has taken a leading role in the encouragement and training of psychotherapists. This is their work, the work of the students, inspired, passionate, and virtuoso, the work that led to their endorsement by the profession. This is the standard. It will serve as literature in its own right and as inspiration for future alumni.

Seán Tate-Manning, MSc, Dip SW, Grad. Dip. in Māori Studies
President of the New Zealand Association of Psychotherapists

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Foreword: Why research matters

Elizabeth Day

A rugby world cup can be a big deal for rugby fans at any time. I'm not a rugby fan so these things mostly pass me by unnoticed. However, when it's a women's side, the Black Ferns, in a sell-out grand final for the first time on home ground at Eden Park in Auckland—as I write—then that exceeds the bubble of the rugby world, reaching into a much wider sphere. Māori and other wāhine being celebrated at national level for their mahi and talent—in whatever field—is a sadly rare occurrence, and so this hyped event brings that into sharp relief. We all get a *lift* when voices not so often heard or sought out, are brought forward. We all are *made stronger* when more of us are represented in our experience. We all have a chance to grow when our various *ways of being and knowing* are admissible.

The voices gathered together by Keith and Emma into this book bring a *lift* to psychotherapy discourse and practice, in their diversity of authorship and method/ology. Our profession is *made stronger* by the warp and weft of carefully honed enquiries that expand our understanding of subjective experience—and our clinical practice grows when we widen our *ways of being and knowing*.

The hard work of conducting research is only one part of the deal, the other part is disseminating (broadcasting, publishing, circulating, distributing) the findings. This is in fact an ethical requirement of all funded research. In our research endeavours, we don't only listen to a wide range of voices, we bring them forward; we centre them. More often than not, however, in the history of our Department at AUT, students have tended to race off to clinical work after graduation, and supervisors are often too busy in the administrative white-water of their roles to follow up with a collaborative journal publication. Thus, those voices fall back into silence.

But that culture has been changing and this book in your hands, or on your screen, is a contributing factor to that change.

Keith and Emma are colleagues and friends and I'm delighted they invited me to write this Foreword because it focused my mind on reading the book, and I've loved being in its presence, enjoying the wealth of skill, relevance, and insight on these pages. The material covers a wide range of relevant foci including: art, colonisation, crying and catharsis, desire, embodiment, empathy, grief, lived experience, love in therapy, Māori culture, men and violation, mothering, mythology, pain, Pasifika culture, rage, and sexuality, and le vā (relational space). I also enjoyed the recent updates to the research, written into the work to acknowledge new contexts and understandings, and the way that research findings morph and require ongoing attention. The wide range of these enquiries has engaged with aspects of my various roles as clinician, academic, researcher, and Head of Department of Psychotherapy and Counselling at AUT.

Keith germinated the idea of this book for some years and worked assiduously to document the history of Master's dissertations completed in the Department since its inception, and to create a thoughtful process for the selection of contributors to the book. It was a great idea as a way to tap the wealth of our student's unpublished work, reconnect with them, and keep research in the forefront of the profession's mind. Keith is full of creative ideas and his list of publications is testament to his capacity to execute them well. He is a leader in research in our field, models an active and prolific approach to quality research, and supports others to achieve in this way.

Emma's time as an academic at AUT was fruitful for her colleagues and research students, and for her, it seems. Fresh from completing her PhD, she hit the ground running through completing publications from her PhD, and winning a grant to write about Whiteness, while mentoring a student into a research role in the process. She was also quick to produce an impressive conference presentation when I had to withdraw from the conference to attend my father's funeral. I volunteered Emma to present in my place, with a last-minute hard-sell that she both saw through but, also, thankfully, obliged.

The contributors to these pages are graduates of our programmes at AUT, some of whom I have met and taught, and all of whom have passed through the ritual of research design and execution to produce high quality work. Alongside them on the journey are current and past colleagues whose passion for the profession shows in the quality research supervision evident in these pages.

In the disciplines of psychotherapy, the term 'research' usually denotes a generously broad and creative range of ways of understanding. The term 'methodology', by contrast, can generate reactivity: it can be rejected as a handbrake on immediacy. Taken together, 'research' and 'methodology' are not infrequently assumed to be an oxymoron. We see this in the false dichotomy of 'clinician' and 'researcher'. Although these terms designate different pursuits, they are not mutually exclusive. We also see this assumption in the anti-intellectualism that can taint our professional discourses.

Relatedly, the invisibility of psychotherapy relative to psychology and other allied mental health practices is a persistent challenge that we grapple with in the profession. Although many of us work in private practice, there are good reasons why we might want to keep abreast of current research, and consider contributing to it through case analyses, or through higher degree research.

To consider how psychotherapy comes to know itself, and how it communicates knowledge beyond itself, compels consideration of the borderland between various discourses within clinical spheres of influence. In particular, we can ask how do we conduct research that matters beyond our field, and how do we cut through with it in order to achieve impact for clients, and resonance if not influence, in public health? How we communicate beyond our bubble to allied fields of psychology, medicine, social work, and public health, while remaining true to our disciplinary bases and praxis, is a pressing question for anyone interested in research in psychotherapy, and the development of the profession.

Our profession is at a crossroads. The crises of the times call on us to innovate beyond traditional ways of clinical work: to be flexible in our thinking, nimble in our responsiveness, and creative in our interventions. In the uncertain work of psychotherapy, one thing is certain: building a solid profession requires the ongoing conduct and dissemination of relevant research.

May this carefully curated collection of research inspire you to think anew about your clinical work, to integrate some relevant changes to your practice; to collaborate in identifying areas for research; and to develop and disseminate research projects that reach into the profession and beyond it.

Elizabeth Day, PhD
Head of Department, Psychotherapy & Counselling, Te Wānanga Aronui o Tāmaki Makau Rau | Auckland University of Technology
Research Committee Member and past Chair, Psychotherapy & Counselling Federation of Australia
Editorial Board member, *Psychotherapy & Counselling Journal of Australia*
Co-editor (with Caroline Noble) *Psychotherapy and Counselling: Reflections on Practice* (Oxford University Press, 2016)

November 2022

Introduction

Keith Tudor and Emma Green

E ngā waka, e ngā mana, e ngā hau e whā, ngā mihi nui ki a koutou arā me ō whānau hoki, tēnā koutou, tēnā koutou, tēnā koutou katoa. To the many talented and esteemed who are propelled together by the four winds, spread throughout the islands, we greet you and your families. We are delighted to welcome you, the reader to this book and to introduce it.

Firstly, we would like to thank Elizabeth Day, our colleague and friend, for her lovely, kind, beautiful, generous, and inspiring Foreword. We are touched and feel blessed by her words. For our part, we acknowledge Elizabeth's leadership of the Department over the past three years. Notwithstanding the particularly difficult global situation and the national local challenges they have brought to working in the university, Elizabeth has not only nurtured staff but also maintained and promoted continuing high standards of research—ngā mihi nui ki a koe, e rangatira me hoa.

The origins of this book lie in Keith's desire to find some way of celebrating the work of the Department of Psychotherapy & Counselling at Auckland University of Technology (AUT). I (Keith) had had the good fortune to be welcomed to the Department in 2009 and to be part of its 20th anniversary celebrations that year, so, when we were approaching 2014 (its 25th anniversary), I proposed to staff that we put together a book about the Department. For various reasons, that project didn't see the light of day, and my attention shifted to focusing on promoting the research of the Department, specifically in the context of its Master's programmes, the first of which was established in 2000, when the Auckland Institute of Technology was incorporated as a university. Undertaking an initial survey into this research base, it became clear that less than ten percent of students' research (as represented by the theses and dissertations lodged in the AUT Library) has been converted into publications (see Tudor & Francis, 2022). Thus, this project became one of making more of this research publicly available. So, as I am also keen on acknowledging and celebrating anniversaries (Tudor, 2018), I proposed—originally to Dr Margot Solomon and later to Dr Emma Green – that we edit a book of papers primarily by students, based on their Master's theses or dissertations. The rest, as they say, is history—in this case, the history of 21 years of the Master's programmes in psychotherapy at AUT. We use the plural as there have been a number of iterations of the programme over these years (as outlined in the Appendix). In terms of promoting research, we are concerned about what is often seen as a gap between research (and researchers) and practice (and practitioners) (for a discussion of which, see Tudor & Francis, 2022), and so were particularly keen to make this book as accessible as possible. To this end, we used some funding from the old School of Public Health & Psychosocial Studies at AUT to engage an editorial assistant for this project and in this we have been fortunate to have the editorial skills of Dr Shoba Nayar who has helped us and the contributors enormously—tēnā koe e hoa. Finally, on this, we decided to make this book freely available and have been able to do so through the good offices of AUT's Tuwhera Open Access Publishing platform, with regard to which we want to thank Luqman

Hayes, Team Leader, Scholarly Communications, for his continued advocacy of open access publishing and support of this particular project—tēnā koe anō.

The first task was to finalise a complete list of Master's theses and dissertations, a process that has taken a number of years and, indeed was only finally completed in the last weeks of preparing the manuscript of this book for publication. In this, I (Emma) want to acknowledge Keith's persistence in completing this task; and we both want to acknowledge Margot's holding of much of the history of the Department, as well as her amazing memory with regard to past students and their work. We also want to acknowledge the detective work of a number of university colleagues in helping us complete this list: Andrew South, Liaison Librarian, and a good friend to the Department and its staff and students over many years; Rudy Bin Mahli, Scholarly Communications Librarian; and Angie Strachan, former Library Engagement Advisor and now Research Assistant—tēnā koutou katoa. This list forms the Appendix, which also notes the students' academic supervisor(s), and references any papers, articles, or chapters published from the students' theses and dissertations, both elsewhere and in this present volume.

Originally, when I (Keith) and Margot were curating this project, we had some initial discussions about possible alumni to invite to contribute to it. Margot left AUT in 2020, at which point she withdrew from the editorial team of the project, but remained an advisor to the project—tēnā koe e hoa. At this point, I (Keith) approached Emma to take up the role of co-editor, to which she agreed, and for which I am very grateful and appreciative—tēnā koe hoki e hoa.

Given that we were originally celebrating 21 years of the Master's programmes, we decided to aim for having 21 papers in the book and so, from over 200 theses and dissertations we set out to identify a short list. In compiling this list, we took account of a number of factors:

- Firstly, we excluded those theses and dissertations that are embargoed and, therefore, not in the public domain ('though we have noted them in the list in Appendix 1).

- Secondly, we excluded those theses and dissertations from which articles had already been published (for a list of which, see Appendix 1).
  Interestingly, what this revealed was that a good proportion of Māori students have already published articles from their dissertations—which is great, although, unfortunately, this means that we have fewer papers in this publication written by Māori alumni.

- Thirdly, we identified theses and dissertations that were strong academically, and of interest both in terms of research method and methodology, and of subject matter, each or all of which would be of interest to the discipline and the profession both here and overseas.

Overall, and despite a certain movement between our initial and final line-ups, we think that there is a good range of subjects, research methods, and methodology (see Table 1), though in recent years the latter has been increasingly informed by hermeneutics.

Table 1.
Master's Theses and Dissertations in This Book: Subject, Method, and Methodology

Paper	Subject	Method	Methodology
1	Men's violence	Semi-structured interviews	Hermeneutic
2	Couple therapy, moral influence	Literature review	Hermeneutic
3	Somatic countertransference, alexithymic clients	Modified systematic literature review with clinical vignettes	
4	Love	Modified systematic literature review with clinical vignettes	
5	Crying	Modified systematic literature review with clinical vignettes	
6	The psychological birth of the psychotherapist	Modified systematic literature review with clinical vignettes	
7	Homoerotic countertransference	Literature review, thematic analysis	Interpretive
8	The body	Literature review	Hermeneutic
9	Grief	Self-search enquiry	Heuristics
10	The impact of colonisation	Data analysis using Te-āta-tu, Pūrākau method	Kaupapa Māori
11	Murderous rage	Literature review	Hermeneutic
12	The violent offender	Literature review	Hermeneutic
13	The pain of others	Literature review	Hermeneutic
14	Kali, Shiva, and psychotherapy	Literature review	Hermeneutic
15	Two cultural worlds	Fa'afaletui Tōfā sa'ili	Teu le vā
16	Sexual fantasy	Literature review	Hermeneutic
17	Hidden assumptions of Western child psychotherapy	Literature review	Hermeneutic, Critical theory
18	Parent–infant psychotherapy	Literature review	Hermeneutic
19	Bereavement by sibling stillbirth	Literature review	Hermeneutic
20	Mourning, artistic creation	Literature review	Heuristic
21	Ruptures and repairs	Literature review	Hermeneutic

This shows a clear predominance of dissertations based on a literature review (the method) informed by and processed through a hermeneutic lens (the methodology). The choice of method and methodology is influenced by a number of factors: not only relevance to the subject, and the interests and expertise of the student and supervisor, but also the demands of the institution. Thus, in the early days of the Master's, staff were encouraged by the Faculty of Health and Environmental Sciences at AUT to work with students on a modified form of the systematic literature review (SLR), as a result of which, between 2002 and 2010, 21 students undertook research on this basis (though not all of them acknowledged that this was a "modified" form of the SLR). This method was also viewed as a methodology (see Papers 3, 4 ,5, and 6). In 2010–2011, new colleagues in other disciplines in the Faculty argued that the SLR, whether modified or not, was not appropriate for psychotherapy research and especially in a relatively short form (then a 60 point dissertation). Staff in the Department were encouraged to point students in the direction of thematic analysis (TA) (see Paper 7) and, despite that fact that no staff in the Department at that time had any

specific expertise in TA, between 2013 and 2017, 13 students undertook TA as their research method—most if not all of whom found it more demanding of their time than was expected in a 60 point paper/course. As a result of this and a greater willingness on the part of staff in the Department to assert themselves and to advocate for student choice and staff expertise, from 2015, there has been a greater uptake of more diverse methods (including self-search enquiry, interviews, and qualitative descriptive study) and methodologies (including Kaupapa Māori, heuristics, social and cultural constructivist, interpretative phenomenology, and critical theory).

- Fourthly, we wanted to ensure that we included theses and dissertations from across the 21 years of Master's programmes as we were keen to have some representation of the work undertaken in the early years of the Department.
  This proved harder to effect, mainly as it was more difficult to contact alumni from 20 years ago than those who graduated more recently. We did have someone from the class of 2001 but, unfortunately they had to withdraw for personal reasons. In the end we have six contributions from the first 11 years of the programmes (2000–2010), and 15 from the last 10 years (2011–2021). The observant reader will no doubt note that the book actually covers 22 years of the Master's programmes. This was due to various delays with regard to this project, not least the impact on everyone's work and energy as a result of the coronavirus pandemic and the switch to online teaching. We have, nevertheless, have retained the acknowledgment of the 21st anniversary of the Master's programmes.

- Fifthly, we also wanted to ensure that there were theses and dissertations from the child and adolescent programme as well as the generic Master's programme.
  In this we have been quite successful in that we have five papers (6, 17, 18, 19, and 21) from this pathway of the Master of Psychotherapy programme. It is perhaps symbolic that four of the last five papers in this book are from this programme (and from this year), thereby pointing to the importance of the mental health of our children and young people and the future health of our nation.

- Finally, we wanted to ensure a good representation of students with certain identities: Māori, Pasifika, ethnic minority, LGBTQI+, and gender diverse.
  As noted above, we have an under-representation of Māori students, and also of Pasifika students.

In terms of our process, the editorial team went through the complete list separately and, from our knowledge of the theses and dissertations (including reading or re-reading the abstracts), ranked them on a three point scale: 1 (definite), 2 (possible), and 3 (reserves). We then compared our lists, confirmed our combined first choices, and discussed, debated, and ultimately agreed our second choices, a process which gave us a list of over 30. Knowing that some people would decline, we wrote to all our first choices, offering them the opportunity to contribute to this project and to do this with their original supervisor if they were still available (eleven did this), or to write something on their own (six did this), or to link up with a current member of staff who would help them and co-author the paper (three did this). Finally, we checked any clinical material with regard to ethics and, specifically,

whether approval for the inclusion of clinical material had been granted by the AUT Ethics Committee (AUTEC) and participant (client) details had been anonymised and disguised.

In the end, we think we have great range of material, and a reasonable range of authors. The publication of the book means that we have doubled the number of papers published from student's research. The project appears also to be encouraging other alumni and staff to publish and we can only hope that this continues as subsequent cohorts of students complete their qualifications. In this sense, we hope that the book marks something of a change in the culture of the Department in favour of publishing.

Finally, for those interested in or concerned about quality assurance of publications such as this (for a discussion of which, see Tudor, 2021), we note that this book has been peer-reviewed in a number of ways:

1. Firstly, the original thesis or dissertation was assessed according to certain learning outcomes by two members of staff at AUT and/or sometimes external examiners in what is referred as a single-blind procedure whereby the examiners were not known to the student, although the name of the student was known to the examiners.
2. Secondly, the initial selection of theses and dissertations for inclusion was assessed by three academics with a combined total of some 40 years' academic experience.
3. Thirdly, the paper produced from the thesis or dissertation was reviewed—in 11 cases by the original academic supervisor, in three cases by a current staff member, and in six cases by the editors.
4. Fourthly, the whole book was reviewed by two colleagues in detail, and by five other colleagues as part of offering their endorsements of the book, to all of whom we are deeply appreciative—tēnā koutou katoa.

All too often it has been the case that the work students undertake as part of fulfilling their psychotherapy qualification—not only at AUT but also in private training institutes—can sit, at least metaphorically speaking, gathering dust in a library, although, with regard to research in the context of training at AUT, most are now available online. With this in mind, we are delighted that the works presented here can and will reach a wider audience. It is our hope that the reader will engage with and appreciate what we have found to be stimulating and thought-provoking pieces of original research that undoubtedly make a contribution to the field of knowledge in both psychotherapy and research methodologies. To those who willingly took up the call to contribute a paper or to help with the distillation of a paper from a thesis or a dissertation (not an easy task), we extend our gratitude—tēnā koutou katoa.

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Paper 1 (2004)

The lived reality of men who have been violated and violent

John Bryant and Keith Tudor

Have you anything to say in your defence?

There is an empty place
in my metaphysical shape
that no one can reach:
a cloister of silence
that spoke with the fire of its voice muffled.

On the day that I was born,
God was sick.

César Vallejo (1918/1992)

Introduction

I (John) came to psychotherapy and, more specifically, to studying and working with male violence through my own challenges as an adolescent from a working-class background that took me to some dark places. I feel very privileged to have found more of the light as my own insights and self-awareness have developed. I met Keith some years ago and we clicked because of a common heritage, personal commitments, and professional interests. So, when Keith approached me to contribute to this project, I was pleased to use this opportunity to work with hm.

For my part, I (Keith) knew of John's work, through Warwick Pudney, a mutual colleague and friend, and one of the founders of Man Alive in West Auckland. When living in the United Kingdom, in the late 1970s and early '80s, I had been involved in anti-sexist men's work; later, in the early 1990s, I worked with and researched projects that ran violence prevention programmes for violent men (Holland et al., 1995; Tudor, 1993a, 1993b). So, when John asked me to support him in the process of writing this paper taken from his Master's thesis, I was grateful for the opportunity to revisit this aspect of what has been a political, personal, and professional interest in my life, and a subject—and social problem—which, sadly, remains to be resolved.

The research

The rationale for this research was to produce an understanding of the impact of men's violence on people's lives from the unique perspective of those who have experienced it—both as a victim and a perpetrator. The intention was, and is, for this information to offer a better understanding of the causes of male violence and to help it to be effectively prevented. In acknowledging that the men in this study had been violated as boys, we are not condoning their subsequent decision to be violent—for a critique of such linking, see Tudor (1993a). We are, however, simply and profoundly acknowledging their lived experience of being victims and perpetrators – and, indeed, the tragedy of the fact that they did or could make the connection in time to prevent their own violence against others.

The qualitative research reported in this paper was based on conversations with five men who agreed to be interviewed about their experiences of violence, both as victims and perpetrators. The interviews were digitally audio-taped and transcribed. The transcripts were then analysed, resulting in the identification of a number of existential themes. Four of these themes—shame, pride, numbing, remorse—have been selected and abridged for the purposes of this present paper, each of which illustrated by extracts from the interviews.

The methodology that informed this undertaking was based on Heidegger's (1927/1962) hermeneutic phenomenology. Phenomenology emphasises the search for raw experience buried in the text; and, in this research, took me (John) to the heart of men's lived reality of violence. Hermeneutics offered a way of making meaning out of the subtext concealed within men's stories of violence. Heidegger's philosophy provided a particular approach for understanding human experience, while Van Manan's (1990) existential lifeworld structures guided me towards violence as it is *lived* rather than as it is thought to be. As such, this study emphasises ontological understanding over epistemological examination.

Shame: The unknown shaper of symptoms

Shame can attack the very heart of our being. The power of shame to bring about the most violent of reactions is in the stuff of myth and tragedy. For example, Delilah's reproach to Samson (in the Old Testament of the Bible) leads her to the very violent act of blinding him, because it is in his eyes that she feels shamed: "Behold thou hast mocked me, and told me lies" (King James, Judges 16:10). Gilligan (2001) asks why feelings of shame are so bottomless and chronic in the most violent men. He suggests that it is due to extremes of childhood physical and/or emotional abuse and neglect. He reports that many violent criminals spoke of how gratifying it was to see fear in the eyes of their victims, as if their own suffering is somehow temporarily relieved through seeing it in the shamed other.

Hegel (1830) identifies the desire for recognition as a major motivating force behind all human history. In his view, the self is socially constructed and created in interpersonal interaction; and what people need, as Solomon and Higgins (1997) note, is "not only

security and material necessities but mutual recognition" (p. 96). According to Gilligan (2001), recognition (meaning to be looked back at or re-cognised) is a synonym for respect, pride, honour, attention, and all other forms of self-gratification. Shame is the emotion people feel when they do not feel recognised or respected. Inattention or disrespect is to be 'dissed' in the vernacular of many men with whom I (John) work. Interestingly, 'Dis' is the Latin word for the underworld. In the context of this paper, shame is the unknown shaper of symptoms such as violence, that represent the underworld (i.e., the disowned aspects of the self).

One common theme that emerges from the data is that men who are violent often feel easily affronted in terms of not being heard, understood, or listened to. It is as if there is some kind of fundamental injury to the self in interactions that contravene self-respect. The integrity of the self cannot be maintained in the face of perceived or real contempt; and, eventually, a susceptibility to feeling humiliated may become part of the daily world. In response to a beating he took in a Nazi concentration camp, Frankl (1946) writes: "The most painful part of beatings is the insult they imply. Indignation is not about cruelty or pain, but about the insult connected with it" (p. 44).

Vic's relationship with his mother illustrates how insults to the self may be embodied: "I think that was the biggest abuse that my mother did, not necessarily the whacking or saying I wish I never had you, but just the fact that she showed no interest in me at all". For Vic, a childhood memory of not feeling heard is more potent than painful physical and verbal abuse. It is as if the greatest hurt of 'no interest in me at all' is symbolic of a much more fundamental and destructive force: perhaps a long slow murder of the self.

Frazier (1974) discusses the debilitating effects upon those who had not experienced extremes of physical abuse or neglect but had experienced a degree of emotional abuse in which parents projected their own shame onto their children that was just as damaging. The consequences of childhood shame are evident in Vic's later life:

> *I felt that she [Vic's wife] was… doing something not right on the farm… and I kicked her in the face in the paddock. I can't remember but it had to do with the fact that I felt unheard or not listened to.*

Vic is unable to create a space between the painful feelings of shame that his childhood lived relationship with his mother has engendered and the feelings he embodies at a perceived rejection from his wife. He is overwhelmed as the horizons of past and present meet and his words echo through the years his feelings of being "unheard". What he takes as a personal insult turns to rage and then violence in an attempt to stave off shame producing rejection. As these feelings are evoked, it is as if lived time has frozen—at this moment childhood and adulthood are undifferentiated. The once protesting and powerless little boy is now a man—a lethal destructive force.

Shame causes the person to feel bad about explosive outbursts that give him the attention that he cannot get from healthy sources such as achievement and friendships. The aggressor has the mistaken belief based on past experience that lived relation represents being controlled and disrespected by others. It is paradoxical that his anger and fear keeps

intimacy away and denies the love that he craves. The ability to accept kindness and love from someone is a skill that has been missed out on. The basic skill deficit of the antisocial self is trust of others.

Another participant, Ric, offers examples of how his mistrust leads to violent thoughts and feelings: "*that my mate who is my boss as well and my best man didn't believe me; I thought if I connect it with me, I'm gonna punch him*." The turbulence in Ric's head is linked to a paranoid process of not being believed. He embodies relationships that leave him feeling jealous and suspicious. He feels entitled to receive a response that fits with his sense of what is right ("this guy's lying to me and he's a friend") and cannot tolerate his own sense of reality being undermined:

> *My stepfather was a very violent man… he used to beat us all up against the wall…. He was a very aggressive man. Maybe that's where I get my aggression from. I don't know what my father was like. I never met him… I was bullied at school. And you felt like although the playground was crowded you felt all alone. Like you were solitary, no one there to help you, no one came up to help you.*

Ric's life contains many of the hallmarks that predict(ed) future violence, including parental abandonment, bullying, and violence. If a fulfilled and happy life is distinguished significantly by meaningful connectedness to others, then it is likely that this heritage has left Ric with a daily reality of distance and feeling like an outcast in relation to others.

Colin's savage beating of his wife threatens every meaningful relationship in his life:

> *I wondered where she was… and I got a phone call at 6 in the morning from a very good friend, a mutual friend of ours, and she explained that I was the biggest arsehole on earth and blah, blah, blah. "What have I done, what have I done?" "Oh, K's in hospital; you've broken her rib; you've fractured her sternum; you know, you've kicked her, you know [blah, blah, blah, blah] and you're nothing but an arsehole". So that's when I, you know, it really hit me, it really hit me.*

Until a friend calls, Colin seems unaware of the damage he has done to his wife. This is an example of the need to deny the consequences of his violence. He had made a pledge to keep his family safe from his unmanageable impulses and broken it. He had hit someone precious to him and then something "hit" him. A friend, his wife, and his baby mirror his shame back to him. In Colin's world, violence is not selective, it is always imminent. This makes him extremely volatile and dangerous; as he himself puts it: "I've got violence in me at the most inopportune times."

Colin speaks of the violence "in me" as if it is embodied constitutionally and can control him even when he does not need it for protection. He has finally realised that the consequences of his actions have cost him the people he needed the most. It is clear that he has seen the error of his ways and does not want to keep on repeating his history. Yet, violence since an early age has had a profound effect upon his destiny:

> *I went down there and lived and it wasn't too long and he was giving me hidings, you know. I was about 14 coming on 15. Oh, real hidings, what I would call real hidings; nothing like*

what mum was giving me. Certainly, that was the first time ever that I really experienced a man you know really giving it to me.

Colin's lifeworld is one of family violence that seems to be intergenerational. Violence is a part of his daily lived reality. Many would describe a child having a ruler broken on them as extreme abuse; however, for Colin, it is relatively minor compared to his beatings. Having been situated in conflict for most of his life, violence is the only way Colin knows how to deal with it. At 49 years of age, he is attempting to come to terms with the cost of such a life. He has alienated loved ones, is estranged from his culture, has many enemies, few assets, and his ability to control his impulses is severely limited. He wants to change but has great difficulty in adapting to new ways of relating to the world and, particularly, others.

These men's stories offer examples of how early development influences the way in which we make meaning as adults. It demonstrates how development may be a significant factor in the embodiment of shame and its consequence of violence.

Pride: Violence as proof of masculinity

Gilligan (2001) states:

> men can prove their manliness… when it has been called into question by an insult or sign of disrespect, by means of violence; and their failure or unwillingness to engage in violence can throw their manliness into doubt, and expose them to shame. (p. 57)

The levels of violence that some of the men in this study both perpetrate and subject themselves to offer evidence that supports the following argument made by Ric:

> *You'd say it was a gang of older boys that were just bullying. I made a resolution that I'm going to be bullied I may as well fight back and go down fighting. As the years went past I got to 17, I went on a bodybuilding course.*

Fighting seems like an issue of pride for Ric. He body builds as a way of expressing his masculinity. In this way, the body becomes a both a sign of physical superiority and a weapon for inflicting violence upon other men. The myth of male invulnerability is one reason why so few men report violence towards them from a woman. The 'real' man must be seen to be able to dominate the weaker woman and may not seek help or support because he must be seen to be in control. Many men in the stopping violence groups that I have run report a fear, often based upon prior experience, of being laughed at or put down by other men, including the police, if they report this type of violence. Sadly, those who are violent describe feeling respected by their peers, often for the first time in their life (Gilligan, 2001).

Colin dramatically reinforces the view that external validation is vital to his sense of self-respect. In prison, his survival depends upon it:

> *I got the beat ups, but he didn't break any bones… I could get up and wipe myself down*

> *which I did right and um because X amount of people witnessed that and my mate right I thought right I'm not gonna lie down and I went straight up there and I hit him from behind right and I dealt to him. I hospitalised [him], I broke his leg that time and I says to him "ever fuck with me again I'll kill ya, I'll kill ya you cunt".*

In the inhumane environment of a maximum-security prison with rigid rules, sterility, and other violent men, lived space is a continual reminder of the need for vigilance and the imperative to gain respect. For Colin, a Māori male, the macho code of masculinity in jail gets confused with mana or genuine self–other respect. A Māori colleague discussed his personal understanding of mana as that of earning the respect of others and a consequent embodiment of self-respect through human qualities such as wisdom, compassion, and courage. However, the type of mana that Colin is describing is founded upon fear—knowing that others fear you and fearing that they do not. In this world, no one is immune and just about all self-worth, according to Colin, is predicated upon notions of power over others, fear, and revenge. The lived reality of "what you do and what you say" is omnipresent and nothing is passed over in a bid to avoid the humiliation of being subservient, of becoming "he tangata kore take" (a person of no substance). Everything in the paranoid lived space of prison involves maintaining and promoting proof of masculinity.

The code of masculinity is evidenced by Colin's ideas about gender:

> *All the women I've hit, and my baby, and I've felt a little bit of remorse ahhh but men no it's different you just don't care you know? It happens and you forget about it, you just don't sort of dwell on it. The only things I remember is when I got the serious bash.*

Colin's attitude of the difference between men and women supports the viewpoint that it is reasonable to treat men as violence objects in his world. The extent that he feels the need to admit that "little bit of remorse" for women and children he has hurt is a token to the violence implicit in his code of masculinity.

In the following extract, Bill reinforces the macho code of masculinity in relation to women, stating "a few good punches and stuff but I didn't fight back cos they were girls". In Bill's world hitting women has to be justified and minimalised because ideally real violence is a male only preserve "I did tap her on the arm and I said to her look at me when I'm fucking talking to you and that's the extent of it, my kids were there."

The 'noble' notion that hitting women is unacceptable seldom matches the reality of the circumstances. Just as war is meant to be about soldiers inflicting violence upon other soldiers, this is rarely the case. The argument for 'just wars', put forward by military proponents and politicians, is morally ambiguous and sanctions the 'right' kind of violence for the 'right' reasons. There are often 'good' reasons for violence in the minds of perpetrators. However, these reasons are of little consolation to innocent civilians maimed and killed in wars or battered wives and children. The argument for selective violence does not hold water and neither does Bill's.

For a start, the level of terror embodied by the victims, including the children, is probably not going to be appeased by the knowledge that this enraged man is going to be more

lenient than if it were a man. In reality, Bill has to justify violence on women because it is seen as unequal, unjust, and, therefore, unmanly to hit a woman. As noted earlier, being seen as cowardly is shameful to a man in the macho culture. Proof of the tokenism inherent in the kind of thinking embodied in the macho code's promotion of the protection of the 'weaker sex' is borne out by the fact that in 20 years, the incidence of wife murder in the United States doubled (Gilligan, 1996). This is thought to be because women than ever are leaving their partners, thereby flushing out many men's dependence on women. The idea here is that women provide many men with the emotional equivalent of a blood transfusion. Gilligan (1996) states, "those who batter and/or kill their wives are precisely the men who experience a life–death dependency on their wives and an overwhelming shame because of it" (p. 131).

Contradictory factors in the male code of masculinity that purports to protect women and children from violence are often manifested as a sense of entitlement and sexual jealousy. An evolutionary perspective on intimate aggression supports evidence of an evolved male sexual proprietal tendency, with a set of features that are virtually ubiquitous across cultures; namely, institutions of marriage with rights and obligations, the valuation of female faithfulness, the 'protection' of women from outside sexual contacts, the conception of adultery of women as property violation, and the special case of a wife's unfaithfulness as a "justifiable" provocation for male violence (Wilson & Daly, 1993).

Historically, society has generally construed women as property and explicitly promoted the social domination and privileges of men. Violence against women, except in its most extreme forms, has been implicitly condoned and legitimised (Gordon, 1989). Attitudes that concur with this viewpoint are in evidence today in Aotearoa New Zealand. For example, Leibrich et al. (1995) undertook a survey of 2000 New Zealand men regarding men's attitudes towards violence in intimate relationships. In-depth follow up interviews of 200 of the original participants' survey results suggested that although Aotearoa New Zealand men would support attempts to stop physical violence in intimate relationships, most tended to condone the use of violence, particularly psychological, in certain circumstances. These interviews identified self-esteem, social constructs of masculinity, and the failure to meet expectations of the masculine code of behaviour, as resulting in a sense of powerlessness and the need to regain power as the main causes for violence.

Vic discussed his violence in relation to ownership:

> *Ownership of her carrying my name, her getting married to me means she is chained to me… can't escape. It is safe for me to do some [violence], there was an issue of ownership connected to it.... feeling wanted is still very important to me.*

Vic's embodied sense of ownership means that he is surprised that his wife would try to protect herself from him. To Vic, lived relation is a sense of his wife being "chained to me". He feels proud of his possession, and in his mind if you own someone it is perfectly normal to dominate her with violence when he perceives her not to be conforming to his ownership. A clue to Vic's intrapsychic functioning is in his need to be wanted. He needs his wife to be the vehicle for the frightened, dependent part of himself. There is evidence that such men find it intolerable to be alone; they report feeling vulnerable and abandoned

(Dutton, 2002). Osherson (1986) suggests, “perhaps in our need to defend and constantly protect women we are trying to tiptoe past the rage we feel if they leave us too much alone” (p. 123).

Ric’s possessive jealousy and fear of being left is dominant throughout his stories of violence:

> *I think okay, what’s all this about? So it’s like everywhere she goes she’s got to make a male friend. I just turned round and said “fuck you!” I shouted, um most of the pub must have heard me, and then I walked home… or staggered home.*

Ric’s sense of entitlement extends to the use of another’s body for sexual gratification, without intimacy or reciprocal sensitivity. His oppressive jealousy and possessiveness are not an expression of love or even desire, but a desperate attempt to keep his partner captive and available to regulate his state of insecurity.

The participants’ stories above have offered support for some the evolutionary biological, socio-cultural, and psychological explanations of male pride and the need to control through violence. Eliciting fear in others is seen as one way to gain a vicarious sense of respect or power as a substitute for admiration or self-respect. Beneath a controlling façade of male proprietariness, and its violent manifestations, a vulnerability and dependency on women is exposed. Gilligan (2001) suggests the purpose of violence is to force respect from other people, “for without a minimal amount of respect from others or the self, the self begins to feel dead inside, numb or empty, and it is clear that this is the most intolerable of all feelings” (pp. 35–36).

Numbing

Most of the study participants described a process of numbing in relation to violent episodes. This is a way in which the internal process of repression—becoming ‘hard’, shutting down, and forgetting before, during, and after violence—manifests. This section explores the questions ‘what is this process of numbing’ and ‘what is its meaning’? How does numbing relate to violence and how does it shape the lifeworld of those who experience it?

Mac discusses an occurrence of numbing or the closing down of consciousness:

> *She thought she was gonna die and from what she’s told me, I was crying, I was yelling, I was bashing [the] heck out of the steering wheel and the dash. And that’s when she had me into the doctors and to psychiatrists and on to anger management. I suppose, I don’t know if blackout’s the correct word, I just don’t, I don’t recall.*

In the above incident, Mac’s violence was to drive in a terrifying manner that made his partner feel as if she was going “to die”. His blacking out alters chronological time by freezing it. He has no recall of a large chunk of time in which he was in a state of extreme distress. However, his partner may have felt lived time as agonisingly slow, in contrast to the speed of the car, as she feared for her life. Mac describes being highly energised, as

reported by his companion he “was crying… yelling… bashing heck out of the steering wheel and the dash”; yet, at the same time, he has no consciousness of this event. His lived experience during this time is of nothingness. Another story from Mac suggests that his numbing process has its genesis in the past:

> *He [father] would come home and he’d probably be drinking and mum would probably say something about his drinking or something .....yeah and we’d just try to hide away from it. ...strange how you can remember things like that and how it affects me now, talking about it, because I haven’t talked about it not even to my former wife.*

In this emotional recounting of childhood experience, Mac offers an insight into the connection between losing control and numbing. Existentialist philosopher and analyst Rollo May (1964) assumes that all beings are centred in themselves and “an attack on this centeredness is an attack on one’s existence” (p. 370). Numbing or dissociation is a method Mac uses, mostly unconsciously, to preserve his own centeredness. His symptoms are his way of shrinking the range of his world in order that his centeredness may be protected from threat. The symptoms represent a way of blocking off aspects of the environment and his own behaviour so that he may be able to bear his suffering and hold onto what remains of his tenuous existence. His lifelong forgetting of this incident, “I haven’t talked about it not even to my former wife”, and many others, protects him from painful memories and feelings and shapes his world. Because of this need to defend himself Mac has not, until relatively recently, been able to bring his traumatic embodiment of the past under conscious control.

His thrownness into a childhood of such insecurity and consequent internal representations of lived relations have conditioned him to respond to present stressful stimuli with anger and numbing. Responsibility or response-ability is a stage of development that is not attained by those whose trauma is not available to consciousness. “Traumatic memories constructed under conditions of high arousal are ‘pre-narrative’, consisting of unintegrated sensations and perceptions” (P. Neimeyer, personal communication, 2002). This means that Mac, and others in his position, are condemned to react to stress producing situations until they are able to stand outside of their present state and make choices about how to respond.

Bill describes the phenomenon of numbing as shutting down or becoming automatic in response to the extreme violence in relation to kicking a beaten man in the face:

> *I always shut down when it comes to that physical confrontation; I just concentrate all my efforts on what’s in front of me. I think it becomes almost automatic now and funny, now that you say it, it’s almost like I think it was because that’s how I dealt with the beatings my mum used to get… Because it was out of my control physically I had to, you know, not let it get to me like that as well.*

Bill describes the violence as “automatic” and “out of my control” as if his will or ability to choose is no longer available to him. He appears machine-like without qualities of empathy and compassion that is normally associated with being humane. It is clear from Bill’s realisation, that the way in which he numbs himself to his own violence was learned in relation to the deadening of emotion he experienced as a child as a way of handling his

stepfather's violence towards his mother. Distancing himself from such emotions as compassion, empathy, fear, and shame seems like a familiar defence against the feelings associated with extreme violence Bill embodied as a child, as well as feelings engendered at inflicting violence upon someone else. He knows that it was wrong for his stepfather to abuse his mother in this way and it is likely that he feels wrong somewhere inside for his own violence. Otherwise, why would he attempt not to allow it "to get to me"?

In relation to numbing, Bill makes a vital link that involves a seeing of his life's circumstances. It is useful to refer to notions of 'horizon' in order to discuss this point. Heidegger (1927/1962) describes 'horizon' as "future, present and having been" (p. 416). Bill realises that time has telescoped, and the past is enacted in the present and with this awareness he can look ahead; he has a meaning for his violence linked to what he witnessed in his childhood. With this 'new' horizon he can make sense of processes connected to his violence. Gadamer's (1960/1982) notion of humans having a "historically effected consciousness" (p. 239) is now part of Bill's understanding.

Vic also understands numbing as a requisite to violence and brings his consciousness of the effects of this embodiment to light.

> *Do you know this song of Pink Floyd 'Comfortably numb… comfortably numb'. That's how you make yourself comfortable by becoming numb and that's what it [violence] does to you and I think that it's a very dangerous environment for someone who has the abusive blueprint so to speak.*

Vic suggests that there is a connection between the lived space of the "dangerous environment" and his blueprint for abusiveness. His comparison of numbing with hardness depicts coldness and control rather than the explosive heat of anger. It is as if the steel of red-hot rage has been tempered into something more solid. In this case, the process of numbing probably dampens or switches off feelings that would make it harder for Vic to be violent towards his wife in future. He gives us an insight into his ambivalence when he informs us that he embodies a tension between becoming both harder and more caring. His feelings towards the animals are expressed in his violence towards them and in his subsequent refusal to eat veal. Perhaps a sense of moral conscience and empathy is silently telling him that it is wrong to hurt another sentient being unnecessarily. Yet, at another moment, he could unleash terrible violence upon his wife. He explains the other side of these complex feelings as he discusses how insensitive he was about his wife's suffering: "I think it expressed itself by the fact that I didn't care about her pain, I was much more involved with my pain… numbed out a different word might be hardening" (Vic).

This type of insight has liberating implications for Vic and is one of the main aims of interpretation in psychotherapy. It suggests that Vic can stand outside of his problem and see that it has a deeper meaning. Vic is now using a uniquely human capability of self-awareness to understand his lack of empathy and compassion for his wife and thereby advances his horizon. This awareness offers an increased capacity for the way in which Vic chooses to be in future relationships. These are choices Vic has not always had. As he comments, "Things coming right for me meant the bruises disappearing and we didn't talk about it... and I knew that this time that was not an option anymore. So yeah, it was very

scary and very, very lonely" (Vic).

At this time, Vic's lifeworld is characterised by alienation and ignorance. He has been used to not talking about his violence towards his wife. He was able to hide his shame, to remain ignorant and wait for the bruises to stop reminding him, but now he is forced to be witnessed by others. His being-in-the-world is defined by his experience of fear and loneliness. The significance or meaning and purpose of his relationship have been subverted in order to maintain and preserve his centeredness.

Numbing has been described as a way to screen out or dissociate from the chronic effects of violence, fear, and shame that the child has to endure during crucial developmental years. It is also a mechanism for preventing men from having to deal with their feelings as they perpetrate violence upon others. For all of the men, there is a long-term discounting or distancing from feelings that is connected to developmental suffering. Numbing seems to promote a vicious cycle of increasing intensity throughout the lifespan. When the effects of their own violence and suffering become too great for them to endure, the men often seek healing through attempting to become more conscious of the effects of their behaviour upon others as well as to the damage it has done to their own lives. Fortunately, the effects of self-awareness and remorse are recursive.

Self-knowledge and remorse: Pathways to freedom

> If we could read the secret history of our enemies, we would find sorrow and suffering enough to disarm all hostility.
>
> (Henry Wadsworth Longfellow, 1857)

In this part, the effects of insights of participants into their own histories, the degree of their realisation of the cost of violence in their lives, and feelings of remorse that accompany their efforts to reduce violence, are examined.

In the stopping violence groups that I (John) run, there are often men who will not accept responsibility for their violence—"He started it" or "she's the one who should be at anger management" are commonly heard statements. I respond by telling the men that we know that other people cause problems for them but this does not excuse the degree of responsibility they have for their own actions. I often support this opposition with pictures and/or descriptions of damage to the neural pathways in the brains of abused children who have either experienced directly or seen and heard the physical and verbal violence of their parents. I then explain that children exposed to trauma and violence are more likely to have physical, emotional, interpersonal, and educational problems. This type of education focuses men away from their preoccupation with defensiveness by feeling owed, winning, or being right, and helps them to gain a sense of the suffering that they cause to others as well as an insight into their own distress and its source. This interaction is designed to facilitate self-knowledge and can introduce thoughts and feelings of benign shame and remorse in men who are otherwise intractable. It is hoped that such insights and emotions may lead to healing and transformation.

I (John) have demonstrated only the destructive aspect of shame that arises from the data. Alan Schore (1994) proposes that not connecting with a child's active bid for attunement leads to toxic shame. Siegel (1999) discusses a different type of shaming interaction wherein "…these types of transactions are necessary for a child to learn self-control and then to modulate both behaviour and internal emotional states in prosocial ways. Shame, in this very specific sense, is not damaging" (p. 280).

Scheff (2001) offers an important distinction about shame. European languages, other than English, have two kinds of shame. In German, for example, there is schande (disgrace shame) and scham (everyday shame). French makes the same distinction, honte and pudeur. With the exception of English, the languages of all modern societies have a word for everyday shame, and another word for disgrace shame. Everyday shame usually carries no offence; a tacit understanding of everyday shame (a sense of shame) is usually treated as a necessary part of one's equipment as a functioning member of a society.

For at least 3,000 years, stories, myths, fables, satires, and, more recently, novels, have explored the theme of the dire consequences of lack of self-knowledge. It is a theme epitomised in a line in one of Goethe's (1879) dramas: *"*The gift of the great poet is to be able to voice his suffering, even when other men would be struck dumb in their agony*"*. Just as a lack of knowledge of self lies at the heart of the emotional drive toward intractability, so lack of knowledge of the other is the key to alienation. We learn about self through knowing others, and vice versa. Impairment of knowledge of the other damages knowledge of self, and vice versa. In a state of unawareness of what is being experienced by both oneself and other it is highly difficult, if not impossible, for the repair that needs to occur when a rupture has taken place. This is a key aspect of successful relations and a vital component of healthy parent to child transactions (Karen, 1998).

Vic expresses the double bind of this inability, "S and I were together for 20 years by that time... and at that time I did not have any knowledge of the depth of the damage that I had done to her". This statement reveals that Vic's embodiment of ignorance and alienation started long before his wife's departure. Bill demonstrates an evolution in the way he thinks and feels about violence, stating "at the time I thought it was justified you know somebody said something and I've cruised in and taken them out and just went back and sat down and had a drink or whatever". However, he is about to experience the consequences of his violence:

> *The cops turn up with four protection orders and when I read the statement I felt sick, I couldn't believe it. I was totally unaware and she would say things like "I've got 20 witnesses that will stand up in court"; you know to rubbish my character and that. I'll never forget that. The first two days after that a bit of a blank but I'm not one to go on a binge, drugs or alcohol. I shut down. I've suffered from depression for a couple of years now.*

Bill has embodied feeling "sick" and lived time has a sense of the surreal as he goes into a state of disbelief, shutting down, and depression. In reporting this event, he has not yet spoken of sorrow; only of his own suffering. In retrospect, he shows a keen awareness of his own state of mind from the vantage point of his new horizon as he attempts to stem the effects of his depression. The following excerpt demonstrates a deeper sense of responsibility for what he has created in another:

> I hit him three times with it. Now when I see him, it bothers me because I see young M and I just see fear on him now. But I go up to him, "hi, how ya going mate? If you want any work give me a call". And he doesn't, he goes "yeah, yeah, yeah". …I feel bad he feels like that now. (Bill)

It is promising that Bill has embodied feeling "bad" as a response to his violence, that he takes no satisfaction in the other man's fear and his remorse is a sign of his recovery. How does this awareness develop? If this capacity is lying dormant, what is the catalyst for self-awareness and the development of higher human qualities such as empathy, compassion, wisdom, and sensitivity to others? It seems that the catalysts for such transformation are either feelings of extreme suffering embodied by the perpetrators of violence such as shame, grief, or the loss of important others. A person's invisible, unformulated sense of worthlessness, fear, uselessness is given a shape and a form that has a releasing effect on their conscience. For example, Colin responds in an entirely new way as he gets in touch with feelings about his own father: "Yeah if I had my time over I'd do things differently with him. I'd probably tell him that I loved him."

Shame and grief are precursors to, and an integral part of, developing a conscience. Remorse is a painful memory of wrongdoing. Lewis (1971) promotes the idea that shame is inherently a social emotion. She asserts that human beings are social by biological inheritance. That is, she implies that shame is an instinct that has the function of signalling threats to the social bond. Just as the instinctual emotion of fear signals danger to life and limb, shame also signals a potential threat to survival, especially for an infant, as a threat to a social bond. In this same vein, Kaufman (1989) proposes that shame dynamics are part of the interpersonal bridge that connects individuals who would otherwise lead isolated existences. Offering men an insight into physiological, psychological, social, and cultural damage they cause is one powerful way of engendering conscience, remorse, and consciousness. It is also a strong motivator to kick-start the process of reducing violence. Colin speaks here of his mother:

> *I was just angry at her. I was just angry and unfortunately, I took it out on her. I have assaulted her several times and the last words that come out of her mouth was you know, "grow up son"; that was the last words that come out of her mouth "grow up son, just take note of what I said and one day you'll grow up" you know. And she walked out and that was the last I seen of her… Yeah I really regret it, really regret it.*

Acknowledgement of at least a small part of the men's alienation and/or hidden emotions, in a way that leaves some dignity intact, means that real progress can be made. Remorse often seems to go hand-in-hand with men understanding their own backgrounds and making meaning out of the past is an implicit part of the healing process. The men's telling of his-stories seems to indicate that remorse and self-knowledge lead to diminishing violence and the gradual process of transformation.

Working with the early life adaptations of shame, numbing, and pride that these men make in order to survive in often impossible worlds requires the therapist to support them to uncover their remorse for the way in which they have expressed and experienced themselves. This means building safe, trusting relationships to help them to access complex

feelings so that they can tell their stories—in order to change and build new narratives that lead to a coherent, less burdened sense of self alongside freedom from the torment they have endured that led them to hurt others.

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Paper 2 (2004)

When doing your best is the best you can do: Understanding how moral influence is mediated in couple therapy

Sue Joyce (edited by Keith Tudor)

Therapists are frequently confronted with clinical situations that challenge their values; and with clients with whom they do not or seem not to share similar moral concerns. Traditionally, it has been believed that these issues are not the concern of psychotherapy and that the therapist must guard against contaminating the field through imposing their own values. Whilst, in theory, such neutrality has some merit, in so far as protecting vulnerable patients from possible unconscious zealots; in practice, it is unrealistic and, in many instances, undesirable. To further understandings of the therapist's role in mediating a moral influence, the research sought to explore the following questions: What is the moral dimension of the therapeutic encounter between the therapist and a couple? How can the 'value influence' of both the therapist and the couple be interactionally produced? How can countertransference be engaged in mediating a moral influence when working with couples experiencing what Morgan (1995) refers to as a 'projective gridlock'?

This paper gives a brief background to the research, reviews the literature, and provides a summary of the original study.

Background

As a trainee couples-counsellor, I was assigned S and M (a middle-aged couple). Our session began with a typical intake assessment covering such basics as the current relationship problem, its duration, and degree of disturbance. By the time we completed the first few lines, the couple was already exhibiting signs of mutual murderous intent. For my part, I felt ill equipped to even stay in the room let alone hoist a white flag! I creatively abandoned the therapeutic enterprise by convincing myself for a few moments that these two individuals were not 'real' clients and that the receptionists were having a joke at the novice's expense. Perhaps my unhappy couple were also entertaining similar fantasies (that I could not possibly be the 'real' counsellor who was charged with helping them with their difficulties). My rather persecutory fantasy was, as it turned out, just that, a fantasy; nevertheless, an apt one, and positioned me in a paranoid/schizoid frame of (no) mind where rational attention to the situation between, and amongst, the couple and myself was abandoned. Rather than providing a container for this couple's distress, I found myself situated in their 'claustrum' (described by Fisher, 1999) entered through 'intrusive identification'. The session deteriorated rapidly coming to a violent end with M (the wife) launching herself across the room to punch me on the chest, shouting, 'shut up!' in response to my request

that they each let the other speak for themselves in relating their view of their problems. Although my ego was more bruised than my chest, this encounter compelled me to dedicate attention to the enormous field of couple therapy dynamics in an attempt to shed light on both how the therapist is 'under the influence' of the couple and how best to engage with the couple in such a way as to positively use this experience (countertransference), in turn, to influence the couple.

I have encountered considerable anecdotal evidence which suggests that couple therapists already do a great deal to promote virtue in committed relationships, but as a profession, psychotherapists tend to be relatively inarticulate about it. Developing a clearer and more informed perspective on virtue might help us become more articulate and, most importantly, more effective in helping couples improve their relationship. If we can accept the need for a moral frame within which therapists operate, it seems most important that we also attempt to render this frame explicit. One way in which I intend to do this is through the lens of countertransference and its vicissitudes.

Countertransference has moved onto centre stage in contemporary debate and with the shift from objectivist epistemologies in favour of inter-subjectivity and constructivism it has become repositioned as a necessary promontory for interpersonal understanding; it is what allows our understanding to become dimensional, to gain a pulse. I locate my focus of clinical enquiry on these unconscious processes as they become manifest and develop within the intersubjective field. In closely considering my moral subjectivity through this lens, I aim to explore and gain understanding of how my countertransference might be usefully engaged in mediating a moral influence when working with destructive couples and, further, to consider how might morality be interactionally produced.

Therapy with destructive couples (where physical, emotional, verbal abuse is present), and those whose 'destruction' is largely unconscious (Morgan, 1995), as those suffering a 'projective gridlock', provide considerable clinical and personal challenges for the therapist. These are unions where the 'moral police' have abandoned the beat as it were; and, in this context, my interest is in how the value influence of both the therapist and these couples might be interactionally produced, with specific attention to the therapist's mediation of a moral influence.

Moral concerns and values are an intrinsic part of being human. Freud tried valiantly to represent his own views as being free of ideology, and in this vein determined that dwelling on moral considerations interfered with the therapist's ability to perform the necessary analytic functions. Thus, according to the traditional view, the therapist needs to take care not to contaminate the process with their own desires, preferences, values, or beliefs (Hinshelwood, 2000). It has been this clinical sensibility that has prevented therapists from fully appreciating the moral dimension of the therapeutic process.

Therapists have an ethical obligation to question the received wisdom, values, and pieties of conventional morality established by tradition and directed by customary rule (Callahan, 1988). In such a reflective morality, we are obliged—individually and collectively—to continuously reflect on what principles govern our actions. Therefore, concepts of

'goodness' are more helpful than principles (e.g., 'unconditional positive regard') in thinking about therapeutic aims and outcomes. Unfortunately, therapists have largely neglected these. When we employ concepts of goodness, we establish therapy goals and evaluate outcomes because we believe that a particular outcome is good, is better than its alternatives, or is the best psychological end for a client. Taylor (1989), an ethicist, argues that we all have 'strongly valued goods' in our lives; and we "cannot help having recourse to these strongly valued goods for the purposes of life: deliberating, judging situations, deciding how [we] feel about people, and the like" (p. 59). It is primarily (but not exclusively) those goods toward which therapy aims.

Psychotherapists (myself included) generally fall on a continuum, varying in the specificity and rigidity of their ethical stances, and accordingly (and somewhat regrettably) exhibit varying degrees of moralism. I believe, that, with rare exceptions, it is not possible for therapists to impose their values on clients: influence, yes; impose, no. In general, therapists simply do not have the power over clients for this to be so. Indeed, if therapists could impose values, it would logically follow, they could impose mental health, quickly eliminating the problems clients bring to therapy. In this paper, and as is customary in philosophy, I use the terms "moral" and "ethical" interchangeably, even though they have distinct technical meanings in other contexts. Moreover, I primarily use the term "moral" as, with our profession, the term "ethics" is often too easily read as referring to professional codes of ethics.

Morality in psychotherapy

In terms of the moral architecture of the psychotherapeutic endeavour, the shift from Freud's natural and transcendent accounts of virtue to a contemporary concept of 'constructed virtue' spans a century of philosophical enquiry of the nature of morality and clinical theory. Freud's interest in morality was focussed on its function in the psyche. He saw how people were damaged through the archaically oversimplified and neurotically exaggerated moral systems that they received in infancy and childhood. Hence, the therapeutic value of a 'morality free' clinical approach (Reiff, 1961). Freud said famously that he found people much more moral and much more immoral than they thought: more moral because of the extraordinary degree of guilt he found, and more immoral because of the boundary-less range of desires they showed in their dreams (Cottingham, 1998).

In Totem and Taboo, Freud (1913) describes the most basic form of morality, that concerning murder and incest. In this mythological scene, after the murder of the primal father, if the group was to survive there had to be a prohibition against murder and another against incest. Hence the utilitarian principle of ensuring the "greatest good" where the object of morality is to promote human welfare by minimising harms and maximising benefits (Bloch et al., 1999). This would seem to be a simple and defined kind of morality so long as no attempt is made to question or analyse it. Once the external set of criteria is removed though, morality becomes an extremely complex problem for how are we to determine from within ourselves what is right and wrong, good and bad? Yet it seems important to do so.

The ancient Greeks believed that we could not possibly be truly happy unless we behaved in a morally good way (Cottingham, 1998). Socrates, arguably the first moral philosopher, believed that once the rightness of a course of action had been determined we could not knowingly act in a contrary manner. By a process of self-examination, we become good and act in a morally correct way. The focus has already shifted from something external to something internal. Following Socrates, Plato's ideas lend themselves to a more spiritual interpretation—essentially rationalistic morality. Aristotle's contribution is more pragmatic and provides the springboard for the development of virtue ethics, where the cultivation of virtuous traits of character becomes the central feature of the moral life. Aristotelian morality is not concerned so much with right or wrong as with the process of deciding which actions are appropriate or not appropriate for seeking the good in each circumstance. Contemporary virtue ethics develops this idea and investigates the role of a person's characteristic motivational structure (Cottingham, 1998).

Any moral philosophy must, at some point, address what is actually meant by 'good'. For Kant, arguably the most famous modern moral philosopher, it was important not to define 'good' in terms of its effects, like the Utilitarians, but to define good as that which was good intrinsically—an internal sense of duty. Kant made an important distinction between acting in accordance with duty and acting for the sake of duty (Cottingham, 1998). For instance, if we act in a way that is expected of us, or in a way that is designed to produce short- or long-term benefits for us, then the action would not have moral worth in Kant's terms (perhaps being similar to narcissistic in-authenticity). This Kantian perspective has direct implications for the ethical consideration of autonomy in therapy. In fact, from this perspective, some think autonomy so important that if therapists attempt to reduce it, therapeutic effectiveness "is not a morally relevant consideration" (Macklin, 1982, p. 36).

However, this view of the pre-eminence of autonomy seems to be inadequate when considering people in actuality as it were, where unconscious motivations can preclude a person from making a conscious and autonomous choice from a range of alternatives. The matter worsens with Freud's descriptions of the splitting of the ego. Here, the split-off part of the mind is no longer part of the whole. Klein further showed that in many instances the split-off part of the mind could be transferred into, and felt as part of, another mind; that is, as part of the mind of another person. For instance, a spouse who has a particularly self-sufficient, 'tough' self-image may be quite hostile towards his more dependant, emotionally 'soft' partner because of his fear of his own vulnerability. He is, in effect, hostile to the vulnerable part of himself, which is 'seen as' the other. This is known as projective identification (Klein, 1946). Further, that part projected into the other, may then be 'owned' by the receiving spouse (see Hinshelwood, 1997; Sandler, 1976). Thus, simply to be antipathetic towards an aspect of our personality and, consequently, that we might 'choose' to resist this, does not mean that we have necessarily acted autonomously (or even in our own best interests).

An important difference between Freudian and Kleinian constructs of the internal world lies with Klein's introduction of the element of value and the assumption of individuals to be moral in their very nature. It describes the evolution of essentially moral categories as the

criterion for normal personality growth: from narcissism and self-interest to concern for the wellbeing of others, for example. Indeed, Rustin (1991) contends the major developmental 'positions' are defined in terms of the moral capacities that typify them. The characteristics of 'depressive' states of mind include a sense of guilt about pain and destructiveness felt to have been inflicted on the loved other, and the urge to make reparation.

This schema importantly repositions the concern with ethics and morality as an interpersonal concern making 'morality' a relational term. This does not mean that everything good or bad is relational; rather, if it is morality that we are thinking of, then it has to be relational. Kleinian theory seems to hold the most explicit moral point of view, a perception shared by certain contemporary Kleinian writers (e.g., Bion, 1991; Meltzer, 1992; Rustin, 1991), as well as by those of the interpersonalist school (e.g., Sullivan, 1953), who emphasised the role anxiety played in determining the way in which an individual shapes their experience and interactions with others and privileged the relational aspect of our development as a central component of psychological wellbeing and of a 'good life'. Contemporary relationalists such as Steven Mitchell (1988, 1993), and intersubjectivists such as Robert Stolorow et al. (1992) emphasise the fully contextual interaction of subjectivities with reciprocal, mutual influence.

One of the major developments in psychoanalytic thinking has been theories of interpersonal relations which hold a promise for ethics in their fundamental notion that people seek others to relate to (Fairbairn, 1952). Psychotherapy then, involves exploration of human relations and patients' development from immature forms of relating to 'maturity' and integration. This model describes ethical relations as psychologically 'mature' ones or, to put it succinctly, ethical relations are 'healthy' relations. Morally right actions towards others can be described thus, in terms of psychologically mature relations. Wolfe (1978), however, argues that clients in successful therapy need to adopt two new "moral obligations": "to refrain from responding to externally imposed moral standards" and to "trust in their own experience" (p. 47). Here, the emphasis is less on the relational aspect of morality, but instead a concern for the individual's entitlement for morality on their own terms.

In constructing a portrait of ethical maturity, the emphasis is on both the intra- and inter-personal development for health and relies on the individual's capacity to learn to sustain affective ambivalence as opposed to resorting to employing the mechanisms of splitting and projective identification. It is the therapist's job to actively foster the development of these affective-relational aspects. Carnochan (2001) argues for the need for a theory of 'constructed virtue' when we take up the inevitable question of what the client needs. This new paradigm has been most clearly articulated by Mitchell (1993), who frames the shift as a revolution in understanding what the patient needs, which "is not a rational reworking of unconscious infantile fantasies… [rather] a revitalisation and expansion of his own capacity to generate experience that feels real, meaningful and valuable" (p. 24).

In this revised view, the tension between preserving relationships that are meeting the fundamental need to be connected to others and retaining a sense of affective authenticity and vitality becomes our central conflict in life. Rejecting the traditional claim that analysis operates in a realm outside conventional accounts of virtue, Carnochan (2001) argues that

the analytic alternative to traditional moralism or humanistic individualism is not tantamount to emancipation from the problem of morality. Instead, therapists have an obligation to both understand and articulate the moral frame from which they operate and to become active participants in the process of 'constructing virtue'.

For Carnochan (2001), the morality of constructed virtue suggests that suffering stems from the experience and belief that maintaining connection requires the subjugation of our affective responses and consequent pseudo-relatedness. In their proper form, affective responses play a dual role in moral life (Punzo, 1996). First, they contribute to our moral vision by serving as guides in the practical reasoning process. Responses such as anger, shame, empathy, or guilt sharpen our moral perception. Wilson (1993) suggests that it is frequently the emotional responses, rather than systematic deliberation, which initiate 'good' acts. Second, emotions serve as guides and are, in themselves, a mark of virtue (Punzo, 1996). Emotions then are rooted in our moral thoughts and beliefs, whether conscious or not.

A question arises here about how 'moral character' is brought to life. Robert Young (2002) points out that the "concept of character adds moral issues to the sanitised scientistic concept of personality" (p. 24). Psychotherapy, he says, is in the business of fostering insight in order to strengthen character and, in doing so, therapists are in the business of character building, an essentially moral enterprise. Therefore, character and morality should be central to our work, and moral accountability should be routine.

These sentiments are echoed by Symington (1998) who discusses the implications for patients that come to therapy without a functioning conscience, instead being ruled by a tyrannical super-ego. Establishment of conscience coincides with integration of self, and this coincides with conscience becoming conscious, all tasks of psychotherapy. Similarly, Blasi (1993) believes that when the focus of inquiry into moral behaviour shifts from specific discrete actions to an overall moral life, it will become apparent that an effective morality must be rooted in a form of identity. Blasi proposes a developmental account of moral identity whereby the continuing interplay between social interactions and one's own moral ideals progresses to such a point that, optimally, the self becomes the source of moral judgements.

Contemporary psychoanalytic theory and practice have an inescapable moral dimension (Bion, 1991; Blasi, 1993; Carnochan, 2001; Hinshelwood, 1997; Hoffman, 1998; Meissner, 1983; Meltzer, 1992; Mitchell, 1993; Montada, 1993; Punzo, 1996; Rustin, 1991; Spezano, 1993; Stern, 1997; Symington, 1998; Young, 2002). Despite these recent attempts to acknowledge moral and ethical concerns more explicitly, the actual nature of moral influence in contemporary analytic therapy remains unclear.

Morality in the therapist–client dynamic

Psychoanalysis has wrestled with issues of influence, persuasion, and the asymmetrical nature of the therapeutic relationship since Freud's original attempts to disclaim these as being present in any problematic way in the work. In Freud's original formulations, the

analyst was only to be the neutral reflecting mirror and with his understandings about countertransference, the emphasis was on interferences with the analytic process introduced by deficiencies, shortcomings, and characterological distortions of the analyst (Mitchell & Black, 1995). Freud's requirement for a training analysis was an ingenious step towards reducing therapist bias from this source. Considerably less attention, however, has been accorded the more subtle variables influencing the therapist's thoughts, techniques, and theoretical predilections, such as temperamental, attitudinal, and cultural factors underlying therapists' modes of perception and ways of relating to another. It is a truism that individual therapists approach work differently (from both themselves and from other therapists) in different kinds of clinical encounters. Anna Freud (1954) spoke to this in terms of differences in personality and style: "of trends of interest, intentions and shades of evaluation which are peculiar to every individual analyst" and which should not necessarily "be looked for among the phenomenon of countertransference" (p. 219).

Mitchell (1997), a major architect of what has come to be known as 'relational psychoanalysis', provides a comparative framework for exploring the concepts of authority, influence, and autonomy. Drawing on Kleinian theory and interpersonal psychoanalysis, as well as object relations, he considers the old ideals like neutrality and anonymity and the nature of knowledge and authority in the current post-modern climate. The problem of influence guides his discussion. How, he asks, can the therapist best protect their patient's autonomy and integrity in the light of their awareness of the therapist's enormous personal impact on the process? Mitchell makes a case for retaining autonomy and authenticity as primary analytic objectives to be achieved through interpersonal influence rather than despite it.

In a similar vein, Maroda (1999), an intersubjectivist, argues that psychotherapy obliges therapists to engage their clients with genuine emotional responsiveness, so that both the client and therapist are open to ongoing transformation through the therapeutic experience. Ultimately, Maroda says, the therapist's real authority and power come from their continued emotional presence and ability to not only maintain proper boundaries of professional relationship, but also to promote emotional honesty and integrity in their clients and themselves. Maroda believes that psychological change occurs through affect-laden, inter-personal processes given that most clients in psychotherapy have problems with affect management. Moments of "mutual surrender"– the honest emotional giving over of client to therapist and therapist to client–epitomise the emotionally intense inter-personal experiences that lead to enduring intra-psychic change.

If the therapeutic relationship is conceived as one of reciprocal influence, the therapist needs also to acknowledge and understand the client's natural desire to have legitimate power to influence the therapist. Searles (1975) speaks eloquently to this:

> For the analyst to reveal, always in a controlled way, his own feelings toward the patient would thus do away with what is often the source of our patient's strongest resistance: the need to force the analyst to admit that the patient is having an emotional effect on him. (p. 183)

Hoffman (1998) argues that the analyst is inevitably experienced as reflecting a certain aura, a power that is an accompaniment of the developmental significance the analyst inevitably comes to play. This is analogous to what Freud (1912) approvingly called the "unobjectionable positive transference", and ultimately is not the authority that the patient will come to respect as a meaningful feature of therapeutic change. As Greenberg (1999) notes, "It can be a small step from saying that authority is granted in the transference to saying that the patient is submitting to the analyst passively or masochistically" (p. 28). Levenson (1983) asks whether there might be a therapeutic cure distinct from persuasion, a unique process which is something more or, better yet, other than, the therapist's moulding of the patient to their particular view. He stresses the 'resonance' aspect of therapeutic work and invokes a Lacanian sensibility in saying "the patient learns what the therapist knows, which is what the patient already knew" (Levenson, 1983, p. 6).

Strupp (1986) claims that the therapist makes a major personal contribution by virtue of their personality attributes to almost every aspect of the treatment process and outcome, to the conceptualisation of diagnosis and prognosis, to the formulation of a treatment plan and, like a self-fulfilling prophecy, to its successful completion. He concludes that one of the most important functions of research in the area of therapeutic processes consists in identifying the nature of the therapist's influence and making it available to their awareness and judicial control. Tjeltveit (1999) echoes this sentiment stating, we "have a professional responsibility to reflect with great care on the values that we hold, less our influence be less than optimal" (p. 12). He argues against the possibility of a value-free therapy and calls for a more fine-grained analysis of the ethical implications of the unavoidable influence dimension of the therapeutic process.

Renik (1995) believes that analysts simply deceive themselves when they contend that their values and beliefs are not communicated to patients. Renik maintains that since our subjectivity is an influential factor in treatment, it is preferable for the analyst to bring their views into the open so that the patient can evaluate them and assess the impact that they have had on them.

Controversy arises when therapists consciously influence the ethical or moral dimensions of client's lives rather than simply addressing them (Doherty, 1995). Consciously addressing these dimensions, however, may also thus influence them. Dreikurs (1967) was more explicit: "Changing the value systems on which patients operate, constitutes an essential part of psychotherapy" (p. 103). This position necessarily calls into question the suitability of the therapist as an arbiter of a healthy value system.

A fundamental difference between the traditional approach to the therapist's authority and capacity for influence, and more contemporary approaches, is that many now believe that each therapist provides a model or theoretical framework that does not reveal what is in the patient's mind, but that makes it possible to organise patient's conscious and unconscious experience in one among many possible ways that is conducive to a richer and less sabotaging existence (Mitchell, 1988). Similarly, McLaughlin (1996) argues that the fundamental task of the therapist is to use their powers primarily to guide the patient toward how they will discover rather than to what that discovery may be; to help the patient grasp how they can contemplate their inner world of self and others, rather than toward what specific experiences and shapings will be found in the search.

Hence, claims for objective authority, from a contemporary perspective, appear both arrogant and epistemologically naïve. However, it is not the case that the therapist is nothing but an influencer, as Wittgenstein (1938) so famously implied when he coined the term, "cure by persuasion". The power of the inter-subjective field resides in the awareness that we cannot gain insight into a patient, or even ourselves, by being merely contemplative, but only by being contemplative about the very inter-subjective field that we and the patient have made (Feiner, 2000). Following this sensibility, we are thus in search of how a relationship is organised, how it means, not simply what it means. Here we need to consider the concepts of transference and countertransference.

Morality and countertransference

First introduced by Freud, countertransference was restricted to the concept of influence that the patient's transferences may have on the analyst's unconscious feelings. Yet countertransference, as originally defined, is only one type of emotional reaction that a therapist can have to a patient. In the 1940s and 1950s, Freud's definition was challenged by authors who suggested that such reactions as the therapist's own transferences, identifications and realistic reactions might all be included under the rubric of countertransference (Heimann, 1950; Mendelsonn et al., 1992; Racker, 1949; Tower, 1956; Winnicott, 1949).

In modern psychoanalytic theory, the term is defined as the therapist's total emotional reaction to the patient and as a joint creation of both participants (Slakter, 1987; Tansey & Burke, 1989). Currently, countertransference is regarded not so much as an obstacle to the therapist's functioning (as Freud feared) but as an indispensable aid to the therapist's ability to understand and intervene effectively with the patient (Gabbard, 1995). The question now no longer seems to be whether countertransference holds informational value about the patient; rather, how best to decipher this information. Considered thus, we can say that countertransference is in and of itself an essential research tool within the practice of psychotherapy.

The concept of countertransference is loosely related to that of projective identification which Klein described as an intra-psychic fantasy of evacuating part of the self and putting it in someone else. Subsequent Kleinian thinkers have expanded this to an interpersonal process (Ogden, 1999; Scharff, 1992). Morgan (1995) describes the use in couple relationships of projective identification as a 'projective gridlock' which is used "expressively and intrusively" (p. 35) with the aim of "maintaining a fantasy of being one with or residing inside the object" (p. 38). Further, she says, therapists working with couples in a projective gridlock are prone to transference and countertransference dynamics or enactment in which there is felt to be no separateness. Like Ogden (1982), Maroda (1999) focuses on the therapist's task in working with this dynamic. Most therapists, Maroda says, believe that a patient tries to communicate disavowed affect so that their therapist can experience,

understand, and find a way to live with it—the idea being that if the therapist can achieve this task, then so can the patient.

Ultimately, countertransference is not merely an error. It is not noise in the system. Rather, it is both what makes possible new understanding and what can stand in its way (when enacted). Most early psychoanalytic theorists seem to have been wary of dealing with couple relationships. Freud assumed that the health and wellbeing of the individual were naturally above that of the survival or intrinsic value of relationships (Scharff, 1992). Systemic thinking, rather than psychoanalytic approaches, has dominated in the couples therapy literature until relatively recently, with the exception of some early psychoanalytic writers such as Edith Balint and Tom Main.

Brodie and Wright (2002) argue for the value of an analytic perspective as derived from the extended metapsychology of Freud, Klein, and Bion. Essentially, this approach emphasises an 'inside-out' model which takes account of the couple's fantasy world and how this impinges upon external relationships. This contrasts with an 'outside-in' model which considers the manner in which the couple relates to each other and how this impinges upon their thoughts, awareness, and beliefs about each other (Brodie & Wright, 2002).

From the analytic perspective, looking for the nature of unconscious fit between partners is crucial in understanding why individuals in a couple chose each other, and how defensive, as opposed to developmental, the relationship is or could become. Understanding these unconscious processes clarifies other related phenomena, especially transference and countertransference. For example, with a couple where projective identification predominates, we could predict that intolerable feelings or unwanted states of mind will be located elsewhere. What we might be able to observe in this therapeutic encounter is the therapist being used as an object in which to put these unwanted states of mind. Countertransference here, will be understood as a relevant source of confirmation of understanding the couple's communications. The therapist's task then, is to determine what figure (or part object) they are representing at any specific moment in the mind of the couple in order to be able to contain these experiences (and themselves).

Colman (1993) draws on Bion's concept of 'container-contained' and Winnicott's 'holding' to inform his discussion of the capacity of the couple relationship to function as forum for psychological development. In couple therapy, the therapist provides a 'containment' directed towards the couple's shared image, and by accepting and thinking about projections of the couple's relationship makes the projections available for re-introjection by the couple in a modified form:

> Marital therapy is primarily directed towards this shared internal image of the relationship, which is essentially an image of the relationship, an image of the couple in intercourse: the container is actually the "container/contained" apparatus. (Bion, cited in Colman, 1993, p. 90)

More often than not, highly distressed and destructive couples have suffered the loss of this containing function; invariably, as a consequence of either one or both partners suffering

from characterlogical difficulties within the borderline/narcissistic range of pathological functioning.

There has been considerable attention paid to understanding and treating these couples in recent times, beginning with Solomon's (1989) comprehensive study of narcissism in intimate relationships. Lachkar (1992), Morgan (1995), Ruszczynski (1995), and Slipp (1995) have all extended Solomon's work and discuss various aspects of the narcissistic-borderline couple, including the nature of the 'fit', the shared unconscious collusions operating within the couple, and the highly projective and conflictual environment that they create. Scharff (1992) has updated the concept of projective identification developed by Ogden and applied it from both a systems and object relations theoretical perspective to couples. They discuss how both introjective and projective identification processes occur in couples and how they are expressed in rigidly established communication patterns by which one spouse holds the powerful role assignment; and the other, the weaker assignment. Projective identification being both an intra-psychic and inter-personal defence mechanism, serves to maintain both the self-esteem of the individual and the integrity of the system. When it is required to maintain the stability of a spouse's intra-psychic system, it generally results in the exploitation by the spouse to complete themselves and interference in the individual development of both partners. Before these couples can increase their level of intimacy, they must make substantial progress toward the resolution and re-internalisation of their projections.

Glickauf-Hughes and Wells (1995) and Links and Stockwell (2002) focus on assessment criteria in considering these couples for treatment, emphasising the need to determine the couple's ability to curtail their destructive acting out, their levels of defensiveness, vulnerability, and general 'workability'. The level of intimacy that can be tolerated by these couples will be determined by their defensive styles. Intimacy is understood here as the ability to be oneself in a relationship while staying emotionally connected to all aspects of the other without needing to distort, change, or control the other. A study of consultations offered to distressed couples revealed that couples presented common omnipotent patterns of thinking which had a direct bearing on how the therapist was made to think and feel, creating in the therapist the countertransference of being the 'moral judge'. Solomon (1989) emphasises that the therapist is the most important factor in the successful treatment of relationship problems and challenges other writers (Skovholt & Ronnestad, 2003) by stressing that couples' work, even more than individual treatment, seems to be influenced by the countertransference reactions of the therapist. Further, when the therapist's reactions to the couple are very strong, treatment generally fails.

Doherty (1995) is emphatic in his prescription for the couples' therapist as a 'moral agent'. He emphasises the value of commitment to what he calls an 'intentional' marriage and takes issue with the supposedly 'neutral' free stance of many couple therapists which he claims harms more couples than it helps (Doherty, 2003). Like Nicholas (1994), he illustrates how questions of courage, honesty, and responsibility for others frequently arise in therapy and argues that if we ignore these virtues, we ignore the client.

In couples therapy, the focus of clinical interest is the interaction between the two people who make up the relationship. The patient, as it were, may be said to be the relationship.

The notion of object relations currently constitutes a major theoretical parameter and underpins the contemporary focus on the transference and countertransference dynamics inherent in any therapeutic encounter (Ruszczynski, 1995). The concepts of projective and introjective identification and container/contained add further depth to an understanding of object relating, and this conceptual and clinical position provides the bedrock upon which psychoanalytic psychotherapy with couples is based.

The original study

In the original study (Joyce, 2004), I addressed the question, "How might moral influence be mediated in couple therapy?" and, in doing so, position the project as a qualitative one. The research was based principally on the epistemological position posited by constructivism informed by several inter-linking philosophies, principally those of the existentialist and phenomenological schools (Husserl, Heidegger, and Sartre), hermeneutics (Gadamer), and pragmatism (Rorty). At the core of constructionism lies an understanding that reality is one of perspective, and understanding is a construction rather than a reflection.

Viewing psychotherapy from a constructivist perspective brings into focus its essential affective, relationalist, and intersubjective nature. When the perspective is understood as a special form of hermeneutic dialogue a certain set of working assumptions is made (Zeddes, 2000). It presupposes that neither therapist nor patient has privileged access to a superior reality and dialogue is constituted by the engagement of subjectivities, each of which influences and transforms aspects of the other. Moreover, contemporary hermeneutic philosophy may be ideally suited for exploring the moral domain of couples therapy because it places that which is moral at the centre of a human existence that is always socially embedded and purposive (Fowers & Wenger, 1997). From this perspective, we need to acknowledge that individuals are moral agents who are always committed to some vision of human good, and considered moral positions taken by the therapist and their clients can have legitimate claims to truth that have validity not only for them, but potentially for others as well.

Countertransference: Tool and case

It is important to make more explicit the implications of constructivist epistemology for the understanding and utilisation of the countertransference which is a critical part of the therapist's epistemological process. Our affects offer a way of knowing each other that reaches to the most fundamental or essential premise of our humanity and so, to gain objectivity, requires a movement towards our subjectivity. Relational factors occupy a similar epistemological position as interpretation. Hoffman (1983), an early advocate of mutuality and shared knowing in the therapeutic relationship, notes that the patient was a credible interpreter of the therapist's experience, and further, that it is the analyst's personal presence that creates the opportunity for a special kind of affective contact with the analyst that is thought to have therapeutic potential. Hoffman (1992) focuses on the personal of the analyst, arguing that there can be no unmediated "truth" about the patient;

our choices are always subjective choices, via our interpretations or understandings. However, decisions and choices have to be made and the consequences dealt with. Therefore, the analyst has no choice but to generate and test hypotheses and to develop criteria for determining if the interventions are accurate (Bader, 1998).

Case study design

Qualitative case study research involves researchers looking for 'cases' of something (i.e., the interactional patterns between therapist and the couple) in order to make 'cases' for something else yet to be known (e.g., how these processes might mediate a moral influence) (Sandelowski, 1996). The cases under consideration for this research are: 1) the couple, 2) the therapeutic relationship, 3) the therapist's countertransferences.

The cases were selected to represent a cross-section of clinical practice and were studied in conjunction with clinical examples taken from relevant literature. I include my countertransferences as an instance of a case and one which is necessarily connected to the other cases under study. As such, this study can be characterised as an instrumental study extended to several cases (Merriam, 1998) where the cases are examined to provide insight (into how the therapist mediates a moral influence through the use of her countertransference).

Methods

I selected one couple with whom I had completed therapeutic work because their partner agreed to participate and because of the detailed quality of my clinical records relating to our work together. Adopting a descriptive and interpretative approach, I gathered information from past therapeutic encounters working with the selected couple. I use clinical vignettes to illustrate points that I make and draw on a combination of my previous therapeutic experiences and cases referred to in the literature. Data and clinical vignettes were collected from a variety of sources and include material gathered from the audio-taping and memo-ing of therapeutic exchanges.

A key idea in hermeneutic approaches to inquiry is that of moving back and forth between the whole and the parts of the 'text'. I began by initially writing an overall summary of each case, using my clinical notes and tapes at hand to provide a beginning 'common-sense' (McLeod, 2001) reading of my text from which I anticipated being able to expand my understandings into more refined 'pieces' of text. Questions that I put to the data included:

> What seems to be the distinctive values embodied in the clinical work?
> How are these translated within the therapeutic relationship?
> How is my countertransference engaged with?
> How does this connect with my moral subjectivity?
> How might this be connected with the client's moral subjectivity?
> What is the nature of my own and the clients' relational 'value influence'?
> What implication might this have for therapeutic progress?

These questions arose from, and contributed to, dividing the text into workable bits whose meanings and properties could be more closely examined.

Data analysis was inductive, and data were reviewed and analysed in relationship to the research question and the relevant literature, with particular focus on my countertransferential responses. These responses were recognised as a research tool in themselves. Through the multiple reviewing of case notes and listening to audiotapes I gained a sense of the whole experience (Noblit & Engel, 1991) where "the sense of things" is understood in terms of "things taken together" (pp. 126–127). My aim was to discover the possible meaning that the therapist–client interactions have for both parties.

Discussion

We are all deeply concerned with the moral. (Unconsciously) persecuted by deep feelings of shame and guilt, J and M aspired to the good (I infer this from the fact that they kept coming to therapy) but could not allow themselves to develop anything like their full potential because of their terribly low self-esteem. They longed for a satisfying marriage but found themselves caught up in a shameful, primitive, and retaliatory part-object relationship involving abuse and subjugation, which resulted in a profound bitterness. Both were aware that things were 'wrong', that their behaviour toward each other flew in the face of the values that they aspired to—values such as respect, tolerance, and fairness, to name a few.

ln this sense, l want to argue, J and M brought the moral framework with them.
What they required of me, I now believe, was the provision of a feeling, thinking, and containing other, who could help them access their unarticulated wishes for a good life, their hidden fears of being essentially unworthy of this, and their capacities and courage to take the developmental steps toward achieving greater self and other awareness and genuine concern. This access and the use of it in their service depended upon my capacity to come to 'know' of their difficulties (and something also of their potential), in large part, through both the registering and subsequent processing of my countertransference responses to them, as individuals, and as a couple.

I should add a caveat: the scrutiny of my countertransference did not necessarily constitute an absolute means of understanding another, nor should it represent an epistemological Holy Grail. There were other means of coming to know involved here, including explicit and specific knowledge of J and M, theoretical knowledge, attention to patterns and cues, as well as clinical reasoning and inference based on our interactions. At times, these means may have provided me with what identification, empathy, and experience of passively and emerging thoughts and feelings could not.

By choosing countertransference and its vicissitudes as the thread around which to organise the understandings of my and the couple's roles in influencing and mediating each other's values in the therapeutic relationship, l have been necessarily implicated in this project as one who 'comes under the influence' of the couple and as one engaged in her own form of persuasion. What differentiated me from this couple in this regard, however, is, I believe,

mainly that I had therapeutic aims as well as a distinct vision of both how unconscious processes contributed to our living, and how my interventions and responses may help them achieve our jointly constructed therapeutic goals. Providing a secure environment, a container for the transformation of projective identifications, and an observing/auxiliary ego, employed conscious and intentional aspects of this therapeutic role.

Who we are is fundamentally what our values are, I believe, and what our countertransferences are. Often, the concept of countertransference has been compartmentalised into being either negative or positive to therapy. In fact, it has recently become more acceptable to view all relationships, in particular couple relationships, as being countertransferential in nature. Couple work then, is really an exponential effect of individual countertransferences and their dyadic pairings and counter-pairings. With such chaotic potential, it is essential for someone in the therapeutic relationship to have some grounding by knowing, as much as is possible, what their countertransferential issues are and to have the ability to make them an overt part of the therapeutic process and the therapeutic relationship.

Traditionally, therapists have endeavoured not to inflict their values on the patient, a position that is fine for those patients who have reliable values but that amounts to professional neglect with those who lack them. Couples, like J and M, with relatively severe narcissistic pathology, not only harm their own prospects for the good life but also do damage to each other. It was part of my job to help them get their destructive behaviours under control and create an atmosphere in which they wanted to identify with values and standards of self-esteem that had not previously been effectively internalised. Helping them build internal sources of self-regard has been essential for their ability to progress beyond their projective gridlock and onto healthier relating.

I have just said that moral constructs are rarely if ever available to me in a conscious form when at the coal face, so to speak. There are goals, however, that I do hold in mind, although I do not generally 'classify' them as moral ones (although I now see that they indubitably are). Zeddes (2000) argues, "whether or not we acknowledge that we are doing so, we are always expressing (through word and action) some understanding or vision of the good life" (p. 224). For this couple, and indeed for all patients, the provision of safety was not only a necessary foundation for therapeutic work but an essential component of virtue; wellbeing requires a deep sense of safety.

The first part of this provision depended on my willingness to listen, which has a significance that goes beyond inquiry. It indicated, implicitly, that J and M were worth listening to and taking seriously. Listening then, became an indication of their value, and the communication of value was reinforced by my empathy. When I provided an empathic reflection, this became a suggestion that their subjective view of the world mattered. This was necessarily grounded in my genuine affectivity. Moreover, at some point, I had to be willing to acknowledge my subjective participation in the relationship, for example, when I confessed to a similar desire to blame when feeling inadequate. This willingness served the demand for therapeutic safety in several ways. On the one hand, my acknowledgement of affective participation confirmed the universality of human subjectivity and vulnerability; that I struggled with similar predicaments and still worked to determine a route to compassion

and offered hope. Equally, for me to bring the countertransference visibly into the room became a statement that the difficulty of human relationship was the responsibility of all involved. On the other hand, my willingness to become more present served the couple's self-esteem, not through false reassurance or collaboration with their sense of narcissistic entitlement, but by meeting their need to be recognised in an authentic and particular way. These aspects of the provision of safety provided a model of constructed virtue. The couple, in turn, had an opportunity to internalise these skills and make them personal. Here, the role of demonstration made itself felt first in the use of affect as information about myself and the other.

Lander and Nahon (2000) discuss the dichotomy of professionalism versus humanity as a pivotal therapeutic dilemma and stress the importance of the therapist being able to transcend relating as an "armamentarium of techniques which poke, manipulate and manoeuvre" (p. 40). Further, they state, that it is much more therapeutic for therapists to clearly draw a boundary by declaring their values regarding what are acceptable versus unacceptable behaviours in their own value system. This provides the couple with a real relationship, where they can dare to articulate and differentiate their own value systems. J and M drew my attention more to a difference of degrees to which they identified with my values than to any values that were fundamentally disparate.

I note here that it is important to discriminate between values based on higher levels of generality and between the level of specific beliefs about say abortion, or using 'white lies' to smooth social discourse, for example. I believe that I did need to share common 'higher level' moral assumptions with this couple. We needed to inhabit a similar moral universe (attempting psychotherapy with a psychopathic personality would be well beyond my capacities, I suspect). Equally, an essential component of technique in psychotherapy is the creation of an atmosphere of acceptance, fostering, as it does, a sense of safety. So, if, at the level of specific beliefs I hold powerfully to a felt value position, this may well cause me to hinder rather than foster progress. It will convey instead a lack of acceptance, if it intrudes on the other's frame of beliefs. There is a place then, for judicious appraisal of my own prejudices and what I can and need to bracket off as having more to do with me than to do with the couple. With this couple, what was encountered was more a difference in degrees to which they and I adopted certain values. For instance, overall, they were relatively content to accommodate a degree of intolerance and a constriction of freedom, which I would personally be unable to live with.

The central values that emerged from the therapeutic work with this couple, and that were negotiated between us, were those of agency, responsibility, self-relevance, compassion, respect, tolerance, and freedom. For the most part, these values were under-developed or under-utilised by J and M in their relationship (although seemed more available to them in other areas of their lives). They formed a part of my thinking from the onset of our work together and were made available to the couple through the sharing of both my thoughts on their relationship difficulties and through discussing with them what components of a healthy intimate relationship seemed most challenging for them to achieve. Of these, the value of personal agency bears closer inspection, involving, as it does, the values of compassion, self-relevance, and responsibility.

Kurri and Wahjstrom (2001) describe 'weak agency' as an inability or reluctance to take action on pertinent issues where a person's non-action is seen as having an impact on their lived reality. We also have to consider that by not doing something an individual is also actually doing something. Poor self-esteem, viewed through the agentive perspective, is not a deficit or an absence, but an actively shaped strategy of adaptive action. In order to gather new experience that might lead to the reconstruction of affective-relational skills, J's old modes of adaptations needed to be set aside. But these adaptations were seen as necessary forms of protection, as the only templates for intimacy, and the thought of reactivating them was terrifying to her. As Carnochan (2001) aptly states: "Out of fear, we actively avoid traversing the route to virtue" (p. 348).

Within the constructivist sensibility, it makes little sense to claim that we are always the agent of our experience. Instead, the more encompassing perspective requires that we understand how we are simultaneously both the object and the agent of our experience. Further, to know how we, and those around us, are determined by experience is to lay the groundwork for compassion. Here, fault becomes an empty concept, and we are thrown back to a sense of forgiveness. Yet, at the same time, to claim her subjective identity and to find herself relevant, to assert her agency, lay at the basis of transformation and growth for J and the possibility of virtue. At this level, responsibility emerges.

It was important for me to retain a fluid relationship to these perspectives, which was largely achieved through closely attending to my countertransferential responses to J's shifting affective states. As Spezzano (1993) writes:

> while the analyst's assigning of personal agency to all the person's subjective experiences... may well be vital to the process of opening up new options, it is often not until the analyst can empathise with the patient's sense that his parents are to blame for at least certain aspects of his current affective distress and pain that the patient can assume responsibility for making important changes. (p. 123)

The definition of moral concern that I have explored here is a far cry from the use of the term in contemporary culture where moral issues are associated with persons in authority telling others how to live. Perhaps, in reaction to this, what Miller (2001) calls a kind of 'moral relativism' seems to have taken hold. He says that these days it is presumed that morality is personal and private, and that each person needs to decide what is moral for themselves. As one might expect with something so personal and private, morality is little discussed. Miller calls for a "truth-in-moral-packaging" rule for psychotherapy, where clinicians and researchers alike are required to identify openly the moral value bases of their work. This demystification of the moral aspects of the clinical work is something that was important from the very beginning in establishing a mutually understood 'playing field' as it were, with J and M. Taking time to discuss with them my perceptions of their difficulties, not just in terms of "this is what I see", but also, importantly, in terms of making known what values informed and guided my work and the reasons these values were held (e.g., that we all have a responsibility towards each other and that we are all entitled to respect, safety, and care) provided them with the opportunity to assess the possible usefulness of my convictions for their endeavours and a choice in whether to engage in therapy with me.

Equally, my deepest ethical convictions seem true to me. But there is nothing inherent in holding such convictions that requires regarding them as certain. I cannot claim more than a partial and imperfect grasp of the meaning of health, compassion, authenticity, courage, and so forth. It seems that it is only in the experiencing of another that I can gain a better understanding of the limitations and distortions of my perspectives. This holds true for both the couple and myself.

Gadamer (1975) provides a useful paradigm for dialogue about disparate perspectives in his concept of 'fusion of horizons'; pointing out that a particular vantage point is a prerequisite for all of our perceptions, judgments, and action, with the horizon being the limit of what can be seen from a particular point of view. Gadamer characterises the genuine attempt to understand and appreciate other's perspectives as a fusion of horizons and from this perspective there is no final, absolutely correct point of view. All positions are seen as potentially valuable contributions to the ongoing exploration of the good for the couple. Similarly, Ogden (2003) contends we "are not inventors of emotional truths, but participant observers and scribes" (p. 593). My feelings about what is true are mere speculations until they are brought into relation to something external to my psychic reality. J and M's responses to my interpretations, for instance, and in turn my response to their responses, served a critical role in confirming or disconfirming my sense of what might be true.

This methodology then, represents an effort to ground therapeutic knowing in a world outside simply of my mind. It takes at least two people to think (Bion, 1962). In the end, Ogden (2003) concludes (as do Carnochan, 2001; Maroda, 1999; Mitchell, 1997; Punzo, 1996, amongst others) that it is the emotional response, what feels true that must have the final word in the work; "thinking frames the questions to be answered in terms of feelings" (p. 596). The underlying moral themes that emerged in my work with this couple constellated around 'doing one's best'. This needed to be considered in the face of both the repetitive and progressive trends in human motivation (Stern, 1997). J and M both simultaneously sought to re-enact and preserve familiar modes of relationship while striving to repair the traumatic past and establish a more pervasively loving relationship.

These tensions saturated my countertransference, creating emotional loops that formed the basis of my therapeutic attitude and largely determined my responses to their struggles. In many instances, my empathic capacities were challenged as I sat in silent condemnation, and flirted with abandoning the couple. To remain still in the face of this negative countertransference seemed to require more of me than I felt I could muster, and it was only with considerable supervision that I was able to create some 'space for thinking' to look more deeply, and to move from the complementary to the concordant perception that lies behind empathy (Tansey & Burke, 1989). Throughout, I was endeavouring to 'do my best' on behalf of the couple. It was my supervisor who needed to point this out to me and enabled me to similarly reflect on this virtue and discuss the application of it with J and M.

'Doing one's best' crucially calls on our capacities for compassion. It relates neither to blame nor innocence but demands of us that we accept both the good and bad within ourselves. This was essentially the most fundamental task for this couple (and for this sometimes super-ego dominated therapist) and relied on developing a capacity for genuine compassion—for oneself in the first instance (and for the other and their efforts). This

invokes the value of generosity and allows for gratitude to develop. The intersubjective approach suggests that patients have needs that must be met by the compassionate action of the therapist for the prospect of change to unfold. To meet these needs for engagement, I needed to rely on my countertransference. It was from the countertransference, from the core of my affectivity, that my capacity for authentic provision stemmed.

Perhaps we need to extend the range of morality beyond some more or less clear set of rules for life (these being, amongst others, that we treat each other fairly, take responsibility for ourselves, develop our sense of agency, demonstrate concern and care, and show compassion). Rather, we need to include a general modal sense of our deepest integrative effort at self-possession and self-orientation throughout our whole life with others and to be authentically engaged in 'doing our best'. Here, we would be retrieving from our current fragmented psychotherapeutic culture (where in the absence of a clear understanding of the moral ends that analytic therapy promotes, our technique has become an end in itself), the moral visions of Aristotle. Aristotle (Ostwald, 1962) wrote of the complete life of activity directed to what we consider our very best possibilities:

> human good turns out to be the activity of the soul in accordance with virtue, and if there [are] more than one virtue, in accordance with the best and most complete. But we must add "in a complete life". For one swallow does not make a summer, nor does one day: and so too one day, or a short time, does not make a man blessed or happy. (p. 6)

Orange et al. (1997) provide a helpful beginning point in applying Aristotle's ideas to clinical practice. They argue that in place of an emphasis on technique, psychotherapy should be viewed as "a kind of practice in the Aristotelian sense", in which an attitude of "inquiry, deliberation, and discovery" (p. 27) is encouraged and where rules of technique are replaced with a striving for wisdom. Here, they appeal to Aristotle's notion of practical wisdom that argued that the mark of a wise man is the extent to which he engages in "good deliberation". Viewing practical wisdom in these terms forces us to reflect on the inescapably moral and ethical structure of the clinical work.

Thinking about the therapeutic work, a moral enterprise stands in sharp contrast to what has heretofore been the conventional "wisdom" within analytic circles of what psychoanalytic therapy is and how it should work. Defenders of the moral neutrality of science and practice often fall back on a means/end distinction, claiming that while the goals of therapeutic work (the ends) may be chosen based upon moral considerations, the methods or techniques (the means) are not. Traditionally, moral neutrality is claimed for the techniques as well as for the empirical evaluation of those techniques. However, as this study illuminates, morality is embedded in the theoretical constructs underlying technique; and, furthermore, the person of the therapist is necessarily involved in technique. Here, the application of technique was dependant on my subjectivity and ability to affectively engage with the subjectivities of the couple via my use of my countertransference. As such, both parties influenced the other to produce mutually agreed-upon values to aim for and a 'good enough' moral framework to operate from. Again, the question is now not so much whether therapists are to be involved with moral questions in our professional work, but how we go about this and to what end. In this case a more thoughtful, self-aware, and dialogic approach to the kinds of ideals we pursue and promote seems vastly preferable to

pretending that we can avoid such questions. It is my hope that this study encourages just such an approach.

Analysis of the data indicates that moral concerns are inextricably embedded in much of the theoretical constructs underlying therapeutic technique as they are in the intersubjective field. Within a constructivist approach, my capacity to integrate and make use of my countertransference as a guide to understanding and action was a primary component of virtue and, further, my ability to make this manner of understanding manifest fostered the couple's emerging capacity to attend to their own affectivity as well as fostering hope for a healthier capacity in relationship to themselves and each other. The central values that were negotiated between the couple and the therapist were those of agency, responsibility, self-relevance, tolerance, and freedom. The underlying moral themes constellated around 'doing one's best' to achieve the greatest good for both the individuals and for the couple.

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Paper 3 (2006)

A conversation beyond words: Exploring somatic countertransference when working with alexithymic clients

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The paper revisits a study undertaken some 17 years previously, and that has been further developed with the benefit of many clinical hours, supervision, and my own personal therapy. This journey has helped me to better understand alexithymic clients and, further, to find aliveness in my practice when working with them. 'Body awareness' guides the therapist and sense-make the bodily communications from their client. Specifically, the use of mindfulness practice is used to tune-in with the therapist's state and go back to body when a session becomes too 'heady', boring, or scary. What am I feeling right now? Where in my body is this feeling impacting? How do I use this information in this moment, in this relationship? These questions are present for me when working with all clients; but I find them particularly useful when working with people who remain in the concrete, non-symbolic realm. Somatic countertransference brings unprocessed information to our session; and, from my developing professional experience, is a key to a more real, profound connection with my alexithymic clients.

Due to the context in which this paper was originally written, online psychotherapy is not addressed here. More recently, working online has presented another layer of challenge to the work with alexithymic clients. This is an area of interest for further exploration.

A conversation beyond words

> Robert enters the room, he is agitated and there is a sense of urgency in his words, as he is taking a seat, he says: I just came from my father's funeral, my chest hurts. Prompted to explore his feelings about the death of this father, Robert describes the service, the people, the food, and the sensation in this chest.

The following sections explore and outline the therapeutic process engaged in whilst working with alexithymic clients, like Robert. Presented first are definitions and aetiology of alexithymia, followed by countertransference in understanding the client's inner world, and then modifications to the therapeutic technique. Finally, somatic countertransference is explored, finishing with a brief discussion and conclusion.

Alexithymia: Definitions and aetiology

Alexithymia is the inability to name feelings and emotions (Krystal, 1982-83), the concept originated in France, in the work of Marty and de M'Uzan (1963) with psychosomatic

patients. The researchers observe that these patients presented with a lack of phantasies and their associations were poor, limited to a recitation of facts and daily realities. Marty and de M'Uzan call these traits *pensée opératoire* (operational thinking). Their work was further developed by psychiatrists Nemiah and Sifneos (1970) in Boston who interviewed 20 psychosomatic patients and found that their associations were mostly lacking thoughts related to their inner world. They relate these findings to the concept of operational thinking and coined the term alexithymia (from the Greek; *lack, lexis* = word, *thymos* = emotion) to identify this disturbance. The outstanding characteristic of this group of clients is their lack of awareness of feelings, and the inability to express their experience in words. Their thoughts are in response to the events of the environment with no link to their drives, desires, or inner world.

Two perspectives from the literature are presented here on the causes of alexithymia—one from psychotherapy and the other from neurophysiology. The object relations psychoanalysts and psychotherapists (Broom, 1997; Krystal, 1977, 1979, 1982-83; McDougall, 1989, 2000; Sperling, 1964, 1968, 1974) support that alexithymia originates in the symbiotic relationship between mother and child in which physical dependence, whether manifested through illness or other physical expressions, was rewarded by the mother. The child learns that physical communications of illness or unwellness were regarded with care, attention, and acceptance. Conversely, when the child manifested their attempts for independence and expressed overt aggression, the mother rejected them. The attempts for independence and separation become evident during the anal phase in which the child is developing their capacity for a gradual separation from the mother (Sperling, 1968). Consequently, the link between illness and mother's love is libidinally charged, while being healthy is linked to rejection and abandonment since the child fails to win their mother's attention (McDougall, 1989; Sperling, 1964).

The neurophysiological view was developed by Sifneos (1970), Heiberg and Heiberg (1977), Hoppe (1977), and Nemiah (1977). Working with psychosomatic patients inspired Nemiah (1970) to analyse the various theoretical models that offered a possible aetiology of alexithymia. He identified three models. First, the psychodynamic point of view that understands alexithymia as the massive use of denial and repression against painful emotions. Second, the developmental thinking that sees alexithymia as an indication of a failure in the desomatisation process by which the child learns to put words to emotions. Third, the neurophysiological theory which considers alexithymia as a dysfunction produced by an inadequate connection between the limbic system (the substrate of emotion) and the neocortex (the substrate for language and the elaboration of systems of associations). Nemiah favours this last explanation, particularly in light of Heiberg and Heiberg's work on twins, in which they conclude that alexithymic traits are largely inherited. Nemiah's physiological reasoning sees alexithymia as an irreversible process. In his view, there is a blockage in the pathway that links the substrate of the brain that processes emotions with the substrate that deciphers this information into language; therefore, emotions are not denied but completely absent.

Alexithymia and psychotherapy

The two different aetiologies detailed above have almost opposite views for the use of psychotherapy with alexithymic clients. Unsurprisingly, Sifneos (1974) finds psychotherapy not possible with this client group, and asserted that clients do not respond to the insights obtained through the psychotherapeutic process. Their inability to respond emotionally within the therapeutic relationship made Sifneos believe that the defect was organic and, therefore, irreversible. Discussing the feelings stirred in the therapist when working with alexithymic patients, Nemiah and Sifneos (1977) expressed feeling frustrated because the relationship with the client never progresses, always remaining at the same point. They remarked on feeling excluded from the patient's inner world because these patients do not disclose phantasies, dreams, or wishes; and do not establish a relationship with the therapist.

There is a more hopeful vision for the work of psychotherapy supported by researchers who maintain alexithymia originates within the baby–mother relationship. Taylor (1977) proposes the therapist should use their countertransferential feelings to understand the client's inner world; and Krystal (1979) points out that some aspects of the therapeutic technique have to be modified in working with alexithymic people. This approach is explored later on in this paper; but, firstly, I define the process of symbol formation which will clarify the implications for psychotherapy.

Symbol and symbolisation in the use of language in alexithymic clients

Symbol is the re-presentation of an object that is absent (Chiozza, 1998; Rycroft, 1995). Symbols may be conscious, such as words and emblems that, in general, have meanings established by convention (Rycroft, 1995); or unconscious, which are a representation of what is kept repressed in the unconscious (Segal, 1957). The ideas represented are of birth, life, and death; the meaning attributed to them is constant (Jones, as cited in Segal, 1957). Examples of unconscious symbols are present in dreams where they play a double role of showing and hiding.

Segal (1957) distinguishes between symbol formation proper and symbolic equation. In the symbolic formation proper, the symbol is experienced as different from the symbolised and represents the object. There is a space between what is symbolised and the symbol and it is within this space that the subject generates the meaning of the symbol. It is in this space that the subject can experience ambivalence, guilt, and all the feelings that arise as a consequence of the separation from the object. This process of symbolisation takes place in the depressive position in which the subject is able to experience and tolerate the separation by mastering the loss rather than denying it (Ogden, 1989; Segal, 1957). The thoughts and feelings of the person who lives in this position are felt as a personal creation; the sense of I-ness, understood as the capacity for subjectivity, develops from this experience (Ogden, 1989).

The symbolic equation referred to by Segal (1957) reflects a subject who cannot substitute the object with the symbol; the symbol *is* the object and any separation is denied. It is as if

by having the symbol, the object has never left. The space between symbol and symbolised does not exist—object and symbol are charged with the same emotional value. This is a predominant characteristic of the paranoid-schizoid position, a mode of experience more primitive than the depressive position (Klein, 1975). There is no thinking about the self; what is perceived and what is interpreted is lived as the same experience. In the paranoid-schizoid position there is no differentiation between the facts and the feelings and thoughts; the therapist is not acting as the mother but becomes the mother (Ogden, 1989). Because symbols are not differentiated from the object, play is restricted to what is objectively perceived, limiting the creative process to realistic, feasible actions and facts (Winnicott, 1971).

McDougall (1989) explains symbolisation as a process of desomatisation; words evoke feelings, the baby can think about their mother, and this provides their first attempts for independence. This language is of fundamental importance in the mental structuring of the baby (Flynn Campbell, 1997; Hurvich & Simha-Alpern, 1997; McDougall, 1989; Winnicott, 1971). However, when this process of symbolisation fails, it can result in deficiency in the use of language to express emotional states. The body remains the means of communication for feelings that find their expression through somatic illness (Shapiro, 1991). When the symbolisation process is not properly developed, the ability to phantasise remains truncated.

Using countertransference in understanding the client's inner world

The alexithymic person communicates mainly in a non-symbolic style; their words are used to separate from others rather than to connect (McDougall, 1978; Taylor, 1977). A therapist's hope is to work with free associations, phantasies, and dreams; but, instead, finds a patient who brings very little and sometimes none of these. Taylor (1977, 1984, 1987) describes his countertransferential responses when working with these clients as boredom, dullness, frustration, and sleepiness; sometimes even experiencing a sense of despair and helplessness that lasted after the session and over the weekend. Rizuto (1988) also identifies amongst the therapist's countertransference feelings of exhaustion, discouragement, anger, humiliation, and the wish to get rid of the patient. Hogan (1995) adds inattention and drowsiness to this list of feelings.

The countertransferential responses can be used as a 'key that opens the door' to the patient's unconscious (Taylor, 1977). In Taylor's view, the alexithymic client perceives their feelings to be dangerous and destructive, and, consequently, buries them very deeply. The countertransference needs to be sustained and analysed, which will help the therapist to expand their interventions and create strategies to work with these clients. Taylor (1977) concludes that working with this client group requires a more creative use of the countertransference and that this may then translate into a rich therapeutic relationship.

Modifications of psychotherapeutic technique in working with alexithymic clients

Alexithymic people relate to others in a distant manner, which is part of the transference that the therapist needs to observe in order to discover emotional aspects expressed through physiological responses (Taylor, 1977). There is also an affective difficulty: the alexithymic patient lacks the experience of putting words to their emotions. Emotions that were felt but cannot be named leave the person with a sense of unreality. When they attempt to observe their inner selves, they frequently use expressions as “maybe”, “it is as if”, “I almost felt”. Sometimes the alexithymic patient has a tendency to express their emotions through psychosomatic symptoms or addictive behaviours; in a setting that arouses anxiety and awakes emotions like psychotherapy, this may trigger the patient to present more physical symptoms than before the therapy (Krystal, 1979; Sperling, 1968).

While these difficulties lead Sifneos (1974) to discard psychotherapy for alexithymic clients, Krystal (1979) considered that acknowledging and using these issues to modify the psychotherapeutic technique could help alexithymic patients to discover their own feelings. Krystal (1977, 1979, 1982) considers that alexithymic traits are present at some point in all clients, and to different degrees. However, these traits are most prominent in psychosomatic, drug dependent, post-traumatic patients (Krystal, 1979; Taylor, 1984), and also in patients presenting depression, panic disorders, and eating disorders (Otero Rodriguez, 1999). In the technique modifications Krystal (1979) proposes that the first step is to observe the disturbance. That is, to educate the patient to understand how their physiological reactions and sensations have taken the place of their feelings. The second step is to help the patient to tolerate their affective responses. This is a lengthy process that aims to give the patient the sense that their emotions are useful signals of what is going on for them rather than dangerous forces. The transference is interpreted in order to help the patient recognise that their emotions are neither unlimited nor uncontrollable, and to discover the maladaptive patterns that support the negative belief about their emotions.

When the client begins to regain the freedom to feel what they feel, they are invited to verbalise their emotions. At this point, the therapist works in a similar fashion to the child psychotherapist and helps the client to find the words to describe what they are feeling. This practice also increases the capacity for self-reflection and begins the process of desomatisation; what was expressed through the body begins to be expressed through words. Krystal (1979) describes this process as tedious and slow; the elements that help the patient to discover their feelings have to be taken from their relation to external objects because there are no dreams or phantasies to guide the therapist to reveal what the patient is feeling, as much as we encounter in neurotic patients. However, Krystal concluded that even when alexithymia presents a serious obstacle in the work of psychotherapy it should not be considered an undefeatable barrier.

More recently, Schumacher-Finell (1997) extends these concepts, proposing to work backwards from somatic symptoms to feelings as bodily reactions are probably the only ones to be cathected libidinally and aggressively. She proposes to use the sensations perceived in the body of the patient to investigate what emotions are attached to them. Schumacher-Finell agrees with Krystal (1979) in that the use of countertransferential

feelings will help the therapist to identify which feelings might be defended against, recognising the tendency alexithymic patients have to use projective identification. According to Klein (1975), projective identification is a phantasy in which the baby projects their impulse to harm or control the mother, perceiving the mother as if she is the one who is persecuting the baby. Consequently, the school of psychoanalysis that follows Klein's thoughts on projective identification understands the therapist's experience as the main theatre where the patient's dynamics and conflicts are to be revealed and recognised (Mitchell & Black, 1995). The modification in technique that Krystal (1979) and Schumacher-Finell (1997) propose presents alexithymia as a treatable disturbance; and it requires for the therapist to be able to draw information from their own somatic countertransferential responses.

Somatic countertransference

Traditionally, psychotherapy has been called 'the talking cure' (Wrye, 1998) because the treatment is based on the verbal communication between client and therapist. The literature also demonstrates how non-verbal communications play an important part in the psychotherapeutic treatment (Arlow, 1979; Bucci, 1997, 2001). These communications include mode of behaviour, facial expression, posture, gestures, and timbre of voice (Arlow, 1979).

Bucci (2001) notes that non-verbal communication is based on the sensorial information perceived through conscious or unconscious processes. It takes place beyond the client's awareness of their feelings or the client's intention to transmit them. These bodily communications are part of the unconscious repertoire of the client and will find a countertransferential resonance in the body of the therapist.

The therapist listens to their client's non-verbal communication using their own body perceptions, defined by Rand (2002) as somatic attunement or somatic resonance. This attunement is similar to the attunement between mother and baby during the first months of life (Stern, 1995). The somatically attuned therapist will use their bodily experience as a tool to understand the patient's emotional states. The somatic reactions of the therapist toward the client are understood as somatic countertransference (Dosamantes-Beaudry, 1997). Ross (2000) defines somatic countertransference as the integration of the physical aspect to previous definitions of countertransference. Therefore, somatic countertransference is the specific emotional and physical responses stirred up in the therapist by the specific qualities of their client. The physical response seems not to have an association with the material exposed by the client or even in opposition to it (Field, 1989). The somatic responses occur before the therapist can put them into words.

Somatic countertransference and client group

Somatic countertransferential responses are evoked in therapists when they are attuned to what their own bodies perceive and feel (Rush, 2000). Somatic responses can be brought up

by any client but I will focus on the therapist's experience in working with clients who struggle to find words for their emotions.

The inability to find words for emotions, alexithymia, is a manifestation of a split between psyche and soma (McDougall, 1982a); and the somatic responses of the therapist are a non-verbal response to the somatic, preverbal communication of the client (Ross, 2000; Samuels, 1985). This is not so prominent with neurotic clients because their way of communication is mainly in a verbal level, as are the responses from the therapist (McWilliams, 1994).

Clients whose mothers were physically or emotionally absent and failed to attune with their bodily communications may evoke this type of bodily response in the therapist (Ross, 2000). Schore (2000, 2001) observes how the caregiver's attunement to the baby's needs provides a base for early brain organisation. The form of communication learnt by the baby during the pre-verbal stage through the somatic mirroring with the caregiver will remain as a part of the communicative repertoire even after the acquisition of verbal language (Dosamantes-Beaudry, 1997). When this attunement fails, the person may develop a pathological way to relate to self and others, which is reflected in a difficulty to express feelings (Schore, 2000, 2001).

Using somatic countertransference

It can be helpful for the therapist to relate their somatic countertransference to their client, perhaps describing them or with metaphoric imagery. Somatic countertransference can be used by describing them to the client, or by constructing metaphoric images. On describing them, Appel (2002) reports disclosing his bodily sensations to the client when the session seemed "to peter out" (p. 73). He notes that the client would answer by correcting or recognising what was said and then was usually able to talk further. Appel remarks on the importance of absolute truthfulness on the part of the therapist, stating that making something up would be "worse than useless" (p. 73). Conversely, Shaw (2004) conducted 14 in-depth interviews and two professional discussion groups concluding that the "psychotherapist's body is used as a means to monitor the psychotherapeutic process" (p. 285). Shaw points out that the empathic bodily attunement with the client represents a deep connection between therapist and client. He considers the risk of translating a non-verbal experience into a verbal experience, which could end up in a reification of an abstract way of communication. The somatic experiences of the therapists interviewed show that the interventions are based on embodied therapeutic knowledge. This knowledge is unique to each intersubjective relationship; therefore, Shaw recommends not drawing generalisations from it.

The somatic responses of the therapist are an intersubjective creation that occurs in parallel to all the other transference–countertransference verbal communications (Aron, 1998; Krueger, 2002; Ogden, 1994). The therapist's bodily sensations are analytic objects; objects that hold meaning within the intersubjective relationship (Ogden, 1994). Due to its unconscious origin, this communication will not have a clear meaning in the therapist's mind at the moment of perception. Some psychotherapists propose that the therapist stay in this

muddle rather than jump into interpretations that they may not be ready to deliver and the patient may not be ready to receive (Boz & Raznoszcyk de Wermick, 1999; Posse, 2004). They suggest that it is better to allow a lapse of time to make sense of what has been perceived. Each therapist needs to respect their own internal time according to their way of relating to their body, which is an intensely personal process (Shaw, 2004).

Somatic responses can also be understood as metaphors of the emotional state of the client. McDougall (1989) and Broom (1997) interpret psychosomatic descriptions as metaphors that need to be deciphered. They understand that somatic manifestations were the first language of the person, before symbolisation was possible. Emotions are composed of a "semantic primitive" (Kövecses, 2000, p. 7); a universal component of the emotion that goes beyond spoken language. The bodily experience between patient and therapist provides the concrete source of our metaphors; the core meaning of the emotional communication lays in the somatic experience (Siegelman, 1990). Through somatic communication, the client brings the semantic primitive, the core meaning of their emotions even before they are capable of recognising them as such. The therapist, by listening to this bodily communication within their own body, is able to symbolise and complete this message which takes the shape of a metaphor. This metaphoric construction reflected back to the patient, helps them to find meaning through imagery and symbols (Barker, 1996).

The two ways of integrating bodily responses within the analytical relationship seem to differ in how these responses are processed before disclosing them. There is a lack of written material on this matter which makes it difficult to know whether a therapist may choose one way or the other, or use a mix of both.

On the use of metaphors, Posse (2004), in an empirical research paper on Jungian psychotherapy, proposes that archetypal myths and stories should be used with alexithymic clients to facilitate their approach to symbolic communication. Posse maintains that the difficulty for this type of client is to communicate their story as an individual and that the use of collective myth helps the process of symbolisation. This approach seems to skip the question of how a person who confines their verbal communications to a concrete, almost photographically descriptive style can feel identified with archetypal images. Posse concludes that more research needs to be done in this field with a large group of patients over a longer period of time.

On disclosing what has been felt by the therapist, Sivak (1997) proposes to name the emotion of the client in order to help them contact their emotional experiences. He points out that the risk in doing this is to transform the therapeutic relationship into a pedagogic experience according to the values and beliefs of the therapist.

Through metaphors, therapist and client may create a safe place for elaborating painful memories; this is particularly important in working with clients who have suffered trauma (Rothschild, 2003). The background of the client should always be kept in mind when choosing the subject matter of metaphors and stories (Combs, 1990). It appears that the balance between the two styles of using the somatic countertransference; that is, by disclosing the image or experiences as they are perceived or translating them into

metaphors, is a fine symphony in which all aspects of the intersubjective relationship play a part.

Discussion and conclusion

Alexithymia is defined as the difficulty to express emotions verbally. This trait can appear at any time in the life of a patient, but is presented most frequently in patients who suffer psychosomatic illness, post-traumatic stress, and addictive personalities. Alexithymia may also develop in clients who lack development in the symbolisation process. This process, when all goes well, takes place during the pre-verbal phase of life and the infant learns to name their emotions. When this process is thwarted, the relation with the object remains in the somatic, pre-verbal phase; the symbol is not a representation, the symbol *is* the object. This is defined as symbolic equation, there is a lack of space between symbol and object, and, consequently, there is no space for experiencing ambivalence (Segal, 1957). Thus, emotional experiences cannot be symbolised in words and remain at a somatic level; the emotions are felt and sometimes communicated unconsciously through bodily means. This way of communication, which begins in infancy, is carried throughout adult life, and can be perceived by the psychotherapist who is familiar with their own bodily perceptions. These perceptions are the somatic countertransferential responses of the therapist to the unconscious communications of the client.

Somatic countertransference is part of the somatic intersubjective dialogue that therapist and client share in the therapeutic process and comprises the physical aspect of the responses that arise in the therapist to the communications of the client. This type of connection is similar to the mother's bodily attunement to the baby, by which the mother understands the baby's needs and feelings according to the infant's cries and gestures. The therapist listens to this somatic communication, which helps them to understand the emotional state of the client. This is particularly important when working with alexithymic clients who describe their life events in detail but struggle to connect them with their feelings.

There is a gap in the literature about how a therapist may use their somatic experiences, which is surprising considering the importance of using the senses is extensively identified by Reik (1948). Proposed here is that by carefully attending to their bodily experience, the therapist can gain access to those unspoken emotions.

There still appears to be a difficulty in disclosing how the bodily perceptions of the therapist are incorporated within the psychotherapy session. Extensive work has been done in integrating the body of the patient into the psychotherapy treatment. Bioenergetics (Lowen, 1975) and the work of McDougall (1989) and Broom (1997) are good examples of this. However, these studies and clinical practice do not include the bodily perceptions of the therapist. There is a combination of aspects to consider that are preventing the body of the therapist from being more present within the literature; namely, the fear of the body in psychotherapy, as noted by Miller (2000), and the lack of inclusion of the body in the training of psychotherapists (Krueger, 2002; Shaw, 2004).

Miller (2000) states that the fear of the body in psychotherapy reflects "our cultural ambivalence towards bodies and body expression" (p. 438). Our family culture and social-cultural view play a crucial part in how we relate to our bodies. This appears more noticeably when therapist and client come from different cultural backgrounds. As migration is prominent all around the globe, and highly prominent in Aotearoa New Zealand, this area needs to be explored and expanded with contributions from therapists' experiences.

Perhaps the fear of the body is influenced by fears of abuse, of failing to hold the framework of therapy, or of being misinterpreted. Psychotherapists are training in a discipline that was born during the Victorian era, when the body was neglected. Perhaps an active way to face this fear is by introducing body work as part of the formal training of professionals. By doing so, therapists will develop awareness of their bodily perceptions and become familiar with talking about their bodily experiences. This does not mean all therapists will have to experience or even use their somatic countertransference. Bodily responses cannot be imposed, and some therapists may never have this experience (Field, 1989). Nonetheless, this recommendation proposes that by expanding the awareness of their clients' somatic perceptions, therapists can gain access to a different source of information from their clients. My recommendation aims to move towards a psychotherapy that is more integrative of body and mind rather than prioritising only one aspect.

Paraphrasing Winnicott (1949), the patient can only appreciate in the analyst what the analyst themself is capable of feeling. In other words, if the body of the therapist remains in the shadows of the therapy room, there is little chance for the body of the client to come to light.

Benefits for personal practice

In processing the data for this paper, I find myself being more aware of how much my personal background is influencing my development as a psychotherapist. I do not identify myself as a body therapist, but I feel comfortable as a psychotherapist who embodies her clinical experience. This research allowed me to validate my experience as the literature identifies many other psychotherapists who have similar experiences. I hope this study will be of benefit to other psychotherapists and trainees so that they may feel comfortable with the somatic facet of their responses in working with clients, especially with those presenting alexithymic traits.

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Paper 4 (2006)

Love in the therapy relationship: A literature review with clinical vignettes

Kerry Thomas-Anttila

This paper contains aspects of a Master's dissertation I wrote in 2006, titled *The Therapist's Love* (Thomas-Anttila, 2006). My experience with a client at the time, named "Elizabeth", led me to this enquiry. The dissertation took the form of a modified systematic literature review, with clinical illustrations. Ethics approval for the clinical material was granted by the AUT Ethics Committee and participant (client) details were anonymised and disguised.

In the dissertation, supervised by Dr Kerry Gibson, I explored the meanings of the therapist's "love", including the ways in which it is described in the literature and the value of this for clinical work. In the study and this paper, the words 'therapist' and 'analyst' are used interchangeably, as are the words 'patient', 'analysand', and 'client', a convention which reflects the different terminology used by different authors. I proposed that in the early beginnings of psychoanalysis, love in the therapy relationship tended to be described from the patient's/client's perspective ("transference love"); whereas, more recently, there had been a move towards also considering the phenomenon of the therapist's love and an exploration of the meanings of this love. This had occurred within the context of increasing relationality and intersubjectivity and included, but was not limited to, issues of countertransference.

The way that the therapist's love is described in the literature fell into three broad areas: "parental love", sexual love and Eros, and a type of love that is particular to the therapy relationship, which Shaw (2003) describes as a "thing unto itself" (p. 268). Each of these areas was explored and discussed in relation to a clinical vignette. For reasons of space, I focus here particularly on love as a "thing unto itself". I have not updated the literature I selected, so this reflects my study at that time; I have, however, altered some of the writing, in minor ways, to reflect how I might now express things slightly differently. I begin with a vignette that illustrates how I was drawn to this topic.

> **Elizabeth**
> *When Elizabeth walked into my room for the first time about three years ago I instantly liked her and felt warm towards her. In fact, she is a rather aggressive-looking woman, who has difficulties in relating to other people a lot of the time. She was chronically and also acutely depressed at the beginning of the therapy and barely functioning in her day-to-day life, although she was holding down a demanding job. This was all she had energy for, and it was a huge struggle for her to keep going. Our first step was to work together with a psychiatrist to find an anti-depressant medication that worked for her, which we eventually did.*
>
> *From the beginning, Elizabeth decided that I was a 'safe' person, who was not trying to take anything from her, in contrast to how she felt about most others in her life. For my part, I*

responded positively to her childlike nature, her innocence, and her seeming trust in me. I felt tender towards her in the face of her sometimes self-destructive behaviours and felt privileged that she was able to talk very freely with me. I admire greatly her determination to work in therapy and in general I feel very alive in our sessions. At the same time, I also pondered the meaning of the "loving" feelings I have towards Elizabeth.

My experience with Elizabeth started a process for me in thinking about how we, as therapists, love our clients, or not. I wondered what this feeling of love was that I was experiencing towards Elizabeth, and how it fitted in the therapy process. What could I call it? Was it real or not? Did I have to be careful of it? How much were my feelings of love towards Elizabeth crucial to her therapy, and how much did they hinder it? How much was this love a countertransference phenomenon, whereby I was responding to her desperate need for a good mother? Could I then call this love parental love, and what were the boundaries of it? How much did I need to be experienced as a good mother? Was there an erotic component to this love and, if so, would I need to be careful of that? Or did I love her for her love of the therapy process, for our joint love of it, for her pursuit of her own truth, and her absolute determination in this and commitment to it?

Being with Elizabeth and asking myself all of these questions and more led me to this enquiry into love in the therapy relationship. I began to read the literature to find out what others have thought about the therapist's love.

Love

Love is perhaps the most written about and thought about emotion. Bergman (1987), Mann (1997), and Green (2005) represent the common psychoanalytic view that there will never be one satisfactory definition of such a complex human emotion as love. Also, that it is the domain of the poet to define love, rather than the psychotherapist, and that there may be as many definitions of love as there are poets (Mann, 1997). In agreeing with this, I thought not to attempt to define love; rather, to review how psychoanalytic writers have written about the therapist's love in the therapy relationship. I questioned the nature of this love, how the description of it has evolved (or not) since Freud, and how an exploration of the therapist's love in the therapy relationship might inform clinical practice. I began with reviewing Freud's stance on love.

Freud and transference love

Freud places love in a central position in psychoanalysis; he is purported to have said that the goal of analysis is to be able to work and to love, though, as Masson (1985) points out in his notes to a letter from Freud to Fliess on February 4, 1888, no source can actually be found for this famous dictum. Freud's most famous discovery in the area of love was that of 'transference love', the love of the patient for the analyst. He was clear about the role of that love in effecting a cure—"Essentially, one might say, the cure is effected by love", Freud (1906, pp. 12–13) wrote to Jung. He was also clear about the dangers of this love and in 1915 wrote a paper on the topic, in which he acknowledged that the analyst is working with

"highly explosive forces" (Freud, 1915/1971, p. 170) and that the lay public may seize upon the discussion of transference love as proof of the dangerous nature of the psychoanalytic method. Bergmann (1997) describes the position that Freud found himself in at that time:

> We will be struck by Freud's audacity. The basic idea that Freud unfolded to an astonished world was novel and bold. He advocated that the sexual current appearing in the treatment should not be repressed, but instead of gratifying it, should channel its energy into curing the neurosis… [this]… had never been attempted before. (p. 90)

Transference love had a shaky start. Person (1993) relates the first story of transference love to come to Freud's attention (in 1882), that of Joseph Breuer and his patient Anna O. Breuer became increasingly fascinated with Anna O. and her therapy, but when Anna O.'s erotic transference to Breuer eventuated in a phantom pregnancy, Breuer became terrified and terminated Anna O.'s treatment. It took a long while for Freud to formulate his understandings about transference love, only gradually coming to the understanding that Anna O.'s reaction to Breuer was more the rule than the exception (Person, 1993).

Many early analysts found this territory difficult to negotiate. Baur (1997) describes the intimate relationship that developed between Jung and his first patient Sabina Spielrein, as well as that between Ferenczi and his patient (later his wife) Gizella, and another patient, Elma (later his step-daughter). She also details many other "romantic explosions" (Baur, 1997, p. 25), on the part of Otto Rank, Victor Tausk, Sándor Rado, Frieda Fromm-Reichmann, Karen Horney, René Allendy, Julius Spier, and others. As Gabbard (1995) points out, "Freud and his early disciples indulged in a good deal of trial and error as they evolved psychoanalytic technique" (p. 1115).

It has been conjectured (Eickhoff, 1993) that the impetus for Freud to write the 1915 paper came from his concern over Jung's relationship with Spielrein, and from his correspondence with Ferenczi about Gizella and Elma. Eickhoff writes that Freud wrote to Ferenczi on 7 July 1909:

> I myself have never been taken in quite so badly, but I have come very close to it a number of times and had a narrow escape. I believe that only the grim necessities of my work and the fact that I came to psycho-analysis a decade later than you have saved me from the same experiences. (p. 50)

Without summarising Freud's (1915/1971) paper in full, the main points are that the analyst must recognise that the patient's falling in love with him is induced by the analytic situation and "is not to be attributed to the charms of his own person" (p. 161). He believes that any passionate demand for love is largely the work of resistance and is an impediment to therapy. He advises on the danger of returning tender feelings, writing that the analyst's control over himself may not be as great as they might imagine it to be, and that the patient who is craving for love must be denied it. Further, he recommends treating the transference love as "unreal", as a situation which has to be gone through in the treatment and traced back to its unconscious origins, and goes on to say that the work is to uncover the patient's infantile object choice and the phantasies woven round it (Freud, 1915/1971, p. 167). At the same time, Freud does not dispute the genuineness of the transference love and concludes by saying that the only real difference is the analytic situation itself, and that the analyst has

a responsibility to the patient to provide an analytic experience rather than any other type of experience. In other words, that, however highly the analyst prizes love, he must prize even more highly the opportunity of helping his patient.

Freud's (1915/1971) writing in this paper is not particularly decisive or consistent and there is a sense that there is much left to discuss. It has also been suggested that Freud's stress on repetition was in part a response to real and threatened public disapproval of the erotic transferences that female analysands developed in relation to their male analysts (Schafer, 1977). In any case, it seems clear that his motivation for writing this paper was, at least in part, to assist analysts to find their way through this difficult terrain. While he does not explicitly write about the analyst's love, apart from the analyst's sexual love, which he proposes as being countertransferential in nature only, he emphasises the analyst's tasks as being to interpret the unconscious, to be ethical, dedicated to the task, neutral, to provide an analytic relationship rather than any other, and to prize the opportunity of helping the patient above all else. We could surmise that this is where Freud saw the analyst's love to lie. At the same time, there can be no doubt that he regarded this area as a very difficult one, filled with potential dangers.

The legacy of the "problem" of love

Love may be at the centre of the psychoanalytic endeavour (Green, 2005); however, I noticed in my reading of psychoanalytic writings that there is some anxiety about using the word 'love', in particular when applied to the love that a therapist might have for their client. Often 'love' has been written about in the context of things going wrong; for example, when a therapist has loving or sexual feelings, or both, for their client and abandons the therapeutic endeavour by acting out these feelings (Gabbard, 1994a, 1994b, 1994c, 1995). 'Love' is a problematic word; indeed, Green asks the question as to whether the reference to love is still accurate or whether there is a better word to describe the nature of the emotional links that are created in analytic relationships.

There are contradictory views in the literature with regards to the therapist's love. Some authors have categorically stated that the love of the analyst is not the curative factor in the treatment (e.g., Kohon, 2005), whereas others have just as categorically stated that it is. Ferenczi (1926), an early explorer of and proponent for love in psychoanalysis, placed love in a central position—"Psycho-analysis works ultimately through the deepening and enlargement of knowledge; but… knowledge can be enlarged and deepened only through love" (p. 17). He defines love as being "neither egoism nor altruism, but mutualism, an exchange of feelings" (Ferenczi, 1931, p. 248).

Writers who comment on the anxiety of writing about the therapist's love include Coltart (2000), who writes that the very use of the word 'love' in psychoanalysis is "often felt to be dangerous, or open to misconstruction" (p. 120). Bach (2006) suggests that love in psychoanalysis is fraught with problems of transference and countertransference, the weight of social attitudes and collegial judgments, special ethical considerations, and even legal concerns. Lear (1990) notes that it is hard to take love seriously and that "love has become almost taboo within psychoanalysis" (p. 156), that as soon as anyone mentions

love, from somewhere comes the response, “Yes, but what about aggression?” Siegelman (2002) posits that we assume that we are on safe ground with the negative emotions, because this means we are not “whitewashing the shadow” (p. 21).

In writing about love, I do not aim to deny the powerful forces and realities of aggression, hate, violence, death, and also their relationship with love. Neither do I wish to make any naïve assertions along the lines that “All we need is love”, that love is in some way ‘absolute’ in the therapy process. Hillman (1989) rightly points out that “to take love as the principle of psychotherapy is again to find a monotheistic panacea for the imaginative complexity of our psychic life” (p. 289). However, I do aim to focus on and explore love in the therapy context, especially the therapist’s love, and to ascertain to what extent love is viewed as being intrinsic or not, valued or not, in the therapy relationship.

As mentioned, it became obvious during my reading that in describing love in the therapy relationship, writers, particularly over the last 50 years or so, have tended to write within three broad categories when writing of the therapist’s love—parental love (i.e., the therapist in a quasi-parental role), sexual love or Eros, and love as a “thing unto itself” (Shaw, 2003). In my dissertation, I devoted a chapter to each of these categories, with a clinical illustration in each, in order to explore them more fully. In some ways it is artificial to separate them out and there is a good deal of cross-over. In this article, however, I focus on the qualities and values of love as a thing unto itself.

Loving attitude versus the interpretation

Traditionally, the analyst’s interpretations have been seen as the analyst’s love in action. Nacht (1962a) questions this, saying that the analyst’s attitude is a decisive factor in what is curative, that this attitude includes loving the patient and is more important than interpretations. The replies to his paper mainly defended the traditional view. So, for example, King (1962) disagrees with him and defended neutrality and interpretation, as does Segal (1962), although Segal agrees with Nacht that a good therapeutic setting must include unconscious love in the analyst for the patient. She does not, however, agree that a mediocre interpretation is helpful if given with love, saying that mediocre interpretations are more likely to be due to an inhibition of love (Segal, 1962). When Nacht (1962b) was questioned as to the nature of the love he was talking about, he replied that it is difficult to describe in common language “although I had to try to do so. It is a kind of openness that one can understand only if he has already experienced it” (p. 233).

Nacht’s (1962a) suggestion that the therapist’s love is more important than the interpretations is taken up by some writers; however, most stress that both are necessary (Field, 1999; Mann, 1997; Natterson, 2003; Steingart, 1995; Symington, 2006). An illustration of this is Symington (2006) describing his analyst clarifying the meaning of the “transference interpretation [being] to remove an obstacle that exists between the analyst and the patient” (p. 1). At that moment, Symington reports, he realised that the transference interpretation is a means and not an end, that the goal of psychoanalysis is to bring two persons into relation with one another and that the function of the transference interpretation is to “dissolve the blur, to banish the delusion which prevents the opening of

one person to another" (p. 2). Symington's description of "the opening of one person to another" resonates with Nacht's (1962b) "kind of openness" (p. 233).

Love as the "moral infrastructure" of psychotherapy

Nina Coltart (2000) lists qualities she feels were essential to practise as an analyst and sums these up by saying that they can all be subsumed under the name of love. I list many of these qualities here, as it is one of the most comprehensive lists in the literature and is representative of what many others have written. It is also striking that she did not shy away from using the word love. Coltart's love includes:

- 'Being with' patients and being on their side (as opposed to taking their side) in the search for truth and health.
- An attitude whereby the patient feels important in the relationship, and of the necessity of the analyst being open to herself and unafraid to love.
- Endurance, patience, and understanding.
- Not using transference or countertransference destructively but only to create greater insight between the patient and ourselves.
- Not exploiting the patient's dependence on us emotionally, intellectually, sexually, or financially.
- Single-minded attention to what is happening, while simultaneously allowing the inner flow of free-associative thoughts and images.
- A detachment rooted in thorough self-knowledge to experience and examine the countertransference and our own feelings, as well as scrutinising the transference.
- Sharply focusing, and scanning, complex involvement in feelings, and cool observation of them.
- Close attention to the patient and to ourselves, distinguishing our own true feelings from subtle projections into us.
- Communicating insight clearly, yet not imposing it.
- Willing the best for our patients and ourselves, yet abandoning memory and desire
- Steering clear of being judgmental.
- A sense of humour, toughness, courage, kindness, enjoyment.

Lastly, she describes the analyst's love as being "the only trustworthy container" in which to feel the full spectrum of feelings, including hatred, rage, and so on, adding that love is the "moral infrastructure of our job" (Coltart, 2000, p. 122).

Loving the patient's psychic reality

According to Steingart (1995), Hans Loewald was the first person to take Freud's position of linking the truth of psychic reality to the love and care for the patient. Loewald (1970) writes that "Scientific detachment in its genuine form, far from excluding love, is based on it… It is impossible to love the truth of psychic reality… and not to love and care for the object whose truth we want to discover" (p. 65). Earlier Loewald (1960) had written that for things to go well, the analyst must have "love and respect for the individual and for individual

development" (p. 229). Steingart describes this as "scholarly analyst love" (p. 118) and is concerned to convey that he is not talking about an intellectual experience but, rather, a "full loving sensibility, which includes, but is not only the equivalent of, a deep sense of intellectual comprehension" (p. 118). He believes that interpretations can only be a "loving response" (p. 118) within the matrix of an overall analytic relationship that is lovingly and responsibly devoted to knowing the analysand's psychic reality. He also maintains that Freud created in his analytic technique a new type of human relationship and that the analyst possesses a real and extraordinary love for the analysand that follows directly and naturally from this relationship.

"Falling in love" with the patient

Bach (2006) agrees with Steingart regarding loving the patient's psychic reality, adding that the patient comes to understand and love the analyst's psychic reality including her whole embodied reality. He describes his "personal prescription for love" (Bach, 2006, p. 133) as paying very close attention and speaks of this as being the "moral equivalent of a prayer" (p. 133): that a basic trust in the patient is needed, as well as a sympathetic resonance with him, as well as an ability to hold them in mind so that they become a "living presence" (p. 133). The effect of this, Bach suggests, is that the patient begins to feel held together by the attention and to feel that more and more parts of him are becoming meaningfully interconnected. He goes on to say that paying this kind of attention, while maintaining one's narcissistic balance, leads to being totally involved in the process, which leads to a "falling in love" with the patient, although he said it is dangerous to say so. Gerrard (1999) writes in a similar vein, describing it as "extreme tenderness" (p. 30) towards the patient, and that the patient cannot reach their capacity for loving without the analyst becoming involved in a passionate way. She stresses that the "tender loving feelings must emanate from one's most authentic place—there is no place for sentimentality here" (Gerrard, 1999, p. 130).

The therapist's "non-erotic" love

Cohen (2006) suggests that the confusion felt by analysts concerning love in therapy is because, owing to the "doctrine of the libido, which links all forms of love with sexuality" (p. 145), many analysts consistently identify love with sexuality. His opinion is that a successful treatment is based on feelings of love, and that there is a difference between love that is based on biological erotic-sexual drives, which he calls 'drive energy', and emotional love without biological drive, which he called psychic-mental energy. In describing the latter, he said this is a non-erotic and non-reconstructed love, directed towards the object and not for the sake of the loving subject, as distinct from erotic-driven love, which arises from the wish that the object gratify a certain need felt by the subject.

In support of his argument, Cohen cites Doi (1993), who writes of the Japanese word 'amae', translated as "indulgent dependency" (Cohen, 2006, p. 142), characteristic of the child's relationship with the mother. He added that he also saw it as arising in relationships between adults and that he considered it a "universal non-sexualised drive for close dependent affiliation" (Cohen, 2006, p. 142). Cohen made a case for the love between therapist and patient as having a 'real' component as opposed to only being

countertransferential and suggested that many writers prefer to hide behind the issue of the analyst's love with terms such as the 'positive countertransference'. He contends that, whereas the literature about countertransference has developed, the literature relating to 'real' feelings experienced toward the patient has not and is full of many contradictions.

Cohen makes some good points, particularly those relating to the squeamishness of therapists talking about their love for their patients, the hiding behind such terms as 'positive countertransference' when sometimes 'love' might be a better word to describe the therapist's feelings, and the real need of some patients for a 'parental' type of love from the therapist, which is caring, understanding, and belonging more to reparative and attachment models than to drive models. However, it could be argued that attempting to separate out 'real' love from sexual love is a fraught endeavour and one that risks denying the unconscious.

Love (and hatred) is not curative but is necessary

Coen (1994) writes about the barriers often in place that serve to prevent loving feelings in the analytic setting, viewing these as mutually constructed, and stating that his intention is not to advise analysts to love their patients but to focus carefully on these barriers, whereby both patient and analyst try to destroy possibilities for loving feelings, especially by wishing to preserve a negative relationship, often sadomasochistic, which emphasises the impossibility of loving and being loved. He mentions that he was taught in the 1960s a dispassionate mode of analysing—"it has tended to interfere with my freedom to enjoy a variety of passions with my analysands" (Cohen, 1994, p. 1108) and talks of a contemporary shift towards an acceptance and welcoming of a full range of feelings, and subjecting these to self-analysis to inform the work. Cohen's view is that persistent negative, critical feelings between the analytic couple, including sadomasochistic engagement, seek to block access to more intense passion, loving, and hating; and he concludes that it is not that love between patient and analyst is curative, but that it is necessary to facilitate analytic change, adding that he would say the same about hatred.

Both immersion and distance are needed

Those who write about the therapist's love often stress that the analytic relationship is a special one which cannot be compared to any other, because even when the relationship is understood in a more egalitarian way, the analyst is still both participating and monitoring conscious and unconscious meanings (Gabbard, 1996; Hoffer, 1993; Kernberg, 1994; Lear, 1990; Loewald, 1979; Modell, 1989; Siegelman, 2002). The combination of distance and closeness is seen as being unique to the analytic situation.

Friedman (2005) writes about the analyst's focused attention and how patients naturally understand it as a sign of ordinary love. He argues that it is a kind of love, but that it is different from other kinds (otherwise it would be ordinary social love). Like others, he acknowledges that this 'different' kind of love is not easy to describe, that it is not just 'understanding', which he takes to be a rather bloodless sort of love. Furthermore, although

analysts are inclined to identify their love with powerful and fundamental growth endorsement, it is not 'parental', since analysts are not supposed to infantilise their patients; and that it resembles the understanding involved in reading, the appreciation of art and literature, but that it is more responsible, personal, alive, and unsettled. A reason for this, he proposes, is that analysts feel personally addressed by their patients, both in speech and in silence. Thus, he posits that analytic love is the personal, first-hand experience of the patient's appeal solely in terms of its value for the patient and its place in the patient's drama. Friedman summarises his view by saying that an actual loving feeling is generated by the union of two analytic features—the taking of distance and immersion in the patient's experience.

This notion of immersion and distance is echoed by others; for example, Lear (1990) who states, "Analytic therapy demands that the analyst embody a unique blend of empathy, sympathy, and distance" (p. 5); and Ogden (1989) who describes the analytic situation as one of "intimacy in the context of formality" (p. 175). Kohon (2005) also stresses the detachment that is necessary for an analyst to do their job and cites Winnicott (1960) who wrote of the importance of the distance between analyst and patient. This detached love, Kohon writes, will allow the analyst to manage the patient's persecutory anxieties and reactions of hate. Siegelman (2002) writes of this immersion and distance by describing the psychoanalytic relationship as a "both real and 'as if' relationship" (pp. 32–33).

Mitchell (2000) also describes the analyst's responsibility at once to be involved with the patient and to provide an analytic experience. He suggests moving beyond the debate about whether love in the therapy relationship is real or unreal:

> We are at the point in thinking about complex emotions in the analytic relationship where we can move beyond polarized positions about analytic love as either real or unreal, and analytic feelings as to be either carefully restrained or loosely expressed. Love and hate within the analytic relationship are very real, but are also contextual. The asymmetrical structure of the analytic situation is a powerful shaper of the feelings that emerge within it, making certain kinds of feelings possible and precluding others. It is precisely because these feelings, as real as they are, are so context-dependent that they are not easily translatable into either extra- or postanalysis relationships. (p. 146)

The subjectivity of the therapist

Most of the writers discussed thus far, describe the analyst's love as being at times more than just countertransference; this has occurred with a shift to considering the analyst's subjectivity. Aron (1991), for example, argues that the analyst's total responsiveness cannot be referred to as countertransference, and that the analyst has too often been viewed as the mother is viewed in relation to her child; that is, as an object for the child—"We have been slow to recognise or acknowledge the mother as a subject in her own right" (p. 30). Shaw (2003) agrees: "Analytic love is not necessarily evoked by the analysand's transference, although it will undoubtedly be mixed in with the analyst's concordant and complementary countertransferences" (p. 256). Schafer (1983) describes his concept of the "analyst's second self". His belief was that analysts in their work are not quite the same as they are in their ordinary lives. That in their work a special kind of love can develop in

relation to the analysand "which would be a mistake to identify with disruptive countertransference" (Schafer, 1983, p. 291).

Symington (2005) laments the lack of words in the English language to describe love and talked about passion, delight, regard, and contemplation with regards to the therapist's love. He described it further as having wonder in it, metaphysical passion, and scientific attention: "In this act the person marvels at the other. It is this act, the act of *contemplation*, there is a focused wonder at the quality of the other" (Symington, 2005, p. 14).

There are many ways in which the patient may evoke feelings of love in the analyst, which may not have to do with the countertransference. Shaw (2003) and Kohon (2005) both mention the importance for the therapist in being part of a mutual process, where both analyst and analysand feel valued, and recognised, for what they have to give; and claim that this is both vitalising for the analyst and therapeutic for the analysand.

Some difficulties in loving

Love under suspicion

Shaw (2003) highlights the suspicion that often accompanies the analyst declaring feelings of tenderness, affection, and love towards the patient. He writes that this is often seen as the analyst "acting out" his narcissistic need to cure by posing as an impossibly perfect parent to a perennially infantilised patient. Shaw argues that suspicions against tenderness have gone beyond their proper safeguarding function (as was Suttie's (1935/1963) argument 87 years ago) and have, instead, led to the inhibition of the growth and development of our thinking about analytic love. Shaw adds that seduction for the purpose of attaining control and domination over another might often happen in the name of love, but is not actually what love is meant to be. Rather, professional neutrality, abstinence, and deliberate withholding of gratification can be equally manipulative means of maintaining domination and control over others.

Are there some patients whom it is better not to love?

Main (1989) describes a type of patient who does not get better but who has a talent for becoming 'special' to the therapist. The feelings aroused in the therapist include wanting to make a special effort to help, feeling that the patient had previously got a bad deal from all the other figures in their life, and that the therapist could be the one to break this pattern and really help, if only they tried hard enough. Main suggests that, with these patients, the stress of treating them means that the therapist can give "unusual services, different from that of other patients, more devotion, greater effort, with desperate attempts to be good and tolerant and to interpret the deeper meaning of the patient's needs" (p. 24). Main notes that it is necessary to be aware of the insatiability and ruthlessness, aggression and hatred in these cases. He cites Klein's work as being helpful in understanding the dynamics involved. By denying the hatred and showing further good, Main argues that the patient deteriorates further.

This brings us back to the question of what we call the therapist's love. Main (1989) has his own definition of the therapist's love for the patients he describes; it is: "sincerity… about

what can and what cannot be given… careful understanding, it is the only way in which these patients can be provided with a reliable modicum of the kind of love they need" (pp. 34–35). He further adds that therapists should not be more loving than they can truly be.

> **Benjamin**
> *Benjamin talks to me about a dream he has had the previous night. As he talks to me I notice the following things happening inside my mind: I notice his body, how is he sitting, does he look relaxed or tense? What sort of response to his way of being with me do I find inside my body, what is my own body telling me about the relationship that is going on between us just now?*
>
> *I am also looking at my own thoughts and feelings in relation to him. This slightly anxious feeling I have; does it belong to me or to him, or to both of us? What might it mean?*
>
> *Already I know a lot about Benjamin and his life. As I listen to the content of his dream my mind cannot help itself going to my own associations. I wait and then ask him to begin associating to parts of the dream. I help him with this as he is not familiar with thinking about how dreams might have something important to say. I feel affectionate towards him as he quickly applies himself to the task. He catches on fast, I think, he's clever. And then I realise that he is being a very good patient, a 'good boy', and I feel loving towards him and moved by his trusting attitude and the way he throws, almost leaps, himself into working with the dream. I begin to ponder his goodness, how his being a 'good boy' also creates problems in his life, and forces him into needing to balance that, to be a 'naughty boy', just to give himself some breathing space where he can feel alive. I feel fondness and a sort of awe for him in spite of his often harmful ways of asserting his freedom. I shelve those thoughts for now and return to his dream, which he is, also, keen to discuss.*

There have been a number of contributions in the literature that have been valuable for me in my clinical work, including with Benjamin. The above vignette illustrates the tension between being at once involved in the relationship and sitting slightly outside of it. I have no doubt that Benjamin is involved in a similar process, and that it is my task to bring that into the room and talk about it. Steingart (1995) describes this as "loving responsibility" (p. 118). Steingart's concept of loving the patient's mind and all that it produces is also useful. Benjamin has a mind that is, for me, very admirable, and it is not difficult for me to be very interested in it and the various directions in which it goes. I enjoy paying him the very close attention that Bach (2006) mentions, and I wondered in the beginning stages of the therapy if I had in fact fallen in love with him. In examining possible countertransferential dynamics, I had to conclude that these feelings were partly, but not entirely, due to countertransference. Yes, he is used to women falling in love with him, and I could choose to see my response solely in those terms. However, I also choose to be passionately involved with Benjamin, as with other patients, and I think that this produces a loving feeling that needs to be considered just as much as countertransferential implications. In other words, both need to be considered.

It is easier to be passionately involved with some patients than others, and this is where an awareness of countertransference plays a part: the necessity to look at those things in myself (as well as in the patient) that hinder my involvement. Coen's (1994) discussion on barriers to loving is useful in this area. Related to this understanding, it is easier to love some patients than it is to love others. However, when I consider what might make one

person more 'lovable' than another, it is difficult to arrive at any common factors that lie within the patient themselves. Here, Friedman's (2005) notion of the analytic love as being the taking of distance on the one hand, and the immersion in the patient's experience on the other, is useful. The questions that arise from this include, what would hinder me in carrying out either of these functions? What disturbances would make it difficult for me to both be distant and involved? Thinking about this has helped me in my work with Benjamin and with other clients, particularly with the necessarily asymmetrical nature of the therapeutic endeavour and my responsibilities within it.

Conclusion

Whereas interpretations have traditionally been viewed as the manifestation of the therapist's love, I have described other ways of viewing the therapist's love and how it differs from love in other settings. Coltart's (2000) list of adjectives describing the therapist's love is more comprehensive than others but is essentially representative of what others have written. A shift towards more relationality and intersubjectivity in the therapy relationship is demonstrated, that there is more to the therapist's love than the words they speak, and that it is not all countertransference. There is the suggestion that the therapist is freer now than earlier to work with a full range of feelings rather than feeling uncomfortable about having loving feelings for the patient, and that there is a connection between loving the truth of psychic reality and the 'object' (patient) whose truth is to be discovered. Steingart (1995), in particular, emphasises a love of the patient's mind, and all that it produces. Bach (2006) went further and described a "falling in love" (p. 133) process whereby the therapist pays the type of attention that he calls the "moral equivalent of a prayer" (p. 133).

There have been changes in the way many therapists practise and some inroads made into a more widespread acceptance of the concept of the therapist's love. At the same time, most writers are saying that we can compare the therapist's love with the love of a parent, a lover, a sibling, or friend; but, in the end, the asymmetrical nature of the therapy relationship means that it is none of these and the comparisons do not hold in a satisfying way. For me, the most convincing contemporary description in reading about the therapist's love, and the one that speaks to me the most in terms of my experience with patients, is Friedman's (2005) concept of being immersed in and at the same time distant from the patient's experience, and how this creates a feeling of love in the therapist which is particular to the therapy setting. This description seems to include the possibility of all the types of love being present in both client and therapist, depending on what both are bringing to the experience (and this may differ from session to session). It reflects the asymmetrical nature of the enterprise, where the therapist participates fully and observes at the same time in order to ensure the safety of the patient.

As Shaw (2003) points out, the therapist's love can easily be viewed in a suspicious light. In the literature, however, there are many therapists who describe feelings of love for their clients, and who suggest that this is even necessary for the therapy. The development of this love is generally, but not always, described as taking place over a period of time, as the therapist gets to know the client, to understand who they are, and why they are the way

they are. The importance of understanding the nature of the love is highlighted, as is acknowledging to oneself the presence of aggression and hate, and for the love to be genuine. The benefits to the client of experiencing the therapist's love are described.

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Paper 5 (2007)

Mind those tears: Crying and catharsis

Emma Harris

> Lorenzo! hast thou ever weigh'd a sigh?
> Or studyied the philosophy of tears?
> (A Science yet unlectur'd in our Schools!)
> Hast thou descended deep into the breast,
> And seen their source? If not descend with me,
> And trace these briny rivilets to their springs.
>
> Edward Young, *Night Thoughts* (Night Fifth, lines 514-519)

The seeds for this study were sown during my clinical practice as a student. I came to notice the diversity in the expression of tears each of my clients had; there were those who would sob profusely and those that seemed unable to shed a single tear. My internal reaction varied in response to different clients' tears. For a long time, I dismissed my noticing—I think primarily because weeping was never theorised throughout my training. My understanding, at the time, was that crying was considered a positive expression of emotion, largely due to the deepening of rapport between therapist and client. Yet, this did not seem to fully account for my subjective experiences with tears, both personally and with clients. In many ways, the idea of studying tears felt like examining the proverbial elephant in the therapy room; it seemed invisible by its obviousness. My interest was further piqued by Karen Maroda (1999) who writes

> In my clinical experience I have observed that the patients who seem to change the most are those who are capable of deep grieving, that is crying profusely or sobbing. Patients who achieve equal levels of insight without this profound affective experience do not change to the same degree. (p. 16)

This paper discusses crying in the context of the therapeutic relationship, and of attachment theory; considers the intersubjective nature of tears; and concludes with a brief, reflective postscript.

Crying, catharsis, and the therapeutic relationship

> Sorrows which find no vent in tears may soon make other organs weep.
>
> Sir Henry Maudsley (cited in Levitz, 2006, p. 1)

Historical influences

Catharsis is derived from the Greek word *kathatikos,* meaning pure; and the English word *cathar*, which originally referred to a medieval sect who sought to achieve great spiritual purity (Thompson, 1995). In psychological terms, catharsis refers to the emotional release of repressed emotion by association with the cause and elimination by abreaction. The belief that crying can be cathartic has been held since early times (Levitz, 2006; Lutz, 1999; Vingerhoets & Cornelius, 2001). For example, Ovid wrote in the first century "by weeping we disperse our wrath. It is a relief to weep; grief is satisfied and carried off by tears" (cited in Lutz, 1999, p. 118). Ovid seems to suggest that crying has the power to 'carry off' unwanted aggression. In the 13th century, crying was considered a means to be cleansed of one's sins through the act of confession in the Catholic Church (Lutz, 1999).

These historical beliefs have served to promote the idea that crying, through the process of confessing one's darkest thoughts and feelings, might produce a sense of relief and release. It is perhaps not difficult to find parallels with the process of psychotherapy. That tears have the ability to emotionally cleanse and even promote healing in the crier may be a tacit belief passed down through the centuries via religion, arts, and sciences. The notion that 'crying is good for you' constitutes a type of folk wisdom ideology; a belief system so implicit that it remains largely unquestioned today. The lack of enquiry into crying as a phenomenon, even in therapeutic settings, is perhaps testament to this ideology (Lutz, 1999; Maroda, 2002; Nelson, 2005).

Historically, there has also been an inherent set of beliefs in Western society regarding the ill effects on the body and soul if one does not weep (Cornelius, 2001; Crepeau, 1981; Kottler, 1996). Shakespeare (Wells & Taylor, 1988) wrote, "The grief that does not speak knits up to the o'er-fraught heart and bids it break" (p. 995). More recently, the idea that the body suffers from not expressing emotion is supported by those who practice gestalt and somatic therapies (Broom, 1997; Groen, 1957; Perls et al., 1994; Scheff, 1979). Similarly, Maroda (1999) alludes to the link between crying and emotional healing by suggesting that an internal affective change can occur through profuse crying. What might be needed then, in the therapeutic relationship, in order for this change through catharsis to occur?

Freud and Breuer's cathartic method

In "*Studies in Hysteria*", Breuer and Freud (1955) conclude that hysteria was caused by psychological disturbance; that emotional affect built up over time and needed to be released. In this way, they aimed to purge the memory of the trauma that caused the affect through a process of hypnotising patients and having them recall the original distress (Blum, 1991). The discharge of affect, which Breuer and Freud describe as "crying oneself out" or "blowing off steam" (p. 8), would allow the ordeal of a painful memory to eventually fade for patients who engaged fully in this process.

However, it seems Freud wrote little about actual tears being cathartic; instead, he used the word 'affect' to describe the emotional outpouring of a feeling. It also seems that catharsis through crying has received little theoretical attention, "leaving the conditions under which crying may be cathartic virtually undefined" (Levitz, 2006, p. 3).

Badcock (1992) attempts to define the conditions on which Freud's cathartic method relied. He described the "safety and confidentiality of the therapeutic setting" and the "personal

influence of the therapist" (Badcock, 1992, p. 28) as pre-requisites for the client to be successfully treated. The patient's "special emotional attachment" (Breuer & Freud, 1955, p. 43) to the analyst has also been emphasised as influencing the success of the work, without which the client may fall silent reflecting their 'indifference' to the analyst (Breuer & Freud, 1955, p. 43).

In Kottler's (1996) view, Freud's method created the discourse that catharsis is inherently therapeutic and that this is the reason crying has been held in the "highest esteem of the counselling profession as the clearest evidence that good work is taking place" (p. 194). Hayes' (2006) suggests Freud soon began to place more value on the patient putting the emotional experience into words rather than the abreaction itself, deducing that this was the therapeutic factor, "the tears simply signified that the emotion had been re-awakened and brought fully into consciousness" (p. 45). This suggests catharsis has more to do with the processing of tears in a particular context, than simply an emotional discharge.

Modern day catharsis

Nichols and Bierenbaum (1978) extol the virtues of catharsis as a means of "disrupting long-held, rigid defences against emotional expression" (p. 728). They suggested that catharsis achieved through crying is often subsumed under different titles such as "discharge", "implosion", or "release" (p. 726). Similarly, participants in Sussman's (2001) heuristic study described their crying in psychotherapy as helpful because it gave rise to feelings of "release," "cleansing", and "purification" (p. 96). Sussman found that the 10 long-term clients she interviewed considered the tears they shed in therapy to be a "vital feature of both their therapeutic process and spiritual development" (p. 96). She writes:

> One of the striking features was the sense of calm and stillness which followed these prolonged periods of weeping, although previously fraught issues were still being discussed. This certainly suggests the release of very long-held emotion and the transcendence of ego-based concerns. (Sussman, 2001, p. 97)

Psychoanalytic technique and catharsis

Psychoanalytic techniques aim to interpret and understand the patient's tears in order to facilitate change. Heilbrunn (1955) describes a case study of a patient who experienced infantile hunger as a result of insufficient breast milk from her mother. After many sessions of her client's relentless sobbing, Heilbrunn understood her client's constant weeping as a sign of regression and interpreted her sobbing as a wish to be returned to intrauterine life to a place of "satiation" (p. 251). Over a period of time, the patient was able to use these interpretations to work through her fear that Heilbrunn would clearly not meet her needs just as her mother had not. This resulted in her continuous crying subsiding, allowing the work to progress.

Heilbrunn (1955) identifies the similarity between her patient's copious tears with amniotic fluid, observing the almost identical composition of the two fluids. The idea that weeping may be an unconscious regression to a pre-natal state and that the chemical composition of emotional tears and amniotic fluid are similar has been noted by other theorists (Szaz cited in Kingsley Mills & Wooster, 1987). Bowlby (1988) at least supports the notion that infants resent their "extrusion from the womb and seek to return there" (p. 350). It is possible

Heilbrunn's patient was protesting this very thing in her regressed state. Interestingly, it has been suggested by Vitanza (1960) that weeping originates in the womb from as early as the ninth week of gestation.

In other psychoanalytic writing, Löfgren (1966) describes the cleansing effect of tears and observes that tears are the only bodily secretion that is clean. There is an implication in his argument that tears are cathartic as they have the power to transform aggressive impulses into what he calls "harmless behavior" (Löfgren, 1966, p. 380). In other words, aggression may be dissipated via the secretion of tears, reminiscent of the words of Ovid "by weeping we disperse our wrath" (Lutz, 1999, p. 118). This theory provides an explanation for the gender imbalance in crying; for example, Shoan-Golan (2003) suggests women cry more frequently, more intensely, and for longer periods than men. Perhaps then, women may disperse more of their aggression through crying, whereas men generally cry less and therefore both hold on to and express greater anger when upset (Tremblay & L'Heureux, 2005).

Greenacre (1965), in contrast to Löfgren (1966), used two case studies where she understood her patients' prolonged crying to be an aggressive act in itself. She concludes that "the show of tears is under some control of the weeper" (Greenacre, 1965, p. 218). Kottler (1996) supports this stance, stating even sociopaths are able to elicit tears to win sympathy and that actors are able to weep on demand simply by revisiting a past tragedy. Using psychoanalytic case studies as evidence that crying is cathartic has come under criticism from Cornelius (2001), a psychologist, who deems the methods used for gathering evidence as being "unsystematic" (p. 200). He argues that those with a psychoanalytic orientation make presumptions that crying is followed by catharsis and that there exists in this setting an "unspoken demand to feel better" (Cornelius, 2001, p. 200). The idea that clients may feel better from crying purely because of a possible placebo effect is not the crucial issue according to Levitz (2006). He contends that if people believe crying has the power to make them well, then this itself holds essential value in the healing process.

Cornelius' (2001) review of literature on crying and catharsis consisted solely of rigorous empirical studies with conflicting results. For example, research studies that asked university students to fill out questionnaires and diaries on their crying behaviour found a positive correlation between crying and feeling better afterwards (Bindra, 1972; Borgquist, 1906; Crepeau, 1981; Lombardo et al., cited in Cornelius, 2001; Frey, 1983; Kraemer & Hastrup, 1986). Conversely, laboratory research found opposing results. Labott and Martin (1988), Marston et al. (1984), and Gross et al. (1994) (as cited in Vingerhoets & Cornelius, 2001) conducted laboratory studies involving participants watching a 'tear-jerker' film while having their heart rates and body tension monitored. Using participant self-reports after the film, they concluded that in this setting, crying produced increased levels of sadness and anger and a decrease in happiness. In other words, crying produced a negative effect in its participants.

These results seem to point to the importance of the social context in which a person cries and, consequently, whether they feel better afterwards. This is acknowledged by Cornelius (2001) who admits "perhaps people do not feel better after crying in the laboratory because their crying is in response to something in which they can do nothing and nothing in the

situation changes as a result of their crying" (p. 206). He also suggests that the regard in which the crier is held by others, and whether there is hope for some resolution of the issue about which they are crying, may have huge implications on whether the person feels better after crying. Although Cornelius deemed psychotherapeutic studies as unworthy of including in his review, his view of what the most optimal environment for catharsis to occur in, is in my opinion, largely epitomised by that of the psychotherapeutic relationship.

Cornelius (2001) also recognises that "it may be the case that crying does indeed have cathartic effects but these appear over a period of time longer than that assessed in most laboratory settings" (p. 205) and that this "raises the possibility that the putative cathartic effects of crying may be due to simply the passage of time" (p. 206). This proposition again appears to support the importance of the psychotherapeutic framework, particularly in long-term work, where both the therapist and client can bear witness to possible changes in the client over time.

I hypothesise that there is a connection between the quality of the therapeutic relationship and the client's ability to surrender to their emotions. Maroda (1999) explains the process of surrender as "a giving over to the patient's own emotional experience—losing herself to herself—within the containing framework of the analytic setting" (p. 54). She uses the work of Russian psychologist Vgotsky to introduce the notion that intrapsychic change itself "occurs as a result of interpersonal exchanges" (Maroda, 1999, p. 67). This lays support for the idea that catharsis through crying may be reliant on the quality and the attachment formed within the therapeutic relationship.

Crying and attachment

> His tears ruffled the water,
> And his image is dimly reflected back to Him by the troubled pool.
>
> From Ovid (cited in Enterline, 1995, p. 1)

Crying as an early attachment behaviour

Bowlby (1982) proposes that in infancy crying is an intrinsic aspect of attachment behaviour, alongside sucking, clinging, following, and smiling; each response functioning to activate an instinctual care-giving response in the mother. The idea that infant crying is a pre-verbal, relationship-seeking behaviour is well supported in the literature (Appel & Healy, 2005; Holmes, 1993; Karen, 2004; Nelson, 2005). Research reveals infant cries are programmed to elicit attention and care-giving, evoking physiological responses such as increased heart rate, blood pressure, and the 'let down' of breast milk in the mother (Kottler, 1996; Nelson, 2005).

In a "good enough" environment (Winnicott, 1990, p. 145), the instinctual responses of the parent (most often the mother) will result in her responding sensitively to the child's emotional signals. This provides a critical context within which the child learns to organise emotional experiences and regulate a sense of "felt security" (Ammaniti, 1999, p. 786). Individuals who develop a healthy attachment to the caregiver may use them as a secure

base from which they can explore their world (Bowlby, 1988). As a result, securely attached children successfully learn to tolerate, express, and value a range of emotions, that includes crying behaviour.

However, instinctual responses in the mother may not always be positive for the infant if the mother herself has unresolved attachment issues (Appel & Healy, 2005; Hayes, 2006; Nelson, 2005). Winnicott suggests, "the advent of parenthood calls into being the new parent's own attachment history" (cited in Holmes, 1993, p. 73). Of a group of young New Zealand mothers surveyed, an alarming 80 percent reported feeling like "bashing" their babies in response to their infants crying (Kirkland et al., 1983, p. 539). Given that securely attached babies are known to cry less (Karen, 1994; Nelson, 2005) it is conceivable that the cries of the infants studied may have in fact stimulated unconscious memories of the mother's own cries in infancy and subsequent negative caregiver responses.

According to Nelson (2005), the mother with historic unmet emotional needs may become distressed by her child's cries, possibly resulting in the mother's abuse or neglect of her child. Perhaps the most relevant point here for clinical practice is Nelson's observation that "the feeling is that the crying must stop because it upsets them (the parent), rather than because the baby is upset" (p. 54). This raises the issue of whether infant crying and mother response has implications for the therapist/client dyad. In other words, might unconscious attachment material be stimulated in the therapist in response to the sobbing of a client, and how might that effect the therapist's ability to 'be with' the client?

The ongoing relationship between tears and attachment

The infant's experience of how attuned the mother or caregiver is to their tears, appears to have a fundamental impact on the way the growing child sees, feels, and thinks about crying as they develop into adulthood. Children who learn that crying is in some way unacceptable may learn to suppress their tears and, consequently, suffer detrimentally in their ability to express themselves emotionally as adults, particularly in relation to grief (Bowlby, 1982; Janov, 1970).

From a psychoanalytic perspective, Greenacre (1945a) links the suppression of tears with involuntary urination in boys. She suggests spontaneous urination in boys may occur at the same time that the boy learns he must control his crying in order to be a 'big boy'. She surmises that for girls excessive weeping may be in response to a related struggle with the parent over urinating during toilet training. Perhaps more like her male counterparts in Greenacre's theory, Carmichael (cited in Nelson, 2005) remembers never crying as a young child when she was sent away to convent school. Instead, she wet her bed on a nightly basis. She writes, "every night my body wept at the wrong end" (Carmichael cited in Nelson, 2005, p. 143).

The child that learns from a young age that the expression of tears and anger are unacceptable to the caregiver and may develop an avoidant attachment, stifling feelings in order to reduce conflict and remain accepted and idealising of the parent (Ammaniti, 1999; Bowlby, 2005). Perls et al. (1994) argue that by adulthood, crying may be so cut off from the individual's emotional repertoire, that not only does the adult no longer have the feeling of wanting to cry, they have also become unaware of the inhibition in their body from

suppressing their tears. An adult with an avoidant attachment then is likely to be dismissive (even incapable) of seeking comfort from or sharing their emotions with others (Karen, 1994). The result of which may lead to diminished attachments and intimacy in adulthood, described by Kottler (1996) as "emotional constipation" (p. 66).

It follows then that it may be very difficult for adults with avoidant patterns of attachment to cry in the therapy room. They may have learnt other ways in which to express their grief and sadness and may unconsciously avoid crying at all costs. Yet the work of Greenacre (1965) seems to resonate with the possibility of what a patient with an avoidant attachment might 'look' like when they cry. She suggests that tears can act to protect the 'disappointed eye' that mourns the loss of *not being able to see* the object that has been lost to them. Greenacre states, "the eye is the most important sensory object in establishing a loss" (p. 210) and establishes a connection between tears and visual activity in humans. Greenacre's hypothesis is that "as weeping is an affair of the eye, it is worthwhile to examine the relation of weeping to looking and to seeing, or to looking and not seeing" (p. 212). In other words, she suggests that tears protect the crier from the reality of a loss until such time that the crier is able to come to a place of being able to see and accept the reality that the lost object is gone. While denial of the loss is a common grief reaction, it might also be particularly fitting for the avoidant individual who has had to deny their own attachment needs.

Alternatively, those children who develop an ambivalent or even disorganised form of attachment (Appel & Healy, 2005) may internalise a heightened sense of distress, often reacting with fear and/or anger to the inconsistent parenting they have received. As they remain hyper-vigilant during separations and reunions, they are often difficult to comfort and soothe (Ammaniti, 1999). These characteristics may remain true for the adult who brings this attachment style to therapy. For example, their tears may symbolise their ambivalence to the therapist, oscillating between anger and fear.

This idea is supported by Booth (2006) and Perls et al. (1994) who propose that tears can serve as a protective mechanism against potential attack in the psychotherapy relationship, particularly when the client themselves feel like attacking the therapist. These clients may need to 'hide' their aggressive impulses toward the therapist for fear of rejection. As a result, they may hold the hope that their tears will be perceived by the therapist as non-threatening or as a sign of surrender (Kottler, 1996). This view appears to fit with Löfgren's (1966) theory which suggests crying can act to dissipate uncomfortable aggressive impulses.

In this sense, crying in the clinical hour might also be seen as a way of *not* engaging with the therapist, for it may be difficult to think, reflect, or even talk if one is racked by sobs. As Barbalet (2005) states, "indeed weeping appears as a negation of speech in the stark sense that weeping physically prevents speech" (p. 134).

From the literature, it seems each client's unique relationship with tears will be embedded in their attachment style. Nelson (2005) states, "Crying that takes place in psychotherapy reveals volumes about a lifetime of attachment and care-giving successes and failures" (p. 153). Therefore, how a client expresses (or not) their tears in therapy may be a good

indication of the client's internal experience, both in the moment and historically from childhood (Mitchell, 1999).

The influence of the therapist's attachment history

Examining the clients' unique relationship with tears is only part of the equation within the therapeutic relationship. Just as the mother's parenting influences the child's developing attachment and relationship with tears, so will the therapist influence the client's ability to cry. In fact, as Nelson (2005) stresses, it seems vital that the therapist explore their own attachment history, specifically in relation to crying. Ammaniti (1999) asks, "How much does the analyst contribute to activating a secure attachment in the patient through his own personal relationships and representational world?" (p. 794). In other words, how do therapists' values, beliefs, and experiences of tears fit with those of their clients? In relation to this idea, Torii (2005) raises the possibility that those who enter the psychotherapy field may do so, in part, to unconsciously heal one's own emotional wounds. It follows that some therapists may have unmet attachment needs that have resulted in their own discomfort with tears (Orbach, 1999b).

Nelson (2005) and Kottler (1996) go as far as suggesting that the therapist's own attachment style and relationship with tears may ultimately help or hinder their client's process of emotional expression and progress in the therapy. Hoover-Dempsey et al. (1986) might agree, surmising that in adulthood we are likely to be "taken back to the images and feelings of infancy when confronted with another adult crying" (p. 22). Debatably, this is why people might feel uncomfortable with their own tears and those of others (Booth, 2006; Kottler, 1996; Orbach, 1999b).

Kottler (1996) provides a clinical example of a therapy session in which he realised, in hindsight, that his offering of a tissue to a sobbing client was out of his own need to silence her tears, rather than out of empathy for her. He concludes that this cut off the important emotional work she was trying to do, and in time he was able to acknowledge how similar this woman's tears were to his own depressed mother whose crying he often tried to prevent.

Booth (2006) acknowledges the discomfort a therapist may feel when experiencing a less than empathic response to a client's tears. Alexander (2003) provides case examples in relation to the tears of narcissistic clients. She suggests it might be common for a therapist to feel unresponsive and unempathic to narcissistic tears that seem lifeless and shallow; even to the extent of wishing the client would leave therapy. She uses the work of Lowen to describe the situation when a child's cries remain unresponded to, describing the child's sobbing as "unable to rouse the mother" (Alexander, 2003, p. 31). This then becomes played out in the therapeutic setting where the client's lifeless, 'dead' crying also fails to arouse the therapist's empathy.

Alternatively, Alexander (2003) suggests that the therapist may feel manipulated, exploited, and emotionally drained in response to narcissist tears that seem performative, inauthentic, and exploitative. This reflects the inner world of the narcissist's own feelings of being "greedily exploited by the mother" (Alexander, 2003, p. 32). Tears evoking a negative

response in the therapist can be an opportunity to gain insight into the internal world of the patient.

Having a greater focus on their own relationship with tears as a part of their attachment history may enhance therapists' insight into what they themselves bring to the relationship. This awareness, coupled with what is known about the client, may then be used as a cross-referencing system in order to understand, more fully, what is being created in the therapeutic relationship.

The intersubjective nature of tears

Stern (2004) believes intersubjectivity is separate from, but complementary to, attachment theory. He argues that attachment behaviour negotiates closeness and distance, whereas the system of intersubjectivity focuses on the actual psychological intimacy of the relationship. Nelson (2005) adds that the intricacies of the attachment bond and intersubjectivity are interwoven; "crying and care-giving are inseparable: attachment behaviour (the patient's and the therapist's) and care-giving behaviour (the patient's and the therapist's) are a mutually interactive cycle in adult psychotherapy" (p. 153).

Neuro-scientific support for inter-subjectivity

Just as the mother and infant dyad influence each other to match the timing and affective direction of behaviour, so too do individuals who empathise and feel attuned to one another (Beebe & Lachmann, 1988). This idea is supported by Pally (1998) who provides evidence from neuro-scientific studies that suggests both the analyst and client may influence one another's body sensations, imagery, thoughts, behaviours, and even words, by unconsciously processed non-verbal cues of emotion. Pally states, "emotion connects not only the mind and body of one individual but minds and bodies *between* individuals" (p. 349). Given these theorists' support for the idea of a shared mutuality in the therapeutic relationship, it is not hard to imagine that the therapist may at times in the therapy feel tearful alongside the client.

Nelson (2005) uses a case example from Bollas (1992) that, to an extent, illustrates the mutual influence of the therapist and client. Bollas describes a client crying for the first time in their work. The client's tears are in response to an interpretation Bollas makes regarding an image he held of his patient as a three-year-old. An image that he felt was created by a kind of "unconscious rapport" (Bollas, 1992, p. 121) between himself and the client. It seems that the client's tears in response to his interpretation were the result of feeling deeply understood by Bollas. This shared experience facilitated progression in the therapy after a long period of frustrating despair on both the analyst's and the client's part. While Bollas devotes just one line to describe his client's tears, Nelson focuses more closely on them, suggesting that the client's tears were a result of an emerging attachment to Bollas. Through this process of attaching, the client was able to allow him to be with her "in her active despair" (Nelson, 2005, p. 164).

Perhaps the strength of the attachment bond formed the basis in which this intersubjective attunement could occur. This is described by Stern as a shared interpenetration of minds that suggests a feeling of "I know that you know that I know" or "I feel that you feel that I

feel" that can be very powerful; for in that moment the dyad share the "same mental landscape" (Stern, 2004, p. 75). In fact, Bollas (1992) describes his interpretation as being a turning point in their work; so much so, it became the subject of a dream for the client a year later.

It seems as if a sense of synchronicity or 'resolution' (described previously by Cornelius, 2001) may have occurred in this intersubjective moment between Bollas and his client. It follows that this sense of resolution might provide a new experience for the client, offering a sense of hope for change and possibly catharsis. Nelson (2005) agrees that crying in the therapeutic relationship is about hope and not just about grief "because they are triggered and shared within the context of an entirely new caregiving relationship" (p. 154).
In contrast, Forester-Miller (cited in Kottler, 1996) describes a session in which she felt mis-attuned to her client's tears, leaving them both in a state of emotional dissonance. Forester-Miller describes counselling a tearful adolescent boy and reflects on her own feelings of emotional pain in seeing him cry, admitting that her own unresolved feelings around crying were caught unawares. In hindsight, she is aware that she may have unconsciously directed the rest of the session to a cognitive level where she felt comfortable and safe, and where the client soon matched her level of affect.

Making sense of the client's tears
Some researchers have noted that crying exists primarily to communicate what words cannot (Hayes, 2006; Kottler, 1996; Nelson, 2005). Nelson (2005) writes "one tear is worth a thousand words" (p. 154). However, Jay Efran and Tim Spangler (cited in Kottler, 1996) found that it is the recovery from tears, not the act of crying itself, that is experienced as most therapeutic. The implications are that helping people to feel comfortable crying is indeed important, but not without also helping them to dry their eyes and make sense of their experience (Kottler, 1996).

Timing, according to Stern (2004), is everything; that the 'present moment' shared between therapist and client needs to be held in precious regard. He argued that too often 'being in the moment' is lost through a process of trying to put words to an experience too soon, which ultimately objectifies it. McCrank (cited in Mills & Wooster, 1987) suggests that in reaction to the tears of another person, a neuro-chemical response is aroused in the observer that has a "quieting effect" (p. 128). This may enhance the observer's capacity to be with a client's tears without the need to make sense of them too soon; yet, this may depend on the anxiety the crying evokes in the therapist.

For Maroda (1999), the emotional experience necessarily precedes "both the acquisition of genuine insight and the intellectual organizing of that experience... the point of change comes at the point of emotional surrender" (p. 63). Hayes (2006), Kottler, (1996), and Stern (2004), therefore, suggest that finding the language to talk about tears is necessary at some point in the therapy in order for the client to gain therapeutic insight, which arguably may be intrinsic to feelings of catharsis as earlier suggested. Speech then, becomes the tool for facilitating understanding as Lacan (cited in Benvenuto & Kennedy, 1986) suggests, and becomes the means by which the client's view of the past can be altered. This process, in turn, may lead to an internal change in the client and eventual healing.

The therapist's tears—Breakthrough or breakdown?

As mentioned previously, Beebe and Lachmann (1988) and Pally (1988) suggest that a congruency of feeling states may exist in some therapeutic relationships. This provides a theoretical explanation for the potential of therapists to experience tearfulness alongside their clients in the therapy process. Another explanation, along similar lines, comes from Sussman (2001) who suggests therapist tears that 'come out of the blue' may be attributable to what is termed as psycho-peristalsis. She describes this as an involuntary, intuitive gut response that is able to pick up affect at an unconscious level in the therapist and client during the therapy. This appears to be congruent with the theories of Pally and Beebe and Lachmann, and suggests that the therapist may not always have control over their tears. Sussman feels it is vital for the therapist to notice the differences in tearful responses with clients. She argues that when tears arise "independently" (Sussman, 2001, p. 91) this may be in reaction to unconscious client material.

According to Nelson (2005), the suggestion that therapists cry with their clients is seldom discussed in the literature. Conducting her own informal study, she noticed a correlation with how therapists personally felt about and experienced crying, and how they perceived the idea of crying with a client. The attachment style of the client may also influence their experience of a therapist's tears; for example, an anxiously attached person may find the therapist crying to be unnerving and confusing, whereas as a securely attached adult may feel more empathic toward the therapist. It seems possible to conclude that, in some cases, the different responses of clients to their therapist's tears may be based upon, in part, the attachment between the client and the therapist, the timing and strength of the relationship, and the intersubjective experience of both parties' relationship with tears.

Maroda (1999) adds weight to the benefit of the therapist's emotionality when she states, "an analyst who is not afraid to surrender to her own and her patients' strong emotions, is more likely to transform them both" (p. 64). There seems to be support in the literature on crying, for therapists to allow themselves to align with the client on an emotional level. For example, in Waldman's (1995) study, all of the participants stated that they thought the idea of neutrality in the relationship needed to be redefined, believing that the notion of therapist crying should be explored in the context of the "interactive influence of both participants in the therapeutic relationship" (p. 89).

In other research, Curtis et al. (2003) found that the majority of the counselling students they surveyed thought that the therapist weeping with the client could "facilitate therapeutic change" (p. 300) but that 20 percent were also concerned about doing so. This illustrates the conflict many therapists may feel about wanting to emotionally engage with patients and being seen as unprofessional if one 'tears up' during a session.

Nelson's (2005) study revealed that most therapists reported that they would "suppress their tears" (p. 175) when working with clients. Yet Nelson herself suggests that tears can be beyond the control of the crier. While it may be impossible to know the answer, what seems to be vital is for the occurrence of therapist tears to be talked about, just as it seems important for the client's tears to be processed. Waldman (1995) concludes that it would be hazardous not to discuss the reality that tears are shed by both therapist and client. She suggests that it is not particularly useful to categorise tears as either a breakdown or a

breakthrough but to see them as “individually powerful moments of the therapy that need to be addressed both in the therapy and by the psychodynamic community at large” (Waldman, 1995, p. 134).

Postscript

Reflecting on 15 years of my own clinical work since this study was undertaken in 2007, my findings that crying contains a multi-layered set of meanings and usefulness within the therapeutic relationship holds true. A potential fly in the ointment is that in 2022 we live in an increasingly medicated world. While anti-depressants certainly have a helpful role in reducing suffering, in my practice a number of clients arrive at therapy already on anti-depressants prescribed by their doctors, often inhibiting their ability to shed tears. Reading through the lens of my research, plugging emotional expression through pharmaceuticals may, potentially, have negative implications for transformative therapeutic work to take place for some people.

Badcock (1992) suggests catharsis was more easily obtained in Freud’s day due to the underlying societal repression of the time, particularly if it involved sexual matters. Today, catharsis may be inhibited through the means of chemical suppression of emotion. Interestingly, Frey and Langseth (1985) found emotional tears to have a different chemical composition than irritant tears. They claim that emotional tears can remove a build-up of chemicals, including manganese, a mineral known for its influence in mood disorders.

Anecdotally, I can testify to clients who have chosen to reduce or stop their anti-depressants in order to experience a wider range of emotional responses, including tears related to grief. This has been transformative for them and, if it has not already been done, further study on the impact medication may have on the beneficial effects of crying could be useful for extending understandings on this topic.

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Paper 6 (2010)

The psychological birth of a psychotherapist: What are the parallels, if any, between becoming a mother and becoming a psychotherapist?

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> In most psychological therapies, a therapist is someone who functions psychologically on behalf of someone else. This functioning, if effective, can maximize the conditions for an aspect of psychological growth to take place in the inner world of the patient. This is similar to a mother who can only function as a mother in relation to a baby: one can only function as a therapist when one is working in an emotionally alive relation to a patient. (John, 2009, p. 85)

As a child psychotherapy student, I observed the developing identification of a mother as part of the mother infant observation paper (course) while, at the same time, developing my own identification as a child psychotherapist. (In the mother infant study, a student directly observes and experiences infant development within the context of a care giving relationship. The observations of an infant and primary caregiver are for one hour every fortnight over two academic years.) It appeared to me that there may be similarities in these experiences. Over the course of my observations, I wondered if a mother's identity was immediate or whether it occurred over a period of time, as a mother nurtures and cares for her infant. Stern described a woman's identification as a mother occurring "when the woman realizes that she knows herself to be a mother in her own eyes" (Stern & Bruschweiler-Stern, 1998, p. 17). Reflecting on this statement, and my own process of becoming a psychotherapist, I wondered if there was a parallel between the two processes. As a student I found my identification as a child psychotherapist was not immediately acquired, but emerged over the years of study, incorporating integration of knowledge and development of clinical skills. This paper considers those parallels.

Several other influences increased my curiosity around the possible parallels between the two processes. One such influence developed from studying developmental object relations theories within the child psychotherapy programme. Some of the ideas and concepts regarding mothering, as suggested by object relations theorists, are also clinical terms used by child psychotherapists working therapeutically with children. For example, Winnicott (1994) proposes that the concept of 'holding' is a function of a 'good enough mother', which he explained is an ordinary mother keeping her child as a whole person in mind (Davis & Wallbridge, 1991). Bion (1962) suggests that 'containment' is a phenomenon that occurs when a baby feels sufficiently 'held psychically and emotionally' by their mother (Waddell, 1998). Recognising that 'holding' and 'containment' are also clinical terms and skills referred to, and used by, psychotherapists in relation to the psychotherapeutic process (Casement, 1985), contributed to my wonderings regarding the possible parallels between the process of becoming a mother and becoming a psychotherapist.

My own personal experience of being a mother while concurrently studying to become a child psychotherapist, further influenced my curiosity regarding the parallels of these two processes. I found my child psychotherapy knowledge enhanced and enriched by my role as a mother. Along with the gained understanding of the importance of a mother providing a 'holding' and 'containing' environment for her child, I have also learned the importance of 'maternal attunement'; defined by Stern (1985) as the shared affect experienced by the mother and her baby as the mother responds to and imitates her baby's affect. Self-psychology has highlighted for me the importance of a child gaining a healthy sense of self, developed through feeling loved, in control, and self-worthy (Miller, 1996). In studying attachment theory, I have come to understand the need for a parent to act as a secure base to whom the child can turn to in times of distress, before returning to an autonomous exploration of the environment (Holmes, 1993). I also began to recognise the importance of the separation and individuation process for my children, especially during the first three years of life (Mahler et al., 1975) and, later, during their teenage years, as suggested by Blos (1979).

Additionally, engaging in personal therapy during my study likewise developed my curiosity about these possible parallels. Through personal therapy I came to understand my internal mother influences which have affected my role as a mother, along with my role as a child psychotherapist. Stern (1995) explains that in the process of becoming a mother, a mother enters into a 'motherhood constellation' which determines "a new set of action tendencies, sensibilities, fantasies, fears, and wishes" (p. 171). According to Stern, the motherhood constellation concerns "three different but related preoccupations and discourses which are carried out internally and externally" (p. 172). One such discourse involves the mother's discourse with her own mother. Through the process of personal therapy, I have explored and become aware of my own internal discourse with my mother and how this relates to me as a mother, and at times as a child psychotherapist within my relationship with a client. Once again, I was left wondering about the possible similarities in the process of becoming a mother and becoming a psychotherapist.

These wonderings led me to my research question for my Master's dissertation: What are the parallels, if any, between becoming a mother and becoming a psychotherapist? Using a modified qualitative systematic literature review method, parallels were identified as centred around three themes: early childhood experiences, the gaining of an identity for each respective role, and the developmental process related to becoming a mother or becoming a psychotherapist.

Early childhood experiences

Early childhood experiences are identified as influential in the development of some mothers and some psychotherapists. A review of the literature reveals the type of influential early childhood experiences are different for each process. However, with further inspection there appears to be an overlap in the different type of early childhood experiences which each process commonly identifies.

For instance, motherhood is considered by some theorists to be formed in early childhood through dolls play, direct modelling of a mother's behaviour, or in practice with siblings (Brazelton & Cramer, 1990; Erikson, 1980; Lax, 2003; Mendell & Turrini, 2003; Stadlen, 2004; Winnicott, 1964; Wolf, 2001). According to Stadlen (2004), girls learn motherhood through watching mothers with babies. Mendell and Turrini (2003) believe that the mother's evolving self is complex, beginning early in life; and Raphael-Leff (1998) suggests the schemas of maternal self-representation began within a mother's own infancy as she is mothered by her own mother.

Similar to a developing mother, early childhood experiences have been identified as influential in the journey of a psychotherapist. Traumatic early childhood experiences, especially, have been identified in the literature as influential in the development of a psychotherapist, particularly where the psychotherapist feels psychologically wounded (Barnett, 2007; Basescu, 2000; Dryden & Spurling, 1989; Farber et al., 2005). These traumatic experiences may create a feeling of isolation and division from others (Dryden & Spurling, 1989). With a sense of isolation from others, developing psychotherapists may feel a yearning to become close to others which, in turn, causes an observation and need to care for and interpret others (Dryden & Spurling, 1989).

Developing psychotherapists do not necessarily have the same exposure for observing experienced psychotherapists during early childhood as developing mothers have in observing experienced mothers. However, it is claimed that the developing psychotherapist's observations of other people, and their relationships with others, influences their interest in becoming a psychotherapist (Dryden & Spurling, 1989). Furthermore, during professional studies it is likely that the student psychotherapist will have exposure to observing experienced psychotherapists, such as through clinical observations or through personal therapy.

Hence, observation of others during early childhood seems to be a parallel between becoming a mother and becoming a psychotherapist. However, what is observed is different; that is, where mothers observe other mothers in learning how to be a mother, psychotherapists may observe other people to understand and interpret other people.

A sense of 'existential loneliness' may also be experienced by mothers after the birth of their child, as they adjust to the disruption in their life, and as they experience internal change (Urwin, 2007). This may be regarded as another parallel between the two processes, where some mothers may experience loneliness in their journey of motherhood, similar to the developing psychotherapist who may experience loneliness and isolation through traumatic early childhood experiences.

Dryden and Spurling (1989) also claim that the developing psychotherapist's interest and ability to gauge other's feelings, as developed from their sense of isolation, develops within the psychotherapist's ability to enter other people's worlds and to feel empathy towards others. In relation to primary maternal preoccupation, Winnicott (1994) suggests a mother intuitively uses her own experiences as a baby, as she empathically puts herself in her baby's place. Empathy seems to be an important attribute for both mothers and psychotherapists.

Further, there does not seem to be a clear-cut division between the type of early childhood experiences of a developing mother and a developing psychotherapist. For example, Abram (2008) unexpectedly discovered that eight of the 11 mothers interviewed in her study had experienced some form of childhood trauma in their life. These mothers viewed motherhood as an opportunity to "heal old wounds left by being inadequately or even traumatically mothered" as they choose not to "pass on the legacy of trauma" (Abram, 2008, p. 192) as they mothered their own children. Therefore, similar to a psychotherapist, early childhood trauma may influence the development of a mother.

Identity

In attaining an identity, there appears to be parallels between the two processes. These parallels seem to be related to the transformation which occurs as the identity is developed, and the influence this has on the sense of self as the identity within the respective roles is formed.

Transformation

Motherhood, for some, has been described as a profound change from career to motherhood, where part of this change is accepting the new identity (Cudmore, 1997; Stadlen, 2004; Woograsingh, 2007). Pregnant women described becoming a mother as "a sense of having entered into, or being on the edge of a 'whole new world' which brought out different facets of their personalities" (Bailey, 1999, p. 347). Mercer (2004) suggests that in becoming a mother, a woman experiences a transformation of self where her existing self incorporates this new identity as she assumes responsibility for her infant.

In describing the identity process of a psychotherapist, Hart (1985) explains there is a transformation of self within the psychotherapist from "what I do" to being perceived within themselves and by others they respect within the profession as "who I am" (Hart, 1985, p. 2). This finding appears to be echoed by Toddun (1996) who suggested a psychotherapist who has achieved a therapeutic identity will experience a sense of cohesion and unity in who they are and what they do. As student psychotherapists develop their professional identity, and as they begin and continue to work with clients, their confidence increases (Aguilera, 2009; John, 2009).

Mercer (2004) posited that maternal identity is characterised by the mother's sense of confidence, harmony, satisfaction in the maternal role, and attachment to her infant. Part of the process of gaining an identity as a mother also involves validation and recognition by others (Ethier, 1995; Juhasz, 2003; McDermott & Graham, 2005). As others accept a mother's performance, she feels a congruence of self and motherhood (Mercer, 2004).

Within the two processes, it appears a transformation of self occurs as the new identity is incorporated within each role. In relation to the developing identity of a mother, this occurs

as the mother nurtures and cares for her child; similarly, for the psychotherapist as they begin to work with clients. A further aspect in the transformation of self is validation and recognition by others, along with, in the case of the mother, the continuing care for her child; or, in the case of the psychotherapist, via their work with clients, which leads to increased confidence within this role. As their respective performances are accepted by others, congruence between self and the role develops until a mother or psychotherapist can respectively claim 'this is who I am' rather than 'this is what I do' (Hart, 1985).

Identification

From the literature sourced, identification emerged as a common theme between the process of becoming a mother and the process of becoming a psychotherapist. Gabbard (1995), for example, considered that identification is crucial to the development of a psychotherapist's professional identity and that it is a key aspect in their functioning as a psychotherapist. Moss (1985) explains identification as a process "by which an aspect of one person becomes like that of another person to who he or she is related in a meaningful way" (p. 2). Some researchers suggest this identification process may occur within supervision as the novice feels a sense of inadequacy in comparison to their supervisor (Kottler, 2003; Moss, 1985). Furthermore, Kottler (2003) maintains that the supervisor, or mentor, is idealised by the beginning therapist, and "continues through stages of worship, subservience, dependent love, work … mutual respect, and briefly equality before the final loss and return to self-direction" (p. 28). The assumed successful outcome of this process is a stronger sense of professional identity and confidence.

Part of the process of gaining a mother identity involves a mother gaining information and observing other mothers and expert models, especially her own mother (Rubin, 1984). According to Rubin (1984), a mother replicates the observed mothering skills, fantasises about being a mother, and de-differentiates as she shifts from expert mothering models to herself in relation to her child. Stern (1995) explains that a mother will revive her identifications with her own mother and other maternal and paternal figures as needed models during the process of identification.

In terms of identification, there seems to be parallels in becoming a mother and becoming a psychotherapist where both the mother and psychotherapist appear to identify and become like an aspect of another significant person. For a mother, this may be her own mother or other expert models. For a psychotherapist, it may be their supervisor or a theorist or a personal therapist who has influenced their process in becoming a psychotherapist. Thus, the models in each role seem to provide the advice and expert modelling relevant to the respective roles as a mother or a psychotherapist.

Self-awareness

Psychotherapy is described as a journey of self-awareness where personal therapy influences the therapist's development (Morgan, 2007). The development of a professional

identity is described by Haber (2009) as “a process that involves the examination of the self” (p. 21), which is frequently in the form of personal therapy.

A developing mother does not necessarily undergo personal therapy; however, she may find herself working through psychological conflicts from previous developmental phases (Baraitser, 2006; Mendell, 2003; Moulton, 1991; Thorpe, 2007) and this may involve re-evaluating her relationship with her own mother (Balsam, 2000; Diamond & Kotov, 2003; Hart, 1981; Holmes, 2000; Layton, 2007). As explained by Stern (1995), a mother may externally and internally have a preoccupation and discourse with her own mother, especially with her own mother-as-mother-to-her-as-a-child. Additionally, pregnancy may provide an opportunity for mothers to further separate and individuate from their own mothers, where becoming a mother may revive past individuation issues (Blos, 1979; Diamond & Kotov, 2003; Thorpe, 2007).

Thus, an awareness of past conflicts is a further parallel between becoming a mother and becoming a psychotherapist. However, there seems to be a difference in how this process occurs. For the psychotherapist, the process in becoming a psychotherapist is a journey of self-awareness facilitated by personal therapy. For the mother, it may covertly occur in her relationship with her mother and as she works through psychological conflicts from previous developmental phases within herself.

In relation to self-awareness, Zeddies (1999) believes that the personal experiences of psychotherapy students influence the kind of therapist they will be. He recommended that in order for a therapist to remain psychologically and emotionally available for their client, each therapist has to have a deep understanding of themselves, and work through personal emotional issues. Similarly, the personal experiences of a mother may affect her relationship with her child, and her child’s security of attachment (Fonagy et al., 1993). When a mother is emotionally available to her child, her child can approach her for emotional refuelling, as defined by Mahler et al. (1975), and for comfort, as explained within attachment theory (Holmes, 1993). Hence, a parallel seems to exist between a mother and a psychotherapist in being emotionally available; in the case of the mother with her child, and in the case of the psychotherapist with their client. Self-awareness and the working through of personal emotional issues facilitate this emotional availability.

From within

Cozolino (2004) believes the “key to being a successful therapist is self-awareness” (p. 205). He pointed out that the primary challenge for a psychotherapy student is not necessarily the mastery of academic material, but having the “emotional courage to move through the inner space that leads to knowing oneself” (p. xvi). He considers the private world of the therapist to be one of the most important tools they use within the therapy room with their clients, and cautions that what a therapist does not know about themself will negatively affect the therapeutic relationship. Similarly, Toddun (1996) considers self-introspection and the therapist’s developing sense of self to play an essential part in their developing professional identity. Leitner (2007) claims that becoming a psychotherapist comes from who the therapist is in the therapy room, not from matching techniques with problems.

Again, there are similarities in relation to becoming a mother. Winnicott (1987) points out that the main things a mother does are drawn from a deeper level of her mind—not from words or books. He suggests this understanding on being a mother begins in early childhood through her doll play, observations of parents, and caring of younger siblings.

With Winnicott's perspective in mind, it appears there may be a parallel between becoming a mother and becoming a psychotherapist in relation to their inner world. The respective role for both goes beyond books and academic material and, ultimately, is drawn from within, either from the psychotherapist's self-awareness or the mother's deeper level of her mind.

Achieving identity

The achievement of an identity is another common theme identified in the literature related to becoming a mother and becoming a psychotherapist. Deaux (1991, cited in Ethier, 1996) explains that in the process of gaining an identity, considerable 'identity work' occurs between the point of a person first imagining themself within the desired role, and then making a commitment to attaining that identity, before they actually acquire that identity (Ethier, 1995). This applies to both the process of becoming a mother and the process of becoming a psychotherapist, where it seems the identity for each role occurs during the following years of respectively caring for a child or working as a psychotherapist.

Stern recognises that a woman's new identity as a mother may begin during pregnancy; however, he suggests that it may emerge more fully several months after caring for the new-born, when she realises and knows she is a mother (Stern and Bruschweiler-Stern, 1998). As defined by Mahler et al. (1975), Bernstein (2006) posits that at the end of the separation and individuation process, at around three years of a child's age, "a new and stable aspect of the woman's personality is formed—the mother" (p. 328).

According to Ronnestad and Skovholt (2003), a psychotherapist's identity formation continues over a long period of time and may extend up to 5 years after the psychotherapist's graduation. Thus, there appears to be a parallel in gaining an identity for both a mother and a psychotherapist in relation to the timeframe this occurs. In the case of the mother, it does not necessarily occur at the birth of a baby. Similarly, in the case of the psychotherapist, gaining an identity does not necessarily occur with the completion of professional psychotherapy graduate studies. Instead, it appears to occur for a mother within her relationship with her child as her child, at around three years of age, separates and individuates from her. With respect to a psychotherapist, the formation of an identity as a psychotherapist may not occur until up to 5 years after graduation, as they gain further experience and confidence working with clients.

Developmental process

Both becoming a mother and becoming a psychotherapist have been described as developmental processes. There appears to be a parallel between these two processes where each is described as a continuous, lifelong developmental process. This parallel will be considered in the following discussion.

Life-long process

According to Stern, the psychological birth of a mother does not occur with the birth of her baby but is a longer process with many phases (Stern & Bruschweiler-Stern, 1998). Motherhood has been described as a developmental process that begins at pregnancy and continues after the baby's birth until the mother attains a mother identity (Stern & Bruschweiler-Stern, 1998; Rubin, 1984). Some suggest this development begins in early childhood, well before a woman becomes pregnant (Balsam, 2000; Blos, 2003; Diamond & Kotov, 2003; Hollman, 2003; Parens, 2003; Turrini & Mendell, 2003). Rustin (2002) believes that "becoming a mother is a developmental process which starts with the baby's experience of being mothered" (p. 19). Rubin (1984) explains the process of becoming a mother as evolving according to the developmental stage, physical condition, sex, and behaviour of the child. Similarly, Bernstein (2006) suggests that becoming a mother is a developmental process which is lifelong and interactive in relation to her developing child.

Ronnestad and Skovholt (2003) describe the development of a therapist as a continuous, slow, lifelong developmental process during which the therapist integrates their personal and professional self as they use reflection and move from reliance on external resources to own internal expertise.

Both processes, becoming a mother and becoming a psychotherapist, are described as continuous and lifelong. For mothers, this development evolves according to the developmental stage of the child (Mercer, 2004). For psychotherapists, this process evolves as the therapist integrates their personal and professional self (Ronnestad & Skovholt, 2003). Hence, there appears to be a parallel between both processes being a lifelong developmental process; however, the way these developmental stages occur differs.

Good enough

A parallel may also exist between the development of a mother and a psychotherapist in relation to being 'good enough', as suggested by Cozolino (2004). He likens the 'good enough mother', as defined by Winnicott (1994), to the 'good enough psychotherapist' where both need not be perfect to be a good mother or a good psychotherapist. Cozolino believes psychotherapists share with parents the "failed struggle for perfection" (p. 73) and encouraged psychotherapists to turn mistakes into the client's advantage; thereby becoming part of the process and development of the therapeutic relationship.

Relevance of research

My research has relevance for developing and experienced psychotherapists in understanding the process of becoming a psychotherapist and the parallels and differences between this process and the process of becoming a mother. While the focus has been primarily upon the development of a mother, the research is particularly insightful to child psychotherapists, who are themselves parents, in understanding the impact each identity they hold has on their sense of self, and how this impacts them within the therapeutic relationship.

Hill (1996) points out that in the transference, the psychotherapist may find themselves becoming a mother, or father, to the abandoned child client. For a psychotherapist, there could be a potential complication of the blurring of boundaries between identities as a psychotherapist and as a mother, particularly when a child client begins to request tasks that are more in line with a mother's role. Supervision can facilitate clarity on the boundaries between the two roles.

For student psychotherapists, an interesting aspect of this study is the developmental process of becoming a psychotherapist. Ronnestad and Skovholt (2003) contend that the identity of a psychotherapist is not necessarily acquired by the time the student graduates, but may take up to five years after graduating. Their study clarifies the anxiety that beginning psychotherapists can experience, with the reassurance that this anxiety is mastered over time. Furthermore, the authors explain that professional learning continues through all levels of experience for a psychotherapist, with an increasing integration between the professional self and the personal self. A student psychotherapist may find this information enlightening and encouraging, to realise their professional development continues beyond graduation and that they are not expected to see themselves as experts upon gaining their formal qualification.

Mothers may also find my study of value in understanding the changes and process they undergo in becoming a mother. The findings from my study illustrate that motherhood is a developmental process that evolves within the mother's relationship with her child, as her child progresses through the developmental stages of life. Her identity as a mother may be acquired when her child separates and individuates from her; however, her development as a mother continues, and as her child continues through each developmental stage, a mother may encounter new experiences as a mother. Furthermore, my study highlights the importance of mothers and the significant change which occurs in a woman's life as she becomes a mother. Mothers, in particular, who feel at a loss when they have their first baby, may feel reassured as they realise and understand that becoming a mother is a lifelong developmental process (Stadlen, 2004).

Furthermore, understanding the process of becoming a mother can be insightful and informative for psychotherapists and other professionals working with mothers and parent–child dyads. Historically, psychoanalytic literature has focused primarily on the influence of the mother on her child rather than the mother's experience of being a mother (Mendell &

Turrini, 2003). Professionals working with mothers and parent–child dyads may find my study of interest as the focus is on the psychological development of a mother according to her experience of becoming a mother. My study also highlights the importance of a mother's evolving relationship with her child as she develops as a mother, which again may provide further insight for professionals who work with parent–child dyads.

As psychotherapists come to understand the parallels identified within my study, their understanding of the process of becoming a mother increases the possibility of enhancing empathic understanding for clients who are mothers. For psychotherapists who are not parents, they may gain greater understanding and be able to empathically attune to their clients who are mothers, through the understanding of the similarities between the process of a mother becoming a mother, and the psychotherapist's own experience and process of becoming a psychotherapist.

Research limitations

My research focused on the parallels between the two processes of becoming a mother and of becoming a psychotherapist. One of the reasons for this was my 'felt' experience and wonderings, as well as the similarity between the two roles, in particular that both the mother and the psychotherapist need to be in a relationship with another person to function within the respective roles, as explained by John (2009):

> In most psychological therapies, a therapist is someone who functions psychologically on behalf of someone else. This functioning, if effective, can maximize the conditions for an aspect of psychological growth to take place in the inner world of the patient. This is similar to a mother who can only function as a mother in relation to a baby: one can only function as a therapist when one is working in an emotionally alive relation to a patient. (p. 85)

Similar to motherhood, fathers need to be in a relationship with their child to function in their role as fathers, and fatherhood can be experienced as a major psychological transformation (Shezifi, 2004). Separation and individuation issues may resurface for fathers, along with their own childhood disruptions as they parent their own child (Diamond, 1986). A common theme among male psychotherapists is the experience of 'father loss' or an 'unattuned father' during their childhood and adolescent years (Gerson, 1997). Gerson (1997) pointed out this may have a bearing on the transferential dynamics within the therapeutic relationship.

One limitation of my research is literature related to working mothers, mothers with disabilities, mother of children with disabilities, adolescent mothers, incarcerated mothers, IVF mothers, LGBTQ mothers, and mothers with preterm babies were excluded from my study. While these topics can be regarded as significantly relevant to the development of a mother, and for psychotherapists working with children and families within these groups, unfortunately it was beyond the scope of my study to explore them further. For instance, my research found a mother's identity may take up to several years in relation to her child's process of separation and individuation before it is fully acquired. A mother who returns to

work during this period of time may encounter a completely different experience of continuing to acquire her identity as a mother, while strengthening her identity as a professional worker (Ladge, 2009). Similarly, a mother of a child with disabilities may experience feelings of inadequacy, hopelessness, and despair (Johnson, 2000). This may have a bearing on the process such mothers experience in becoming a mother.

Another limitation of my research is the exclusion of literature related to psychotherapists from minority cultures, particularly those living in a society where another culture is predominant, or psychotherapists who are LGBTQ (or psychotherapists who are not parents). Brauner (2000) points out that these groups may have different life experiences than their counterparts. Considering that this study found early childhood experiences to be influential in the journey of a psychotherapist, the life experiences of psychotherapists who are LGBTQ or from minority cultures further expand understandings on the process of becoming a psychotherapist.

Reflections 12 years on

Most of the sourced literature in my research was from a Western perspective on becoming a mother or becoming a psychotherapist; hence there may be themes which were not identified, such as spirituality. For Māori, the Indigenous people of Aotearoa New Zealand, wairua, defined by Hall (2015) as the soul and spirit, is integral to Māori identity, health, development, and way of being (Hall, 2015) and needs to be considered within Aotearoa New Zealand psychotherapy. Given that all Aotearoa New Zealand research is of interest to Māori (National Ethics Advisory Committee, 2021), research is needed exploring the parallels for Māori in becoming a mother and becoming a psychotherapist.

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Paper 7 (2013)

Getting “under the covers”: Homoerotic transference and analytic desire

Jane Tuson and John O’Connor

It is only in the last 30 years that the profession of psychoanalytically informed psychotherapy has begun to address erotic transference in any depth, despite it being an enduring feature of psychoanalysis since its late 19th century beginnings. Erotic countertransference appears to have been even more ardently avoided. Tansey (1994) writes: “Despite our advances, our profession remains paralyzed by phobic dread of countertransference that is sexual or desirous in nature and by a glaring and deeply unfortunate absence of self-examining papers on the subject” (p. 140); and, referring to Maroda’s work, Barrett (2003) observes that there is “the traditional analytic tendency to believe that if the analyst is sexually aroused, then the patient was being seductive” (p. 168).

This paper examines the phenomenon of homoerotic countertransference as it is written about in psychoanalytic literature. Specifically, it provides an overview of research undertaken by way of a thematic analysis of 27 articles. The paper begins with an outline of the motivations for the research, followed by an outline of the methodology and findings of the study, and concludes with a discussion of the clinical implications of the research findings. The first author was the primary researcher and the second author the supervisor of the original research (Tuson, 2013) on which this article is based. Where the first-person pronoun “I” and “my” is used in this article, this refers to the first author.

Eroticism and our analytic ambivalence

The subject of eroticism in our work may be shrouded in a veil of professional puritanism; yet my experience with colleagues suggests a repressed yearning amongst clinicians to hear and talk more about it, as exemplified by Charles Silverstein’s (1991) experience. He facilitated a workshop at the Institute for Human Identity Conference in New York, USA, where he asked participants to write about an erotic fantasy they had had about a patient. From this, he identified a theme emerging that suggested that therapists can become quite dependent on their patients for love and affirmation. This workshop went on to become a regular fixture at the conferences due to its popularity. Therapists, he said, were relieved to discover that others fantasise about their patients and appreciated having a safe forum to discuss their erotic feelings. “Each year the room is filled to capacity, by therapists wanting to learn more about how their own erotic needs are expressed during psychotherapy” (Silverstein, 1991, p. 2).

The 21st century has heralded a slightly more expansive view of the erotic in the psychoanalytic relationship, although predominantly in the realm of the male/female dyad. There is a paucity of material written about same sex attraction in the analytic dyad, indicating it has perhaps not benefitted from the same curiosity, reflection, and understanding. We find this perplexing given the apparent acceptance of eroticism in the early parent/infant relationship that is unconstrained by gender boundaries. The Oedipal complex is discussed from both same sex and opposite sex permutations, and some suggest it is essential that the child feels desired by parents of both sexes in order for a healthy maturational process to take place (Burch, 1996; Davies, 2003; Elise, 2002a; Mann, 1997). Should we not expect to see the same, same-sex erotic attachments replicated in the transferential matrix? This question planted the seed for this research.

During my training, I was surprised to realise any eroticism in the transferential matrix was disconcerting for me. After a patient declared his sexual interest, I took the issue to supervision. I focussed all my energy on the erotic transference which I now realise was a disavowal of my own desire. It was as if the issue belonged entirely to the patient. When asked about my countertransference, I replied that I was surprised, uncomfortable, and fairly certain I had not colluded in any way. Of course, the transference was an elaborate co-production with layers of meaning for both the patient and me. My embarrassment and shame at feeling anything like erotic countertransference alerted me to how difficult having any erotic feelings can be for a therapist. Indeed, it seems my inhibited response is not unique. Dianne Elise (2002b) gestured to how this response reverberates through the profession:

> This inhibition on the part of analysts extends to our participation in a particular professional community where, along with our colleagues, we generally act as if we are the parents who never "do it" or at least not in any way ever known to the "children". (p. 189)

I became more curious about the labels we attribute to people's sexual orientation, questioning their accuracy and utility, given the fluidity of attraction. All these elements were warming me to the question I would eventually posit for the purposes of the research: *How is homoerotic countertransference written about in psychoanalytic literature?*

Later, I read a paper by Eric Sherman (2002) "Homoerotic countertransference: The love that dare not speak its name". Sherman is one of the few authors who challenge therapists to think about same sex attraction in the therapeutic dyad. He proposes that there may be a myriad of reasons why therapists fail to address their homoerotic feelings in their work, including; something not resolved regarding their own sexuality, homophobia stemming from both individual and socio-cultural experiences, or feelings of guilt and shame. I began to wonder who else shared his opinion. I also reflected on my own attitudes and wondered whether I would feel comfortable discussing homoerotic countertransference with my clinical supervisor and peers? I concluded that I would find it difficult. This was a painful realisation, particularly as I worked in an agency where issues of gender identity and sexuality were a constant focus.

From Freud (1910/1953), who believes, "no psycho-analyst goes further than his own complexes and inner resistances permit" (p. 145), through to Hedges (2011), who states

"intimate relationships, including the psychotherapeutic one, provide us with an opportunity to experience ourselves and our sexual natures in ever new and rewarding contexts" (p. 169), there is a clear signalling that being open and honest with ourselves infuses the work with the greatest potency. With this in mind, I began my journey of systematically working my way through literature that made even the merest mention of homoerotic countertransference, with the hope of exploring the themes in the writing that might inform my attitude and that of others, in the service of understanding these phenomena which arise in the uniquely intimate therapeutic relationship. I was particularly interested in what themes were embedded beneath the surface of the writing, not necessarily immediately obvious to the reader, given the fact that homoerotic countertransference appeared so often to lurk in the shadows rather than be addressed openly and directly.

With the above motivations in mind, the following section provides an overview of the methodology and methods which informed this thematic analysis research.

The research

Methodology

Thematic analysis is particularly helpful in organising data from a range of sources due to its inherent flexibility (Braun & Clarke, 2006). It allows for a detailed and intricate exploration of multiple analysts' thinking on the subject, of homoerotic countertransference, and enabled the identification of underlying themes.

Definitions

The concept of countertransference has been defined more and more broadly as psychoanalytic thinking has developed (Freud, 1910/1953; Kwawer, 1980; Racker, 1953; Searles, 1959). Definitions have become more inclusive of all aspects of therapists' subjectivity. I therefore utilised the inclusive interpretation of the phenomenon by English and Pearson who state, "It is impossible for the physician not to have some attitude toward the patient, and this is called countertransference. In other words, *everything* that the analyst feels toward his patient is countertransference" (as cited in Orr, 1954, p. 649; italics in original text).

Similarly, I employed David Mann's (1997) explanation of the erotic because of its broad conceptual reach. He describes the erotic as being at the heart of all phantasy:

> I bring both the idea of love and sex into the unifying concept of Eros. The erotic includes all sexual and sensual feelings or fantasies a person may have. It should not be identified solely with attraction or sexual arousal as it may also include anxiety or the excitement generated by the revolting. (p. 6)

Because the topic is *homo*erotic, the focus for this research was on all erotic material arising between same sex individuals, regardless of sexual orientation. Again, I concur with Mann's (1997) assessment of "homoerotic" that it "relates merely to a kind of erotic desire and does not imply a compulsion to express itself in action" (p. 103).

Data collection

The primary search used the Psychoanalytic Electronic Publishing (PEP Archive 1 Version 11) database which contains comprehensive coverage of psychoanalytic journals and 70 classic psychoanalytic books. OvidSP, Sage Journals, ProQuest Central, and EBSCO databases were also included. The search therefore covered thousands of peer-reviewed journals, e books, and books. Table 1 summarises the primary search.

Table 1.

Summary of Search

Engine	Search Terms	Results
PEP	Homoerotic AND Countertransference	194
PEP	"homoerotic countertransference"	7
OvidSP	Homoerotic or "same sex" AND countertransference	38
OvidSP	Homo* adj5 countertransference	52
OvidSP	Homoerotic adj5 countertransference	12
ProQuest	Homoerotic AND Countertransference	155
EBSCO	Homoerotic in all text AND Countertransference in all text	62
EBSCO	"same sex" in all text AND Countertransference in subject	9
Sage Journals	Homoerotic AND Countertransference in all fields	34
	Total:	563

Braun and Clarke's (2006) six recommended phases of thematic analysis were then applied. The first phase, referred to as data familiarisation, involved reading, rereading, and recording any initial responses to the selected data set. The second phase involved the generation of initial codes. A selection of the particularly pertinent articles was identified and coded. Once all data were collated and coded, a broader examination of the embedded themes began, and 18 themes were identified.

The fourth phase involved the construction of a thematic map arising from these themes, in which the data were reread, and additional coding or recoding occurred. Phase five involved "identifying the 'essence' of what each theme is about" (Braun & Clarke, 2006, p. 92). Finally, phase six involved distilling the findings, and, in particular, the essence of the themes that had emerged both explicit and implicit, regarding homoerotic countertransference. Phase six enabled illumination of overarching themes that bound the separate sub-themes together in a meaningful way, and involved the following two stages, which ultimately distilled the material into four predominant themes.

Stage one

Stage One involved an allocation of the 18 themes into four discrete categories based upon what I considered to be synergistic concepts. I looked for any obvious characteristic that linked or separated themes. The four categories I distilled were: fear, taboo, desire, and acceptance.

1. Fear. Avoidance, homophobia, defending against/resistance, fear, therapist negative affect, professional superego, enactment, and dangerous all seemed to have elements of anxiety and fear in them. The list of coded material that had an element of fear embedded in it was extensive.

2. Taboo. The next stand out feature of the remaining themes was a sense of taboo regarding the phenomenon. Transgression, forbidden, shame, guilt, and difficult fell into this broader theme.

In considering both fear and taboo, I concluded that, while there is some overlap, they were distinct in important ways. Freud (1950) comments: "Taboo is a primeval prohibition forcibly imposed (by some authority) from outside and directed against the most powerful longings to which human beings are subject" (p. 35). Fershtman et al. (2008) offer a more contemporaneous definition, "[a] taboo is an 'unthinkable' action, that is, even the thought of violating it triggers social punishment. Taboos are the social 'thought police', discouraging individuals from considering certain types of actions" (p. 1). It appeared that taboo linked to homoerotic countertransference was related to an external authority, the collective attitudes of the profession, and the influence of society's response to same sex attraction. Within the literature, taboo was evidenced, for example, in Mann's (1997) comment that homoeroticism in the therapeutic relationship is more alarming because homosexuality is still believed to be a perversion by some people. Frommer (2002) comments that homoerotic countertransferences in males and females are multiple transgressive sites. These comments reflect the attitudes of wider society as they impact on and are experienced in the therapist. If taboo reflects the external prohibition of wider society in relation to homoerotic countertransference, fear is often the internal manifestation of this external pressure, within the clinician.

3. Desire. This left the themes of desire, developmental references, beneficial potential of homoerotic countertransference, qualities in the therapist, and seduction. Desire and seduction were clearly linked. I assigned the term 'desire' to this new broader category.

4. Acceptance. When considering the themes 'beneficial potential of homoerotic countertransference' and 'qualities in the therapist', both of which feature in the above category of desire, there was an important binding characteristic that warranted a discrete category and that was 'acceptance' of the phenomenon, something that was often not evident, and indeed defended against, in relation to 'desire', in the literature reviewed.

Developmental

I realised that of the four themes I had arrived at—desire, fear, taboo, acceptance—there were developmental references that traversed each of these, often multiple times. For example, the coded meaning units in Table 2 illustrate how 'developmental' coded meaning units could then be related to the broader overarching themes of desire, fear, taboo, and acceptance.

Table 2.

Illustration of the Redistribution of Coded Meaning Units Related to Developmental References

Coded meaning units related to developmental references	Distribution into new broader themes
Therapist as father experiences lust as incestuous	Taboo Desire Fear
Same sex desire seen as healthy part of Oedipal situation	Desire Acceptance
Gets patient in touch with need to be desired by father figure	Desire Acceptance
Ignoring desire avoids intimacy—therapist becomes rejecting mother	Desire Fear

I was tempted at this point to add 'developmental' or more specifically 'Oedipal' as a fifth discrete theme, but decided that, whilst developmental references were prevalent, they were not predominant in the same way as the other four named themes. Nevertheless, my consideration of developmental references led me to stage two of phase six, the identification of overarching themes and the search for any potential overlap or intersection of ideas.

Stage two: Desire, a central theme

The following illustrates how I interpreted desire, and how it had a presence in all references to homoerotic countertransference in the literature.

Desire

> v.t To wish or long for, crave, to hanker after, to covet, to yearn for, to solicit and to have a sexual appetite for. (*Collins Dictionary of the English Language*, 2001)

Desire, as it is defined above, appears frequently within the researched literature across all four main themes identified above, and, I concluded, was a central theme linking all other themes in this analysis. In deciding which were central themes I was guided by the principles outlined by Morris Opler (as cited in Ryan & Bernard, 2003) who believes that the importance of any theme related to:

> (1) how often it appears, (2) how pervasive it is across different types of cultural ideas and practices, (3) how people react when the theme is violated, and (4) the degree to which the number, force, and variety of a theme's expression is controlled by specific contexts. (p. 87)

In naming desire as a central theme, I came to view it in a broader, more inclusive sense. I saw it as being much more than phantasy, seduction, and enactment. It occupied a latent presence in all the second-generation themes when I fully considered what was central to each meaning unit.

For example, desire's relationship to love, arousal, and excitement, elements featured in early coded meaning units, is clear. It also underpins all the defences named in the coding such as avoidance and disavowal, both ways of neutralising desire. Guilt was affectively linked to the therapist's desire, for example Sherman (2005) speaks of how the guilt related to his desire prevented him from "thinking straight" (p. 62). Phillips (2002) contends therapists feel guilty about arousal even when no boundary is actually broken. Arousal, I interpreted as being a physiological response to desire.

Homoerotic desire evokes worry about dangerous enactments in both patient and therapist (Mann, 1997). Desire was written about by many of the authors as being dangerous (De Peyer, 2007; Mann, 1997; Meyers, 2001; Morrison, 1998; Sherman, 2002a, 2002b, 2005) and ownership of desire in the therapist was noted as feeling dangerous for some (De Peyer, 2007). Sherman (2002a) describes writing about homoerotic countertransference as 'dangerously uncertain'. Additionally, desire has been described as anxiety provoking (Coen, 1996; Elise, 2002a, 2002b; Flower, 2007; Hedges, 2011; Kassoff, 2004; Mann, 1997; Meyers, 2001; Morrison, 1998; Sherman, 2002a, 2005), and frequently seen as problematic (Coen, 1996; Elise, 2002a, 2002b; Flower, 2007; Mann, 1997; McWilliams, 1996).

There were coded meaning units where some licence was taken in interpreting desire as a component. For example, with the meaning unit, 'gay therapist afraid of leading patient on', I would make the assumption that desire is implicit in the meaning unit. As the analysis progressed, desire moved from being linked only to desire and seduction to permeating all aspects of the literature on homoerotic countertransference. It underpinned both the positive and negative aspects of the clinician's experience and was central to the earliest developmental explanations of erotic connection. Table 3 summarises the second-generation themes reappraised as having links to desire.

Table 3.

Second-Generation Themes Linking to Desire

Desire	Homoerotic countertransference seen as a transgression
	Forbidden
	Shame
	Guilt
	Difficult
	Dangerous
	Professional Superego
	Homophobia
	Fear
	Enactment
	Avoidance
	Defending against/Resistance
	Therapist negative affect
	Desire
	Developmental references
	Seduction
	Beneficial potential of homoerotic countertransference
	Qualities in the therapist

Fear

> n. The anxiety that is produced in relation to the outcome of something. An unpleasant emotion caused by the threat of danger, pain, or harm. The likelihood of something unwelcome happening. (*Collins Dictionary of the English Language*, 2001)

Having recognised desire as ubiquitous, I returned to consideration of the theme of fear, and upon reflection reappraised fear, like desire, as an overarching construct. I had originally conceptualised fear as a theme based on any reference to anxiety or fear in the literature. However, upon re-examining the second-generation themes, I recognised that underpinning a significant portion of them was fear, and that this affect was often embedded somewhere in the latent meaning.

For example, fear is at times closely linked to 'enactment'. Maroda (2001) notes that the difficulty in working with erotic transferences, no matter the sexual orientation of the dyad, is the combination of fear and a desire that the feelings will be acted on. Coen (1996) writes of ways others well versed in the complexity of erotic countertransference, such as Glen Gabbard, managed their fear of homoerotic countertransference, opting for interpreting a paternal transference rather than working with the mutual desire for love that was in the room.

Fear did not maintain a solely negative thematic presence in the literature. Some authors write about the impact of facing their fear of homoerotic countertransference and how it aided the patient (Flower, 2007; Phillips, 2002). Fear was, more often than not, linked to the defences against homoerotic countertransference; for example, denial of homoerotic countertransference unwittingly increased fears of being manipulated or misused by the patient (Meyers, 2001). Fear was implicit in any homophobic coded meaning unit and these units were numerous. It was also a significant contributor to the categories of dangerous and developmental references. Avoidance and fear were often entangled, for example, Coen (1996), Elise (2002a), and Mann, (1997) all refer to avoidance as being a way of preventing something painful occurring. Fear was written about as though it emanated from within the individual.

As previously discussed fear and desire were clearly linked. Subsequently, when the other two central themes of taboo and acceptance were identified, it was clear that fear was closely linked to these themes as well. For example, with the coded meaning units 'tensions present between danger and anxiety' (Sherman, 2002a) and 'gay therapists afraid of being out of control' (Rosiello, 2001; Sherman, 2005), I could recognise elements of fear, taboo, and desire.

Fear and acceptance could have a positive impact on the work, as Meyers (2001) illustrates. She felt that the therapist's acceptance of their own sexual feelings and that of the patient, helped abate the patient's fear of abandonment. Fear and acceptance, in this case, added an unpredictable potency to the work. In addition, after careful scrutiny of the meaning units, I found a number that linked to both themes of fear and desire (see Table 4).

Table 4.
Second-Generation Themes Relating to Fear and Desire

Fear and Desire	Dangerous
	Professional Superego
	Homophobia
	Fear
	Enactment
	Avoidance
	Defending against/Resistance
	Therapist negative affect
	Desire
	Developmental references
	Beneficial potential of homoerotic countertransference
	Qualities in the therapist

Taboo

> n. A custom prohibiting or restricting a particular practice or forbidding association with a particular person, place, or thing. (*Collins Dictionary of the English Language*, 2001)

If the significance of a theme is related to the frequency of its appearance or the response to its violation (Opler as cited in Ryan & Bernard, 2003), then taboo asserted itself as a theme of some prominence. Within the literature, it is almost as thematically pervasive as desire.

The themes and sub themes identified in the analysis support this proposition. For example, transgression suggests a violation of accepted or imposed boundaries, especially those of social acceptability. It implies the breaking of a socially constructed taboo. There is a large body of evidence suggesting that the profession viewed homosexuality, and by inference same sex attraction, as a transgressive activity, therefore taboo. This is exemplified in any meaning unit with a homophobic or heteronormative reference. Sherman (2002a) believes that society's views of what is normal and acceptable get transgressed when a therapist experiences homoerotic countertransference. This relates to homonegativity which is directed at anything that is believed to be a flouting of conventional, acceptable practice.

As established in Stage One of this phase, transgression, forbidden, shame, guilt, avoidance, all had a relationship with the theme of taboo. I was able to add developmental references and professional judgement to this theme as they, too, had elements of taboo embedded. The incest taboo was most commonly mentioned when homoerotic countertransference was linked to the Oedipal phenomenon (Elise, 2002a, 2002b; Mann, 1997; Sherman, 2002b). Professional judgement was linked to taboo with coded meaning units such as Friedman's (1998) wondering whether any same sex feelings were acceptable.

There is a sense of taboo that causes confusion, guilt, and secrecy, particularly amongst gay practitioners (De Peyer 2007; Morrison, 1998; Sherman, 2002b). There is the sense that acknowledging the homoerotic countertransference will expose one to shame and professional judgement (Coen, 1996; Friedman, 1998; Morrison, 1998; Rosiello, 2001).

Frommer (2002) thinks that homoerotic countertransference represented multiple transgressive sites because it frequently violates the socially constructed roles linked to gender. If an individual feels that they have transgressed a societal taboo, shame can become the by-product. Denial of homoerotic feelings in the therapist may be linked to a taboo surrounding the procreative primal scene (Mann, 1997). Some authors wonder whether *any* homosexual feelings are acceptable in the work (Friedman, 1998; Morrison, 1998).

As the coding was revisited, it appeared that there was both a distinction between fear and taboo and a strong relationship between them. Therapist negative affect, enactment, professional superego, desire, fear, avoidance, defending against/resistance, homophobia, dangerous, and developmental references are themes that transcended both categories (see Table 5). Perhaps one of the most omnipresent examples of the marriage of fear and taboo is homophobia which is frequently mentioned in the context of homoerotic countertransference. Flower (2007) refers to its pervasiveness in the following quote: "Psychotherapists working with gay men may well then have to contend with a range of responses that are rooted both in collective homophobia and unconscious homosexual feelings, including towards their own same sex parent" (p. 440).

Table 5.
Second-Generation Themes Relating with Desire, Fear, and/or Taboo

Desire; Fear; Taboo	Dangerous Professional Superego Homophobia Fear Enactment Avoidance Defending against/Resistance Therapist negative affect Desire Developmental references
Desire; Fear	Beneficial potential of homoerotic countertransference Qualities in the therapist
Desire; Taboo	Seduction Homoerotic countertransference seen as a transgression Forbidden Shame Difficult Guilt

Acceptance

The final overarching theme that illustrates how homoerotic countertransference is written about in psychoanalytic literature is acceptance. I defined this broad, inclusive theme as a willingness to undertake an exploration of homoerotic countertransference even in the face of personal and professional discomfort. I also viewed it as willingness to consider homoerotic countertransference as being valid and potentially useful.

The second-generation themes of homoerotic countertransference—transgression, shame, guilt, forbidden, fear, avoidance, desire, developmental references, homophobia, defending against/resistance, beneficial potential of homoerotic countertransference, qualities of the therapist, seduction—all linked to this broader theme in some way. As explained earlier, when homoerotic countertransference was written about in a positive light, its potential as a therapeutic tool was frequently referred to. Table 6 offers a selection of meaning units that were included under this theme and which linked strongly with the theme of desire.

Table 6.
Coded Meaning Units Linked to Both Desire and Acceptance

Desire and acceptance	Literature on homoerotic countertransference mostly written by females
	Can arise in any treatment
	Therapist needs to make use of the homoerotic
	Therapist needs to engage in dangerous psychic acrobatics
	Relationship between symbolic sexual "play" in analysis and the capacity for creativity

Sometimes a seemingly negative affect like shame was interpreted from a positive point of view. For example, Frommer (2002) thinks that shame in response to homoerotic countertransference could be useful, as it can allude to something in the patient. Similarly, Mann (1997) considers that homoerotic desire could be an expression of pre-Oedipal sexuality when people in general are more in touch with polymorphous perversity. Many authors (e.g., De Peyer, 2007; Elise, 2002a, 2007; Mann, 1997) refer to the power of the homoerotic countertransference in an Oedipal sense. The patient/child feels desired by the same sex parent which is often a reparative developmental experience. Others speak of the loss if this has not occurred either in the patient's past or in the transferential matrix (De Peyer, 2007).

Acceptance was characterised in many comments in the literature by what a therapist could or should do in response to their homoerotic countertransference. Whilst not explicitly stated, this implied that acceptance of the phenomenon could lead to some positive gain therapeutically. An example of such a comment is from McWilliams (1996) who says that, in order to help gay and lesbian patients, straight therapists need awareness of non-dominant wishes. Flower (2007) also said that grappling with one's homophobia and defences leads to acceptance and, therefore, greater depth to the work.

Some of the literature alluded to how therapists can become fixed in the meanings they attribute to feelings and actions that link them to a particular sexual identity, potentially limiting the work that they do. Some of the analysed material acknowledged this in relation to homoerotic countertransference and made reference to what could be achieved if clinicians remained more open to their countertransferential experience (Elise, 2002b; Flower, 2007; Mann, 1997; Meyers, 2001; Searles, 1959; Sherman, 2002b). Sherman (2002b) feels that in his treatment of Kevin the sensual desire that infused the treatment created potential. He values his ability to play with the homoerotic countertransference as it had a potentially positive impact for the patient. Meyers (2001) finds that a therapist's acceptance of their own sexual feelings and those of the patient, helps abate the patient's fear of

abandonment. Furthermore, potential is created when the therapist is prepared to confront their own prejudices (Flower, 2007; Mann, 1997; McWilliams, 1996). Coded meaning units such as these came within the scope of acceptance. I supposed that the authors are implying that if the therapist accepts their own process, then the work is enriched.

Beneath the umbrella of acceptance was a theme of 'qualities in the therapist'. This theme included any reference in the literature to ways in which the therapist could best utilise the homoerotic countertransference. In my opinion, it also implies acceptance. There were many direct references to what the therapist 'needed' to do; for example, 'roll with complexity' (Sherman, 2002b), 'allow a full range of sexual feelings' (Sherman, 2002b), 'feel not just think' (Elise, 1991), and 'lift superego injunctions' (Mann, 1997). These things could not be incorporated into the work without acceptance.

Discussion

The following discussion of the findings described above considers their implications for clinical practice, training, and research.

Desire

The findings of this research place desire as a central theme with the other three themes—fear, taboo, acceptance—being in response to desire. It may seem unsurprising that desire is such a central theme, given the 'erotic' material being analysed. One can recognise that semantically and conceptually there is a connection between eros and desire. However, what was striking in the analysis of the literature was that while desire emerged as central, it frequently surfaced out of the shadows and was not consistently at the forefront in the literature. This we found less predictable but illuminating. For example, a coded meaning unit such as 'analyst shares something forbidden' (Sherman, 2002b), in the context of the literature from which it emanated, is underscored by desire; yet the desire is not explicitly stated. The fact that the desire is forbidden, highlights its relationship to the themes of taboo and fear. This is one of many examples that reflected the avoidance or shyness surrounding homoerotic desire.

The literature spoke of how desire can lead to fluctuating responses in the dyad. As Sherman (2002b) described it, there can be sudden moves from hyperarousal to stiff rigid professionalism in the therapist. At times, the writing intimated that the feelings of homoerotic countertransference surfaced only to be disavowed by either the author's professional or personal superego or both. For example, Rosiello's (2001) comment that disclosure of desire brings professional risk, Elise's (2007) expectation of disapproval from the profession, and De Peyer's (2007) reference to the 'professional analytic costume' that shrouds desire.

It is also important to note that the desire that permeated the literature on homoerotic countertransference was not exclusively erotic. Desire was frequently linked to intimacy. The psychotherapeutic relationship is uniquely intimate. As Schwartz (2000) commented, intimacy is all about desire—a desire to know and be known.

Fear and taboo

As the analysis revealed, taboo and fear are dominant motifs in homoerotic countertransference. Taboo reflects the external societal anxiety and fear is often the individual subjective and internal manifestation of this external anxiety and prohibition. Sometimes these two themes had a symbiotic relationship, each justifying and sustaining the other's existence. However, fear was not exclusively entwined with taboo. For example, anxieties that were coded and linked to the theme of fear were sometimes a reflection of how the therapist responded to feeling any desire at all towards the patient and a lack of knowing about how to manage such strong feelings (Elise, 2002b; Kassoff, 2004; Mann, 1997; Searles, 1959; Sherman, 2002b).

Taboo is a response to a perceived external authority, perhaps most overtly recognisable in the many comments that refer to the fear of professional judgment regarding homoerotic countertransference. However, the taboo that emerged throughout the analysis was multi-faceted. Homoerotic countertransference was at times ardently defended against as a phenomenon leading to challenges issued within the literature such as that from Maroda (2001), who suggests that disavowal of the homoerotic can potentially indicate something unresolved in the therapist, and from Flower (2007) who wrote that challenges arising in the countertransference are linked to the intrusion of personal prejudice and discomfort. Both authors are potentially referring to introjected societal taboos. Taboo also had strong links to the relationship between desire and the analytic frame. For example, Mann (1997) comments that many writers feel the need to reassure the reader that they do not act on their erotic countertransferences, stating "The underlying anxiety seems to be that if you talk about the erotic then other therapists will think you act on your feelings; to think about it is to do it" (p. 193).

The research illustrated the effort some therapists make to repress and disavow their homoerotic desires. Yet this was in contrast, at times, to other threads of meaning woven throughout the analysis, such as the importance and legitimacy of the early developmental expressions of polymorphous inclinations. This eschewal of same sex desire in the therapeutic dyad negates the principle that we can regress and express any number of early developmental and relational experiences in the transference. By association, it also potentially undermines developmental theorists' opinion that our sexual orientation is not hardwired from birth. Recent brain imaging research indicates that our sexuality is inherently idiosyncratic and ever shifting (Hedges, 2011). This research supports Freud's (1910/1953) early declaration that we are all born with polymorphous inclinations and, according to Nancy McWilliams (1996),

> Freud was not wrong about polymorphousness. We all can find in ourselves dormant or latent aspects of every kind of sexual longing.... A genuinely empathic stance requires more than the intellectual "admission" of polymorphous trends; it requires that the therapist be able to feel and enjoy them. (p. 211)

What this research revealed was that the authors were comfortable referring to same sex longing within the context of Oedipal phenomena, legitimising the emergence of the earlier themes of 'developmental references'. However, Oedipal and post Oedipal expressions of desire were less easily tolerated and frequently defended against or disavowed. The findings of this research suggest that we need to acknowledge our bisexual participation in the

Oedipal drama that can play out in therapy and, in doing so, we then allow much more creativity to emerge in the work (Elise, 2002b; Flower, 2007; Hedges, 2011; Mann, 1997).

Seduction is perhaps the errant child of desire. Some literature (e.g., Maroda, 2001) is scornful of seductive behaviour originating in the therapist from an ethical perspective. We suggest, however, that whether or not we are comfortable with it, these responses and behaviours can enter the therapeutic frame quite unconsciously. We need to be prepared to explore this countertransference openly, regardless of the gender of the dyad. In this analysis, coded meaning units related to seduction were interpreted as being clear derivatives of desire and, therefore, a key aspect of how homoerotic countertransference is written about in psychoanalytic literature.

Perhaps the findings of this research reflect that we as clinicians are at risk of disavowing one of the core principles of contemporary psychoanalytic thinking—that we are inherently object seeking, and that, for most of us, there is deep desire within to be known and felt regardless of the gender of those with whom we interact.

The data set was heavily weighted to gay and lesbian writers as it is they who have initiated much of the discussion in this domain. One may argue that this is predictable given that same sex attraction is within the realms of their everyday experience. However, given that most psychoanalytic training institutions only considered openly homosexual/gay candidates for training in the 1980s, at the very earliest, and that homosexuality was pathologised to such an extent that it was a classified disorder in the American Psychiatric Associations' *Diagnostic and Statistical Manuals of Mental Disorders* until 1973, it may have been risky to reflect on any erotic attraction as a heterosexual, gay, or lesbian therapist. In some contexts this may not have changed. This gives further resonance to Elise's (2002b, 2007) writing. She reflects that we act as though therapists are not supposed to be sexual beings. Her reasons include a lack of focus in analytic training and theory on issues pertaining to sexuality, and to the familial nature of the therapeutic relationship, inciting feelings of discomfort if either person in the dyad is desired.

The analysis further highlighted that any desire, taboo, or fear that the patient experiences and defends against is likely to be evoked in the countertransference. Clinically we need to be attuned to this and accept that it is important information.

Acceptance

The theme of acceptance which related to any positive aspect of homoerotic countertransference or a willingness to at least think about the negative aspects, imbued the work with hope for better outcomes in the dyad by attending to the erotic coproduction between therapist and patient. Acceptance also intersected with the more negative themes of fear and taboo. Negative aspects of homoerotic countertransference such as fear, shame, and guilt need not be disavowed but acknowledged, accepted, and even appreciated. Analysis of the literature suggested that when this occurred the therapy had greater puissance. Clinically, acceptance requires an open mind and a willingness to sit with discomfort. It demands a dismantling of defences and a curiosity about the intersubjective experience.

Clinically we are trained to value the transferential matrix as an important source of

information, and to realise that the work lies in recognising and making sense of all feelings that emerge, not just those with which we are comfortable. Nor can we 'blame' our patients for some of our strong reactions.

It is in the best interests of the client and the work to keep an open mind regarding the range of possible feelings, and a willingness to accept that some responses, such as homoerotic countertransference, are potentially outside our range of previous experience. This may seem an obvious proclamation; however, if it was a generally accepted and practiced truth, then we suggest taboo and fear would not have been uncovered as such prominent and predominant themes within this analysis.

Desire and Acceptance

The findings of this research illustrate that desire, and the multitude of ways it can emerge in therapy, is a dominant theme in the writing about homoerotic countertransference. Despite the prevalence of this central theme, there are authors who believe desire in the therapist can potentially signal something much more problematic and unresolved (Bonasia, 2001; Gabbard, 1994). In some cases, this may be accurate. However, to view countertransferential desire solely through this lens, would seem reminiscent of more archaic ways of viewing countertransference, where any feelings in relation to the patient were pathologised, seen as questionable, and in need of further analysis. The findings of this research suggest that perhaps desire in the intimate therapy setting is inevitable. We propose that whilst there are important boundaries essential for keeping patient and clinician safe from sexual acting out, this does not necessitate the disavowal of desire. Additionally, the clinician who experiences desire is not necessarily 'lovesick', a term Gabbard (1994) used to describe the therapist who responds to sexual overtures from the patient as a means of sating their own narcissistic requirements. As the research illustrated, desire, and in particular homoerotic desire, is shrouded in fear and taboo. We contend that the findings of this research support the notion that it is not desire that is problematic, but the fear and taboo that underscores it and the consequent disavowal of potentially rich clinical data, which homoerotic countertransference offers. The theme of acceptance points to the possibility that when we accept desire and other aspects of homoerotic countertransference as phenomena that inform clinical work, and we are willing to think about their complexity and meaning, then the greatest gains are made.

Recommendations

Training

From conversations I have had with colleagues, the little education/training in psychotherapy I received concerning erotic countertransference is reflective of the training many others have received in other psychotherapy educational programmes. This research exposed the fact that other psychoanalytic writers have also experienced a deficit in this domain. It appears that it is not uncommon for issues pertaining to the erotic and sexuality to be avoided despite the inevitability that they will form an important aspect of the work therapists do. This avoidance, however, has seemingly led to us not knowing what to do with our feelings and to a fear of speaking out about them.

Elise (2002b) refers to our avoidance as a profession of issues pertaining to sexuality in general:

> When in training is there discussion of our own sexuality and how it would be appropriately integrated into our professional lives? The absence of such discussions further reinforces the sense that the "sexiness" of clinicians is a completely inappropriate topic. Yet we know that we use ourselves as our analysing instrument. (p. 189)

Mann (1997) thinks that the profession's historical homophobic attitudes towards training gay people has impacted how we view the homoerotic in the work today. He discusses how lack of preparation for these feelings in training can lead to concealment. Mann believes if therapists do not deal with their homoerotic feelings in their personal analysis, it will hinder the same feelings being attended to in the transference and countertransference with their patients. Writing in 1998, Morrison wonders whether any homosexual feelings are acceptable to the profession and said, "One's psychoanalytic training institute may be seen as a collective ego ideal that sits heavily upon a candidate's shoulder, whispering judgments about what is and isn't acceptable" (p. 358). We suggest that in training we need to face the reality of all forms of erotic countertransference feelings in order to extract the best from ourselves and the work, and in the best interests of the patient.

Homoerotic transference was never mentioned in my training. Yet there was an intense focus given to Oedipal dynamics in the work we do and the acknowledgment that homoerotic feelings are a common feature of the parent/child dyad. Given the general avoidance of homoerotic transferences in the literature and training, one could perceive that there is little expectation that these feelings will be mirrored in the therapeutic dyad. However, after completing this analysis, we are now of the opinion that these feelings do emerge in the work but, as a profession, we tend to disavow them, due to the discomfort within the profession and society in general with same sex attraction. Simply put, it is as if the homoerotic is absolutely explicable and predictable in a developmental sense but beyond that these feelings are aberrant. Why else would we work so hard to ignore or shroud them?

Clinical practice

At the beginning of this paper, we noted that erotic countertransference can be difficult to discuss in clinical circles. Given the findings of this research, we are confident homoerotic countertransference would take this impasse to a whole new level. The research clearly illustrated that this particular expression of desire is complex, ambiguous, and not at all easy to talk about. One of the explanations that emerged out of this analysis is the implicit heteronormative influences within the literature, the profession, and society at large. To be complicit with this heteronormativity as a therapist means to assume a restrictive lens through which to view the therapeutic relationship. It forecloses many opportunities to learn about the patient, oneself, and the intersubjective experience. We have concluded that not attending to homoerotic countertransference, due to the overbearing influence of fear and taboo, only serves to cauterise our efficacy as clinicians and bolster the false self in both patient and therapist. It may be useful for clinicians to think more spaciously about the binary constructs of homo and heterosexuality in terms of countertransference, particularly if we acknowledge that our sexuality has the potential be quite fluid in nature. It may be that we also have to acknowledge that our sexual orientation may have an unconscious life

of its own. As Miller (2006) contends:

> No one group has ownership of the homoerotic or heteroerotic… Simply put, the law of Eros operates regardless of how we may experience our conscious sexuality. Eros draws us toward contact with what the psyche needs. (p. 396)

Desire in the uniquely intimate analytic setting, be it hetero or homoerotic, is necessarily bound by explicit and implicit rules regarding acting on these feelings, which are essential for keeping both the therapist and patient safe. But denial of such feelings is potentially more dangerous than acceptance and utilisation of these feelings in the service of the work. We suggest that by encouraging clinicians to explore honestly their transferential feelings, including the homoerotic, there is considerable potential created to broaden the scope of our work, thereby fulfilling the intent of the therapeutic endeavour to assist our patients to live and love fully.

Conclusion

This research has explored homoerotic countertransference in psychoanalytic literature. A thematic analysis was undertaken of 27 articles looking for the explicit and latently embedded themes. The findings indicate that desire, taboo, fear, and acceptance are the four major themes that reflect the essence of the writing explored and that Oedipal material is woven within each of these. Desire, in a range of guises, was seen to be the formative underlying presence. Desire was seen in the erotic aspects of the work, the yearning for intimacy and connection within the dyad, and, at times, was notable by its absence. Fear and taboo were discrete and, at times, intertwined themes. Fear described the internal experience of the clinician and taboo appeared to reflect the socio-cultural impact of attitudes towards same sex attraction within the work. The Oedipal material woven within these themes reflected the inevitability of homoerotic feelings, which within the psychoanalytic literature analysed are assumed to occur in pre Oedipal development and are strongly disavowed in the therapeutic dyad. Acceptance was a theme that referred to the beneficial aspects of embracing the phenomenon of homoerotic countertransference. It encompassed all references to what could be both understood and achieved when the homoerotic was not defended against or avoided. This research strongly supports the need for clinicians to embrace the homoerotic in their work with the same curiosity, candour, and receptivity as any other dynamic that may emerge in the transferential matrix.

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Paper 8 (2014)

The body as a resource in psychotherapy: A framework

Rosemary Beever

> You do not have to be good.
> You do not have to walk on your knees
> for a hundred miles through the desert, repenting.
> You only have to let the soft animal of your body
> love what it loves.
>
> (Oliver, 1992, p. 110)

The notion of *the body as a resource* implies a relationship to the body as a source of wisdom, guidance, strength, and creativity; a state in which we can allow the "soft animal" of the body to "love what it loves". My dissertation (Beever, 2014) explores this concept within psychotherapy, through a hermeneutic literature review. This paper outlines the core findings of my dissertation and their implications for practice. In my original dissertation, I identify two overarching themes and four main ways of relating to the body as a resource in psychotherapy. In elaborating on this framework while writing this paper, I have extended the findings to include a fifth mode. I describe and discuss this, with reference to some of the literature reviewed. I also touch on the challenges I experienced in writing about embodiment in an academic style.

I was drawn to exploring the experience and use of the body as a resource because my own experience in personal therapy, as well as in a range of somatic practices, had continually deepened my conviction that embodied awareness and movement are keys to psychic and somatic change and growth. My concurrent training in bioenergetics (a form of body psychotherapy developed by Alexander Lowen), and in psychodynamic psychotherapy, generated an ongoing creative tension within me between these two different yet connected approaches, and a passionate interest in exploring how they could inform and enrich each other, both theoretically and in practice.

The word 'resource' attracted me early in my research process, when I came across a dialogue about the way body psychotherapists "see the body as a resource" (Carroll & Orbach, 2006, p. 76). Etymologically the word "resource" comes from the Middle French *resourdre* "to rise up again", from the classical Latin *resurgere* (Oxford, 2014a). It is connected with the word source, meaning "the spring or place from which a flow of water takes its beginning" (Oxford, 2014b). Understanding this explains why the word seems to encapsulate, for me, a sense of something life giving, vital, and vigorous.

Within psychotherapy, the word resource is used particularly in trauma therapy, where the work of building a traumatised client's resources is generally considered to be a fundamental aspect of the first stage of trauma work, which Herman (1992) names "establishment of

safety" (p. 155). Ogden et al. (2006) state that "by *resources* we mean all the personal skills, abilities, objects, relationships and services that facilitate self-regulation and provide a sense of competence and resilience" (p. 207) and that "somatic resources comprise the category of abilities that emerge from physical experience yet influence psychological health" (p. 207).

Body psychotherapy and somatic trauma therapies have a substantial knowledge base regarding the use and experience of the body as a resource. They privilege somatic awareness and experience, giving this a central place in the therapy process. Historically, psychoanalysis has largely ignored this aspect of the body, despite Freud's initial focus on body-based drives. However, contemporary psychoanalysis and psychodynamic psychotherapy, influenced by intersubjectivity, affective neuroscience, and trauma therapy, have increasingly acknowledged the body. Somatic countertransference, in particular, is seen as an important resource. Thus, I reviewed literature from all of these approaches; comparing, contrasting, and synthesising the wisdom they offered regarding the body as a resource. In keeping with my hermeneutic approach, I also incorporated some of my subjective responses to the literature.

A hermeneutic inquiry is a process of interpreting a text. It is understood that the researcher is part of a tradition and that their reading is "informed and shaped by the values, beliefs and 'prejudices' of that tradition" (McLeod, 2001, p. 27). It is not possible to achieve a wholly objective view; only to become more fully aware of our "prejudices" and our particular context, and to expand and enrich our "pre-understandings". Smythe and Spence (2012) describe the process of engaging with literature as seeking "conversational partners (through literature) to compare and expand… *(one's)* emerging thinking" (p. 21). The researcher's subjectivity and prior understanding is assumed to be an integral aspect of the research, to be recognised and held in mind while engaging with literature.

I struggled at times throughout the process of writing my dissertation; with the irony, contradiction, and, sometimes, pain of using conventional academic writing to explore the subject of embodiment. This academic "voice" frequently felt at odds with the somatic experiences I was writing about. I found Stern (1988, 2004) validating of this difficulty. He writes poignantly about the loss that occurs developmentally as a child begins to acquire language and move into "the sense of a verbal self" (Stern, 1998, p. 162), fracturing her rich, embodied "modal global experience" (Stern, 1998, p. 176). Stern (1998, 2004) highlights the inadequacy of language, particularly prose, to capture significant aspects of human experience and discusses the losses that occur in the process of making implicit knowing explicit and verbal. Thus, at times, I included a "voice" that emerged more directly from my body and emotions, wanting this voice to contribute to the "conversation" of my literature review; finding it enlivening, albeit vulnerable, when I did so.

Themes and findings

The first overarching theme that emerged in virtually every aspect of my research was that of body awareness. Compassionate awareness of one's internal somatic experience seems to be both a fundamental starting point, and often an end in itself in terms of somatic

resourcing. This deceptively simple capacity underpins every aspect of experiencing the body as a resource for both clients and therapists. Essentially, it involves deliberately focusing one's attention on body sensations which can include "the whole range of somatosensory phenomena: our breath, pulse, posture, muscle strength, fatigue, clarity and speed of thought, sense of boundedness; our skin, mucous membranes, bodily tension, facial expression, taste, smell, pulse, vitality" (Shapiro, 1996, p. 298). Helping clients to develop somatic awareness is a key aspect of body psychotherapy; and is seen as a particularly vital skill in somatic trauma therapy, as it allows clients to learn to regulate their affect and autonomic arousal (Levine, 1997; Ogden & Minton, 2000). While the need to develop this capacity is most dramatically apparent for dysregulated, traumatised clients, I believe it is an important resource for all of us, and one that requires regular practice of some kind to maintain and deepen. Psychodynamic psychotherapy places strong emphasis on insight and emotional awareness but does not tend to focus overtly on somatic awareness (Shapiro, 1996). I agree with Shapiro that this is a significant omission and that to include the "experiential body" (Shapiro, 1996, p. 298) more in our clinical work can deepen and expand its scope. I also resonate with Shapiro's difficulties in attending to the experiential body and its needs whilst engaged in academic writing. I concur with Johnson (2000) who suggests that the experiential body practices of Western academic life, which remain largely unexamined, nonetheless shape the kind of consciousness in which we engage. I often felt that working in this way, within the conventions of academic writing, limited the expression of my experiential body and the ways in which it might directly resource me and my writing. On one occasion, when feeling a familiar sense of flatness, dullness, and boredom in writing about body awareness, I decided to try to write about awareness from the inside, from my body:

> *Dropping down, following the breath into a place of stillness that is in perpetual movement. Feeling the solidity of my body holding me, earth supporting me, that I may let myself soften, become more fluid. Heart opening, sadness at how far I drift from this home that is my body. The insistent tightness in my neck, embodiment of this struggle. Movement impulse to let my head, neck, sway and release, stretching back shoulders, arms, opening chest, yawning expansion, connection from the mouth down into chest, belly, coughing as I land more deeply in visceral stuck-releasing centre, emotion-sensation all one. Finding feet, legs, pelvis, freedom to move what is stuck, kindness for what is stuck, feeling the ground I've gained, and so many miles to go. Movement releasing and energising, bringing something new into being that would stay forever unborn in the muted, frozen, rigidity that my body has learned, is unlearning, one breath at a time.*

This simple act of tuning into my body awareness, allowing and following it, describing and free associating to what I experienced, had a profound effect on my energetic state. I felt more alert, alive, relaxed, and grounded. This practice demonstrated to me, once again, the importance and power of embodied self-awareness. I saw this as part of the conversation that was happening within me, between my mind and body, as I worked on my dissertation.

The second key theme that emerged time and again in my literature review was the contrast between the body in solitude and the relational body. I came to see both of these as important aspects of using and experiencing the body as a resource. The concepts of self-regulation and dyadic regulation were fundamental to this understanding.

The foundations of our capacity to self-regulate are laid in early infancy, via attachment relationships, as researchers such as Schore (2012) demonstrates. Babies are born with a very limited capacity for self-regulation; thus, depend on their caregivers to help them to regulate arousal and affect. This requires that caregivers are psycho-biologically attuned to shifts in infants' states in order to regulate them, and also aware of their own misattunements in order to repair inevitable failures. This dyadic regulation gradually facilitates the development of the infant's own capacity to self-regulate (Schore, 2012). Similarly, in therapy, in working with developmental deficits, relational experiences of regulation may be vital in order for clients to learn to self-regulate. At the same time, I concur with Cornell (2008) that

> what the relational perspective too often overlooks is the fact that we as infants, children, and adults spend significant amounts of time *alone*, in a solitary relation to our own thoughts, affect states, reveries, and bodies. And when alone, we are not simply waiting desperately for someone else to show up so that we can be engaged in some sort of dyadic completion. An enormous amount of learning, of psychic growth, of self-organisation and disorganisation happen through our bodily experience when alone, engaged with one's self in the tasks of psychomotor mastery and in interaction with the physical environment. (p. 32)

Hence, the importance, also, of solitary experiences of regulation and connection with the body as a resource in therapy. Ultimately, I arrived at a simple framework which outlines five main ways of relating to the body as a resource in psychotherapy:

1. ***Therapist self-resourcing***: The therapist uses their own body as a resource for their self-regulation (which indirectly benefits their clients in significant ways).
2. ***The therapist's body as a therapeutic resource:*** The therapist draws on their somatic countertransference (Jacobs, 1973) as a resource to understand their client's experience and inform the therapeutic work.
3. ***The therapist's body as a resource for the client***: The client draws on the therapist's body as a resource. They may use the therapist's body as an "auxiliary body" or as part of a corrective emotional experience. This can be understood as "regressive dyadic regulation" (Rolef Ben-Shahar, 2014, p. 22).
4. ***The client's own body as a resource:*** The client is able to use their own body as a resource and self-regulate.
5. ***The shared, intersubjective body as a resource:*** Therapist and client draw on the intersubjective body as a resource, in a bi-directional, mutual yet asymmetrical way. This can be seen as "generative dyadic regulation" (Rolef Ben-Shahar, 2014, p. 23).

I will explore each of these ways of relating to the body in turn, with reference to some of the literature I drew on in my review. I do not see these states as a linear progression, or indeed as well-defined and separate; rather, I see them as interweaving in different ways. These ways of relating to the body also reflect the three modes of therapeutic action described by Stark (1999): i) one person psychology, which describes classical ego psychology and, as Klopstech (2009) notes, Lowenian bioenergetics; ii) one-and-a-half person psychology, which refers to approaches that posit the need for corrective emotional experience, such as self-psychology; and iii) two person psychology, which denotes relational or intersubjective approaches.

Therapist self-resourcing

In writing my dissertation, I coined the term "therapist self-resourcing" (to the best of my knowledge), as I feel that this has a slightly different emphasis from the term "therapist self-care". To me, therapist self-resourcing suggests a more active process of replenishing and developing somatic, emotional, and cognitive capacities. I concur with Baker's (2003) description of elements of therapist self-care, that self-awareness, self-regulation, and balance are key elements in somatic self-resourcing. I believe that the notion of somatic self-resourcing addresses the therapist's active development of their own somatic resources, both for their personal benefit *and* for the direct and indirect benefit of their work with clients. In terms of my framework, I believe that, to some extent, therapist self-resourcing is a foundation for all the other states. It is difficult, if not impossible, to support our clients to draw on their bodies, or our own, as resources, if we are not grounded in our own experience of somatic self-resourcing.

In reviewing the literature that related to the topic of self-resourcing, I found that this was an area in which trauma therapists, especially Babette Rothschild (2006), have taken a lead. Both psychodynamic and body psychotherapy literature seemed to be scarce. However, in my personal experience of body psychotherapy, I found that somatic self-resourcing was a strong focus throughout my bioenergetic training, which was not the case in my psychodynamic training. I also believe that, by its very nature, body psychotherapy fosters a greater attention on the part of the therapist to their own somatic experience, as well as bringing physical movement into the sessions which therapists will frequently demonstrate and participate in along with their clients. Both these factors, I suggest, may predispose body psychotherapists to be more conscious of the somatic dimension in their own self-regulation and self-care.

Rothschild (2002, 2004, 2006) draws on neuroscience to explore the dangers of empathy, and to provide guidelines for trauma therapists to protect themselves from vicarious traumatisation (McCann & Pearlman, 1990), via somatic awareness and techniques. Rothschild (2006) describes body awareness, and especially awareness of one's autonomic nervous system arousal, as a crucial tool in managing the demands of trauma therapy. She encouraged therapists to use somatic techniques to 'put on the brakes' of their own autonomic arousal (Rothschild, 2000), and to "apply the 'empathy brakes'" (Rothschild, 2004, p. 5); for example, increasing muscular tone in response to immediate stress may help to regulate arousal. Other techniques include working with physical boundaries and physical space; cultivating body armour in specific, vulnerable areas; "pushing away with the eyes" (Rothschild, 2006, p. 142); and maintaining an awareness of one's body "edges" through feeling sensations on the skin.

Harris and Sinsheimer (2008) are the only psychoanalytic writers I came across who reflected on subtle aspects of somatic experience in relation to therapist self-care. They engage specifically with the notion of "analytic vulnerability", suggesting that the analyst's body is "both crucial to analytic functioning and insufficiently cared for, at a theoretical as well as a practical level" (Harris & Sinsheimer, 2008, p. 255). This is consistent with my experience and reading.

I suggest that body psychotherapy, including but not limited to Rothschild's (2006) suggestions, offers a wealth of techniques, underpinned by theoretical frameworks, which could fill this gap. As Rothschild emphasises, somatic awareness in and of itself is central to therapist self-regulation. Equally, I see somatic awareness as fundamental to the use of any somatic techniques and exercises. With this in mind, as a constant foundation, I propose that bioenergetic principles such as breathing, grounding, motility, containment, charging and discharging could provide a comprehensive framework for therapist self-resourcing. These are also core principles in bioenergetic therapy with clients, and fundamental tools to support clients in experiencing their body as a resource, as I will discuss later in this paper.

The principles which I have named above, translate into a wide range of potential tools that can be used for self-regulation and resourcing in myriad ways. I will illustrate this by discussing the bioenergetic concept and practice of "grounding", as one example of how therapists may use such tools for their own self-resourcing.

Grounding is a foundational concept and practice within bioenergetics, articulated and developed by Alexander Lowen. Grounding is also a developmental foundation, and is thus a primary task in a somatic psychotherapy for many clients (Judith, 2004). The underlying purpose of grounding is to facilitate somatic, energetic, and emotional connection with the earth, and with a deeper centre of gravity within one's body, thereby increasing one's sense of security (Lowen & Lowen, 1977). Lowen (1975) sees grounding as synonymous with being in touch with reality. Being grounded enables a person to tolerate greater levels of affect and charge, and to discharge excess excitation (Lowen, 1975). Judith (2004) notes that "when we are grounded, we can be present, focused, dynamic... Our experience is direct, sensate, immediate. We are confident yet contained, connected with our own source of support" (pp. 62–63). Clearly this is an optimal state for therapists to be in when working with clients.

In practice, grounding generally consists of simple exercises centred on movements with the feet and legs, done with focused awareness of one's body sensations and feelings. For example, one of my favourite grounding exercises involves standing on both feet and shifting all of one's body weight onto one foot at a time, with the knee bent, for a minute or two. This exercise mobilises sensation in the legs and feet (Lowen & Lowen, 1977). In my experience, I find that grounding exercises have different effects at different times. Standing exercises generally help me to feel my feet and legs more fully, and to feel more connection and cohesion between different body parts. This has a subtle but profound energetic effect whereby I feel more solid and robust, and more able to draw on the support of the earth. Sometimes grounding exercises calm me; sometimes they energise me, often both simultaneously. Thus, they seem for me to have a naturally regulating effect, supporting both charging and discharging of energy. At times, when I feel especially overwhelmed or vulnerable, I find that grounding through lying on the floor is particularly soothing and balancing. During a yoga workshop with Donna Farhi (personal communication, January 30, 2021), she noted that lying on the back generates a mild sympathetic response, while lying face down generates a parasympathetic, enteric response which has a more sedating effect. It is always difficult to write about one of these principles in isolation, as they are naturally interconnected. For example, conscious breathing is generally part of any grounding exercise I do, and contributes to its effectiveness.

The notion of therapist self-resourcing mandates reflection as to how and when we incorporate such exercises into our lives and clinical practice. Maintaining awareness of our body sensations during sessions with clients is both supportive and protective for us (particularly in working with trauma), as well as imperative for the more therapeutic uses of the body as a resource, which I will outline in subsequent sections.

The therapist's body as a therapeutic resource

Being well resourced and grounded in our own somatic experience provides a solid foundation for working with the somatic countertransference that we may encounter in our clinical work. This, then, becomes a valuable therapeutic resource, facilitating implicit communication from our clients that we can receive and use to inform our work. Somatic countertransference is considered to be particularly linked with early pre-verbal, affective communication between mother and baby (Jacobs, 1973; Ross, 2000). It is understood in different ways by different writers. It is linked with empathy (Jacobs, 1973), and the "ability to put ourselves in the skin of another person and to hear, smell, see, taste, and touch the roses and the weeds of another" (Bady, 1984, p. 530). Ross (2000) sees it as a form of projective identification (T. H. Ogden, 1979) which may be either defensive or developmental (Hinshelwood, 1991).

Orbach (2003, 2006) writes engagingly about a range of dramatic somatic countertransference experiences in her clinical work. These seem to encompass different types of countertransference. She describes a number of cases where she experiences a concordant countertransference (Racker, 1957); that is, she has a somatic experience that seems to be similar to her patient's experience of their own body, and is indicative of the early object relations that shaped their relationship to their body. For example, Orbach (2006) describes a concordant countertransference with her client Colette, where she found herself feeling dowdy, unattractive, and negative towards her own body in relation to Colette. This constellation begins to shift after Orbach has a dramatic experience of feeling an intense burning sensation across her skin, while writing her notes after a session with Colette. At the next session, Colette tells her, for the first time, that she had a brother who burned to death as an infant, before she was born. Orbach (2006) comes to understand this unusual bodily countertransference as encoding "a sense of grief, horror, agony, shame, fear and hesitation that may have lain inside her mother's body and that her mother brought to her physical mothering of Colette" (p. 103). Thus, we can perhaps understand this as a complementary countertransference (Racker, 1957) of Colette's experience of her mother, albeit a complex and unusual one. The awareness that Orbach gains through this somatic countertransference seems to be instrumental in deepening the affective work of Colette's therapy. Orbach (2006) says that:

> working through these emotional cadences in my body and finding words to speak of bodies that were desolate, bleak, and sorrowful we began to break up the viscera of Colette's monolithically false body and to enliven it, albeit with painful affective states of sorrow and sadness. (p. 104)

Thus, Colette moves into a period of mourning in her therapy. As she begins to claim her desire to have "her body and not her mother's" (Orbach, 2006, p. 104), Orbach begins to feel less dowdy, and to have a sense that Colette is starting to be able to absorb and make use of her body.

The therapist's body as a resource for the client

The therapist's connection with their own body as a resource can enable clients to draw on their therapist's body as a resource, as the previous case example from Orbach implies. Rolef Ben-Shahar (2014) describes this as "self-object" or "regressive dyadic regulation", where the therapist functions as a self-object, essentially regulating the client on her behalf. To facilitate this, the therapist needs to focus on her inner work "strengthening her embodied presence, centering and grounding" (Rolef Ben-Shahar, 2014, p.22), resourcing herself in order to resource and regulate her client. This is akin to the notion of one-and-a-half person psychology (Stark, 1999). Orbach (2003, 2006) suggests that clients with troubled relationships to their bodies need to use the therapist's body as a temporary external body as they work through their body distress, and eventually become able to internalise the therapist's body. This is similar to the notion of the therapist providing an external auxiliary ego when the client's own ego capacity is limited or temporarily disabled.

To my mind, Orbach describes and seems to work with an intangible energy of embodiment, a deliberate stance of holding the body in mind. She writes about the need for the therapist to make her body available for the client to use; however, she does not generally seem to mean this in a physically active sense. It is interesting to compare her approach with a body psychotherapy approach where the therapist may also make her physical body available for the client to use. Cornell (2009) writes of offering his clients a "somatic dyad" and "a space within which one can *act* as well as *think,* to experiment with movement, aggression, tenderness and physical contact" (p. 76). He goes on to say that he wants his clients "to have the opportunity to affect and be affected by the actual body of another" (Cornell, 2009, p. 79), and gives an extensive case example of this type of work. His client, Elizabeth, while highly functioning in many ways, including in relationship with friends and family, comes to see him for body psychotherapy, as she has never had an intimate, sexual relationship. Their work grows to include sensory experiments where Elizabeth is invited to notice and explore her movement impulses towards her therapist. Eventually, via both sensorimotor and verbal work, she is led to recognition of her experience of her body as "presumptuous... within the maternal field" and "not evoking pleasure or desire in another (mother)" (Cornell, 2009, p. 88). It seems to be a pivotal awareness, which gradually facilitates Elizabeth to connect more with her aggression and agency.

The use of touch as a therapeutic intervention is a feature of many schools of body psychotherapy, while being generally avoided, for any purpose, within psychodynamic/psychoanalytic therapies. The issue of touch has been a significant area of contention between these disciplines, historically and to this day. Discussing the polarising history and robust arguments for and against using touch is beyond the scope of this paper. Suffice to say, within body psychotherapy "knowing when to touch and when not to, and how to touch, needs just as much insight and training as knowing when and how to interpret" (Halsen, 1995, p. 103).

With or without touch, our conscious embodiment can, in itself, assist our clients to connect with their bodies. Westland (2009) gives a clinical example of how deepening her own body awareness during an assessment with a client, which was initially cognitive and superficial, supported the client in contacting a deeper level of her own being. Westland describes her own presence as becoming

> more spacious and less cognitively insistent. Gradually the client *drops down into herself* (i.e. her breathing has deepened and fills more of her whole body, she looks more relaxed across her chest and arms). She slowly comes to what feel like central life statements with feeling tones attached to the words. (p. 124)

Orbach (2003) describes somatic experiences she has had which she understands as becoming, transferentially, what her patients need her to be. For example, she has an intense, visceral fear of being violently raped by her client, Rob, which she comes to understand as "a corporeal translation of a famous Winnicottian paradoxical formulation: the patient needs to destroy the object and the analyst needs to survive the destruction" (Orbach, 2003, p. 6). She feels that she needs to receive Rob's hatred and aggression at a bodily level; and to manage her fear, allowing herself to be disturbed, but not to collapse. She feels that she is required to "remain stable, rooted in my own body in order for there to be a body in the room for him. He could only put together a body for himself via a violent encounter with another" (Orbach, 2003, p. 6).

In contrast, Orbach also describes a pleasant experience with a client who has a troubled body where she has a sense of deep physical contentment and wellbeing such that she feels like a purring cat. She understands that:

> with Herta, my purring body became the means by which she could relinquish her hated, diseased body. She needed a body in the room that was wonderfully at peace and bountiful, and she had conjured one up for me to hold and inhabit since she was not yet able to do this for herself. (Orbach, 2006, p. 102)

In the latter case example, it seems that the patient is invoking the good object, or the self-object she requires, in her therapist. I find this a delightfully hopeful and creative possibility, that a client could generate in the therapist the qualities that they most need, that they can then slowly internalise. Orbach's examples highlight for me the diverse and creative ways that clients may use the therapist's body as a resource.

The client's own body as a resource

Clearly, it is an important goal in an embodied psychotherapy that the client develops the capacity to draw on their own body as a resource. The case examples in the previous section suggest that using the therapist's body as a resource may enable the development of this capacity. Also, there can be great value in the client engaging in solitary somatic experiences in (as well as outside of) their therapy. This may deepen the capacity to draw on their body

as a resource. This is perhaps akin to a one-person mode of therapeutic action (Stark, 1999), characteristic of traditional bioenergetics as developed by Lowen, and other traditional modalities of body psychotherapy. It is also a fundamental aspect of somatic trauma therapies. Such somatic experiences can range from specific, structured exercises to more open-ended explorations, depending on the therapeutic needs of the client.

As mentioned in the section on therapist self-resourcing, bioenergetic psychotherapy is underpinned by core principles which translate into myriad exercises and somatic experiments that can be utilised with clients, as needed, for a wide range of therapeutic purposes. For example, I think about my own use of grounding techniques (which I described earlier) in different clinical situations. I have used these exercises at various times with clients who are dissociating to help them come back to their bodies and to the present moment. I have used them with clients who are in an anxious state; clients who are generally disconnected from their somatic experience or emotions; and clients who are hyperaroused and distressed. In each case, the exercises seem to have facilitated an energetic shift, to a greater or lesser degree, from one state to another. Using such exercises with clients can assist them to regulate themselves and help them to learn to use their body as a resource.

Body psychotherapy can also provide a space for clients to explore their own self-organisation, via less structured somatic experiences. Cornell (2008) gives a clinical vignette describing work with body awareness and movement that supports his client in this kind of experience. This work emerges organically over time, with Cornell's gentle encouragement, from the client's material. In this piece of work, he is largely a witness as his client attends deeply to her own "process of somatic inquiry and gradual reorganisation" (Cornell, 2008, p. 40).

In trauma therapy, assisting clients to experience their body as a resource tends to be especially vital. The connection between mind and body in the psychophysiology of trauma is particularly evident. The characteristics of posttraumatic stress disorder include an array of interconnected somatic, affective, and cognitive symptoms. Moreover, trauma can interfere with declarative memory, and trauma memories are frequently stored in a somatosensory form (Van der Kolk, 1994). Hence, trauma survivors may be plagued by disturbing somatic symptoms, and it may be difficult and frightening for them to be present in their bodies. Thus, somatic trauma therapies, such as Somatic Experiencing developed by Peter Levine (1997, 2010); Sensorimotor Psychotherapy, developed by Pat Ogden and colleagues (Ogden & Minton, 2000; Ogden et al., 2006); and Babette Rothschild's (2000) aforementioned approach to trauma therapy, include focused work with the body.

It is beyond the scope of this paper to describe, compare, and contrast these modalities; however, each offers distinct ways of working with the body as a resource, including a considerable focus on helping the client to experience their own body in this way. A core skill in all of these approaches is the capacity to observe and track body sensations, which the therapist helps the client to develop. This directly assists clients to modulate their arousal. Somatic Experiencing and Sensorimotor Psychotherapy also articulate specifically somatic approaches to processing trauma; for example, guiding and encouraging clients in allowing the body's instinctive responses to complete themselves. A common example of this is

working with the instinctual flight response by encouraging a client to physically feel the urge to run in their legs and to allow the legs to move while connecting with the physical sense of strength, power, and agency in this part of the body (Levine, 2010). As well as providing physiological discharge of the frozen residue of energy, which Levine sees as underlying traumatic symptoms, this type of intervention can generate a new somatic experience of the body as capable, powerful, and strong. Thus, through somatic forms of trauma therapy, clients who may have only experienced their bodies as sources of pain and disturbing, overwhelming symptoms, slowly develop the capacity to experience and use their bodies as resources.

The shared, intersubjective body as a resource

Finally, the body as a resource can be viewed from a more intersubjective, systemic perspective. This is akin to a two-person psychology (Stark, 1999). Rolef Ben-Shahar (2014) elucidates a more sophisticated form of dyadic regulation which he describes as "generative dyadic", or "mutual regulation", which involves "working directly with the shared field—with the intersubjective body: surrendering to a shared field of self and then retrieving the balance of the system" (p. 23). He proposes that "the shared body-mind is frequently more resourceful and contains greater possibilities and flexibilities than the individual selves of which it emerged" (Rolef Ben-Shahar, 2014, p. 23); which implies drawing on the shared, intersubjective body as a resource.

Rolef Ben-Shahar (2014) uses an extended example from his own life to explore different modes of regulation. He wrote about a difficult time when he and his two young daughters became very sick with whooping cough. He and his wife attempted to support their healing by regulating the girls in myriad ways. However, Rolef Ben-Shahar found that this was only fully successful when he was able to surrender to the larger, intersubjective body which they all co-created, and allow it to regulate them; he states:

> when we are able to surrender to connection, to open to a wider mind—the resources that are available for us are richer and wider… According to this view, the major therapeutic act is not helping the other to regulate but to become part of the system: an act of positioning and surrender and not one of skilful doing… Through these lenses, the self has lost its individual skin-bound definitions: it is no longer the client or the therapist, it is the dyadic dance, but this novel autonomous dance can self-regulate. (p. 26)

Rolef Ben-Shahar contends that working in this way carries both potential risks and rewards for therapists, since "influence is bidirectional—I am influenced as well as influencing. Additionally, both positive positioning and painful states cross the interface between us" (p. 25). He notes that in all his prior attempts to regulate his daughters, he himself remained unwell. It was only through surrendering into the shared field of the self and allowing it to regulate them all, that he himself began to heal, and very quickly. This points to what could be seen as both risk and reward for the therapist in this type of therapy: "we might deeply change together with the client" (Rolef Ben-Shahar, 2014, p. 26).

Concluding comments

The notion of the hermeneutic literature review as a conversation with the work of others within the tradition of one's subject was central to my dissertation process. I found myself "inclining" towards the work of particular writers (Smythe & Spence, 2012, p. 17), and these writers feature most prominently in this paper. I found that reading the work of William Cornell, Asaf Rolef Ben-Shahar, and Susie Orbach tended to make me feel energised, vital, and inspired. I was touched by their vulnerability and courage in writing about their clinical work. No doubt this response, and my "conversation" with them included an idealising transference (Kohut & Wolf, 1978), and perhaps an "eventual identification-internalisation" (Brightman, 1985, p. 307).

In this paper I have described the two main themes which emerged in my dissertation and outlined a framework of five ways in which the body can be used as a resource in psychotherapy. These ways of relating to the body are distinct yet interconnected. It will depend on each unique therapeutic dyad which modes are used and how. They may all be used at different times in psychotherapy with a single client. Yet, many therapies may never utilise the final mode of drawing on the shared body as a resource. It may be that immersion in the intersubjective body requires that the client has good ego-strength, a good enough capacity for self-regulation, and for relating to their body as a resource.

I see the concept of regulation as capturing an essential part of how the body may be used and experienced as a resource in psychotherapy, and this has been a large part of my focus in this paper. At the same time, I see "the body as a resource" as encompassing the potential for much more than regulation. Perhaps the capacity to self-regulate, and to use others for self and mutual regulation is a *foundation* that can be built in psychotherapy, when it has been lacking in early development. This foundation may then support the development of other ways of experiencing the body as a resource for pleasure, creativity, sexuality, expression, and expansion.

I was inspired in my dissertation process by a quote from Johnson (1995), discussing the origins of the word "somatic" in the Christian mystical tradition, and the New Testament whereby:

> Paul distinguishes between the Greek word *sarx*, which has the sense of "a hunk of meat," from *soma*, which Paul used to designate the luminous body transformed by faith. Hanna argued that it was the sarcal body, gross and mechanistically conceived, separate from mind and imagination, that dominated Western thought and medicine. In his view, the teachers of embodiment practices were recovering a hidden sense of the wise, imaginative, and creative body. (p. xv)

To my mind, this phrase, "the luminous body transformed by faith", is a beautiful, evocative depiction of the body's potential to be a vessel for spirit. Judith (2004) articulates the ways in which comprehensive psychotherapeutic work with our somatic and psychological issues can pave the way for a grounded opening to our spiritual nature. Ben-Shahar's (2014) description of the "dyadic dance" in the previous section also hints at this possibility in intersubjective body psychotherapy. While I recognise that it may be well beyond the scope

of most psychotherapies, I nonetheless see this as the ultimate potential for the experience of the body as a resource.

Epilogue

In writing this paper and reflecting on developments and changes in the world of psychotherapy since I wrote my dissertation eight years ago, the most obvious impact to me is that of the COVID-19 pandemic. For most psychotherapists worldwide, including in Aotearoa New Zealand, the pandemic has necessitated prolonged periods of practising psychotherapy remotely, either online or over the phone; something which many therapists would have never previously considered. This has had a significant impact on the practice of all modalities of psychotherapy, but, arguably, especially for body psychotherapies. Thus, I offer a few observations on the impact of remote psychotherapy on the experience and use of the body as a resource.

It seems to me that therapist self-resourcing has been both deepened and challenged by the experience of online work. For most of us this has involved working from home, which has enabled more time and space for somatic practices and other forms of self-resourcing. However, the experience of working online for the entirety of one's working day has also taken a toll on our bodies, especially our eyes. I personally find that online work makes it subtly harder to remain grounded and present in my body, even (or especially?) as I attune to my clients. And of course, it is that much harder to attune to clients without all the implicit information that we receive when meeting physically. Thus, our somatic resonance and communication is stymied.

I have found that it is surprisingly possible to facilitate clients in experiences of their body as a resource in online sessions; especially for clients with whom I have previously worked in person, and are familiar with observing their somatic experience and utilising somatic practices. These can include grounding techniques, experiences of containment using props such as cushions or bolsters, and expressive techniques. The fact that clients are on their own in their physical space necessitates and potentially furthers more autonomy and self-regulation on their part, which may well be beneficial.

I believe that both forms of dyadic regulation and resourcing, which I have outlined in my framework, are significantly compromised by working online. We are no longer two bodies meeting in a contained physical space; rather, two bodies at a distance mediated by technological means. Frechette (2021) notes the imitations of what is possible with different physical positioning, and how to mediate these limitations. This may require asking our clients to report more detail of their bodily tensions and other sensations than we usually would. Clearly interventions which involve physical contact and touch are not possible. And, as we make the transition back to working in person, I wonder about the lasting psychological effects of this pandemic, which has taught us to feel "threatened by the body of the other" (Moselli, 2021). No doubt a fruitful ongoing inquiry for embodied practice.

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Paper 9 (2016)

A psychotherapist's experience of grief: A heuristic enquiry

Bronwyn Alleyne and Keith Tudor

This paper focuses on the heuristic research method by which the first author engaged with her experience of grief, both professionally and personally, during the period of her education/training and placement at a hospice, and, specifically while preparing and writing her dissertation (Alleyne, 2016). This was under the supervision of the second author, who has a specific interest in heuristic research (Tudor, 2010, 2017), and in supervising heuristic research (see Tudor, 2022, in press). The paper briefly introduces heuristic research, and its stages or phases; discusses its limitations and the question of validity; and then illustrates the heuristic process with examples from the original research, in which the first author's experience is represented by the use of first-person pronouns ("I", "me", "my").
The repetition of the heuristic phases in the second and third parts of this paper reflects the iterative process of heuristic research. The specific findings of the research are reported both in the original research (Alleyne, 2016) and in a separate paper (Alleyne & Tudor, 2022).

Heuristic Research

Although heuristics dates back to the Ancient Greeks, heuristic research in psychology was developed by Clark Moustakas (1961, 1967) and later, by others, notably Sandy Sela-Smith (for a summary of which, see Sultan, 2019; Tudor, 2022, in press). In his work, Moustakas (1990) identifies and elaborates a number of concepts—identifying with the focus of inquiry, self-dialogue, tacit knowing, intuition, indwelling, focusing, and the internal frame of reference—which form the basis of the process of discovery and what McLeod (2003) refers to as "a powerful discovery-oriented approach to research." (p. 97). Thus, given my own losses and lived experiences of grief, I had a strong association and identification with the focus of this particular enquiry. As a result of reflecting on his own experience—in his case, of loneliness (Moustakas, 1961)—he also identified certain stages or phases of heuristic enquiry, i.e., initial engagement, immersion, incubation, illumination, explication, and creative synthesis (which we elaborate later in this paper).

Sela-Smith (2002) acknowledges Moustakas's contribution to research in the field of psychology but is also critical of his research. She considered that, "due to unacknowledged resistance to experiencing unbearable pain, Moustakas's research focus shifted from the self's experience of the experience to focusing on *the idea of* the experience" (Sela-Smith, 2002, p. 53; our emphasis). Her critique gave me permission to stay with the focus of my research, and on the interiority of my own experience, rather than shifting its application to the experience of others; as she puts it: "Within this interiority, feeling responses to the external circumstances combine to create meaning, and out of meaning, personalities are

organised, personal and cultural myths are formed, worldviews are constructed, and paradigms are set in place" (Sela-Smith, 2002, p. 54). This helped me to surrender to my own subjective experience.

Ings (2014) suggests some disadvantages to the use of autobiography as a research focus. He warns that this approach can turn into a non-productive ponderance on the part of the researcher, which lacks scholarly worth, unless we view the transformative nature of the process as tangential rather than central. The central theme being a communicative text which requires astute and critical monitoring to ensure its positioning as a work worthy of scholarly merit. He cautions that this style of research could be critiqued as a narcissistic pursuit, the purpose of which can easily become self-focused and confused, thereby compromising its usefulness to the discipline—in this case of psychotherapy. He also warns of the emotional cost, particularly the need to "separate critique of the manner and quality of the discourse from criticism of the self" (Ings, 2014, p. 681). I was initially seduced by these arguments, for fear of being branded over-indulgent or narcissistic, criticisms which are often used to wound a healthy self-focus, and often in or from hatred or envy. However, personal transformation is at the heart of any heuristic journey; it is what fuels the sustained effort required to enter the process more fully; and it is saved from being self-serving by the fact that the meaning being investigated is central to human existence and the human condition, the telling of which connects us all (Moustakas, 1990). Nevertheless, the usefulness and relevance of my research to the discipline of psychotherapy was—and still is—worth considering, which brings me on to the question of validity.

The validity of heuristic research cannot be measured quantitatively but, rather, must be measured by the subjectivity of the researcher herself, as she is the only one who has undergone the recursive process of analysing and judging what is significant, and therefore can answer the question: "Does the ultimate depiction of the experience derived from one's own rigorous, exhaustive self-searching and from the explications of others present comprehensively, vividly, and accurately the meanings and essences of the experience." (Moustakas, 1990, p. 32). I know the subjective truth of this and my vigilance in the process. Lincoln and Guba (1985), who discuss the trustworthiness of qualitative research, listed certain criteria that ensures validity, i.e., credibility, transferability, dependability, and confirmability, criteria I considered and employed in assessing my research.

Credibility is enhanced by employing protocols such as prolonged engagement, persistent Observation, and triangulation. Transferability is enhanced by providing a "rich, thick description" (Creswell & Miller, 2000, p. 128) of what is being studied, descriptions which are dense, deep, and detailed in order to create verisimilitude. The intention of such descriptions is that they produce in the reader the feeling of the experience being described in the study; thus, "credibility is established through the lens of readers who read a narrative account and are transported into a setting or situation" (Creswell & Miller, 2000, p. 129). Moreover, doing so successfully enough is also an indicator of whether the experience and/or phenomenon of what I am describing is then transferable into other situations (Amankwaa, 2016). Dependability is aided by the transparency of my research method and how it was employed, and, again, by triangulation of sources. Patton (1999) suggests that triangulation is not for the purpose of confirming the same result; rather, it is an attempt to look for consistency and inconsistency which, in his view, should be

considered an opportunity for illuminative deeper insight rather than a weakening of the research enquiry. The primary triangulation sources for this research were the constant immersion into my own experience; my depictions; my long-term work with the bereaved; personal psychotherapy; individual, group, and peer supervision in both a general and a hospice setting; and, perhaps most importantly for my feeling space, resonances through the personal accounts of grief I read in my literature review.

The phases of heuristic research

Initial engagement
This phase required that I identified, defined, and clarified my research question, one which was compelling to my own experience, was autobiographical, and has social value, including for my significant relationships (Sela-Smith, 2002). Given that the context of my research question was my experience as a psychotherapist, and that it needed to fulfil certain learning outcomes for the dissertation paper (course) I was studying (regarding which see Tudor & Francis, 2022), it also needed to have relevance to the study and field of psychotherapy. Self-dialogue precipitates the plunge into the inner search for the question and is often answering a call from deep within to something which consciously or unconsciously needs exploring, clarification, or completion. My question sought both subjective inner meaning and external truth (Sela-Smith, 2002), and, in this respect, the heuristic method supports a systematic and disciplined approach to making sense of and understanding experience—in this case, my experience of grief.

Immersion
This phase required me to live and become intimate with the question, both with myself, with others, and within wider contexts, in waking, sleeping and all states in which I found myself. Sela-Smith (2002) asserts that, with the question formed, "it draws the image of the question everywhere in the researcher's life experience" (p. 65). There is movement from inner experience to outside stimuli and back again, usually to what still lingers in the researcher (Sela-Smith, 2002). My grief depictions captured these lingerings and oscillations with others.

Incubation
This phase involved a detached retreat, which allows the seeds or produce of immersion to be discovered without intense concentrated effort. This is where the tacit dimension wrestles with new depictions and reorganises meaning (Sela-Smith, 2002). I found that, once I had written a depiction, I would retreat, often somewhat painfully, to get some buoyancy in my unconscious, which parallels the need that grief has to ebb and flow in order to allow living. In this phase, I would, however, be invited back into the depiction, and into my grief spontaneously, a process that was readying me for its illumination.

Illumination
This is a process whereby new awareness results from the researcher's open and receptive attitude, which allows her tacit knowledge and intuition to forge a breakthrough of the themes called for and searched for in relation to the question (Sela-Smith, 2002). In practice, this process involved adding further narrative to my depictions and further

exploration in therapy, supervision, in literature, and other sources as intuitively found. There is some debate with heuristic circles as to whether this is a phase or, rather, a series of moments (see Tudor, 2022, in press).

Explication
This phase is where the illuminated themes are fully examined and comprehended in order to discover, as "nuances, textures and constituents of the phenomenon" (Moustakas, 1990, p. 31), so as to depict the major components and essence of my experience. My task was to focus consciously on and attend to, in a deep examination, what was woken in me during the previous phases. This involved many oscillatory visits through the phases of immersion and incubation, and moments of illumination.

Creative synthesis
Only once the researcher is thoroughly familiar with and has mastered the data, can the core themes and the meaning of the experience be synthesised into a narrative or creative form for others to view. Sela-Smith (2002) argues that, if the researcher has surrendered to the heuristic process, then a transformation emerges, one that resonates and can be observed.

The research process

In this part, I offer some sense of the actual research into my experience of grief—and the implications for the heuristic process.

Initial engagement
The initial engagement with my experience of grief became more intense with my experience not only as a bereavement counsellor, but then, also with the death of my Dad and the psychotherapy patients with whom I worked. Although my stated altruistic goal is to add to the understanding of what it is like to be a bereaved psychotherapist, my drive to elucidate the experience was, at least initially, really a personal one. From my perspective, my research method could only be heuristic, that is, one of experience and discovery. I was captured by my own grief. I needed to tend to my own experience. I needed my own answers.

I was driven to understand my own experience so as to feel less alone; to be available again to more intimate relationship(s); to be out of the traumatised state I often found myself in; and to feel less resentful of the needs of my more challenging patients. Ultimately, I held the desire to use my experience to inform my empathic self and use this well, lest I unwittingly and unconsciously impose my need or healing agenda on my psychotherapy patients. Douglass and Moustakas (1985) refer to this as an effort to solve a personal problem in an effort to know the answers to my own questions. I want to restore myself to a vibrantly lived human being and, as a result, be more available as a psychotherapist.

Whilst Moustakas (1990) wanted the question to be rooted in passionate concern, important social meanings, implications, and disciplined commitment, for me, the reality at the onset is that I was plunged into this experience, like it or not. Death came to those loved

by me. My grief pervaded and changed my whole experience of myself. This was—and still is—my own intimate, autobiographical, and personal search. My depictions are of my own experience, and reveal my own perception of reality. I oscillate around immersion, incubation, and illumination, recursively and painfully. This is the middle circle in Figure 1 (which we discuss later), the circle in which my tacit knowledge is continually being built and reorganised by my experiences and how I subjectively understand them, and then further processed in a self-reflective, intuitive process, both in supervision and in reviewing literature, to refuel another oscillation. The process for me is organic rather than forced, and the illuminations—and explications—emerge out of the process partly, due to the heuristic process, and partly due to the nature of grief. Grief cycles allow an assimilation of the full impact of the loss (Neimeyer, 2000).

Immersion

My primary method of capturing my grief experience was through self-dialogue (see also Ozertugrul, 2017).

> *I often wake in the middle of night [when] my grief pursues me and asks me for its meaning and associations. I drift with it. It's dark, it's quiet and I don't escape its anxiety. My attempts to get up and journal during this process usually hamper the flow of the experience and becomes too intellectual and laboured. I have learned to wait to narrate my experience later. I narrate my grief in therapy, in supervision and in group supervision, to my journal, but mostly to myself. In the early stages I also would swim, to dip in and dip out, I found floating would hold me.*

I sensitised myself to wanting to deepen my understanding of my initial questions from the perspective of clinical practice—they surface for me regularly and push in to for a search for their meaning. Although I have read widely and been influenced theoretically in leading up to being in this process, my current process is emotionally led; my research is looking for feeling resonances, rather than comprising intellectualised searches for the answers. I have potentially toppled my usual practice of widely reading to approach my work to soothe my anxiety; to provide new ways to think about my situation or my patients; and to change my perspectives and my ways of thinking about the world. I have moved from an expert stance, to feeling first. The meanings found are embedded deeply in their relationship to my own experience and their relationship to the development of my clinical practice.

In this sense my heuristic process began with my own experience. Douglass and Moustakas (1985) suggest that: "heuristic inquiry begins with immersion, self-dialogue, and self-exploration, and then moves to explore the nature of others' experiences" (p. 43)—for me, these were the experiences with which I found resonances. Also, I suggest an intermediate step. The experience of grief is, at heart, a relational one. How I am responded to affects how I experience my grief. How I was responded to when I shared my grief often precipitated another immersive deep dive. I found that the impact of those responses could not be disconnected from my self-exploration and my research. Thus, we propose, contra Moustakas, that immersion (as a phase), self-dialogue (as a concept), and self-exploration (as a process) are not linear stages which proceed engagement with others, but, rather, are all informed by the relational experience of "we"ness (Tudor, 2016)—as well as any separation or isolation from "we"ness.

Via my own self-dialogue and using my intuition, I followed my focused eye and intuition until I found the tacit dimension—and some illumination that I could breathe into, a process in which I also found some relief.

My grief depiction journal (in Alleyne, 2016) documents the end results of my efforts, with regard both to the individuals I lost and my grief about them. I read literature on grief and on working with the dying, and, in heuristic fashion, followed my own associations to new sources of literature (see Tudor, in press). For the most part, I was drawn to the personal accounts of therapists: they speak to my own experience, and I felt understood and soothed. I moved from judgement, self-recrimination, and pathology to compassion, humanity, and mutuality. I also read many accounts of the dying, which provided me with the richest and the most poignant help in understanding my patients.

Most importantly, the grief process resides in my own experience. This process feels much like the heuristic method itself: it is immersive; subject to incubatory retreats; receptive to awakening illuminations, explications, and a synthesis that continues to transform my experience of myself and my relationship to my patients.

I am drawn to notice parallels in this research and the process of how I am in supervision and, therefore, can take counsel from what academia says about supervision for autobiographical research. Tenni et al. (2003) suggest that the criticality of supervision is a professionally intimate and high trust relationship, rather than one that is distant and objective. In this context, a supervisor needs to be responsive to the emotions and impact of the work, and to bring proportion and reason to the "vulnerable edge of [my] courageous inquiry" (Ings, 2014, p. 690). From this perspective, the supervision enquiry lens not only develops my professional self as a psychotherapist, but also draws into close proximity my development as a person. A supervisor's humanity and authenticity will be valued and privileged over their interpretive prowess, although I appreciate the intellectual and emotional pursuit of this as well.

This immersive process of the original research and dissertation proved to be invaluable, both from an illuminative perspective and in knowing myself in a fuller sense. However, the writing of the original dissertation was an incredibly difficult experience, on which I had to stay intentionally in the immersive pain of grief long enough to explicate and synthesise its riches. To convey this experience in words often felt tortuous.

Incubation

For me, the incubation phase was problematic in that I didn't often experience a detached retreat from grief. As Neimeyer (2000) puts it: "The intimacy required to explore and name the multiple losses associated with any given death" (p. 90) cannot be assured or arrived at prematurely. In this phase, I was both challenged to go beyond my current understanding, and to stay in my grief longer. Given my increasing depth of understanding of myself, I wanted to stay in the process longer before moving out too soon. However, the deadline of needing to complete and submit the dissertation loomed. In fact, Moustakas (1990) writes:

> The heuristic research process is not one that can be hurried or timed by the clock or calendar. It demands the total presence, honesty, maturity, and integrity of a researcher

> who not only strongly desires to know and understand but is willing to commit endless hours of sustained immersion and focussed concentration on one central question, to risk the opening of wounds and passionate concerns, and to undergo the personal transformation that exists as a possibility in every heuristic journey. (p. 14)

I experienced the clock and the calendar of the submission deadline as a conflict, and, moreover, one that is in direct contradiction to the heuristic process—a point which Sela-Smith (2002) acknowledges as a critique of the method. My constant access to new grief and death situations meant that I had unlimited access to new depictions, and, at this point, it felt like my exploration would never be completed.

Illumination

My illuminations came from a process of pondering, reflecting, revisiting, looking away, dipping in and out of my grief again and again, and using my own therapy, supervision, and my theoretical associations and resonances found in literature in this repetitive intuitive process to make sense of my experience in an autopsy that added to my depictions and ultimately resulted in some illuminations provoked in me, which were then fully examined and comprehended in the explication phase, and are summarised below.

My illuminations often centred around the intensity of my grief and how my grief was responded to by others, as the responses often increased my suffering. I came back again and again through the tacit dimension to the illumination that how my grief is responded to changes by subjective experience of grief. I was driven to explicate this fully so as not to disenfranchise my own grief. My grief matters.

Some depictions which preceded this illumination:

> *I am at a party, it's late and I am speaking to someone I don't know very well. Her much beloved Mum had recently died in a nursing home and she recounted to me her grief and isolation in the months since and also the love that was given to her Mum by her caregivers. Our conversation flowed towards the death of my Dad, my work as a hospice psychotherapist, my writing a dissertation and the profound grief I feel in response to the death of some of my patients. She responded with a spontaneous 'but it's not real, the relationship is not real'. I felt deeply wounded by her response and brought our conversation to an end perhaps regrettably without letting her know why I might grieve my patients and how hurt I was by her response. I felt her dismissal of my work and my grief.*

A depiction of my experience after dissertation supervision, after sharing my last moments with my long term client:

> *I shared my sense of panic as I sat beside my client's hospice bed in her last days. Words were no longer possible so I sat listening to her laboured breathing. I intentionally try to review our time together but at times her breathing would resemble a death rattle and my sense of panic would increase. I didn't want her to die. I especially didn't want her to die on my watch, I wanted her 'boys' to be there, not me, I wasn't her daughter.*
>
> *I return to this bedside scene often in my grief, not because of my feeling of panic, but because I was asked if I thought it was useful to my patient to have a panicking therapist beside her. This response woke up intense guilt about the possibility that I may have let her*

down that day beside her bed. As a therapist I needed to bracket my feelings and be there for her. My dissertation supervisor responded with something like, 'it's just a feeling, it's how you felt'.

I feel very vulnerable after reliving and sharing this moment. I was given the understanding that it was very human to have my own response. I feel liberated in being real but at the same time I know there is still a pull to be the perfect therapist in me which could hamper my capacity to provide care and seed my entering death situations chaotically.

Explication

With regard to the original research, I only moved to explication for the purposes of presenting my initial findings to my fellow dissertation students and members of staff in the context of the paper (course) requirements. The process/phase of explication—and of creative synthesis—required courage, concentrated effort, and heartache. Being and staying in the earlier stages felt painful but comforting, and I noticed my resistance and ambivalence mostly at the beginning and at the end of each experienced phase.

Nevertheless, and in the context of the external constraints on the research, I did explicate from my experience a number of themes. These were: shame and the desire to hide the depth of my feeling due to social discrimination; trauma—and the need for attuned understanding and the pull to be in my humanity; the isolation of the therapist's grief and the culture of therapy as an inhibitor of normal mourning; death anxiety and aggressive responses; guilt, fate, and failure, all intermingling in a grief autopsy process; denial and the provocation of knowing of my mortality; splitting (in a team) and survival; moral imperatives, namely, those of saving patients as well as intense countertransference responses; and the mutuality of patient and therapist need in psychotherapy. These are discussed more fully in Alleyne (2016) and Alleyne and Tudor (2022).

Creative synthesis

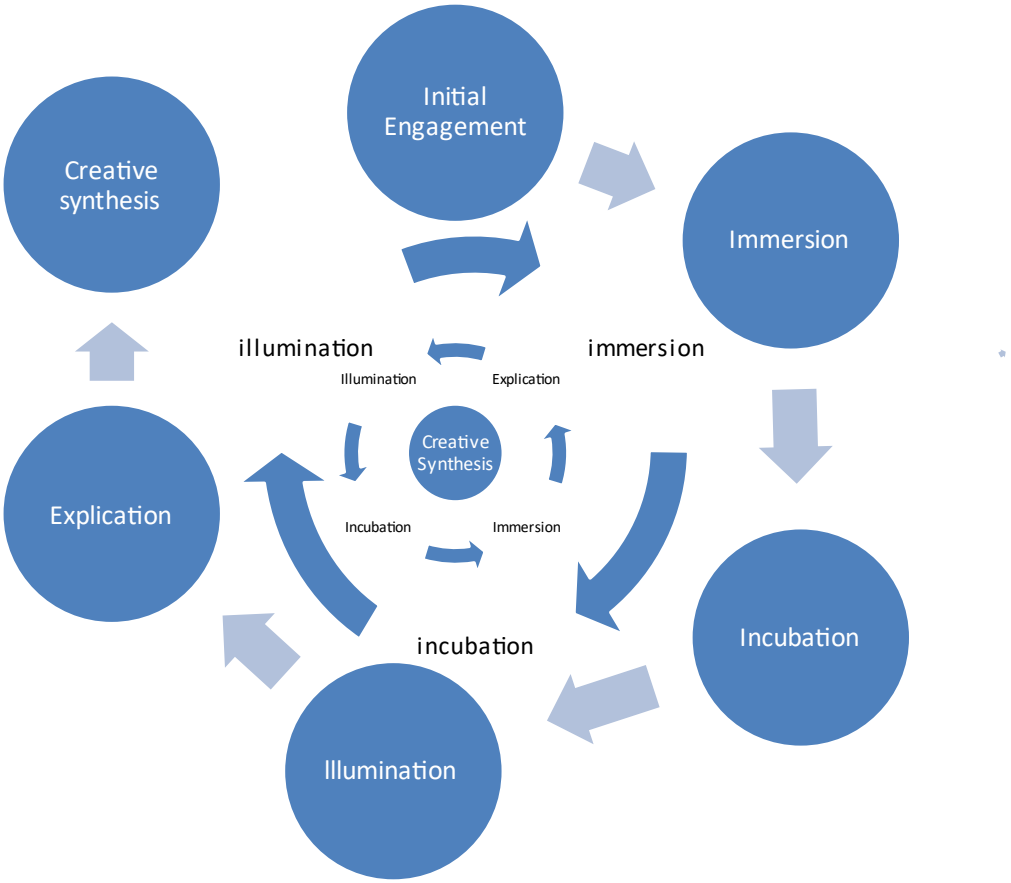
The synthesis of my original research was creative in that the explication of the themes identified (as noted above) came about as a result of a reflective, intuitive, emergent, and creative process. These themes also illuminated implications for psychotherapy practice, such as a revised understanding of grief which forefronts the humanity of both patient and therapist and the continuing bond with patients who have died; the need for a place to mourn; the reactive need to be deeply understood in a twinship relationship with someone who has known emotional trauma; a model of supervision which recognises and holds therapist grief and the unresolved and unconscious conflicts of the therapist as they are likely provoked in death situations.

Moreover, another creative synthesis emerged which took the form of a reflection on and contribution to the heuristic research method (as represented in Figure 1).

We have referred at various points in this paper to the tension between the open-ended nature and process of heuristic enquiry and to the fact that the original proponents of this approach to research, notably, Moustakas (1990) and Sela-Smith (2002) argue that it can't—and shouldn't—be rushed. At the same time, as Tudor (in press) acknowledges, time and other limitations, in this case, the context of the research (including the fact that it is assessed against specific learning outcomes) is part of the contextual realism in which we

live, work, study, and conduct research. Thus, in Figure 1, the six phases of heuristic research as described by Moustakas (1990) are displayed in the outer circle from Initial engagement and moving clockwise. The middle circle represents the repetitive deep dive into immersion, incubation, and illumination that my research and my grief pursued. Given the necessary move to explicate and creatively synthesise, which I felt a resistance to, like swimming against the tide, this is represented by the inner circle that recycles certain phases in an anti-clockwise direction. Although I found swimming against the tide difficult, in finally reaching my explication of this therapist's grief, it was ultimately rewarding.

Figure 1
The Six Phases of Heuristic Research (developed from Moustakas, 1990)



Conclusion
My heuristic research synthesised my findings into a communicative felt narrative which ultimately determined that my grief was seeking deeper connection. The heuristic method and methodology supported a repetitive deep dive into immersion, incubation, and illumination of my grief, which eventually allowed me to explicate and synthesise its riches, the validity of which was assessed and critiqued with vigilance to ensure its worth to the discipline of psychotherapy.

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Paper 10 (2016)

Our Māori connection: The impact of colonisation on one southland whānau

Verity Armstrong (Ngāi Tahu) and Wiremu Woodard (Tuhoe)

Ko Aparima te awa
Ko Takitimu te mauka
Ko Takitimu te waka
Ko Takutai O te Titi te marae
Ko Kati Mamoe me Kāi Tahu te iwi
Ko Verity Armstrong taku ingoa

This paper is based on a dissertation written by the first author under the supervision of the second author.

These are the stories that my mother has told me about my tipuna over the years. My tūpuna, Riria Te Auta, was the daughter of the rangatira Te Auta of the Purakanui marae of inland Otago and Murihiku. As a young woman, she met a European whaler and together they had a daughter named Kuini. In her early years, Kuini travelled to Aparima, connecting with whānau at Takutai o te Titi marae at the southernmost end of Te Waipounamu, looking out towards Te Punga o Te Waka a Māui. While there, living at the Aparima kaik, she met a Pākehā seaman. They had a daughter, Caroline, who lived with Kuini at the kaik. This Pākehā man had another wife; and he adopted Caroline, having her live with them. Caroline's father died after falling off his horse and his Pākehā wife returned Caroline to the kaik, where she lived again with her mother.

My great-grandfather, a Scottish farmer and son of the local Member of Parliament, met and fell in love with Caroline, much to the disapproval of his Pākehā family. They sent him back to Melbourne, where they were from, in an attempt to separate him from this Māori woman. However, after three years he returned and sought out Caroline. While visiting her, he met a three year old boy who was clearly his son. Against the wishes of his family, William insisted on marrying Caroline and they had a large family of 10 children, one of whom was my grandmother, Mabel. My great-Aunt, Mona, told my mother how they felt sorry for their mother, Caroline, because when their father's family came to visit, she would serve them food but never ate with them. My grandmother never talked to my mother about her Māori mother and my mother's generation had no knowledge of their cultural background.

My mother grew up near her ancestral home in Invercargill until she was a teenager when she moved to Christchurch with her family. She met my father there, the son of recent immigrants from the North of England. Together, they moved away from Christchurch, eventually moving to Auckland, where they both taught at secondary school.

I grew up in a Pākehā home in the 1970s in Auckland, where my mother's Māori ancestry was never mentioned. My exposure to Māori culture was through the school where my Pākehā father was the principal. I was interested in their kapa haka group and I treasured that piupiu and korowai that were made for me by staff members. However, I did not consciously identify with this culture and had no knowledge of my own whānau's cultural history.

I was a teenager in the 1980s in Aotearoa and the socio-political landscape was changing. In 1982 Māori activists began to vocalise their views about colonisation and aligned themselves with other Indigenous peoples in the Pacific basin (Walker, 1984). At the same time, as many people were protesting against colonialist practices, many iwi began to seek redress from the government for previous injustices and dishonouring of the Treaty of Waitangi (Barrett & Connolly-Stone, 1998). In 1984, the fourth Labour government came into power. They introduced important new legislation and policy, including The Treaty of Waitangi Amendment Act 1985 that increased the power of the Waitangi Tribunal to examine claims dating back to 1840. This was a governmental acknowledgement of the injustices that had occurred (Palmer, 2013).

While this change was occurring in Aotearoa, my own family were beginning to question and explore our own history. My aunt became interested in our Māori background, something their own mother had never spoken about. Through their efforts we began to learn something of our whakapapa within my more immediate whānau. My mother's generation began to connect with their Ngāi Tahu iwi, an opportunity directly assisted by the Ngāi Tahu claim against the Treaty of Waitangi. In 1996 Ngāi Tahu signed a settlement document with the New Zealand Crown, acknowledging the breaches made to the Treaty of Waitangi in the Crown's dealings with the iwi since 1840. The settlement of the Ngāi Tahu claims can be seen as the government finally honouring the Treaty of Waitangi in practice, as well as in spirit, a hugely significant step for Māori and Pākehā searching to rebuild relationships.

As an iwi, Ngāi Tahu were providing opportunities for whānau members to connect with the iwi and offering financial support to iwi members. My mother's generation registered themselves and their children as members of Ngāi Tahu. Looking back, this seems to have been a significant step in the process of decolonisation within my whānau. My mother talked about her own mother's unwillingness to be open about her Māori mother and grandmother. We were now feeling pride and a sense of connection with our Māori ancestry, rather than shame. This was assisted by the wider socio-political movements of the time; the anti-racist, feminist, and Māori protest movements.

However, this reconnection still felt quite academic and removed from my felt sense of being Māori. As an adult, after working as a social worker and becoming a mother, I returned to study at AUT in the psychotherapy department. Part of the psychotherapy training involves an annual noho marae. My first noho marae deeply impacted me. I had stayed on marae two or three times previously and had always felt a stirring of discomfort and pain. I had not attempted to identify the cause of this pain previously. However, the psychotherapy training involved an examination of our feelings in relation to our marae experience. After sharing my pepeha at my first AUT noho marae, I had a strange and deeply

moving spiritual experience. In an almost physical tangible way, I could feel my ancestors moving through my body like an aching and healing wind. I imagined that I could feel their longing and loss, as well as their joy at being met and felt. This was also the first time someone had referred to me as Māori, something that had always been unthinkable for me.

Following my first AUT marae visit, I joined the roopu of Māori psychotherapy students. I also joined Waka Oranga, the National Collective of Māori psychotherapists. I am studying te reo through Te Wānanga o Aotearoa. I have visited my marae, Takutai o te Tītī on the southernmost coast of Te Waipounamu. This was also a painful experience, being greeted as part of a group of Pākehā visitors. My great, great grandfather, James MacKintosh, had been given a korowai, as a distinguished Pākehā settler and Member of Parliament in the area at the time. Years later, my cousins returned the korowai to the marae and we were greeted as the ancestors of James MacKintosh. I was struck by how our Pākehā credentials were again acknowledged but not the connection with my Māori great grandmother Caroline Bennet. Yet again, the Pākehā male was prioritised over the Māori woman.

At the beginning of 2016, I made another journey to my tūrangawaewae with my whānau. During this visit we stayed on our marae, helping with the harakeke and exploring the nearby whenua. I experienced a huge range of feelings during this time. I felt a sense of gratitude to be able to stay at this beautiful place and to connect with my ancestors. I felt the pain of being a visitor and the impossibility of regaining what had been lost to my whānau. I felt anxious to be respectful of the marae and distressed about the lack of knowledge in my whānau about Māori protocol. I also felt hope and a desire to continue with my journey of reconnection, to support my marae, and make further connections with my wider whānau.

My journey of rediscovery and decolonisation continues to involve feelings of loss, shame, and grief; as well as joy, discovery, and pride. I realise that this has been an important part of my journey as a beginning psychotherapist in Aotearoa. As painfully personal as my own journey has felt, I have also realised that all Māori in Aotearoa have been impacted in different and shared ways by colonisation. A growing number of Māori researchers are exploring the internal experiences of Māori in relation to their cultural expression and identity (Bishop, 1996; Dacker, 1994; Hall, 2015; Houkamau, 2011; Moeke-Maxwell, 2005; Te Rito, 2007; Wanhalla, 2009; Wirihana, 2012; Woodard, 2008).

History

European colonisation has at its roots the policies of expansionism and imperialism in the 'Age of Discovery' of the 15th century. During this time, Portuguese and Spanish explorers set out in an exploration of 'New Worlds'. In the following century, Britain began its own exploration and colonisation of various 'nations', competing for resources with the Dutch.

The British also began to colonise Aotearoa, where early relationships with Māori were based on trading and whaling settlement at the end of the 18th and beginning of the 19th centuries. Due to more humanistic views and a desire to control potential unhindered greed, the British colony of New Zealand was based on a treaty; the impetus for which was

initiated by reports of anarchic behaviour of the small number of European settlers. Additionally, French and American interests in Aotearoa were growing in the areas of whaling and missionary work (Orange, 1987). There was also concern expressed for the depopulation of Māori, because of wars and infection (King, 2003). Māori rangatira were also becoming concerned about the impact of European settlement on their way of life. In 1840, representatives of the British Crown and 46 of New Zealand's Māori rangatira signed Te Tiriti o Waitangi. There was an English version and a Māori version, with most rangatira signing the Māori version. Immediately, there was confusion surrounding Te Tiriti, leading Governor Robert Fitzroy to say, "some persons still affect to deride it; some say it was a deception; and some would unhesitatingly set it aside; while others esteem it highly as a well-considered and judicious work, of the utmost importance" (Orange, 1987).

Te Waipounamu

The history of Te Waipounamu begins with Māui, his waka, and Rakura, its anchor stone, Te Puka o te waka a Māui (Hiroa, 1949). Waitaha, the first people of Te Waipounamu, came on the Uruoa waka. Ngāti Mamoe and then Ngāi Tahu followed (Ngāi Tahu, 2016). Ngāi Tahu are descended from Tahu Pōtiki, with important ancestral connections to Ngāti Porou, Ngāti Kahungnunu, and Ngāti Ira (Anderson & Tau, 2008). Ngāti Mamoe and Ngāi Tahu moved south and settled in the area of Murihiku, amongst them my ancestors.

Te Rauparaha was a chief of the Ngāti Toa tribe, of the Kawhia district. Ngāti Toa was a small tribe related to the nearby Waikato and Ngāti Maniapoto tribes. Te Rauparaha engaged in many battles with neighbouring and further afield iwi. In the 1820s, Waikato tribes decided to rid themselves of Te Rauparaha. In response, he headed south to raid important Ngāi Tahu settlements, looking to gain access to the pounamu for which Te Waipounamu was famous (Ngāti Toa, 2016). As a result of these attacks, the population of Ngāi Tahu was reduced and weakened (Anderson, 1998).

During the late 1800s in Aotearoa, the population of Māori in the southern part of Te Waipounamu decreased. When Te Tiriti was signed in 1840 there were approximately 70,000 Māori in Aotearoa and about 2,000 permanent non-Māori residents. By 1896, the census figures showed the non-Māori population to be 703,000 and the Māori population approximately 40,000 (New Zealand History, 2016). It is not clear within these figures where many mixed-descent people already living in Aotearoa would have been placed. These figures perhaps already reflect the impact of assimilatory policies, encouraging children of Māori–Pākehā intermarriage to identify with their more Pākehā side and customs. The effect of exposure to Western disease had also taken its toll on the Māori population mixing regularly with the whaler/sealer immigrants.

Māori suffered extensive loss, including language and cultural paradigms, the loss of political and legal power, as well as the structures fundamental to Māori life—that of whānau, hapū, and iwi. The losses were also experienced in the loss of land, food security, and the ongoing production of wealth. "By 1865, the Crown had acquired the South Island, Stewart Island, and much of the North Island either by purchase, confiscation or it had been claimed as 'wasteland'" (Te Puni Kōkiri, 2007, p. 6). The events surrounding the settlement

of Aoteroa by vast numbers of European settlers “interrupted and disrupted the intergenerational transmission of tikanga (protocols), reo (language) and mātauranga Māori (Māori knowledge)” (Pihama et al., 2014, p. 249). Woodard (2008) describes these losses as being linked with “the felt experience of psychological anguish and pain for Indigenous Peoples” (p. 20).

Inter-marriage/assimilation

In the early 19th century, many Māori women left their kaik to marry European men. In 1844, Tuckett estimated “that between Banks Peninsula and Riverton (Aparima), ‘two-thirds of the native women who are not aged, are living with Europeans’” (Anderson, 1998, p. 94). Wanhalla (2007b), a Kāi Tahu historian, described these marriages as “sites of resistance to colonial authority”, but also an illustration of “the extent to which private life was structured by colonial policy” (p. 805), pointing out that the early whalers needed protection, a patron, and land; therefore, marrying well was important.

According to Wanhalla (2009), Māori marriage protocol reflected the organisation of society, mainly revolving around chiefly authority; and intermarriage was “carried out in accordance with certain cultural and social protocols, and designed to integrate newcomers into the tribal group” (p. 4). The inter-racial marriages were also seen as an “opportunity to regulate economic and social encounters with newcomers” (Wanhalla, 2009, p. 4). Dacker (1994) notes that marrying into earlier tangata whenua lines by more recent arrivals has always occurred, “sometimes through political marriages between leading whānau, sometimes through conquest and sometimes a mixture of both” (p. 5).

Another important part of the context for Māori in the 1830-40s, was the devastation caused by the introduced diseases. In 1835, when measles struck the Indigenous people of Aotearoa, it was described as “the enemy greater than Te Rauparaha” (Dacker, 1994, p. 10). Elders and chiefs recognised that bloodlines including European whakapapa had greater resistance to these diseases. This was another aspect in the decision of elders in arranging such marriages (Dacker, 1994).

Scholarship provides clues to the experience of these early mixed-race families. Anderson (1998) notes that Christianity affected many areas of life, frowning upon many Māori practices. Christianity was easily grasped by Māori, with familiar whakapapa bloodlines of the Old Testament and concepts of darkness and light, familiar to both spiritualities (Dacker, 1994). The written observations from missionaries assist our imaginings of the Māori experience:

> John Howells, for example, forbade his half-caste wife Caroline, who initially spoke little English, from sitting about with Māori or attending Māori prayers, and Wohlers, who was visiting Howells, sought to reinforce this instruction by explaining to Caroline that she had a certain status as the wife of a gentleman. (Anderson, 1998, p. 27)

It is significant that in these communities it was almost always marriages between Māori women and European men. During this period, these Māori women faced racial and gendered inequalities.

Mixed descent experience

The children and descendants of these Māori women have had different experiences again as 'half-caste' people. Feminist perspective describes these people of mixed descent as being viewed in contrary ways, "sometimes as lost and adrift, belonging to neither settler nor Indigenous worlds, and, at other times as 'half-way' to 'civilised' and eminently civilizable" (Bell, 2014, p. 63). It is important to remember that when talking about inter-racial marriages, a concept of race that is cultural in its roots is being used. Race does not describe a physical reality; rather, a cultural categorisation. As Fish (2011) contends:

> 'race' is a word, rather than a thing. It is a cultural concept, like ghost or unicorn—or, for more scientific examples, phlogiston or the ether—that does not refer to empirically observable phenomena. Those cultures that have the word, define it differently and use it differently. (p. 25)

Inter-racial marriage between Ngāi Tahu women and European men created physical transformations within the iwi. Physical 'disappearance', an outcome strongly associated with inter-racial marriage, was traced by state mechanisms such as the national census. From 1874, the census was informed by racial beliefs, which defined racial categories and boundaries. Inter-racial marriage was regarded as a tool of assimilation by both Māori and Pākehā. Māori acceptance of 'mixed blood' whānau was more inclusive because of negligible eugenics beliefs relative to Europeans and whakapapa systems that contain multiple lineages with senior and junior lines (W. Woodard, personal communication, April 6, 2016). In contrast, European officials used the census to monitor and comment on the success of assimilation, with decreasing numbers of people identifying as Māori or Ngāi Tahu (Wanhalla, 2009). However, Wanhalla (2009) documents the accommodation made by Ngāi Tahu of their mixed-descent peoples (e.g., participation at Native Land Court hearings and maintenance of customary activities such as muttonbirding), as evidence of a different experience for whānau than that reported in the census figures. More recently, a reversal of figures is occurring as many mixed-descent people from all over Aotearoa register their whakapapa back to Ngāi Tahu. My own whānau's desire and ability to connect with the Aparima Rūnaka and stay on our marae is another example of the way Ngāi Tahu is reversing the assimilation process.

During the late 19th and early- to mid-20th centuries, the movement of eugenics had taken hold in many countries, including Aotearoa. Eugenics involved "the study of agencies under social control that may improve the racial qualities of future generations, either physically or mentally" (Wanhalla, 2007b, p. 165). During this time, various social engineering methods were used to try to maintain the 'health' of the white 'race', including sterilisation, immigration restriction, segregation, and restrictive marriage laws (Wanhalla, 2007b).

Much of the historical documentation raises questions about what has been transmitted to the offspring of these early mixed-race marriages. It also raises questions about what the experience was for the women involved, how they felt and thought about their experiences. Where is the experience of loss and grief? Where are the expressions of protest and anger? Perhaps by tracing the experiences of ancestors, future generations can understand how such loss of culture has occurred. This 'coming to terms' process may elicit many responses—a sense of peace, a call for reconnection and action, lessening of shame, and a feeling of compassion for those encountering the initial phases of colonisation. It may also elicit feelings of anger and deep loss. Further investigation is needed to explain the internal experience of colonisation in Southland.

Many generations who have come from the mixed-ancestry peoples of Southland have found their mixed-ancestry to be a source of shame. This has been the case for my own whānau. The younger generations now feel a different source of shame, located closer to their "cultural poverty" and "the erosion of ties to a Ngāi Tahu identity, at both whānau and tribal level" (Wanhalla, 2009, p. 160).

Dacker (1994) writes of whānau in this area, describing an accurate match with my own whānau experience: "Those living in the Pākehā world were often not proud of their Māori whakapapa because of a widespread ambivalence towards half-castes" (p. 85). There is also evidence of Māori ambivalence, for example, giving land to Māori/Pākehā partners in land known as half-caste ground (Dacker, 1994). "Some families, as features paled with the passing of generations, either hid or denied their Māori connection. And some European families broke all contact with members of their family who married Māori" (Dacker, 1994, p. 85). This was the experience of my own whānau and illustrates the loss we have suffered. What seems lacking in the literature is more extensive explorations of those families who hid or denied their Māori connection. Wanhalla, Dacker, and Anderson have written about families who remain in the Southern region of Te Waipounamu. There has been less written about families who have dispersed into Pākehā society throughout Aotearoa.

Williams (2000) describes a model of Māori identity, which categorises Māori into four main types: 1) those with a traditional Māori core; 2) those who are primarily urban and bicultural; 3) the "unconnected"—who are biologically Māori but know little of their Māori heritage and culture; and 4) a large group of people who are socially and culturally indistinguishable from Pākehā. This final group could be used to describe my whānau whose previous generations saw themselves increasingly as belonging to the Pākehā world. There is less literature about these whānau and the experiences of those descendants who are journeying their way back to their Māori ancestry (Houkamau, 2011).

Moeke-Maxwell (2005) notes one of the dominant narratives available to Māori women as the assimilated identity which "is also a colonized identity, but escapes being viewed as pathological because assimilated individuals are perceived to be privileged with Pākehā beliefs, values, practices, and norms and aligned with whiteness/racial superiority and privilege" (p. 502). In addition, Bell (2014) reports those with mixed-descent backgrounds as potentially experiencing a reduction of "the individual to the sum of their parts and the hyphen [mixed-race] stands to represent a juncture; a chasm that cannot be united" (p. 75).

Hybrid identity

Postmodern thinking has allowed for the critique of previously held "essential" truths; thus, freeing writers and thinkers from fixed beliefs. "Postcolonial refers to the practice of critique and redress which helps in examining the experience of "mixed race people" (Bolatagici, 2007). An important group of writers is now exploring the experiences of mixed race people, often referred to as possessing "hybrid identity" (Anderson, 1998; Bell, 2014; Bolatagici, 2007; Dacker, 1994; Moeke-Maxwell, 2005; Sakamoto, 1996; Wanhalla, 2009). Bolatagici (2007) claims that the experience of mixed race has been viewed historically as a clash between the cultures, embodied as an internal division. In contrast, she quotes Sakamoto (1996), describing how hybridity retains a sense of difference and tension between two cultures, but without assuming hierarchy" (pp. 115–116). There is an uncomfortable tension in this work. In Aotearoa there continues to be dominant cultural practices, favouring the Pākehā worldview. The struggle we have as a nation can often be reflected in the internal world and the identity of those of mixed race. Perhaps the hybridity discourse seeks to enable biculturalism to emerge from the inside out. As a person of mixed-race, I wonder whether my Pākehā side continues to colonise the Māori part of me.

Moeke-Maxwell (2005) writes about the experience of Māori women with different cultural identities and charts the call for Māori sovereignty in the 1970s, when Māori challenged the government to "reinvoke the Treaty of Waitangi as the nation's founding document" (p. 499). It was an important part of this process that Māori adopted an essentialist identity via whakapapa, whenua, te reo, and wairutanga. Moeke-Maxwell goes onto explore the diverse experiences of Māori women:

> Some, such as those adopted as infants into Pākehā families, live without whakapapa, while others are also estranged from their whānau, iwi, landscapes, with minimal cultural contact with Māori culture. Many have little Māori language. Yet, they claim Māori as a significant ethnic identity, even when this identity sits uncomfortably alongside others. (p. 501)

Writers who explore the regions of hybrid identity point to the celebration of mixed identities. Perhaps these writers can provide answers for those who have become disconnected with their Māori identity. Bell (2014) describes the historical view of those of mixed descent as being 'half-way' between the settler and Indigenous worlds: "Their in-between position made individuals of mixed descent favoured targets of a number of assimilatory policies" where "intermarriage was seen as a key route to 'breeding out the colour' and further goal of assimilation" (p. 63). As a descendant of those targeted for this form of assimilation, I have grieved the loss of Māori identity both within my whānau and within myself. I have felt excluded from my own Māori history. Bell's "answer is to embrace and celebrate the hybrid nature of all identities" (p. 60). This celebration describes a different form of the decolonisation process. It has been an important part of decolonisation with Aotearoa to treasure those essential parts of te Ao Māori, such as whakapapa, whenua, tikanga, and te reo. It has also been a vital part of decolonisation to

seek redress for the deep harms done to te Ao Māori by colonisation. For those alienated from their Māori identity, it is important to be able to reclaim and learn about what has been lost. Throughout Aotearoa, wānanga are providing opportunities for Māori and others to learn te reo, karanga, rongoā, and many other practices and learnings of te Ao Māori. The celebration of our hybrid identities appears to be another gift in this learning.

However, there is something missing from this dialogue, which is the pain of the unrecognised Māori part of those who identify as Māori but who have light skin. As someone going through a form of 'identity crisis' while exploring my own Māori roots, I have chosen to emphasise my Māori ancestors and my identity as Māori. This has felt uncomfortable at times and it often feels easy to fall back into my more obvious Pākehā identity. A strong desire remains, however, to overcome my own sense of grief and loss of my Māori heritage.

Reconnection

Te Huia (2014) writes about the need to create space for Māori cultural and linguistic development in a discriminatory post-colonial society. It is in this reconnection that I focus this discussion. How are members of Southern whānau/hapū finding ways back to their marae, to their reo, and to their cultural practices?

> Many Māori have a desire to connect with their language and culture; however this desire could possibly remain a desire unfulfilled if the individual is not embedded within a set of culturally affirming relationships, or if the individual is not supported to create connections to their culture. (Te Huia, 2014, p. 236)

How have individuals experienced support towards creating these connections. If your whānau have wandered from their cultural home, in what ways have members of the whānau been able to make their journey back towards their Māori cultural practice? It is this reconnection and the factors that support it which is less obvious in the literature around the whānau from the Southern regions of Te Waipounamu. When those whānau members can identify what has supported them, it can then assist them in understanding what can be passed onto future generations.

Methodology

When thinking about possible methodological approaches for my research, I wanted to choose one that reflected the goals of my research; hence, Kaupapa Māori Research (KMR). My methodological choice also reflects my experience of dislocation from my Māori heritage and the impact in my whānau of loss of language and connection to our Māori voices. My study examined the question: "What has the impact of colonisation been on the identity of a Southland whānau and how have different whānau members reconnected with their Māori identity?" As a process of decolonisation, this piece of research seems to fit comfortably within KMR.

When my Māori grandmothers adopted the myriad of cultural practices of their Pākehā husbands and fathers, they began to lose the practices that lived in them for centuries before European colonisation. My great-grandmother was a fluent te reo speaker; yet my mother was not even aware of her Māori heritage. Only two generations and so much was lost. One goal of KMR is to assist people with the process of reclaiming their Māori-tanga; to respect Indigenous voices and to allow those voices to help shape future decisions regarding our society.

From the 20 excerpts chosen from the pūrākau, as part of the analysis, several themes appeared in the different stories. These themes ran through the stories of our ancestors, and my whānau members and are titled:

1. Te āta pō (The deep night)—Grief and loss
2. Te wheiao (Liminal space)—Inter-marriage and assimilation
3. Te āta kura (The red dawn)—Denial and shame
4. Te āta tu (Day break)—Te reo
5. Ka awatea (Daylight)—Reconnection
6. Ki te whaiao (Towards the light)—Future generations
7. Te ao mārama (The world of light)—Hybrid identity

Tāhū (Themes)

Te āta pō: Grief and loss

A recurrent motif that appears in this research is that of grief and loss. The pūrākau told within my whānau speak in a matter-of-fact way about deep loss; early childhood loss of the mother. This pragmatic approach may hide an intergenerational transmission of trauma, and a disassociation from the pain of this loss which is paralleled with the loss of culture and language, the mother tongue. These actual losses have a devastating impact on the psyche of those experiencing them. It is a trauma which carries through the generations. This trauma can manifest in different responses: carrying trauma, anger, impaired bonding, survivor guilt, and somatic symptoms (Pihama et al., 2014).

I have noted dissociation from the difficult feelings for my own whānau in the rupture that occurred when they lost their Māori connection. There are many possible impacts that further generations live with related to this rupture and the losses experienced. Woodard (2008) speaks of the alienation that occurs when the bond is disrupted between Indigenous Peoples and their land that has “meant alienation for Indigenous Peoples from their indigenous self” (p. 21).

While this grief has not been fully acknowledged within this whānau, it appears within their stories. Alienation from their Indigenous selves has been a devastating blow of colonisation for this whānau. The pain of it seems too difficult to be felt and the identification with their assimilated Pākehā selves is a strong protection against the pain of loss.

Te wheiao: Inter-marriage and assimilation

The pūrākau of my whānau often returns to the marriages that have been such a defining aspect of its cultural history. It is the Māori women's stories that have captured the imagination of many whānau members and have been gathered and held within my whānau, possibly handed down in a matrilineal line. The pūrākau within this whānau imagine their ancestors' marriages. It is interesting to listen to these pūrākau with the ears informed by current research about the process of colonisation for Māori at this time in southern Aotearoa. And while we do this, it is also important to remember that these pūrākau have been written down in the last part of the 20th century by whānau members who already identify as Pākehā within their whānau and are themselves discovering their "hidden" Māori ancestors.

The pūrākau describes the motivation for the whaler to set up home with a "Māori maiden". It does not describe the motivation of the "Māori maiden" or her whānau. Dacker's (1994) academic research suggests the possibility that Riria's marriage to Weevil may have been planned for by the chiefs of her hapū in the hope of gaining greater resistance to the introduced diseases for her tamariki and to strengthen the health of her people (Dacker, 1994).

Many of the alliances and marriages of my Māori ancestors and the Pākehā men they met suggest a certain sense of autonomy by the women involved. Riria appears to have made a decision regarding a new choice of partner. Kuini also takes a strong role with her daughter, returning to stay with whānau during her pregnancy to William. This supports Wanhalla's (2007) assertion that "an examination of interracial marriage amongst Ngāi Tahu offers an opportunity to 'acknowledge Māori women's agency in cultural encounters' and to explore the multiplicity of encounter narratives in southern New Zealand" (p. 807).

It widens the texture of the stories told about assimilation during this period within Aotearoa. Much has been written about the assimilatory policies which took many forms—intermarriage, forced child removal the privatisation of Indigenous lands, the inability to speak te reo at school, and the later policy of urbanisation amongst other forms (Bell, 2014). These policies were enforced through the passing of such legislation as the Native Land Act 1862 and the Native Schools Act 1867. This research continues to contribute to the richness of voices and experiences of this time.

> Tracing intermarriage patterns in New Zealand is the first stage in developing literature that highlights the diversity of early communities in this country, while also pointing to the complex ways in which families were formed in our colonial past, that were not just European or Māori, but both. (Wanhalla, 2007b, p. 808)

Te āta kura: Denial and shame

A strong theme that runs through the pūrākau of whānau members is the invisibility of their Māori ancestors until quite recently. There are also tales of whānau members who find the presence of Māori ancestors something to still be embarrassed or distressed about. There is a care shown for these whānau members and a desire to respect their distress. It seems that this is an area of pain for my whānau that is not yet able to be thought about fully.

There are painful stories told throughout the whānau of Caroline Bennet, being shunned by her mother and sisters-in-law because of her ethnicity. Aunts and uncles remember being

teased at school about being Māori. It is hardly surprising that an association grew strongly in the minds of whānau members that it was preferable to be white and that their Māori parts were a source of shame. This shame seems to allow for a sort of cultural amnesia about their whakapapa within my whānau. Now, there is a sense of another form of shame existing within whānau members, manifested as a hesitancy or inadequacy in claiming their Māori identity. It is not physically obvious to others that these whānau members are Māori. This requires a claiming of something, of their hybrid identity.

Te āta tu: Te reo

Two of the whānau members have spent much time in their lives learning te reo, something they have felt to be a vital part of reconnecting with the Māori part of themselves. This is an experience I share with these whānau members, having taken several classes at different periods of my life to learn te reo. As with both of my whānau members, I acknowledge that I have not yet achieved my goal of becoming a fluent te reo speaker. It is perhaps through the re-learning of lost language that the process of decolonisation can occur. The struggle that many te reo learners face also reflects the barriers introduced by colonisation. As Bell (2014) notes, "we are all significantly the products of our cultural and political histories" (p. 5). These political steps taken generations ago, can ripple ahead in the internal world of those future generations.

My great-grandmother was a fluent te reo speaker, learnt from her mother. Conversely, my mother grew up without any knowledge that she was Māori, which illustrates how quickly te reo was lost in my whānau, in a time when governmental assimilatory policies were at their strongest in Aotearoa.

> In the early years of contact, European sealers, whalers and settlers had to speak te reo Māori for their survival, because they were totally dependent on trade with Māori. As the number of settlers increased, the balance of power changed and te reo Māori went into a sure but steady decline. (Tipa, 2007, p. 27)

The power imbalance that occurred resulted in damaging government policy, which caused further decline in te reo speaking. The *Native Schools Act 1867* provided funding for primary schools in Māori communities and required that all Māori children in these schools only speak English. Te reo is one of the ways that whānau members are presently finding their pathway back to te Ao Māori.

Ka awatea: Reconnection

While the sadness of loss can be felt in the pūrākau, there is also a sense of passion and gratitude for experiences of reconnection. There is less in the literature about the joy of reconnection. This is a tenuous process when whānau have disavowed their connection to their Māori ancestors; and, perhaps, for many whānau in Southern Aotearoa this process is happening in an organic way. Many mixed-descent people have registered as being of Ngāi Tahu descent and within the Ōraka-Aparima Runaka many descendants of people from this runaka are registering and visiting the marae. The process can stir many of the feelings associated with the loss of culture—shame, fear, and grief. In the process of reconnecting, whānau are confronted by their lack of understanding about how to reconnect (e.g., Pōwhiri protocol and language limitations).

Hall (1990) notes, in the process of reconnecting, we find our identities in relation to ancestral experiences, and in this we can gain a felt understanding of colonisation. So decolonisation must in itself bring a greater understanding of the experience of being colonised:

> Far from being grounded in a mere "recovery" of the past, which is waiting to be found, and which, when found, will secure our sense of ourselves into eternity, identities are the names we give to 'the different ways we are positioned by, and position ourselves within, the narratives of the past… It is only from this …position that we can properly understand the traumatic character of the colonial experience. (p. 233)

Ki te whaiao: Future generations

It seems that many members of my whānau feel increasingly more connected with the Māori parts of themselves and with their Māori history and place in the world. There is a sense of the necessity to pass this on to future generations and for this mahi to continue.

Future generations of mixed-descent people living in Aotearoa continue to face different realities. There is a sense of optimism within my whānau stories about the future generations; a connection to te reo, to nature, and the land. The use of pūrākau in this research has many goals, including the opportunity to pass these stories onto future generations, thus reconnecting with traditional reasons for pūrākau. "Pūrākau is a genre of Māori literature [in an oral tradition] that was a regular feature of daily life, closely connected with ako as a tool for teaching and learning" (Lee et al., 2005, p. 12).

Te Ao mārama: Hybrid identity

There is no doubt that many whānau members of this Southland whānau are now very proud of the Māori part of themselves. It is also interesting how they choose to identify themselves. These voices add to the experiences described in much of the writing about hybrid identity. This research has sought to move away from the position of ethnic categorisation. Rather, this research represents a different picture of mixed-descent peoples' inner worlds and outer experience that has moved forward from the colonial representation of mixed-descent people.

Whānau members are clear that they are proud of both their Māori and Scottish ancestry, suggesting that these whānau members have been able to celebrate the differences between the cultures that exist within them. The more inclusive idea of hybridity "provides an explanation for the bi/multiracial women's ability to straddle two different and opposing cultures, providing some understanding of the chameleon-like changes necessary for a hybrid" (Moeke-Maxwell, 2005, p. 503).

The topic of identity poses many challenges and opportunities for healing in Aotearoa, especially with our history of colonisation. Colonisation has impacted Māori in many ways, including the identity of an Indigenous self. The superimposition of Western notions of self over the Indigenous 'selves' has had devastating impacts on Māori in Aotearoa (Woodard, 2008). The Māori nationalist movement invoked specific essential elements of Māori identity "via whakapapa/genealogy, whenua/land, te reo Māori/ Māori language, and wairuatanga/spirituality" and then "challenged the Government to reinvoke the Treaty of

Waitangi as the nation's founding document" (Moeke-Maxwell, 2005, p. 500). This has been an important strategy for Māori in ensuring the survival of te Ao Māori and to invoke tino rangatiratanga.

A common experience of difficulty in claiming our Māori identity runs through the experience of whānau members. I have struggled with my identity as a Māori woman in Aotearoa. As with many internal challenges, the very thing that has motivated my interest in this subject has been the source of the majority of pain and barriers during the process of carrying out this research. There has been a great deal of writing about internal division experienced by mixed-descent peoples. Bolatagici (2007) writes about the negative perceptions of "mixed race" people as "the embodiment of an inherent internal division and has been perpetuated in literature and cinema through the stereotyped 'tragic mulatto' narrative" (p. 75).

Instead of this representation, the hybrid identity can be viewed as a new 'third space'; in this case, a new identity emerging from the Māori and Pākehā roots of this whānau. "The presence of the hybrid woman challenges the colonial agenda by consciously, and unconsciously blurring the Māori/Pākehā binary" (Moeke-Maxwell, 2005, p. 8). Those whānau members who have had the opportunity to feel more embedded in the Māori culture, through learning te reo; connecting with their whenua, whakapapa; and making connections with whānau, hapū, and iwi, appear to have a more integrated and stronger sense of the Māori parts of themselves.

Conclusions

Colonisation in Aotearoa has both formed and devastated the Southland whānau who have provided some of their pūrākau for this research. Our Māori ancestors lived in the southern part of Te Waipounamu during a time of deliberately assimilatory social and political policies within Aotearoa. The inter-marriage that characterised many of the relationships in Southern Te Waipounamu at the time formed my whānau's experience. Great loss was experienced, and as a result none of my whānau members speak fluent te reo. In addition, there is an
enduring feeling of not being "properly Māori" within members of my whānau.

An important theme that runs through the pūrākau is the desire for, and steps taken towards, reconnecting with their Indigenous selves. There is a striving towards learning te reo by many whānau members and a desire to hand this onto mokopuna. This reconnection has also occurred as an internal process for many whānau members feeling able to claim their Māori identity. Many whānau members feel a strong pull towards their ancestral whenua and marae. The Ōraka-Aparima Runaka continues to grow in members, with whānau linking back to their whenua and tupuna. This process within my whānau has occurred in a physical, emotional, social, and spiritual way. This process of reconnection can be seen in terms of Durie's (1998) whare tapa whā model of health and wellbeing as providing deep health to tinana, hinengaro, whānau, and wairua.

These findings, especially concerning the hybrid identity and reconnection to our Indigenous selves, have implications for social policy and clinical practice within Aotearoa, when

working with peoples of mixed descent. Social policies that can acknowledge the impact of colonisation and provide opportunities for treasuring te Ao Māori can have profound impacts on many levels. When a space is provided for Māori to reconnect to their Indigenous selves, many possibilities exist. The grief experienced and transmitted throughout generations can be felt and acknowledged. Those excruciating feelings of alienation can be recognised and assist us in returning towards our ancestors. When this happens, the potential for celebration of our different selves exists.

This study has been a grounding and healing experience for myself as the collaborator and gatherer of pūrākau. As Joseph Selwyn Te Rito (2007) describes his experience in tracing his whakapapa, "it has helped ground myself firmly in place and time. It connects me to my past and to my present. Such outcomes certainly confirm identity and a deep sense of 'being'" (p. 9). In realising my own role in the production of my identity, I feel empowered to celebrate those different parts of myself.

Recently, absorbed in the process of reconnecting with my whakapapa, I had a dream. In my dream I was at Port Levy, a place of significance for my Pākehā partner's family, who have farmed there for several generations. Port Levy, or Koukourarata, was the largest Māori settlement in Canterbury in the 1800s. My great, great, great grandmother Riria travelled to Lyttleton during the 1800s, where her daughter, Kuini was born. Lyttleton is across the harbour from Koukourarata and it is possible that Riria and Kuini spent time there. Koukourarata is a bay, typical of contemporary Canterbury landscape, with rolling grass covered hills, dry and yellow in the summer months, with a large opening into the harbour. In my dream, Koukourarata was very different and I left it by lifting a curtain of draping ferns and vines. I walked out of a landscape of waterfalls and rocky crevices and into another world. This new world felt dusty and less lush. There were buildings, and amidst a group of European style buildings stood two small traditional looking whare. I pointed this out to the woman beside me and she explained that they were two specimens of a past time used for the museum. I wanted to return to Koukourarata and she said that she would have to help me to return but that it would not be an easy undertaking. I think the dream was about my ancestral journey away from our cultural home and my strivings to return to this home. This home has now changed and can never be the same. There was a strong longing to return to that lush landscape of the past. It is not an easy process to reconnect with this home and the journey is filled with pain and uncertainty. There is no doubt though that it is a worthwhile journey and I believe that I am accompanied by my ancestors in this journey.

Many traditions have woven diverse narratives around dreams and their meanings. The psychoanalytic tradition explores the unconscious yearnings behind the content of dreams. From a te Ao Māori perspective, I can understand that my dream was a way for my ancestors to visit me, to provide support and guidance on my way. The loneliness associated with alienation can give way to a sense of warm union. Like the precious korowai that has featured in the pūrākau, I can feel wrapped in the past as I walk towards the future.

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Paper 11 (2017)

Clinical understandings of a mother's murderous rage towards her infant

Angela Shaw and Dianne Lummis

Mothers commonly experience non-acted out thoughts and feelings that are, perhaps, indicative of more or less conscious murderous rage towards their infants. In my training as a psychodynamic psychotherapist, I (Angela) have experienced difficulties in finding a way to remain with a mother's experience of murderous rage towards her infant, in the context of both the need to ensure the safety of the infant and the mother's fear of losing her baby. Two frequent clinical approaches to such thoughts can be identified in the literature based in the defensive positions of devaluation and idealisation. However, if thoughts and feelings of murderous rage are understood as normative, there may be a third, integrative position available for clinical practice—bringing the devaluing and idealising clinical stances together in synthesis.

This paper mainly comprises Angela's research for her Master of Psychotherapy dissertation (Shaw, 2017). As such, Angela's voice is the first-person narrator. Dianne Lummis, co-author, has provided additional theoretical input.

The research method was a hermeneutic literature review. Congruent with the method, I told the story of the research to convey the evolution of my thinking and feeling. My research question was: What understandings do the psychoanalytically informed psychotherapy literature and other relevant contextual texts give to clinical work undertaken with a mother's murderous rage towards her infant?

Murray and Finn (2012), in their feminist critique of the psychology literature, identify two frequent clinical approaches to such phenomena wherein the thoughts are: 1) indicative of depressive illness; 2) an extension of maternal vigilance and care. The first approach is characterised by the authors as pathologising, with the second approach perhaps being more idealising. The approaches can, therefore, be considered opposing.

I identified three key emergent and sequential themes: maternal ambivalence, idealisation and devaluation, and fear and anxiety. I have come to understand the dominant clinical stances as influenced by both the mother's presentation and the clinician's incorporation and use of primitive psychic defences operating in the socio-cultural and organisational realms. I have further explored how clinical attitudes can evolve developmentally from the defensive positions of idealisation and devaluation toward more capacity for thought, thinking about, and thinking with; specifically, the clinician's capacity to think with the mother, to mentalise or contain strong feelings, and for the mother to continue to be in relationship with her actual infant and her internalised infant and good mother. This will require the clinician to confront their own omnipotence, to allow them to stay with their

own vulnerabilities and with the vulnerabilities of their patients, with increasing capacity to tolerate primitive anxieties and affects.

Key contextual texts

> When I woke up it was almost dark in the room, the sky was full of black clouds, the weather had taken a turn for the worse. I had four boys: the ones in my sleep and the ones in the room, beside me. The four of them didn't know each other, I was the only one who got them confused, who knew about getting from one world to the other, and the pain that always lurked in between. (Olmi, 2010, p. 60)

I resonate with the French novelist Veronique Olmi's (2010) metaphor of the changeable weather of the experience of mothering; her evocative black clouds seem threatening, menacing. They scare me. I am a psychodynamic psychotherapist trained to reflect on my internal world, so I chose to begin this hermeneutic inquiry with that which evokes the most feeling. I searched 'infanticide literature' and was drawn towards Olmi's novella *Beside the Sea*. I immersed myself in the feeling space of a mother about to commit that most unthinkable of acts; she will murder by smothering her two pre-pubescent sons. This act will occur in a dingy hotel in a seaside resort, on a rainy weekend in the off-season.

The relationship between the internal world and external realities is subject to ongoing inquiry. I sought further understandings of the relationship between individual experiences of love and hate and socio-cultural expressions of the same. In this regard, I re-viewed Olmi's (2010) novella *Beside the Sea*. I chose this literary text because it evoked a felt sense that informed me as I encountered other, academic texts. Olmi is a novelist and playwright who conceived her idea after reading a newspaper report containing abbreviated details of an act of infanticide. Almond (2010) suggests that the novel form is important because it puts into words, for the reader, subjective states of mind, in a way that many patients cannot, expanding our horizons.

Olmi's (2010) novel is set within the present stream of the protagonist's consciousness, with little background to the unfolding events. What is foreground is the unnamed mother's external deprivations; she is mothering alone without a partner or other social support, has limited economic means, and an unspecified mental health diagnosis. Rye (2012) draws attention to the 'rock-bottom' social position of the mother.

> I let go of Kevin's hand to help Stan carry one of the bags, hard to say who was helping who, who was hanging on to what, one thing was sure: we were pretty depressed about having to climb so many floors, the staircase was steep and there was no light, perhaps if there had been a light we'd have felt more like it. Without light it was like going into a tunnel, an underpass, we couldn't picture what the room was going to be like, everything was too brown, too dark, no room for the imagination. (Olmi, 2010, pp. 20–21)

No room indeed for thinking or for hope, only a hotel room that will become her place of psychic retreat (Steiner, 2011). The struggle up the stairs feels, to me, like a kind of punishment of self, atonement for not being able to show her boys the ideal seaside. The

tone is ominous, my sense is of foreboding. In her devalued position, the stage is set for a projective solution, it is intimated from the beginning of the novella that she will murder her boys. There do not seem to be any barriers to taking this path; "that was when I realised that the hotel was deserted, we hadn't met anyone and, apart from the bulb on the blink, we couldn't hear anything" (Olmi, 2010, p. 23).

In the hotel room, the mother finds relief from her paranoid anxieties. In her enactment of her murderous rage, she is ostensibly protecting her boys from the hostile external world. In her omnipotent denial of her own hate, what she achieves instead is the annihilation, by projective process, of the very aspects of her self that would prevent her from doing this. Klein (1991d) suggests that "it is not only a situation and an object that are denied and annihilated—it is an object relation which suffers this fate" (p. 182). A part of the mother's ego, her capacity for loving nurturance, has also been murdered. Stern's (1995) writing on the motherhood constellation talks directly to the support system a mother needs to develop the capacity to parent, and what can happen when it is not available.

The mother's internal and external experiences are privileged by Olmi (2010) in her literary exploration; however, what are the possibilities for an infant's psychic development where a mother is unable to think about her hate for her infant? To this end I immersed myself in a hermeneutic contemplation of the film *The Witch: A New-England Folktale* (Eggers, 2015). The premise is a 1600s Puritan family ostracised from their migrant community for a deed unknown, apparently committed by the father.

The film strikes me as an exploration of where good and evil reside, with questions posed about who gets to decide which is which. In passing his sentence, the judge opines "we are your judges and not you ours" (Eggers, 2015). Again, a punitive superego is evoked with Phillips (2015) describing it thus: "internally, there is a judge and a criminal, but no jury" (p. 110). The family is banished from the liberties of the plantation, gates banging shut behind them, left to fend for themselves on the edge of a wood. Their Puritanical religious convictions include belief in the essentially corrupt nature of humans, "born in sin, empty of grace, bent unto sin" (Eggers, 2015).

The eldest daughter, Thomasin, a girl on the cusp of womanhood, is looking after her baby brother, playing a game of peek-a-boo. As she removes her hands from her face Thomasin says, "there you are" (Eggers, 2015). Siegel and Bryson (2012) suggest that being seen, or having one's mind perceived empathically by another, is an integral part to becoming securely attached, with Karen (1998) describing a mothering style that is "warm, sensitive, responsive and dependable" (p. 6). Asen and Fonagy's (2012) work on mentalisation, and Schore's (2019) writing on the development of the unconscious and attachment are more recent theories speaking to this. But what is it that this mother-substitute sees when she looks at her baby? What is it that she can't bear to see? Baby Samuel disappears as Thomasin has her eyes covered. Reminiscent of Olmi's (2010) hotel room, perhaps this mother-substitute is also "sheltered from view" (Steiner, 2011, p. 2) behind her hands in a symbolic place of psychic retreat.

Almond (2010) writes about her clinical experience with a mother who became inexplicably blind after the birth of her infant. Perhaps this mother did not want her infant but was

unable to acknowledge her unconscious wish; "if you can't see your baby, *you can't take care of it, but you also cannot hurt it*" (Almond, 2010, p. xvii). In the film, baby Samuel has been taken by the witch, the identity of whom remains unknown. With the disappearance of the infant, his mother is able to remain loving and good. Her ambivalence is externalised and her grief all-consuming. However, this projective process does not allow for integration of her normal maternal ambivalence. The inevitable incompleteness of her projections means that the mother's hate and badness remain inside, more or less conscious.

The possibilities for the witch are Thomasin, younger twins Mercy and Jonas, or their mother. Blame is passed around and I perceive projective and introjective processes running amok in this family, tearing it apart. Berke (2012) suggests that the metaphor of "the witch represents the cruelly rejecting, depriving, devouring, treacherous mother, more concerned with her own looks, feelings, and needs than her child's" (pp. 1–2).

Towards clinical understandings

> In the process of acquiring knowledge, every new piece of experience has to be fitted into the patterns provided by the psychic reality which prevails at the time; whilst the psychic reality of the child is gradually influenced by every step in his progressive knowledge of external reality. (Klein, 1991c, p. 150)

As I engaged hermeneutically with my own writing, re-reading, and questioning, my impressions and the expanded understandings contained within emerged. This entailed my movement from the parts back to the whole (Smythe & Spence, 2012), as illustrated in the following discussion of 'don't blame the baby', 'the spotlight', and 'to turn a blind eye'. In this way, I sought to bring together the various iterations of my hermeneutic spiral. In concordance with Gadamer, the "text does not therefore present itself as evident truth but rather both reveals and conceals the authors' 'conscious and unconscious interests at Play'" (cited in Smythe & Spence, 2012, p. 14).

Don't blame the baby!

This research focused, in part, on unconscious aspects of the mother–infant relationship. Whilst speaking with a colleague about how my supervisor consistently reminds me that the infant also projects into the mother, I spluttered 'but you can't blame the baby!' I have become aware of a previously unconscious quality or preoccupation in my writing of searching for someone to blame. As I have grappled with blame, I have come to understand that mothers can direct their negative feelings either at their infant (externalised ambivalence) or at their own mothering (internalised ambivalence). I have been more comfortable with a mother blaming herself and consequently feeling guilty about her maternal ability than with her seeking to find fault with her infant. How can I, therefore, reconcile that the infant can project without equating this to culpability? Intellectually I know that neither mother nor infant is to blame, especially given that mother was an infant in her turn; but I found it difficult to integrate this external knowledge into my internal

psychic reality (Klein, 1991c). Biran (2015) provides assistance, stating that "there are no guilty parties: it took place in the space between container and contained" (p. 7).

Klein (1975) suggests that projection is necessary for the infant to allow them to survive, or to go on being (Winnicott, 1960). Projection allows the infant to enhance and develop their internalised sense of a good self and their internalised good mother. The attuned caregiver's role is to contain and digest the infant's negative projections, as suggested by Bion (1962), and be able to contain their own nihilistic thoughts without giving back to baby. Certainly, the boundaries of self and other do not even exist in the first few weeks; and, therefore, there is no projection and introjection—there just is.

The spotlight

I became interested in a mother's unconscious phantasies that might be associated with Klein's (1991c) depressive position, especially those which may demonstrate the qualities of a mother's curiosity about her relationship with her infant. I consider that I came to grasp something about such phantasies and named these insights 'the spotlight'. I focused on the metaphor of the spotlight to further comprehend the literature reviewed in this hermeneutic process. Particularly, I revisited Klein's (1991b) epistemophilic instinct and Bion's (1962) K link.

I previously conjectured that phantasies about the nature of the mother–infant relationship might show a preoccupation with guilt. At the outset I noted my struggle to find a way to remain with the mother's experience of murderous rage towards her infant, in the context of both the need to ensure the safety of the infant and the mother's fear of losing her baby. I came to understand maternal fear as based in guilty feelings that arise from internalised maternal ambivalence, with the clinician's fears also arising from the incorporation and use of primitive psychic defences operating in the socio-cultural and organisational realms. To develop this further I drew on my own fantasy life:

> *During a difficult interaction with my husband I had the fantasy of approaching a great light source, like the sun but not the sun. I felt glorious expecting to be well-received and enriched, but the light did not care much about me. As I approached its glare intensified and I felt increasingly diminished. I realised that there was nothing there for me and I turned, shoulders hunched, and walked away. The felt-sense was of warm expectations turned to cold shame. And then came prickles of irritation…*

Perhaps any mother experiences herself as in the spotlight? It is bright and could offer warm, attentive care, and, perhaps, acknowledgement for her work. However, the mother in *The Witch* (Eggers, 2015) is in the spotlight and scrutiny of her community and their particular socio-cultural defence system against infantile fears and anxieties of the loss of the good mother (Menzies Lyth, 1988; Parker, 1995). Her family has been found wanting, guilty, and banished, leaving her to mother alone. When life is bleak, unrelenting, and precarious, a mother can find it difficult to keep her children safe. She might turn with hunched shoulders and walk away from this persecutory light, her surfeit of guilt adversely affecting her capacity for curiosity and thinking. Olmi (2010) illustrates how such a mother might then attempt to rid herself of her infant; alerting me to the mechanism by which

other mothers might withdraw psychically from their infants, ostensibly to protect the infant's goodness, and, by extension, their own goodness and love. The difficulty is that normal maternal ambivalence is unable to be resolved. A mother is left with fears and anxieties about her maternal adequacy, and particularly whether she will then create a monstrous infant (Almond, 2010). Such a mother may also fear that she is such a bad mother that she will not successfully keep baby alive. In a way, murdering the infant may then feel proactive, rather than just waiting for baby to die passively (Tracey, 2000). A mother, such as Olmi's (2010), might then seek to put both herself and her infant out of their misery.

A mother labouring under such guilt might then begin to feel the spotlight emanates from her infant—the concentrated, persecutory beam of her infant's needs and demands. The spotlight becomes an intense, shining light from which there is no escape, with her infant experienced as a despotic dictator. Mothers can feel persecuted by babies who do not sleep, struggle to feed, and cannot settle. It might be that mother's first emotional response is one of shame; the shame of her inadequacy in the face of such neediness and dependency. But in the presence of such overwhelming guilt, vulnerability to any suggestion of inadequacy cannot be allowed. The more accessible emotional response is her irritation at this demanding infant, an irritation that can quickly fan towards outrage. Outrage is defined variously as "a wantonly vicious or cruel act", "a gross violation of decency, morality, honour, etc", or the "profound indignation, anger, or hurt, caused by such an act" (Collins, 2022). As I ponder these definitions, and wonder whether the act itself comes first or the affect, I remember Menzies Lyth's (1988) reflections on the "obscurity about the location of psychic responsibility that inevitably arises from the massive system of projection" (p. 58).

I suggest that in the spotlight of the socio-cultural defence system, a mother's own depressive anxieties, curiosity, and ability to think about her relationship with her infant come under attack from fearful and anxious infantile phantasies that belong to the paranoid-schizoid position (Diem-Wille, 2011). These phantasies are prompted from both within and without; and, according to Berke (2012), have the effect of exaggerating badness and negating goodness. A mother can regress to Klein's (1991d) paranoid-schizoid position and her experience of unconscious persecutory anxiety might then find an outlet in frighteningly conscious fantasies of murderous rage. Fisher (2006) has written persuasively of the intrusion of hate (or love) into the capacity for K, or a mother's ability to think about her relationship with her infant. Those prickles of irritation that are not thought about can develop into anger, rage, or murderous rage with a range of associated behaviours, depending on a mother's consciousness of her feelings and attendant impulse control. There are many acts of aggression on a continuum, perhaps beginning with the way an infant is held, gently or not gently. Heads can be left to loll. Games can be played where babies are dropped.

My image of the spotlight allows for impacts on a mother from both a persecutory socio-cultural defence system and from her projecting infant. However, in *The Witch* (Eggers, 2015) Thomasin and her mother become locked in a projective battle to determine in whom the badness resides; has mother given birth to a witch or is the witch inside of her? The witch archetype provides a potent symbolisation of the anti-mother or hate (Berke, 2012)

and the spotlight helps me understand the degrading impact of hate on the emotional experience of feeling curious (Fisher, 2006). It has become possible for me to think of Thomasin as being in the spotlight of her mother's infantile murderous rage, and to allow that Thomasin in the role of infant is not powerless. The infant, through projective identification, can create feelings of frustration and aggression in the mother that mother cannot process. Psychoanalysis lends meaning and understanding to the part played by both the actual infant and the more primitive infantile states of the mother in the phenomena of a mother's murderous rage towards her infant. The infant's primary defences and nascent character structure form in the spotlight of her mother's distress and perhaps escalating rage, the inter-generational repetition anticipated by the concept of 'ghosts in the nursery' (Fraiberg et al., 1975).

To turn a blind eye

There is also the shadow that lies outside that concentrated beam of light; the spotlight can swing elsewhere leaving a mother in the dark. The temptation is to look away from a mother's thoughts and feelings of murderous rage, to turn a blind eye. I think of the spotlight as swinging away when the socio-cultural defence system finds a mother wanting, devalued. Olmi's (2010) nightwatchman turns a blind eye, as does Egger's (2015) puritanical society. Such mothers have their own rage, their infant's rage, and the wider rage of the socio-cultural defence system to carry on their own, in the dark. How does such a devalued mother make sense of this inside of herself? I looked to Bion's (1962) concept of the ego-destructive superego. O'Shaughnessy (1999) perceives the pathological superego as an expression of Thanatos; "the abnormal superego usurps the status and authority of a normal superego and entices the ego to turn away from life, to dissociate itself from its objects and ultimately to destroy itself" (p. 861). How does a mother, or her clinician, come to turn a blind eye to themselves?

One way in which this can occur is when, as a result of the infant's curiosity to know what is inside of mother, the infant discovers that their mother's internal objects are damaged. Where a mother's inside is so defended and frightening her infant's phantasy may well be that they have caused this damage through their curiosity about her, or perhaps through their own aggression towards her. Ordinary guilt becomes amplified, and the infant can no longer turn towards mother to look inside of her, hoping to find a reflection of themselves. This prompts a turning away from the maternal object and a shutting down of curiosity and thinking. I have come to understand that curiosity and thinking about the mother–infant relationship is, therefore, not only at risk in the paranoid-schizoid position but also in the depressive position. Even where the infant has achieved the developmental integration of their objects indicated by the depressive position, there is still only that damaged maternal object available for internalisation. Pathological levels of guilt can send the infant back into the paranoid-schizoid position, contributing further to a harsh and punitive superego. A persecutory superego encourages us to turn from our own selves, to find ourselves wanting, to find ourselves guilty. In the presence of pathological guilt the oscillation between the paranoid-schizoid and depressive positions is both accelerated and exaggerated—"guilt too has omnipotent qualities" (Temperley, 2001, p. 56).

Implications for practice

Writing in *Civilisation and its Discontents* Freud (1975) began with the phenomena of the so-called oceanic feeling, described as "something limitless, unbounded" and conceptualised as being located between the ego and the external world. Freud's understanding of the oceanic feeling is evocative of love. The oceanic feeling itself was outside of Freud's personal experience and he ultimately weaves a more complicated understanding of Eros and Thanatos. Olmi's (2010) novella is set beside the sea, also suggestive of the boundaries between the internal world of the ego and realities of the external world and telling that more complex story of maternal love and hate. It seems to me that any clinical consideration of a mother's thoughts and feelings of murderous rage towards her infant is concerned with these boundary issues.

I conceive of Klein's (1991d) paranoid-schizoid and depressive positions as descriptive of the fears and anxieties associated with negotiating the interface between the internal and external. I began with Olmi's (2010) description of a mother's struggle with the boundary between sleep and wakefulness. The mother who is not quite asleep and not quite awake is perhaps, to some extent, outside of both paranoid-schizoid and depressive anxieties. This intermediary state, with its temptations of partial relief from fear and anxiety, might be indicative of Steiner's (2011) concept of psychic retreat. This is a place where curiosity and thinking about the mother–infant relationship is inhibited and where the unthinkable might occur; the ego is tempted to turn away from life, Eros, and the capacity for loving and nurturing behaviour.

The alternative life-affirming parent–infant state, prior to both the paranoid-schizoid and depressive position with their attendant anxieties, is the merged state. This state of merger integrates Winnicott's (1960) concept of primary maternal preoccupation and the infant's experience of being merged, or not separate from, their primary caregiver. Ogden (1989) captures this infant experience in his writing on the autistic-contiguous position. Returning to consider the dominant clinical positions from which we can practice, I now understand Murray and Finn's (2012) identified approaches as defended positions, influenced by both the mother's presentation and the clinician's incorporation and use of primitive psychic defences operating in the socio-cultural and organisational realms (Menzies Lyth, 1988). Murray and Finn's work was a major impetus for this research, igniting my interest in the exploration of the underpinnings of the relationship between mother and clinician. In their pathologising or devaluing clinical approach, undigested fear and anxiety for the mother's sanity can be left with the multi-disciplinary team. In the rush to action, I have seen that the healthy part of the mother can be split off and placed with the clinician who is then mocked and attacked. When hatred escalates, feelings do not become linked to thoughts.

In Murray and Finn's (2012) idealising clinical approach, a mother's fear is more likely to be normalised and fears for the safety of her infant denied. A mother with more ego strength can hide and minimise her fears and anxieties somewhat better, making it a more straightforward matter for the clinician to encourage her in the good job that she is doing. My experience is that normalisation either has the effect of making the phenomena disappear, in that little further discussion occurs about thoughts and feelings of murderous

rage, or the mother's distress escalates. Both responses are, perhaps, a reaction to feeling not understood or misunderstood. In the sweeping away of a mother's feelings, no one understands how close she has come to acting out her rage.

This research has been concerned with identifying a third, integrative position for clinical practice. I have found a third place—but it is one that represents real danger for a mother and her infant, the place of psychic retreat (Steiner, 2011). This is the place of the rush to action, for the mother, clinician, and the multi-disciplinary team. It is also the place where a blind eye can be turned. It is in coming to understand how and why a retreat from maternal fears and anxieties is so alarming that I have begun to be able to contemplate the features of an integrative position for clinical practice. I now realise the advantage of the paranoid-schizoid position in enabling a mother to idealise the good in herself and her infant in order to keep it safe from the bad world. These defences allow the infant and their mother to grow and develop their internalised good objects and their sense of good infant and good mother (Klein, 1975). This development of the good object/self helps the mother and infant to withstand negative thoughts, feelings, and the undertow towards Thanatos or the death instinct. It may be that the most potent clinical possibility is the attempt to bear such difficult fears and anxieties, tolerating and staying with them to embrace ambivalence, tracking the oscillations of devaluation and idealisation, and seeking to understand our complicated stories of love and hate.

Philosophy of the psychotherapy

I have contemplated the relationship between a mother's deeply ambivalent unconscious and her morality, the barriers that stop her acting out her hate. The unconscious has no morality, which is why we are not responsible for the content of our dreams. A mother's thoughts and feelings of murderous rage are most often like this too; in that we do not really want to act on them, although it can feel like we do. If there is no morality in the id, no sense of right or wrong, should morality live in the clinician? Freud's is an amoral, perhaps unmoral psychotherapy, reflecting in part the climate of World War I. I argue that a particular morality is expressed in our collective socio-cultural defences against maternal ambivalence, often based in the devaluation or idealisation of mothers. That external moral climate leaves its residue, as evoked by Olmi's (2010) mud, that gets traipsed from the outside, across the hotel lobby, and upstairs.

Schwandt (2000) helped me with the philosophy of psychotherapy when he argues that "social inquiry is a practice, not simply a way of knowing" (p .203) and that "completely absent in this way of thinking of the moral life is the notion that morality is about argumentative resolution of competing moral claims" (p. 204). Perhaps if curiosity and thinking can remain open, with awareness of hate and love, but not an intrusion of either, then it becomes more possible to make moral judgements? As Phillips (2015) argues "we know, in a more imaginative part of ourselves, that most actions are morally equivocal, and change over time in our estimation; no apparently self-destructive act is ever only self-destructive; no good is purely and simply that" (p. 100). It is when curiosity and thinking shut down that danger lurks.

Summary of implications for practice

In this hermeneutic literature review I came to the following expanded understandings that I would now like to communicate to clinicians who work with high-risk mothers and infants:

- The story of maternal love and hate is complex, concerned with the boundaries between the internal world of the ego and realities of the external world.
- The particular qualities of a mother's fears and anxieties are of utmost importance in assessing how she is negotiating that interface between the internal and external.
- Murray and Finn (2012) alerted us to how our dominant clinical approaches can be conceived of as defended positions (devaluation or idealisation), influenced by both the mother's presentation and the clinician's incorporation, and use of primitive psychic defences operating in the socio-cultural and organisational realms (Menzies Lyth, 1988).
- Danger to the mother and to her infant resides in the place of psychic retreat (Steiner, 2011), a place of the rush to action (a dangerous place also for her clinician and the multi-disciplinary team).
- An advantage of the paranoid-schizoid position is that it enables a mother to idealise the good in herself and her infant in order to keep it safe from the bad world (in Murray and Finn's (2010) idealising position, clinicians can also seek to take advantage of this position, to the detriment of the therapeutic relationship).
- For clinicians, it is in our attempt to bear such difficult fears and anxieties, tolerating and staying with them to embrace ambivalence, tracking and noticing the oscillations of devaluation and idealisation, that we are best positioned to enable expanded understandings of a mother's complicated story of love and hate.

Strengths and limitations

I have considered the implications for clinical practice but how can I validate my thinking without clinical data? Psychoanalytic theory is usually based on the interpretation of clinical data. My intention, instead, is to offer opinion and use the hermeneutic method to investigate the underlying ontology of psychoanalytic theory. The question of validation relates to the elucidation of meaning and is enhanced by returning to the texts. Dilthey (as cited in Moustakas, 1994) puts it thus, "the horizon of experience widens: at first it seems to tell us about our own inner states but in knowing oneself one also comes to know about the external world and other people" (p. 8). This contrasts with positivist ways of knowing to identify evidence-based best practice (Grant & Giddings, 2002).

My inability to draw explicitly on clinical experience might, paradoxically, also be considered a strength of this research. I have been forced into reliance on the hermeneutic literature review method and, hence, my chosen texts and my own reflective capacity. A benefit has been an increasing identification of my own self with the hermeneutic method, hopefully transforming into an expanded way of being in the world. Through the process of this research, I have made further sense of my own life, training, and clinical experiences, as well as the relevant body of theory.

Interpretive methodology and the hermeneutic literature review method provide a framework for thinking, so this research is both strengthened and limited by my own ability to continue to think. Given my hermeneutic journey, I am understandably wary of falling into idealisation and devaluation in my consideration of the strengths and limitations of this research. I am also wryly philosophical about this possibility. In her discussion of the self and other in hermeneutics Schuster (2013) observes that:

> Parts of the texts affected me in a way I was not prepared for. …the impact of my negative, judgemental feelings made it hard to go further into the process. The threat of different ways of thinking and acting can be powerful in its denial of the other, thereby inhibiting human growth and learning. (p. 197)

I cannot resolve this by intellect alone. I will need to come to an existential knowing, a living into my ambivalence rather than a thinking through it. I continue my clinical work with mothers of infants, allowing further understandings to emerge. Schuster (2013) describes this as living a hermeneutic existence.

Perhaps the most obvious limitation with the methodology is the subjectivity of the individual researcher, given that a different researcher would tread different paths, with different insights into the nature of the barriers that help a mother stop herself from acting on her murderous impulses toward her infant. However, I hope this research offers an invitation to others to engage with this difficult and challenging material. I would wish for each reader to encounter their own particular constellation of defences, adding to the sum of our collective human knowledge.

Perhaps a criticism could be the age of some of the psychoanalytic literature engaged with, but newness is not a reliable indicator of significance and importance to the current research (Smythe & Spence, 2012). While possible to argue that the psychoanalytic literature is too old or narrow; equally, it may be that the ideas contained within this literature require more elaboration to come to fuller fruition. The expanded ideas of Steiner (2011) and Fisher (2006) provide weight to this argument.

Areas for further research

Hermeneutic practice encompasses contemplation of what it is that I have learnt to ask differently. The answer to this question likely provides indications for areas for further research. Bernstein (1983) suggests:

> We should always aim at a correct understanding of what the 'things themselves' [the objects of our interpretation] say. But what the 'things themselves' say will be different in light of our changing horizons and the different questions we learn to ask. (cited in Schwandt, 2000, p. 195)

The simplest answer is for me to continue with my own process of hermeneutic enquiry, engaging with this research as I have written it. The incorporation of my own clinical vignettes seems the next step towards further understandings of the processes of

projection and introjections, and the defences of idealisation and devaluation as they relate to maternal ambivalence. The inclusion of psychoanalytically informed parent–infant research will also help to inform the next phases of this research. I anticipate that these additions will assist in elucidating further the implications for clinical practice.

Another answer is for other researchers to engage with this literature to determine how their own historical horizons illuminate existing theory. There are subjective voices that are largely absent from the literature and they are important (Smythe & Spence, 2012). Engagement with clinical vignettes and the voices of other researchers will expand our understandings of how women of varying ethnicities and socio-cultural backgrounds experience and seek to resolve their experiences of maternal ambivalence.

I began this research contemplating the record of infanticide and apparent maternal indifference in the history of mothering. I find myself now wondering about the corresponding historical record testifying to maternal love. Parker (1995) sought to resolve this split, citing notes of love pinned to abandoned babies, as external validation of what might have been the private sentiments of many women; "what the historians of motherhood could focus upon, and what the history of motherhood does display are the sets of social, economic, political and religious circumstances which either condoned or condemned ambivalence on the part of the mother" (p. 52). My interest is piqued.

Acknowledging frustration, irritability, and anger

At times in this research process I have been despairing, finding myself almost unable to write, let alone think. I have come to recognise that alongside my despair has been a certain amount of frustration, irritability, and even anger. My developing understandings of the defensive positions of devaluation and idealisation unsettle me and I am more aware of my oscillation between them. This new attentiveness seems partly attributable to the container–contained relationship in supervision, allowing for the triangulation of processed material, with my supervisor encouraging me to write about my engagement with this disturbing content. And suddenly, whilst irritably lamenting my lack of time and how I will fail to meet my self-imposed deadlines and standards, I felt extraordinarily sad. Halton (1994) wrote that "giving up the comforting simplicity of self-idealisation, and facing the complexity of internal and external reality, inevitably stirs up painful feelings of guilt, concern and sadness" (p. 14). My body sagged against the shower wall; Olmi's (2010) mother speaks to the possibilities of mourning as she contemplates the night watchman:

> Why did he have to look at me like that? Hadn't he ever seen anyone cry? Where do people cry? I often wonder about that, funny you never see people blubbing in the street. They make phone calls much more than they cry, maybe we'd hate each other less if we cried a bit more. (p. 65)

In that moment, it occurred to me that a paragraph I had already written contained the germ of what it is that I really want to say. This could be understood as attaining Klein's (1991a) depressive position, for however long it lasts, and allowing again the possibility of my relationship with this research; a glimpse of the possibilities for anger to be managed

and transmuted towards grief and mourning rather than escalating towards murderous rage.

Summary

I have described and experienced a variety of defences used by mothers against thoughts and feelings of murderous rage towards their infants. In some ways, this hermeneutic literature review has followed a developmental trajectory of defences against maternal ambivalence, encompassing more primitive defences of splitting, idealisation, and devaluation, before moving towards consideration of more developed defences against fear and anxiety. This phenomenological experience has allowed me to explore the relationship between the fears and anxieties associated with the paranoid-schizoid position and the depressive position. It has also allowed for identification and description of the dangerous place where such fears and anxieties recede and acting out of murderous rage can occur. I have considered the socio-cultural underpinnings of the common clinical positions from which we can practice. I have sought understandings of how our clinical attitude can evolve developmentally from the defensive positions of idealisation and devaluation towards more capacity for thought and for thinking about. I have come to understand that this will require the clinician to confront their own omnipotence, to allow them to stay with their own vulnerabilities and with the vulnerabilities of their patients.

Concluding remarks

This research represents my embodied experience of the hermeneutic spiral, beginning from where I used to be, my psychic reality at the time (Klein, 1991c). It is a hermeneutic spiral rather than a circle because I am changed with every rotation; following Klein, my internal psychic reality is gradually influenced by every step in my progressive knowledge of external reality. I sense that Schuster (2013) alludes to this play of the internal and external, alongside the hermeneutic relationship of whole and part, when she says that “recognising the embodied existence of a researcher opens up the possibility of unveiling hidden fore-meanings, especially the destructive ones, affecting the research process” (p. 203). Psychoanalytic psychotherapy and hermeneutic method appear to come together as good partners, sharing and elucidating something of the development of the relationship from part object to whole object.

I feel positioned to enter another hermeneutic iteration, having worked through something in my relationship to learning. It is perhaps the hermeneutic method itself that I have taken inside of me. I have documented my struggle to stay with not knowing, or negative capability, the K link, the epistemophilic instinct, so as to develop my understandings of the value of such an approach in the clinical situation. I have understood something about how to allow my infantile phantasised anxieties into effective contact with current external realities. This is what I would wish for in a best practice clinical intervention for a mother experiencing thoughts and feelings of murderous rage towards her infant.

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The violent offender: Human, monster, or both?

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> Even the most sadistic and destructive man is human, as human as the saint.
>
> (Erich Fromm, 1973, p. 9)

> Plenty of humans were monstrous, and plenty of monsters knew how to play at being human.
>
> (Victoria Schwab, 2013, p. 289)

Introduction

Our human history is laden with vast accounts of horrors and tragedies, from stories of genocides to those of slavery and colonisation. With the advent of the internet, the world has now become a smaller place with easier access to global information. Nowadays, for a lot of people, it would be hard not to see the universality of violence in wars and violent crimes from which we might previously have been detached or removed. In some people, this increased closeness to violence may evoke confusion and repulsion; in others, curiosity and a search for meaning.

Since its inception, the field of psychoanalysis and psychodynamic psychotherapy has often helped offer great insights into various aspects of the human experience as they are able to tap into human consciousness, and the depths of the unconscious, thereby opening a door to new horizons. This paper is concerned with violence and the violent offender in the context of the forensic field and psychoanalytic and psychodynamic theory. Based on the first author's research, under the supervision of the second author, the paper seeks to open a door to understanding the complexities inherent in our relationship with violence. Employing the metaphor of the monster, the paper considers psychic dynamics and processes, as well as the complex and unconscious interactions we individually and collectively have in relation to violence and violent offenders in Western society and its forensic institutions. It is hoped that this paper informs the work of psychotherapists with violence and violent offenders, as well as the victims of violence.

Background

On the 14th of February 2018, as I (the first author) sat in my lounge watching TV, I saw on the news that a young 19-year-old, Nikolas Cruz, went into his former high school, Stoneman Douglas High School in Parkland, Florida, and fired several rounds of bullets killing 17 people and wounding several others. This tragedy became one of the deadliest school

shootings in US history. Some days later, the family that took Nikolas Cruz into their home said in an interview with the *Sun Sentinel*, a mass media outlet, "we had this monster living under our roof and we didn't know" (McMahon, 2018, para. 3). Nikolas Cruz, in a literal sense, is human; yet, at the same time, he was called a monster.

Some families of the victims wanted the death penalty for Nikolas Cruz, they wanted to see him die (Al Jazeera English, 2022). On the 13th of October 2022, following a death sentence trial, a jury in the US sentenced Nikolas Cruz to life in prison without the possibility of parole. The jury found that the aggravating factors proven beyond a reasonable doubt did not outweigh the mitigating factors, one of which included the fact that Nikolas Cruz had a diagnosis of foetal alcohol syndrome (Al Jazeera English, 2022). Following the verdict, one of the mothers who had lost her son in the shooting spoke to the mass media and said,

> I never thought I could be so ugly inside, but I wait and welcome the day that I get that call that tells me that that murderer was murdered in prison, and that's going to be a very happy day in my life. (Al Jazeera English, 2022, 1:10)

A sister, who had lost her brother, also spoke to the media and said that there was "no excuse for letting this piece of garbage breathe." (Al Jazeera English, 2022, 1:25).

What does it mean to be human? Who is a monster? Is a person either one or the other or can a person be both? The quotes at the start of this chapter by Fromm (1973) and Schwab (2013) allude to the dialectic play vis-à-vis the violent individual as human or monster or both, and how we grapple with making sense of violent individuals, as well as making sense of what about them scares us, horrifies us, disgusts us, and yet, captivates our attention.

These two words, *human* and *monster*, one might say carry debatable meanings, although are commonly understood as dichotomous within most societies and cultures. When a person is described as human, it carries the implication that the person is 'good'. Conversely, being described as a monster implies 'evil'. Monsters are generally regarded as irrational creatures who produce fear, and possess predatory instincts, and are mostly seen as morally abhorrent, emotionless, and psychologically gruesome (Asma, 2009; Shildrick, 2002). Beal (2002) writes that monsters usually stand for beings we project as 'other' or 'not us' in our world. To the family that housed him, and perhaps to several people, Nikolas Cruz was a monster.

Inquiry

It was during my post-graduate programme research study that I became intrigued with the metaphorical monster as it relates to violent offenders, and then decided to make it the focal point of my hermeneutic inquiry. My interest was in exploring the deeper meanings and the symbolism of the word monster and its connection to the humanity of violent offenders. I wanted to better understand the aversion I had to the usage of the word monster in relation to forensic patients who had committed violent crimes, as well as patients who continually showed violent tendencies. I wanted to understand why I cringed when I heard colleagues characterise some forensic patients as monsters. In addition, I was

curious about the experience of those who considered it apt to describe another human person as a monster, and what this revealed in a larger context of our humanity and society. I hoped that exploring some of these questions would provoke thought and, ultimately, better inform and improve psychotherapy practice and other health-related practices in the forensic mental health arena. The findings of my inquiry will be referred to below (Ajayi, 2018).

The violent offender

In the forensic sphere, the use of the metaphorical monster to describe violent offenders is not unusual. On many occasions, I have heard people say "he is not human, he is a monster", when such individuals have perpetrated horrific acts of physical violence or sexual violence. Although the focus of this chapter is on the violent offender, I should note that the metaphorical monster is not restricted to those who have committed physical and sexual violence but has also been used to describe those who have carried out fraudulent financial acts that have impacted the lives of others, such as in the case of Bernie Madoff (Fishman, 2009).

Foucault (1999/2003) believes that in modern times, the social construct in Western society is that "monstrosity is systematically suspected of being behind criminality. Every criminal could well be a monster" (pp. 81–82). The inability of individuals in society to see beyond the horror of the violent act leads to the perception of the violent offender as a monster, as powerful feelings of anger, fear, terror, hate, and revulsion are evoked in society.

The dichotomy of human and monster is one that appears to be unambiguous—but is it? Douard and Schultz (2013) show that the violent offender is framed as a monster so as to dehumanise them, to define them as an 'other', as 'not us'. Their humanity is denied, and they are "excluded from the moral order of being a human person" (Zimbardo, 2007, p. 307). The violent offender is perhaps no longer seen to be human because they have perpetrated what another considers outside the realm of humanness. This, however, raises the question whether the violent act (e.g., murder) that led to the violent offender being characterised as a monster is an inhuman act or a human act. If we assume it is a human act, this then invites us to ask what it really means to be human, and is there a chasm or a congruence between human and monster?

According to Asma (2009), some people believe that having emotions represents a vital element of being human. Therefore, the idea that the violent offender is human may be unacceptable to those who equate emotions with being human and consider violent individuals to be without emotions. Zimbardo (2007) notes that to dehumanise the other, there is not only the attribution of animal-like qualities to the person but a denial of the existence of human emotions, and there is a denial of their human essence. He calls this a form of "emotional prejudice" (Zimbardo, 2007, p. 312). Consequently, when a person is perceived to have no emotions because of the violence that was perpetrated, it becomes much easier to frame them as a monster. With certain victims and their families, however, the monster metaphor proceeds to the level of being made concrete.

With the concretisation of the metaphorical monster, the symbolic quality the metaphor holds is lost, or perhaps denied, in the psychic process of the person calling the violent individual a monster (Campbell & Enckell, 2005). Thus, when the word monster is used as a figure of speech (involving comparison), the person would conclude that the violent individual is not like a monster, but actually is a monster. One may contend that the concretisation of the metaphorical monster tells us more about the psychic process and the experience of the person labelling the violent offender a monster, and less about the violent offender.

Asma (2009) also discusses the view held by some that having emotions alone is not enough to qualify as human, as animals have emotions too. However, the capacity for empathy, a person's ability to put themselves in the shoes of another, is what separates humans from other animals and beasts, and is that which separates humans from monsters. Since the violent offender's act is viewed as an act without empathy or compassion, they are, therefore, a monster, and not human.

Fromm's (1973) assertion that "even the most sadistic and destructive man is human, as human as a saint" (p. 9) seems that a person's humanity or humanness is not determined by their violent actions and, therefore, the 'monster' is human in the literal sense of the word. Fromm also seems to be inviting us to think about how we define humanity, and whether it precludes the monstrous. Similarly, Douard and Schultz (2013) are of the view that violent offenders are human beings even though their actions could be described as monstrous. Fromm and Douard and Schultz, it would seem, do not link the violent offender's humanity to their emotional essence and empathy or lack thereof.

Another interesting point that emerges from the literature, as it pertains to the characterisation of the violent offender as a monster and not human, is the self-deception or denial that the violent offender is different from every human. I wonder if perhaps this presents the illusion that the violent offender actually looks like a monster with horns, as we see in the movies. It seems to us that failing to see the 'monster' as human may lead to denying the dangerousness of those closer to us who perpetrate violence, until severe harm is done, and it is too late.

Like Schwab (2013) states, "plenty of humans were monstrous, and plenty of monsters knew how to play at being human" (p. 289). Some women may deny the violence of their male partners, and vice versa; and some parents may deny the dangerousness of their children because they are 'not like those monsters'. This begs the question of how quickly we characterise as monsters those we have no connection with compared to people closer to us—perhaps a neighbour, a friend, a father, a mother, an aunt or uncle, a husband or wife.

Why does it matter whether the violent offender is perceived as human or seen only as a monster? Zimbardo (2007) says it matters because it influences the way the violent offender is treated. Zimbardo notes it is easier to be callous towards dehumanised individuals, and refers to the experiment designed by Albert Bandura and his students that demonstrated the power dehumanising epithets have in fostering harm against others. In the experiment, labels attributed to a group of subjects unconsciously influenced the way the subjects were

treated (Zimbardo, 2007). The experiment seemed to suggest that if the goal is to dehumanise the violent offender, the monster metaphor helps to achieve that. However, if the goal is not to dehumanise the violent offender, then their humanness would need to be acknowledged.

Dichotomy of human and monster

A central theme that emerges is the dichotomy of human and monster. This dichotomy invites the notion that the monster is the antithesis of the human person. If we consider that the human person is the antithesis of the monster, then it would be reasonable to ask whether the violent offender is human, a monster, or both? The answer to this question is complex. Besides this complexity, the answer is subject to the meanings and understandings each of us give to experience, and that it is fundamentally ontological.

One of the most enlightening illuminations that emerged regarding this central theme was the contrasting views with respect to what it means to be human. On one hand, being human is often associated with qualities such as vulnerability, the presence of an emotional essence, the capacity for empathy, and the capacity for compassion. To be human is to be humane; to be capable of, and to show goodness. This perspective negates the humanness of the violent offender and suggests that it is fair to characterise them as a monster because they have perpetrated a heinous and horrible act, and therefore lack the qualities of a human person. It further suggests that they are nothing but a monster, which implies that they are not like a monster, but they are actually a monster. This position where the monster metaphor becomes concretised (Campbell & Enckell, 2005) in such a manner may be held by some victims of violence who find it difficult to see any humanity in the perpetrator.

On the other hand, in reality, being human is not about being good or the lack thereof, that "even the most sadistic and destructive man is human, as human as a saint" (Fromm, 1973, p. 9). It suggests that violent offenders and even infamous dictators in history, such as Hitler and Pol Pot, who have committed some of the most heinous and monstrous acts in human history, are as human as those who have not perpetrated violence. The inference I make here is that the violent offender's humanness is not defined by their actions, either violent or not, and though they may be viewed as a monster, they are human, as human as you and I. This perspective appears to be a more biological one.

An interesting and different dynamic that emerges, as it pertains to the dichotomy of human and monster, is the notion that the violent offender is human because they have a dark part, a monster within. What do I mean by this? Basically, what I suggest here is that being human is fundamentally about the presence of the good and the evil parts. To be human is to have the conflict of parts. Conceivably, from this perspective, one could argue that the violent offender is framed as a monster because there is an outward manifestation of the monster within them.

The dichotomy of human and monster is a construct that perhaps allows us to split good from evil, and therein allows violent offenders to be declared as 'not us'. The dichotomy of

human and monster in terms of 'good people' and 'evil people' is inherently deceptive and dangerous because we are often drawn to judging a book by its cover. Schwab (2013) writes that "plenty of humans were monstrous, and plenty of monsters knew how to play at being human" (p. 289). I also point to the account of a victim of domestic violence, who stated that her husband could go from being the "sweetest kindest person to a complete abusive monster in minutes" (Boyle & Crane, 2018, para. 66).

Interestingly, it was revealed that those we consider like us, those we often view as human—a father, mother, brother, sister, spouse, friend—may outwardly manifest the monster within. Violence statistics in New Zealand state that most violence is committed by someone you know (Department of Corrections, 2015): the victim in 69% of cases knew the perpetrator, and in 44% of cases, the perpetrator was a family member. This makes me wonder whether the dichotomy of human and monster is moot, and a misconception.

The archetype of monster

I was surprised how the findings within my study (Ajayi, 2018), as they pertain to the dichotomy of human and monster, brought my attention both to the violent offender and to us. This drew me to the idea of the monster within being represented by the archetype of Evil (Costello, 2002) or the archetype of Monster, which is repressed in the unconscious—the collective unconscious (Jung, 1970). What emerges for me is the idea that although we may not outwardly manifest the monster within like the violent offender, the archetype figure of the Monster manifests in other ways. It reveals itself when we watch movies, play video games, and read novels as we cheer when disliked or evil characters and virtual/fictional enemies are annihilated and destroyed.

The archetypal Monster may also reveal itself through a victim's thoughts, desires, and impulse for revenge on the perpetrator, highlighted, for example, by Sebold's wish to murder the man who brutally beat and raped her (Ajayi, 2018). Likewise, my own experience of being brutally beaten and kicked while in boarding school highlighted my desire to enact revenge on my attacker. These examples, I would argue, reveal the archetypal Monster. Clearly Nietzsche (1886/1966) recognises this archetypal Monster and its potential for an outward manifestation when he says that "he who fights with monsters should be careful lest he thereby become a monster. And if thou gaze long into an abyss, the abyss will also gaze in thee" (p. 83). However, in a victim, the archetypal Monster could be inhibited by social norms, religious values, the law, or perhaps the fear of punishment. One could also assume that some victims are impeded by the lack of opportunity to carry out vengeance on the perpetrator.

Because revenge is not likely or possible for the victim, the law becomes the only recourse, with the victim, their families, and society's strong desire for the perpetrator to be punished (Booth, 2015). We seek punishment for the perpetrator, and do not oppose dehumanising and monstrous punishments, such as solitary confinement—locking the violent offender in a cell for extended periods, depriving them of sunlight and human contact.

We may also call for the violent offender to be locked up and for the key to be thrown away. This is highlighted, for example, by a victim stating to the media, “I hope he rots in a cell” (Monster’s history of violence, 2017, p. 8). Some may also call for the ultimate punishment—death—as mentioned earlier in the case of Nikolas Cruz (Al Jazeera, English, 2022). Such punishment, I contend, would be considered monstrous if inflicted on an innocent person, but for the violent offender who is not seen as an innocent person, society construes it as appropriate and just, and the monstrosity of the punishment is seldom questioned. I will let you imagine what society’s reaction may be if it was later discovered that the violent offender was innocent of the crime.

This leads me to wonder if punishment, particularly when it is agitated irresponsibly by media framing (Douard & Schultz, 2013; Hodgkinson et al., 2017), is another manifestation of the archetypal Monster at a societal level. I must clearly state here that my wonderings are neither a judgement about the right or wrong of punishment, nor is it a suggestion that victims and their families cannot or should not seek for the most severe punishment against those who have violently harmed them. Rather, my wonderings are intended to shed light on psychic processes and manifestations that may be hidden from our awareness.

What should I infer from this? I think it is reasonable to suggest that the monster within is both manifested in the violent offender, and in us. Again, I am inclined to doubt the dichotomy of human and monster, and the polarity of ‘us and them’, which has created the chasm between society and violent offenders that appears to exist in Western culture. I contend that the dichotomy of human and monster is neither clear-cut nor black and white. The dichotomy of human and monster invites us to think about how we see ourselves and violent offenders, as well as how we relate to ourselves and violent offenders.

Again, we come back to the question: is the violent offender human, a monster, or both? I do not think there is a definitive answer to this question; however, my understanding is that they are human with a monster within, and so are we. My view is that because the violent offender’s dark part is manifested outwardly against the law, it leads to them being viewed differently from us, but, essentially, they are not. They become the monster we reject in ourselves or that we deny exists. This brings me to the second theme of this chapter.

Disavowal of the monster within us

Another significant theme that emerges is around the difficulty in acknowledging the monster within us. What is being proposed here is that there is a distancing from the dark parts of humanity by society, and two interesting dynamics in relation to this theme emerge. First, we disavow and negate from our awareness the monster within us by denying the monster within the violent offender; and second, we disavow the monster within us by projecting the monster onto the violent offender.

If we consider the violent offender as a mirror by which we look at ourselves, our monster is reflected back to us. However, we may choose to deal with this reflection by denying the monster in the violent offender, by denying their dark parts. Marshall (1996) rejects the idea of viewing violent offenders as monsters. By adopting Marshall’s position, we are then able

to deny the dark part of our humanness, which then indicates that we are not vicious animals capable of horrific acts of violence and should not be afraid of each other. From this perspective, we see the violence committed by the violent offender only as an aberration.

I wonder whether this is why some encourage us to separate the violent offender from their behaviour. For example, Marshall (1996) argues that we should have compassion for the violent offender while we loathe the behaviour. To illustrate this further, I draw from my experience in the Christian faith. Some Christians choose only to see the 'good' in people, attributing the violence to an external entity, the Devil. I am reminded of the numerous times I have heard some in the Christian faith talk about the Devil being responsible for the violent behaviour of a person, implicitly suggesting that being violent is not human. Here, the violent action of the offender is perceived as the Devil's doing, not the human. This perspective helps the Christian person maintain a sense of self-righteousness and the sense of purity in human beings.

My study, however, points to a more pervasive dynamic in society: a disavowing of the monster within us by projecting the monster onto the violent offender (Ajayi, 2018). This suggests that we hold a position of self-righteousness and superiority to the violent offender, and unconsciously designate them a scapegoat for our own monsters. The violent offender becomes the scapegoat monster, so that we can feel pure. Like the scapegoat in the book of Leviticus 16:8–10 in the Bible (King James Bible, 1769/2017), they are the sacrifice for society. It is important to mention that in the Bible it is noted that scapegoating was a recurring practice, and perhaps it should be expected that every now and then we seek another violent offender on who we can project our monsters.

Waddell's (1998) description of a scapegoat seems to me to explain this dynamic of disavowing the monster by means of projection quite well. Waddell argues that society disavows or evacuates unacceptable aspects of themselves, as they locate those aspects in another and then persecute them, who then becomes the storehouse for feelings and thoughts which they cannot acknowledge as part of themselves. White (1923) also emphasises this dynamic when he notes that:

> The criminal thus becomes the handy scapegoat upon which he can transfer his feeling of his own tendency to sinfulness and thus by punishing the criminal he deludes himself into a feeling of righteous indignation, thus bolstering up his own self-respect and serving in this roundabout way, both to restrain himself from like indulgences and to keep himself upon the path of cultural progress. (p. 13)

The man who goes to war and kills those he considers as enemies can disavow the monster within himself. He is greeted as a hero on his return, a contradiction to the dark part he refuses to accept in himself. The woman who fights in a boxing ring and knocks her opponent out cold can also deny the dark part of herself. She is greeted as a champion and her victory may bring her large sums of money.

The soldier and the boxer are not framed as monsters; rather, their violence is framed by society in a positive way. What I infer is that by disavowing the monster within us we are able to hide from the complexity of our nature and our humanness, maintain the split

between good and evil, and therefore dehumanise the violent offender. This brings me to the final theme of this chapter.

Dehumanisation of the violent offender

The powerful influence inherent in the monster metaphor and its prevalent use in Western society today has been revealed. When the metaphorical monster is employed in society it unequivocally symbolises the dehumanisation of the violent offender. Douard and Schultz (2013) note that the violent offender is framed as a monster so as to dehumanise them, to define them as an 'other'. What was surprising to me, however, was the depth and significance of this symbolism.

The metaphorical monster has the power to negatively influence the way we relate to violent offenders. What is interesting is that its influence may be out of our awareness, that is, operating outside our consciousness. There is an impact on the conceptions of the human experience as a result of the metaphor (Douard & Schultz, 2013). Its influence is, however, not limited to individuals in society, and its influence, according to Wardle (2004), has the potential to affect policies, laws, legislation, and funding that essentially determine how a government deals with and reacts toward its violent offenders. It could, perhaps, be the difference between building more prisons and building more social housing. Furthermore, it could be the difference between recommendation of harsher sentences and recommendation of psychotherapy treatment.

The violent offender's humanity is denied, and they are "excluded from the moral order of being a human person" (Zimbardo, 2007, p. 307). It seems to me that they are transformed into a monster in the mind of society, and are like the Beast in the fictional story of *Beauty and the Beast*, who becomes a pariah and a target for hate. The negation of the violent offender's humanness leads to a withdrawal of empathy and compassion for them. It is partly for this reason, I believe, that Asma (2009) notes that we close off any real understanding, and neglect to give attention to the complexities of this person.

Douard and Schultz (2013) state that the metaphorical monster makes it possible for the violent offender to be excluded from the human community. I wonder if their exclusion from the human community communicates to them the idea that they are rejected and unloved by all. Therefore, they feel alone in the world, disconnected from society, and disconnected from themself. This seems to speak to R. M. Fishman's (1978) contention that offenders endure more pain than most because they are rejected by their families, society, and themselves.

I am reminded of the many violent offenders I have worked with over the years who have spoken of feeling lost and dead inside, of feeling alone in the world. This is worth mentioning in relation to Māori, particularly because they have consistently been disproportionately overrepresented in the criminal justice system in New Zealand, in prisons as well as in forensic hospitals (Department of Corrections, 2007, 2015). In the Māori worldview, *whanaungatanga*, the sense of relationship and connection, is fundamentally essential to the person's place in the world (Durie, 2001). With a sense of disconnection

from self, others, and the land, the person feels psychologically and socially alienated, which can lead to substance use problems (Durie, 2001), mental health problems, and further violence.

Furthermore, there is a suggestion that the monster metaphor induces the notion that the violent offender is void of emotions and void of an emotional life. This reminds me of Gilligan's (2000) notion of violent offenders being "dead souls" (p. 45), which, according to Gilligan, emanates from the violent offender's early life experience of being physically or sexually abused, neglected, or rejected. His view echoes the story of the serial murderer, Aileen Wournos, who had a very traumatic childhood of physical, psychological, and sexual abuse. I wonder if this perceived lack of emotional life allows the violent offender to be treated like a caged animal in a zoo.

In an attempt to dehumanise the violent offender, there is the attribution of animal-like qualities to them (Zimbardo, 2007). The monster metaphor allows for the violent offender's human dignity to be stripped from them. However, because they are viewed as a monster, the violent offender is not just an animal, they are a predator looking for prey, and an enemy (Zimbardo, 2007)—an enemy of the whole society (Foucault, 1999/2003). Being an enemy, they evoke fear and the wish to annihilate in the consciousness of society, and perhaps this partly explains why they are related to in a callous, cruel, and insensitive manner even after the law and society say they have paid for their crime.

Looking at the themes that have emerged, the task of reintegrating the violent offender back into society appears to be a difficult and problematic goal. Society has rejected them, framed them as a monster, and treated them like an animal and an enemy, perhaps to the point where the violent offender has internalised these qualities, as they see themself through the lens of society.

This makes me wonder whether this is partly why some violent offenders I have worked with say they feel out of place and do not belong in society, and why some reoffend so soon after returning into the community. For some of these violent offenders, particularly the repeat offenders, I wonder if at an unconscious level being in prison feels more like home, where they are among those who they consider to be like them and can empathise with their inner reality.

I have become more aware and curious about the lack of attention given to the dehumanising experiences violent offenders endure. I wonder about our expectation of reducing recidivism and rehabilitating violent offenders considering the psychological mark the monster metaphor leaves on them. This leaves me to ponder on Gilligan's (2000) description of violent offenders as dead souls, and the hope that they may one day feel alive again.

Implications for psychotherapy

The important question to answer now is of the significance of these new understandings for the discipline of psychotherapy, particularly with respect to violent offenders. What do these new understandings that have emerged mean for psychotherapy practice?

From a practice perspective, the study calls into question how we as psychotherapists consciously and unconsciously view the violent offender, and to what degree our perceptions impact our relationship with the violent offender. It also calls into question how much influence society's view of the violent offender influences our treatment approach of the violent offender.

It would be important for us, as psychotherapists, to make a conscious effort to assess within ourselves our relationship to the metaphorical monster because we may be caught in the web of the dichotomy of human and monster without even knowing it. We may be unaware that we perceive the violent offender as an other, as an enemy to be feared and dehumanised.

Perhaps this is reflective of the current paradigm in psychotherapy for violent offenders, where the central focus is the violent act. The violent offender is assessed, understood, and treated in the context of their violent act (Welldon, 1997; Yakeley, 2010). I wonder if by adopting this seemingly narrow approach we psychotherapists disavow our own criminality, and the monster within us, and may potentially become society's tool in enacting and maintaining the dehumanisation of the violent offender. I am reminded of a number of clients I have worked with who noted the multiple times they have had to talk about their violent act, and how they get tired of talking about it and how they feel reduced to their crime.

I should make it clear that I am not suggesting that the violent act of the offender should not be addressed in psychotherapy. My contention is regarding the narrowness and one-dimensionality of the psychotherapy process when it comes to violent offenders. Interestingly, Freud (1904/1959) states that one should not allow the morbid condition to blind one in making an estimate of the patient's total personality. In this context, the violent act of a patient is considered to be the morbid condition.

The metaphorical monster as we have repeatedly indicated symbolises the danger and risk the violent offender poses, and also symbolises their dehumanisation. However, the experience of dehumanisation of the violent offender is an area that appears to be inadequately addressed or completely ignored. It is possible that some in society may argue that the trauma of punishment and the trauma of being treated less than human should be ignored in psychotherapy, and that the primary consideration, or only consideration, should be the safety of the public.

I would contend that by addressing their dehumanisation, one is able to access the violent offender's emotional life, as the violent offender is held empathically in the psychotherapist's mind as a human person with self-worth and someone to be understood. I wonder if by being thought of and held in the psychotherapist's mind in this way, does the

violent offender grow to recognise their humanness with all the dark parts? Hepburn (1992) notes that for growth to happen, the client needs to be helped in mind. Hepburn further implies that when there is a failure of being held in mind, the result is continued disintegration of the mind. I also wonder if by the violent offender being held in mind, they begin to learn to hold the psychotherapist in their mind as well, which could lead to improving their capacity for empathy for others.

If a psychotherapist decides to address the experiences of dehumanisation that the violent offender may have, it begs the question of whether the monster metaphor can be useful in the therapeutic process. I believe that the metaphorical monster can be useful on two fronts: addressing the dark parts—the monster within—as well as the dehumanisation of the violent offender. Metaphors are generally thought of as useful tools in psychotherapy because they can be used to examine a person's experience (Tay, 2013) and can be used to help bring unconscious processes to the conscious, and access repressed parts of a person (Reider, 1972). According Eynon (2001), metaphors have a special role in enhancing the communication between the psychotherapist and the client. In fact, Arlow (1979) argues that psychotherapy is basically a metaphorical enterprise.

The metaphorical monster can be a way to help the violent offender process and understand the potential for danger or risk they present with—the monster within. To be clear, I am not suggesting that the psychotherapist calls their client a monster, neither do I expect that they will call them that. This, in my view, is ethically wrong. It might likely be offensive to the client and could lead to jeopardising the safety of the psychotherapist. It could potentially provoke some clients to become violent, which may result in physical and psychological harm to the psychotherapist.

Rather, I am proposing that working with the dark part of the violent offender may involve helping them to understand the monster within themself. It may also involve helping them to assimilate and integrate this dark part with their entire personality (Casement, 2006; Costello, 2002). To a large degree, I do not concur with Adshead's (2013) view of transforming the monster within because I am more inclined to agree that it is universal, and an inherent aspect of our humanness.

Besides its use for understanding the dark and unacceptable parts of the violent offender, the monster metaphor can be useful in helping the violent offender's emotional experience as they process and work through their past and present dehumanising experiences. It could be a tool to help the psychotherapist empathise with the experiences of the violent offender in prison who feels dehumanised because they are locked in solitary confinement and have had no sunlight or human contact, and who is repeatedly asked to strip naked and have their body orifices searched, losing their human dignity. It may be experiences of abuse from other prisoners and prison guards, who they feel treat them like an animal, or perhaps the rejection and ostracisation by family and friends who do not want anything to do with them.

Conclusion

Undoubtedly, questions remain regarding the symbolism of the monster, and our understanding of the dichotomy of the human and monster construct with regard to the violent offender. Nevertheless, we hope that this paper has provided fresh insights and new thinking toward understanding some of the inner conflicts and complexities we experience and observe with regard to violence and those in our world who perpetrate physical and sexual violence, thereby bringing terror and tragedy to their victims, their families, and society as a whole. One such insight highlighted in this paper relates to how we each choose to understand what being human means in the context of violence, and the influence this understanding is likely to have on our experience of violence, and interactions with violent offenders. Another insight relates to the 'hidden' or 'not so hidden' monstrosity within us, and the psychic mechanisms such as disavowal/denial, splitting, projection, and rationalisation are at play in our internal relationship with violence. The paper also brings attention to the idea that violent offenders, having dehumanised their victims, will also experience forms of dehumanisation. In this context, we invite psychotherapists and forensic health workers to think actively about their relationship with violence and the violent offender, and to position themselves consciously in their practice as they carefully consider the question: human, monster, or both?

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Paper 13 (2018)

Facing personal adversity while dealing with the pain of others: A hermeneutic literature review

John Francis and Kerry Thomas-Anttila

In April 2016, while I was in my third year of postgraduate psychotherapy training and only a few months into clinical work, my grandfather died. I journeyed through a hollow and non-linear grief experience while beginning to work with clients—many of whom were in great pain of their own—and began to notice that the experience of adversity among my peers while they, too, entered clinical work was seemingly ubiquitous. This indicated to me that most psychotherapists, while they work with their clients, are likely to experience some form of pain or suffering. The human scene is, after all, filled with surprising and disturbing events (Symington, 2016). As these embryonic observations were gestating in my mind, my wife's father was suddenly diagnosed with an aggressive and late-stage oesophageal cancer. This event excruciatingly reopened my slowly healing wound of grief. Then, in my last months of psychotherapy training, an even more chaotic and disorienting event occurred in my life. This would both shatter the delicately balanced equilibrium just restored and, ultimately, consolidate my desire to better understand the myriad issues that arise when the therapist's personal and professional lives touch (Morrison, 2013).

In what follows, which is extracted from my dissertation (Francis, 2018), the research for which I conducted under the supervision of Dr Kerry Thomas-Anttila, I first outline the methodology and methods of my research on therapist experiences of adversity. Following, I explore the impact of these experiences on the psychotherapist themselves. Here, I focus particularly on the therapist's internal experience when crisis presents outside of the therapy room. Next, I explore the multifarious impacts that such experiences can have on the therapeutic relationship; that is, the relationship between therapist and client. I conclude by exploring different ways of digesting experiences of adversity and directions for future research. In investigating this topic, my hope is that those who already think in terms of the influence of life events on the therapeutic relationship might find some resonance with what emerges. For others, I hope to offer a new way of conceptualising the inevitable intersection of the personal and the professional (Kuchuck, 2014). I also seek to draw attention to the fact that it is not just our histories that may influence our clinical work, but our current day-to-day lives as well (Adams, 2014).

This study was initially conducted in 2018 as part of a dissertation. Since then, the world has faced levels of adversity arguably not seen in decades: an ongoing and devastating pandemic, a worsening climate situation, a potential looming economic depression, other serious epidemics, and various crises of industry and relationship. Advances in technology continue to subsume our former analogue selves, and the impacts are only just being understood. Underscoring the urgent and disturbing conditions currently facing humanity is a new and frightening war that is being waged on Ukraine as I write these very words. In a

way, the very notion of therapist experiences of adversity has changed dramatically since I wrote my dissertation. Our experience as therapists aligns, perhaps, more closely with our clients than it ever has before. However, the focus of this paper remains the day-to-day moments of upheaval that most psychotherapists will experience to some extent in their working lives. By this, I mean events like sickness in the family, falling ill ourselves, purchasing a house, separation or divorce, losing money in an investment, facing difficult personal decisions, or encountering some other moment that challenges us in some way.

I do not intend to discuss historical trauma, a topic that has been well covered in literature on the popular concept of the "wounded healer" (Adams, 2014; Cvetovac & Adame, 2017; Farber, 2017). In addition, "therapist burnout" is a vaguely defined yet commonly discussed concept pertaining to exhaustion resulting from working in a helping profession (Emerson & Markos, 1996). As wounded healers and therapist burnout are well covered in the literature, I believe understanding the impact of current, day-to-day moments of crisis and adversity on the therapist and the therapeutic relationship is of great importance. We cannot circumvent global and personal catastrophe; we must find ways to continue to live and work through it.

Methodology and methods

I settled upon the methodology of hermeneutics, and employed the method of the hermeneutic literature review. I chose hermeneutics because of its strengths in uncovering and furthering understanding of human experience, and because it values subjectivity and seeks to bring the "shadowy and latent... into the clear light of day" (Crotty, 1998, p. 89; Laverty, 2003; Smythe, 2012). In conducting a hermeneutic study, I wondered whether the painfully uncertain shadows cast over my own small world may have some light shed upon them. Central to this methodology is the hermeneutic circle (Boell & Cecez-Kecmanovic, 2010) which pertains to the researcher's non-linear immersion in the literature. While in the hermeneutic circle, the researcher reads and re-reads the literature while engaging with data, conversation, and writing; ultimately seeking to expand and develop their understanding of their research phenomenon (Boell & Cecez-Kecmanovic, 2014). The circular clarifying of different parts of the whole through interpretation and reinterpretation ultimately leads to a deeper understanding of the literature and thus of the research topic itself.

Given that the theoretical underpinnings of my training were substantially psychodynamic, this review primarily examines psychoanalytic/psychodynamic literature on the therapist's experience of adversity. However, I also include literature from psychology, counselling, medical, and more general scientific disciplines where it seemed particularly relevant. In keeping with the hermeneutic tradition, my approach to research was firmly grounded in interpretivism and was fundamentally "concerned with the life world or human experience as it is lived" (Laverty, 2003, p. 24). As such, each time I chose to engage with a piece of research, I entered a process of self-reflection. My experiences of and responses to the literature were considered, revisited, and considered again, and are interwoven throughout this study.

A vagueness comes over everything: The psychotherapist's experience of personal crisis

As I began to explore literature pertaining to the traumatic experiences of psychotherapists, I remembered an experience shared by a well-regarded instructor in my first year of postgraduate training. I recall him telling us of falling from a ladder during renovations to his home. What struck me about his story was that after the fall his immediate concern was not what might have happened to his body. Instead, he feared that his *mind* might have somehow been compromised. He was not concerned with spinal damage, paralysis, or some other enduring bodily injury. Instead, he was concerned about his brain and how damage to this precious organ might impact his ability to work as a psychotherapist. It occurred to me that as a therapist my brain and, by proxy, my mind and all of its power to connect me with another, is one of the most potent instruments in the orchestra of therapeutic engagement.

Mirroring the experience of my instructor, perhaps the most disconcerting element of my own encounters with adversity, both during clinical training and my more recent work as a psychotherapist, has been the subsequent worry that my mind might be somehow compromised by the experiences I am facing. I stumbled upon the poem *Fog* by Amy Clampitt (1997) within which I found an eerie resonance. Clampitt writes:

> A vagueness comes over everything,
> as though proving colour and contour alike dispensable:
> the lighthouse extinct,
> the islands' spruce-tips drunk up like milk in the universal emulsion; houses reverting into the lost and forgotten;
> granite subsumed,
> a rumour in a mumble of ocean... (p. 5)

For me, this poem evokes images and feelings reminiscent of my experiences of crisis—a fog rolling quickly in over my mind, the panic that sets in after the fading of clarity and, like granite subsumed by universal emulsion, the fear of becoming cut off, or torn away, from critical faculties that were once so easily accessible.

In moments of crisis I tend to liken my profession, which ultimately occupies a delicate position at the subjective crossroads of science and art, to more practical trades. I worry that if a carpenter could not work without a saw, a dentist without a drill, a pianist without keys, then surely a psychotherapist could not work without a fully intact mind. Perhaps there is a fear that a degree of cognitive collapse will tear at the very root of what it is to be a psychotherapist, given that, as a psychotherapist, I *am* the therapeutic instrument (Morrison, 2013).

Poets and scholars have long emphasised a personified "root" to the human psyche, recognising that this root can be damaged or split. In Plato's *The Symposium* (380-375BC/1989), he recorded that a central belief within Greek mythology was that humans

initially had four arms, four legs, and two faces. However, after becoming increasingly concerned about their power, Zeus split them in two, condemning them to live in a perpetual search of their other halves. This act served to split in two the very core—the root—of the human being. Moreover, in the late 18th century, Hebel wrote, "we are plants which—whether we like to admit it to ourselves or not—must with our roots rise out of the earth in order to bloom in the ether and to bear fruit" (as cited by Heidegger, 1966, p. 47). Additionally, in 1918, Hoyt wrote the poem *The Root*, essentially a lover's lament about a root becoming torn in one's heart after loss. The human experience of being torn at the root seems to have long been acknowledged, by poets and scholars alike.

Similar ideas can be seen among the earliest writings within the psychotherapeutic tradition. More than a century ago, Freud wrote of an internal "tearing" that can occur during times of loss (Clark, 1980). Reflecting on his father's death, Freud wrote, "I feel now as if I had been torn up by the roots" (as cited by Clark, 1980, p. 160). I was struck by this line as it so accurately captured my own experience of internal compromise. I wondered whether Freud, too, might have experienced a blunting of his perceptual tools at this time. Did he experience a fog settling over his previously clear mind? In his seminal *Mourning and Melancholia*, Freud (1917) observes a similar phenomenon, suggesting that "the ego debases itself and rages against itself" (p. 257) when the individual is in mourning.

More recent authors have discussed a similar phenomenon. This seemingly violent internal experience is also present in Stolorow's (2008) personal account of losing his wife. Stolorow writes "her death tore from me the illusion of our infinitude" (p. 41). Throughout his painful account, Stolorow refers to a subsequent collapse which precipitated major changes in the way he perceived the world.

Pines (2014) writes of her own encounter with mortality in terms of "tearing" after experiencing a stroke, expressing that her "life was torn asunder" (p. 224) after this traumatic event. What I noticed about her problematic and challenging journey back to health after her literal neurological tear was her discussion of shock. She describes this feeling as one of violence—recalling it was as though someone had broken into her house and beaten her. She had been in excellent health and could never have predicted this terrible event. Though I dare not compare my experience to a stroke, I was curious about her experience afterward. This idea that being robbed of something, being stripped bare to reveal one's total and complete vulnerability, could underpin a tear in some internal emotional fabric.

The idea of shock is also picked up by Hanscombe (2008), whose experience of ejection from psychoanalytic training offers another example of intrapsychic detachment. After Hanscombe's removal from training, which came without explanation, she notes that one of her primary responses was shock. Curiously, she writes that she had the sensation that her mind no longer belonged to her. For me, this spoke to another form of what Freud (1917) might refer to as "debasing", a tearing away at some kind of central part of the self. Hanscombe's experience of otherworldliness is echoed by Stolorow (2008), who refers to his own mourning leading him to feel that he was not of this world anymore.

A kind of intrapsychic detachment, then, seems to be a common thread running through therapists' experiences of personal trauma. In *Mourning and its Relation to Manic Depressive States*, Klein (1940) refers to "struggling against the chaos inside" (p. 144) while discussing her most likely fictitious patient, Mrs. A, who lost her son to a sudden medical event while he was at school. Attempting to re-establish social connections after this traumatic event, Mrs. A takes a walk down a familiar street only to find herself quickly overwhelmed by a sense of alienation in what should have been a familiar place. After retreating to a restaurant for relief, Mrs. A finds herself feeling "vague and blurred" and that the external world had become "artificial and unreal" (Klein, 1940, p. 144). Gradually, she manages to recover her sense of connectedness; but not until she has endured a period of detachment. Interestingly, according to Glover (2009), Mrs. A was a metaphor for Klein's own experience of grief. Tragically, Klein's son, Hans, had fallen from a precipice and died while out for a walk not long before she wrote this article. Thus, like Freud, Klein's account provides valuable insight into the potentially chaotic inner experience of a therapist undergoing personal trauma.

These feelings of alienation, otherworldliness, and detachment capture the essence of my experience of personal crisis. In their own way, each author has described an internal tearing which, in my opinion, often precludes difficulty thinking clearly. I do not believe these experiences exist in isolation, only occurring "out there" in the psychotherapist's personal life. On the contrary, I feel that they must impact clinical work in some way. As Stolorow (2008) suggests trauma can nullify all possibilities for being, reducing us to "skeletal consciousness" (p. 41). The pervasive and reductive impact of trauma leads me to wonder about what neurological mechanisms are at play in the brain when we experience the internal tearing of trauma. It seems to me that by first understanding this, we might gain a more comprehensive understanding of what happens in the therapeutic relationship during experiences of adversity in the therapist's life.

Trauma and thinking

Ringstrom's (2014) poetic and troubling lament "trauma, trauma everywhere and not a thought to think" (p. 147), captures the limited cognitive state—the "skeletal consciousness" that can be evoked by trauma. Ringstrom describes trauma as an assault which can incapacitate the mind and one that can "shatter heretofore illusions about reality" (p. 149). The human brain is "the master organ of stress and adaptation to stressors" (McEwen et al., 2016, p. 18). When confronted with psychological stress, two main mechanisms are activated to help restore neuropsychological equilibrium, known as homeostasis (Pabst et al., 2013). The first mechanism is faster-acting and involves the activation of the sympathetic nervous system, which is responsible for stimulation of the fight or flight response. By releasing catecholamines, such as dopamine and norepinephrine, the sympathetic nervous system readies the body for action. The second mechanism is slower and involves the hypothalamic–pituitary–adrenal axis, which releases the glucocorticoid cortisol from the adrenal cortex (Pabst et al., 2013).

The increased release of catecholamines and cortisol can lead to impairments in thinking and decision making as they affect the prefrontal cortex, where numerous glucocorticoid receptors—important moderators of stress—are located. Moreover, increased sympathetic nervous system activity has been linked to negative affect, which can impact neurological processing. Worry and other types of stress-related thinking have been shown to prolong this neurophysiological response, which can have neurological ramifications weeks and months later (Connor et al., 2013).

Van der Kolk (2000) discusses the "disintegration of experience" as one of the primary stress-related symptoms when facing trauma. For me, this concept jumped off the page as it seemed to be linguistically aligned with the concept of tearing. According to Van der Kolk, the neocortex, brainstem, and limbic system are those regions in the brain tasked with maintaining homeostasis and, put simply, overwhelming these areas results in difficulty thinking, in placing oneself in the world, and in finding words and language by which to describe one's experience. Although this allows the individual to maintain a certain emotional distance from the trauma, it inevitably reduces some areas of cognitive functioning.

Psychotherapeutic thinking

The correlation between trauma and cognitive impairment led me to consider what stress might do to psychotherapeutic thinking. The broad concept of psychotherapeutic thinking is frequently mentioned in the literature; yet, few authors offer a concise definition (Speeth, 1982). Fewer still discuss the concept in relation to therapist experiences of adversity. Speeth (1982) hypothesises that this is likely a consequence of psychotherapy being "an undefined technique applied to unspecified problems with unpredictable outcome" (p. 142).

Freud (1900) outlines the importance of the psychoanalyst's evenly hovering attention. To this end, Freud encouraged the analyst to become free from all preconceptions so as to appreciate everything the patient says equally. Speeth (1982) draws on Freud's early conceptualisation, developing a contemporary model of panoramic psychotherapeutic attention which emphasises that all therapists, regardless of orientation, are confronted with the same raw data—what they can see, hear, or sense as well as what they have going on inside them. Paying attention to this raw data is, for Speeth, the essence of psychotherapeutic thinking.

More recently, Mozdzierz et al. (2014) suggest that thinking like a therapist requires the ability to formulate cases, interpret the meaning behind certain behaviours, the need to understand the client's position, and to develop a plan that incorporates the unique set of social and emotional circumstances in which the client finds themselves. Mozdzierz et al. also emphasised the importance of "non-linear" thinking in psychoanalysis; a concept pertaining to seeing "beyond the facts to the patterns that emerge" and realising "that there may be more to a situation than is presented on the surface" (p. 2). Mozdzierz et al. assert that the benefit of therapeutic thinking is that it "maximises therapist flexibility in dealing with the infinite variety that clients and their circumstances bring to the treatment setting" (p. 2). Moreover, the authors contend that therapeutic thinking can transcend the

constraints of preconceptions and worldview. This is an important factor when attempting to attune empathically to a client.

Heidegger (1966) differentiates between calculative and meditative thinking. The latter of these, to my mind, bears strong similarities to psychotherapeutic thinking. According to Heidegger, calculative thinking is always happening as we consciously and unconsciously make plans and process increasingly "economical possibilities" (p. 46). Conversely, meditative thinking floats "unaware above reality" (Heidegger, 1966, p. 46). This form of thinking exists outside normal understanding, requires practice and patience, and must be carefully crafted. It is not dissimilar to the type of thinking one must do when sitting with clients—a form of *reverie* which involves "our ruminations, daydreams, fantasies, bodily sensations, fleeting perceptions [and] images emerging from states of half-sleep" (Ogden, 1997, p. 568). Heidegger emphasises the importance of this form of thinking, suggesting that it is awakened, facilitating deeper understanding, or the noticing of "what at first sight does not go together at all" (p. 53). Given the obvious significance of this thinking state, I feel it important to consider what can happen when it is interfered with.

Preoccupation

For me, when in the depths of adversity, it is easy to become preoccupied with those events raging in my personal life. Consequently, the clear, meditative, and psychotherapeutic thinking, previously mentioned, can become significantly more difficult. As I reflect on this experience, I am reminded of the popular use of the term "unthinkable" in relation to experiences of trauma (Foehrenbach & Lane, 2001; Ringstrom, 2014). For me, there was something unthinkable about my personal experience, and this fed into my professional life. Mendelsohn (2013) calls this unthinkability "preoccupation", suggesting traumatic preoccupation can reduce the therapist's ability to be cognitively present during times of crisis. Mendelsohn describes his sense that he had lost his own "clinical bearings" after the loss of his young daughter who had a congenital heart condition.

The concept of losing one's clinical bearings reminded me of a wayward compass (Lombardi, 2010). I imagine the adventurer encounters a great amount of despair when the compass, a utilitarian object, whose only purpose is to aid navigation, becomes useless. This despair is picked up on by Mendelsohn (2013), who remembers anxiety and self-interest emerging amid frequent hospital appointments, detracting from his ability to think psychotherapeutically. He recounts the turmoil of being told that his daughter would die soon only for her to recover, and then decline once more. He also recalls the constant feeling of fear while under the cloud of his daughter's inevitable yet unpredictable death. Over time, Mendelsohn worried that preoccupation with his daughter's precarious medical situation was impacting his clinical judgment.

Mendelsohn (2014) develops the idea of preoccupation in writings about his divorce. He describes his decision to separate from his wife of 29 years as both hopeless and hopeful—an act that risked long-term security and disrupted the familiar; yet one which was bold, offered the promise of new possibilities, and required facing into powerful and destabilising forces. Mendelsohn remembers this as a time of pain, loss, and grief; all of which

contributed to an overall preoccupation, making it difficult to think psychotherapeutically. He relates the experience of divorce back to the death of his daughter, suggesting that during this time he felt he was under a "shadow" that made it hard to think. This impacted his connectedness with clients and made him worry about his continued effectiveness and ability to think as a therapist.

Preoccupation is a concept that emerges elsewhere in the literature. Adams (2014), for instance, writes of the anxiety that followed a professional complaint that a client had made about her. At the time, she felt she could "bracket" her distress but, after the complaint had been resolved, many of her clients and supervisees advised her that they had felt something was wrong throughout this arduous period in her life. This led her to wonder retrospectively about whether, under stressful conditions, she could retain a level of thinking light enough to continue to spark connections and remain attuned to the needs of her clients.

I encountered a similar phenomenon when I read Flax's (2011) reflection on her experience of serious illness in the family. Her daughter experienced an unexpected seizure, leading to the discovery of a brain tumour which ultimately damaged her ability to speak. Flax's reflection on this time is underpinned by resentment toward her clients as she remembers the struggle to continue caring for others while being preoccupied with her ailing daughter. This resentment is a familiar sensation for me as I have sometimes wished that I could just be alone with my difficulties, rather than continue to make myself available to others.

The relational impact of therapist experiences of adversity

Trauma can evoke alien feelings, feelings of overwhelm, distraction, disturbance and, troublingly, occasionally it may provoke emotional deadness, causing those affected to feel nothing at all (Stolorow, 2008). Certainly, sitting calmly in my comfortable chair in my office while chaos reigns supreme in my personal life has presented multifarious challenges not present when the waters of adversity were placid. Some authors suggest that such disruption to the therapist's affective equilibrium can result in problems in the psychotherapeutic relationship (Colson, 1995; Goldstein, 1997). Others, such as Adams (2014), suggest that the experience of personal trauma can draw the therapist nearer to their client. Moreover, the contrast between experiences of affective chaos and subsequent feelings of numbness can unsettle psychotherapists (Morrison, 2013). Thus, what happens within the dyadic client–therapist relationship during and after the destabilising of the psychotherapist's emotional radar is a question worthy of pondering.

Countertransference and its disequilibrium

Countertransference is a fundamental tool in the work of a therapist and might be thought of as a therapist's 'emotional radar' (Racker, 1957). Historically, countertransference was understood primarily as an impeding disturbance within the therapist which needed to be worked through in personal therapy (Frank, 2014). Since then, however, countertransference has come to be thought of as the multiplicity of feelings and emotional

responses experienced by the therapist—everything that arises within the therapist (Racker, 1957). The therapist's feelings are no longer pathologised or thought of as detrimental to the therapeutic process. Instead, they are viewed as guidelines to understand more fully the client's experience and can assist in interpretation and intervention.

The scope of countertransference has been further broadened by the idea of "subjectivity"; the notion that the therapist is, in actuality, *completely* involved in the relationship (Gerson, 2013). In classical psychoanalysis, the patient divulges their mental content which is then interpreted by an analyst who serves a purely objective function (Mitchell, 2000). Benjamin (1990) critiques such approaches which essentially define "other" as object, suggesting that they deny both parties the full experience of their own subjectivity. Benjamin postulates "where objects are, subjects must be" (p. 184). As such, countertransference reactions have more recently been reconsidered and are now thought of as "essential and necessary aspects of who we are" as therapists (Gerson, 2013, p. 14). Therapists may respond to trauma in their personal life in ways which can disrupt "stability, tranquillity and equilibrium" in the professional environment (Morrison, 2013, p. 43). Morrison calls this "countertransferential disequilibrium", and suggests that upsetting the delicate and finely tuned emotional compass within the therapist can make the process of therapy difficult. He contends the therapist *is* the analytic instrument and, therefore, any instability in this instrument can have disastrous consequences for the work. Specifically, he points out that disruption to the "self-state"—or sense of self—of the analyst "shakes up the calibrations on that delicate appliance" (Morrison, 2013, p. 44). This makes it difficult to truly "hear" the client, appreciate their emotional states, and unpick and understand the subtle transferential elements of the therapeutic relationship.

Khan (2003), too, observes that "personal crisis... is a time of acute emotional disequilibrium in which the boundaries that people set up to protect themselves are bombarded by the presence of immediate situational stress" (p. 51). For Khan, the "explosion of regularity and dependability" (p. 51) in the therapist's personal life is only exacerbated by the anxiety of disruption to clients. This sensory bombardment can impact the way that the therapist perceives and understands their clients, especially given that therapists often rely heavily on emotional and bodily responses (Rytohonka, 2015).

Disclosure

Disclosure is a hotly contested topic also relevant to this discussion. It is interwoven throughout the literature on the implications of therapist experiences of adversity (Comstock & Duffey, 2003). Disclosure is a concept synonymous with countertransference, and there are many differing opinions on the subject (Foehrenbach & Lane, 2001). Several therapists who have written about their experiences of adversity refer to disclosure as problematic, recognising that the very act of writing about personal trauma is essentially disclosure (Chasen, 1996; Morrison, 2013). It seems, however, that writing is generally perceived as a safer and more grounded option than openly disclosing to clients in session (Mendelsohn, 2014).

There are some theoreticians who staunchly deemphasise any benefits of therapists disclosing difficult life events, inferring that this can only intrude upon the therapeutic relationship (Comstock, 2008). Ivey (2009), for example, postulates that disclosure of personal adversity contradicts "the analytic attitude and the very essence of psychoanalytic inquiry" (p. 86). For Ivey, such disclosures create narcissistic potential as they can become about the therapist's needs. Moreover, clients may find therapist disclosures of personal crisis to be burdensome (Morrison, 1997). They may feel that their own issues are trivialised by the difficult experiences of their therapist or may lack the tools to engage with such expressions by the therapist. This thinking appears to be underpinned by the notion that "one cannot determine... that self-disclosure is a manifestation of anything in the psychoanalytic moment" (Busch, 1998, p. 519).

There is also some argument that client knowledge of their therapist's personal crises can encourage transference and countertransference enactments that negatively influence the therapeutic relationship (Colson, 1995). Colson observed that his own clients fantasised about the catastrophic consequences that may occur if they did not protect him after learning of his wife's terminal illness. He concludes that this had a largely detrimental effect on therapy. Similarly, Morrison (1997) posits that client knowledge of difficulties in their therapist's life may foster the desire in some to care for their therapist, which can convolute the delicately balanced dynamics of the therapeutic relationship. Thus, the therapist's disclosure of challenging personal events can make them vulnerable to analysis by their clients (Mills, 2012).

Mendelsohn (2013) takes a different position, arguing that the self-disclosure debate comes down to "the question of acceptability, to both participants, of the analyst's emotional situation" (p. 39). Mendelsohn wonders whether it is appropriate to disclose aspects of the therapist's personal situation to some clients; while for others, it may be entirely inappropriate to disclose anything. Additionally, Comstock and Duffey (2003) suggest that as the role of the therapist is to assist the development of the client's relational capacities, by ignoring the influence of personal crises on their professional relationships, therapists may inadvertently teach clients how not to access their own emotional world.

Bemesderfer (2000) discusses the capacity of adversity and trauma to disrupt usual boundaries around self-disclosure. Upon learning of her son's cancer diagnosis, she experienced heightened maternal awareness and noticed herself becoming more reactive to anything that would stir this in her. Consequently, she found herself making more conscious and more inadvertent disclosures than she felt she would otherwise have done. In one interaction, she startled herself by responding openly to a client's constant questioning about her family that she was married and had four children. Bemesderfer concedes that while this was an unnecessarily full disclosure, it allowed her client to explore more deeply the dynamics around her own large family and stimulated the admission that she felt in competition with her therapist, which was ultimately useful for the therapy.

Greenspan (2008) discusses the benefits of disclosure as breaking "through the fiction of psychotherapy that the therapist is some kind of superhuman being and is there only as the total transference object" (as cited by Comstock, p. 184). Morrison (1997) also suggests that disclosure of personal adversity can augment the humanness of the therapist, thus fostering

a realness in the relationship. Through this lens, disclosure might be thought of as augmenting the therapist's genuineness and authenticity; helping the client to feel included and important, reducing the possibility of feelings of betrayal should they discover that an event such as a life-threatening illness has not been relayed.

Amy Morrison's (1997) account of her decade-long battle with breast cancer is a moving depiction of the challenge of unavoidable disclosure. Around the time of her diagnosis, she chose to disclose only to clients who asked, even when she wore a wig after treatment. An interesting dynamic that emerged was that the clinical material presented by those who did not directly enquire about her illness or feelings tended to centre on struggles with wanting to know, yet not wanting to know. Khan (2003), too, was diagnosed with breast cancer and, after a course of rigorous chemotherapy, also wore a wig. Khan notes that, around this time, frequent last-minute cancellations of appointments and fluctuations in health and energy levels were prevalent, which meant her clients came to know of her illness.

Unavoidable disclosure is a theme picked up on by Andrew Morrison (2013) in his discussion of "enforced disclosure" (p. 42). According to Morrison, enforced disclosure occurs when there is no way of concealing the event or its impact from clients. In Morrison's case, because his ailing wife's office was next door to his own, his clients inevitably discovered her illness. Morrison discusses struggling with pervasive shame and guilt around the imposition of his personal circumstances on his clients as he observed them become less able to freely explore their own associations and inner processes.

Shame and guilt

As I read more about the emotional impact of therapist experiences of adversity, and particularly Morrison's (2013) account, I began to think more about shame and guilt. These difficult emotions seem to emerge both when the therapist must decide whether to disclose difficult personal circumstances, and more generally within the experience of adversity itself. To make this point, I turn first to a personal vignette. A little over halfway through this project I was tasked with presenting the progress of my research to a room full of faculty members and peers. This was a difficult and interesting experience in which various criticisms and encouragements were shared. I was surprised by the responsiveness of my audience to the specific ideas of shame and guilt. After presenting, I was approached by several individuals, each very generously sharing their own experiences of divorce, difficult clinical encounters, and other challenging personal circumstances. Each narrative was underpinned, in its own way, by a pervasive sense of shame and guilt for not having "done enough", been "available enough", or been "attentive enough".

I felt it important to include the responses of my audience as they indicate to me that the experience of shame and guilt felt by therapists in times of crisis may, in fact, be commonplace. Each response was, of course, coloured in a slightly different way, revealing different aspects of each individual's experience of these potent emotions. Consequently, it was no surprise that shame and guilt are themes that also proved to be prevalent in the literature. Comstock and Duffey (2003) suggest that therapists are especially vulnerable to such feelings because they receive the covert message "handle yourself as a professional

regardless of what happens to you" (p. 77) throughout the course of their training and into clinical work. Mendelsohn (2014) captures this well, writing of his divorce, "my internal experience—particularly insofar as it is suffused by shame and guilt—works its way into the...field" (p. 195). Shame may emerge around lacking the energy and passion for the work, and guilt may be felt about continuing work while not knowing if we 'should' be doing so.

The challenge of facing shame and guilt when crisis emerges in the psychotherapist's personal life is acknowledged by Comstock and Duffey (2003). They observe that discourse within the broader psychotherapeutic community suggests "if... it does affect your work, know it's affecting your work and take time off" (Comstock & Duffey, 2003, p. 77). Comstock and Duffey also recognise a more insidious element of this discourse which implies "but take care not to take too much time off" (p. 77). I have felt this deeply in my own moments of crisis, an invisible motor driving worries about how much time I could take off, if any. What about my clients? When would my mind settle and clear? What if I could not meet mounting academic or clinical demands? As Henry (2009) writes "I can't keep [my client] afloat when I feel like I'm drowning. Yet I feel I can't abandon her while she is barely holding onto herself" (p. 296).

As beginning therapists, we are often not taught that a "good enough therapist" also experiences struggle and painful distractions (Comstock & Duffey, 2003). It can be difficult to know when to 'down tools' and when to continue working. Consequently, the expression of overwhelm, preoccupation, and countertransferential disequilibrium, all often underpinned by some form of shame and guilt, can be difficult, potentially leading the therapist into hiding (Schlachet, 2013). Miller and Ober (1999) point out that sometimes adverse experiences can be unspeakable, and leave the therapist "crouching in the shadow of [their] lives, unpredictable, a locus of rage, of despair, of fear, looking for an opportunity to be heard" (p. 21). Hirsch (2008), too, discusses the wish for emotional tranquillity in times of crisis, suggesting that conditions that disallow this can lead the therapist into an unspeakable realm. This unspoken, shameful realm seems almost "secretive", as if it must be kept hidden (Chasen, 2013).

Reading about shame and guilt in the face of adversity led me back to Pines (2014), who outlines the challenge inherent in processing and expressing shame in the wake of crisis. Pines writes that after experiencing a stroke she felt she *had* to return to work, a step that was complicated by the fact that she was now bereft of many of the skills that she had previously taken for granted. She found that she had to develop a new way of working with her clients while simultaneously having to process the shame and self-doubt associated with feeling that she was somehow now 'less' than her clients and colleagues. I was struck by Pines' desire, and ability, to 'press on' through the pain, and by her ability to acknowledge that things were different. Chasen (2013) eloquently summarises this hope for continuing on, writing, "the stabbing pain has turned to a dull agony. I am aware of the constant presence of an absence. I function. I more than function. I've changed" (p. 20).

Conclusion

Enquiry into the phenomenon of therapist experiences of adversity has revealed that many aspects of the therapist's world—the therapist's mind and the therapeutic relationship, the decision about whether to go to work, the emotional state of the therapist, and the therapist's personal and professional relationships—are touched, in some way, by personal crisis. Encounters with adversity have the potential to throw the finely tuned emotional equilibrium so critical to the therapeutic relationship into disarray (Morrison, 2013). Equally, however, such moments can deepen the therapeutic relationship by affording us a window into our client's experiences of distress and suffering. As Gerson (2013) posits "personal struggles with crises... sometimes enhance, sometimes limit but always affect our clinical work" (p. 13).

I feel that my approach to personal crisis now, both as a practicing psychotherapist with several more years' clinical experience and as a human being and a patient with more years on the couch, differs to my approach at the time of writing. As my understanding of myself has deepened, the way I have negotiated such moments has changed. In this way, perhaps the psychotherapist is actually particularly well-placed to deal with crisis, having often completed years of their own therapy, possibly already being in therapy when the crisis occurs or at the very least having ready access to supervision and therapy services (Adams, 2014). This unique position affords close proximity to resources which can help one deal with circumstances that might otherwise be devastating. As such, one avenue for future research may be to explore differences that may exist between beginning and experienced psychotherapists.

It is also true that however experienced, the therapist must notice when they become overwhelmed by personal adversity, paying "deliberate and focused attention to this dimension" (Morrison, 2013, p. 44). Retaining a degree of self-awareness both of the intrapsychic and intersubjective ramifications of such conditions may mitigate the impact of the intrapsychic tearing at the root that I have referred to, and the ensuing countertransferential disequilibrium that can arise. Ultimately, we must be true to who we are and attend to our unique needs, both as human beings and as therapists, whether or not life is going smoothly (Gerson, 2013).

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Paper 14 (2018)

The Kali and Shiva dance: Using mythology to formulate and guide treatment

Vijay Mahantesh

This chapter arises out of research undertaken as part of a Master's dissertation that examined myths about Goddess Kali and her consort Lord Shiva from Vedic Indian literature. The research aimed at using the story of Kali and Shiva to think about the psychotherapeutic encounter. The impetus for the research came from my Indian ethnic background and being exposed to Vedic Indian mythological figures at a young age. When theoretical formulation and treatment planning did not quite grasp the essence of the dynamic at play in the therapy room, myths and mythological figures proved useful to help navigate the complexity of the therapist–patient dance.

Application of hermeneutic thought offered the necessary environment to engage simultaneously with literature about Kali and Shiva myths and the psychotherapeutic encounter between therapist and patient. Speaking of hermeneutics as a methodology, Gadamer (2004) identifies "dialogue between the reader and the text, between readers and between texts" (p. 272) as necessary to gain insight. Through such dialogue, there is an opportunity for "fusion of horizons" (Gadamer, 2004, p. 319); the perspective of the text meeting with the perspective of the reader. In essence, Gadamerian thought emphasises that hermeneutics is not about the author's view of the truth; instead, it is "about what truth the reader makes of it and how the text comes alive for the interpreter" (Regan, 2012, p. 292). This methodology invites the reader to not remove subjectivity from understanding; rather, 'move closer into it' and become one with the text to co-create meaning (Bleicher, 1980).

I consider there are parallels to hermeneutics, the process of psychotherapy, and the emergence of Vedic mythology. Just as hermeneutics provides a template to think about the literature at hand, to 'become one with' and co-create meaning, engagement with the content and process of therapy assists the therapist and patient to also co-create meaning. Similarly, Vedic myths emerged when great seers of ancient India immersed themselves in contemplative meditation—they were enlightened with images of deities during this process. It was necessary for one to let go of individuality; it was only then there would be room for transformative material to emerge during meditation (Sanskrit: dhyan) (Ray Chaudhuri, 1956). What comes about following such forfeiture is from the depths of the unconscious mind, taking shape into a verbal form or visual imagery (Ray Chaudhuri, 1956). Through such a process of 'dhyan,' visionaries (viz. poets, priests, meditating sages) were able to access the transformative power of imagination, become conscious to the presence of deities, and respond to such divine company in their day-to-day lives (Mahony, 1997).

Kali the Goddess

Kali myth is believed to be projected out in a crude and raw form, without modification, without attempt at secondary elaboration, and without attempt to make it meaningful to the conscious mind (Ray Chaudhuri, 1956). In Vedic texts, Kali is located either on the battlefield or on the fringes of society. She is always black or dark, usually naked with long and dishevelled hair, her lips have blood smeared over them, and her tongue protrudes showing dreadfully sharp teeth (Kinsley, 1975). Kali has blood rolling down the side of her cheeks which glistens over her body; she is often seen adorned with garlands of human heads and she wears dead bodies of human infants as earrings (Colonna, 1980). Her bracelets are made of serpents, and her loin has a girdle of severed human hands (Ray Chaudhuri, 1956). Kali has well-formed fleshy breasts (Shukla, 2014), and her four hands are shaped like a lotus. In her left hands, she holds a blood-dripping sword and a freshly severed human head; from her right hands, she offers assurance (Kinsley, 1975). Kali gets drunk on the blood of her victims (Shukla, 2014) and is described as cruel and shameless (full of lust and death), someone "who frightens man with her gaping vulva, humiliating, mistreating, and castrating him" (Kohen 1946, p. 50). Yet, she is also revered as the mother goddess who consoles, nurtures, and protects (Kripal, 2003). She is both "good and evil, motherly as well as cruel, chaste and shameless, and in whom heaven and earth are enclosed" (Kohen, 1946, p. 50). Literature reflects both her terrifying and nurturing nature in much detail. Kali can give blessings (with her right hands) and can also decapitate (with her left hands). She is called 'the Black Goddess'—she who "brings opposites into harmony" (Colonna, 1980, p. 349).

Figure 1
Kali and Shiva. (https://en.wikipedia.org/wiki/File:Kali_by_Raja_Ravi_Varma.jpg). Copyright 2017 by Wikimedia Commons.

One of Kali's well-known manifestations occurs during a great war. When Gods are trying to save the world from Raktabija (the king of the demons), two other demons, Chanda and Munda, approach 'Goddess Durga' with readied weapons. Upon seeing Chanda and Munda prepared to attack, Durga becomes enraged and from her "furrowed brow" (Humes, 2003, p. 146), Kali springs forth and leaps into battle. She tears these demons apart with her hands, crushes them in her jaws, and decapitates them with her sword (Kinsley, 2003). Kali represents "Durga's personified wrath, her embodied fury" (Kinsley, 2003, p. 25). In the same battle, there is a cosmic conundrum. With each spilt drop of Raktabija's (translation: blood seed) blood, "rise one thousand more demons" (Dowd, 2012, p. 15). Kali manifests herself again and joins in the fierce fighting to annihilate the reproducing demonic 'male power' and restore peace and equilibrium (Mookerjee, 1988). To keep Raktabija from multiplying and rid the world of demonic threat, Kali drinks his blood (Kinsley, 2003). Although she comes into being to slay demons and restore order, Kali becomes consumed by bloodlust after drinking Raktabija's blood and turns demonic herself on the battlefield. Her ensuing rage threatens to destroy the world which she is supposed to protect (Dowd, 2012).

Shiva the dancer

Godlaski (2012) describes Shiva, Kali's consort, as the "the most complex God in the Hindu pantheon" (p. 1067). He is often featured as an ascetic sitting in peaceful contemplation in the Himalayas. He wears a snake around his neck, and he is said to be aware of all phenomena coming into existence and passing away (Godlaski, 2012). Like Kali, Shiva is known as the destroyer of evils; and through his cosmic dance (Sanskrit: tandab nrithya), he creates and preserves life (Sinha, 1972). Shiva is generally venerated as a serpent (Nagaraj) or a phallus (Sanskrit: Lingam), the latter arising often from within a ring or female genital (Sanskrit: Yoni). This construct, the lingam and yoni, represents procreation and fertility (Lederer, 1964-65). According to Shaivism (Shiva-based philosophy); creation, destruction, and death are not separate but are part of an eternal continuum (Godlaski, 2012). Shiva embodies such cosmic conundrum, suggesting that "without destruction, there can be no creation; without death, there can be no life" (Godlaski, 2012, p. 1078). Shaivism also proposes that all instinctual acts are creative and 'worthy of worship' (Patel, 1960). Therefore, within Shaivism, sex (often repudiated by most religious traditions), is not condemned but accepted as the primary need of life (Patel, 1960). There is recognition that instincts are not to be feared, rejected, or destroyed, but accepted. This philosophical belief is represented in the worship of sex organs (Shiva Lingam) by followers of Shiva philosophy.

Shiva is popularly known to be the first and 'master Yogi' (Sanskrit: Adiyogi; adi, meaning first), the God who gave Yoga to the world. As part of his yogic practices, Shiva abstains from completed intercourse with his consort. When the sexual act is carried out, it "is disciplined and ritualized: The seed must not fall" (Cantlie, 1993, p. 225). Tantric literature and practices which endorse the practice of an 'uncompleted intercourse' have honoured Shiva with a special place for his virtue of discipline and ritual (Feuerstein, 1998). Some regard Shiva as the "primal shaman" with impeccable understanding of all shamanistic arts and bringer of this knowledge to humankind (Ratsch, p. 1067, as cited in Godlaski, 2012).

Furthermore, it is known from a particular myth that when Gods and demons churn the ocean for the divine nectar of immortality (Sanskrit: amrita), the process produced a poison (Sanskrit: visha) capable of destroying all creation (Patel, 1960). All activities had to cease until the master yogi—Shiva—drank the poison. Through yogic discipline, Shiva held the poison in his throat; earning him the name 'blue throat' (Sanskrit: neela kanta) (Nair, 2009). Shiva also lives on the cremation ground where he dances, and through his dance, all appearances of illusion (Sanskrit: maya) are destroyed and reintegrated into the 'absolute' (Groom, 1991).

The Kali–Shiva complementarity

Although iconographic representations of Kali and Shiva mostly depict Kali in a dominant position over Shiva, their ferocity and complementarity is depicted in several mythological exchanges between the two. For example, when Kali becomes intoxicated by blood lust of battle and her rage threatens to destroy the world, Shiva invites her to a dance to soothe her (Kinsley, 1998). In their dance, they both "appear as mad partners", destined to destroy creation (Kinsley, 1975, p. 105). Kakar (1989) also writes of a myth whereby Kali becomes frenzied after slaying a demon. When Kali's world-destroying frenetic dance does not come to an end following the demon's death, Shiva throws himself "under her feet" (Curran, 2005, p. 184). After realising that she is trampling her consort, Kali "hung out her tongue in shame and stopped" (Kakar, 1989, p. 360). Although Shiva enters the scene supine, he becomes a 'container' for Kali's destructive energy and power (Kakar, 1989).

In yet another myth, to destroy a demon who has been given the boon that he can only be killed by a female, Parvati (a loving, less aggressive form of Kali) enters the body of Shiva and transforms herself from the poison stored in his throat; reappearing as the ferocious Kali, she slays the demon (Kinsley, 2003). Further, after a particular battle, Kali's fury does not dissipate and threatens to destroy the world. Shiva then transforms himself (through maya) into an infant (Kramrisch, 1988). Hearing the infant's cries, the Goddess cradles it as if it was her own child and suckles the infant at her breast—an act through which infant Shiva drinks the fury of Goddess Kali along with her milk (Kramrisch, 1988). These myths convey the transformative qualities of the Kali and Shiva relationship and highlight the perils and vulnerabilities inherent in them. Referring to this relationship between Kali and Shiva, Chassay (2006) notes, "there is an archetypal patterning to the proximity of creativity and destruction", and they reside a heartbeat away from each other, "each infused with the seed of the other" (p. 212). The central message here is that destruction or "sacrifice is necessary for creation, or creative change" (Miller, 1972, p. 183). Elements such as destruction, dying, and death are epitomised in the Kali–Shiva relationship and recognised as the "longed-for method of being un-born and then re-born" (Kinsey, 2003, p. 30).

Understanding Kali—The original violence, losing paradise

Writing about the archaeological figurine Venus of Willendorf from Palaeolithic Europe, Kohen (1946) suggests psychoanalytic study of characters such as Kali, Medusa, Demeter,

and Madonna shed light on unconscious human anxiety. This anxiety is first experienced when we are pushed out of the warm comfort of the womb through the birth canal into the "hardship of individual life" (Kohen, 1946, p. 50). Birth is considered the first experience of ambivalence toward the mother (Kohen, 1946); "the original violence that gave rise to the 'I' as a divided consciousness" (Arvanitakis, 1998, p. 42). Woolverton (2011) puts forth the idea that, upon birth, the infant's sensitive and immature brain is "bombarded by the myriad and complex sensations of internal and external life" (p. 1). It is, perhaps, for this reason the womb is identified as the "paradise lost", and the endeavour to find this lost paradise is our eternal, unconscious aim (Kohen, 1946, p. 50). Holding these notions of "original violence" and "paradise lost" at the fore invites a curiosity about Kali's anguish about her own birth. Literature does not provide straightforward answers to this question. However, when we consider the myth of Kali which speaks of her birth from the brow of Goddess Durga and that Kali was "brought into being" on the battlefield (Kinsley, 2003, p. 25), it is easier to appreciate both the trauma of her birth and experience of trauma at birth.

Becoming demonic—A clinical presentation which is all-too-common

Winnicott (1974) writes that people who suffer a traumatic disruption often live in a fear of breakdown that has already "happened but has not been experienced" (p. 106). Anger, guilt, sadism, and masochism are said to pervade the world of these individuals (Roth, 2000). Although some adapt to traumatic experiences with "flexibility and creativity", others are caught up in the trauma memory and lead a "traumatized and traumatizing existence" (van der Kolk & McFarlane, 1996, p. 3). The freneticism with which Kali presented on the battlefield is common in those who have suffered trauma. During these experiences, survivors of trauma regress into discrete child selves (Davies & Frawley, 1992), with limited ability to contain experiences and function effectively (van der Kolk, 1996). When the "traumatic complex is triggered", the individual becomes "absorbed, preoccupied and taken over" (West, 2013, p. 85) and appears not to be able to function or consider others, nor is the person able to mentalise in the way they usually might. This sense of being 'taken over' can be compared with the image of Kali 'becoming' drunk with blood lust and her ensuing wrath exemplifying the aftermath of trauma in all its rawness.

Traumatic experiences also become encoded at an implicit level within an individual, as sensory fragments (van der Kolk, 1996). Levine (1997) highlights physiological and psychological responses to trauma are "locked in" (p. 35) the body. It appears as if the trauma becomes a 'demon' that is internalised and wreaks havoc on both the internal and external world of the survivor; and they, in turn, express rage toward themselves and others. I recognise such 'internalised trauma demons' and 'rage' in Schneiderman's (1964) comments about Kali; he notes, these deities must slay the ubiquitous demons over and over again but, in doing so, place themselves at 'risk of turning into the demons' being pursued. In my clinical practice, I have been witness to such 'Kali-rage' expressed by patients. These patients live in an "inner hell" made up of "demons, witches, sirens, and monsters" and are unable to leave because of fear that they may fall into an even darker "objectless black hole" (Seinfield, 1996, p. xi). Psychotherapy offers a path out of such darkness; providing an opportunity to process what "has not been experienced" (Winnicott, 1974, p. 107).

The perils of dancing with Kali—Transference, projective identification, and enactment

In the clinical setting, the "abuser figure, which is disavowed by the patient, becomes manifest in persecuting the analyst for the 'wounds' that the analysis evokes" (West, 2013, p. 73). Kali's rage upon Shiva who invited her to dance similarly reflects a transference of the original aggression felt toward Durga; the unavailable mother, whom Kali, could not "directly confront or hold to account" (West, 2013, p. 87). This disavowed relational hatred is projected onto the therapist so they can 'feel the pain'. In psychoanalytic literature, this process is typically characterised as the defence of "projective identification" (Klein, 1946, p. 104). Although such defensive operation is set up to prevent further trauma and protect the self, it leaves the individual at risk of killing outer relations which eventually affects both the self and the relationships (Kalsched, 2013). In this regard, Roth (2000) notes transference can either be "maladaptive" because of its potential to leave us a "perpetual victim to the repetition compulsion", "adaptive" because it reflects the urge to repair the past and provides opportunity to do so, or it can be "integrative" because it "draws the richness of the no-longer-visible past into the present" (p. 18). Considering this, it would be the task of the therapeutic other (the Shiva-therapist) to recognise these possibilities and facilitate movement away from the maladaptive toward the adaptive and integrative aspects of transference.

The risk of mutual destructiveness

> People who have fallen out of love remain ensnared in love's dark side—unable to stay together, unable to separate, caught up in a merry-go-round of mutual destructiveness from which neither can escape. (Colman, 1994, p. 500)

Even Shiva, Kali's consort, is not safe from the rage. The wild dance between this mythological couple epitomises the 'mutual destructiveness' resulting from the trauma of losing love. This wild, cosmos-threatening dance between Kali and Shiva runs a parallel course to the process of enactment common to the psychotherapeutic dyad. Jacobs (1986) identifies enactments in psychotherapy often follow well-meaning attempts by the therapist to help the patient. Shiva approaching Kali in an attempt 'to soothe her rage', was one such 'well-meaning attempt'. The ensuing wild dance in which they are both carried away to the brink of destroying the worlds is, therefore, an enactment, much like what occurs between a therapist and patient. Patients are known to "externalize and constellate the traumatising-abusive figures from their past" (West, 2013, p. 91) as part of an enactment. In the Kali–Shiva myth, the trauma of separation from the womb and the trauma of the battlefield are 'externalised and constellated' by Kali unto Shiva, her consort who invites her to dance. The following suggestion by Whitmont (1973) about archetypal elements of Kali offer a way to resolve enactment in a therapeutic situation. Whitmont suggests,

> unless men and women come to relate to the archetypal figures with awareness and consciousness, these archetypal figures will possess, obsess and rule them in primitive and

> uncompromising ways, rather than contribute to their personal growth and individualisation/individuation. (p. 86, as cited in Gordon, 1997)

Developing a conscious ego ideal

Devotees of Kali identify with their powerlessness against human tragedy (birth, separation, attachment injury, and death) and recognise that the pathway to accessing Kali's nourishing, creative, and constructive aspects is by "having a vision" (Schaffner, 1972, p. 191) of her through worshipping, submitting, and willing to sacrifice to her. This view of Kali worshippers explains Shiva's eventual act of lying down supine in front of Kali, offering himself to be trampled upon. It is as if Shiva was able to 'have a vision' of Kali and recognised her 'good' side despite the threatening and dreadful, 'dark', 'devouring', and 'castrating' side. Daly (1938) recommends that one must develop such conscious ego ideal to escape the domination of primary emotions such as those which Kali characterises. Contrasting it with the unconscious superego, which is identified as primitive and created in infancy; Freud describes conscious ego-ideal as "consciously held values acquired in later life by which conduct is guided in outer contemporary reality" (p. 102, as cited in Guntrip, 1995). The hermaphroditic form of the unified Shiva and Kali (complementarity of 'masculine' and 'feminine') known as Ardhanarishvara (Figure 2), embodies such consciousness necessary to address Kali's rage (Maduro, 1980).

Primal fusion

It is considered that Ardhanarishvara, Michelangelo's hermaphroditic sculptures, and other such figures depicted in world art speak to the experience of primal fusion and is evidence of our inherent hope of "regaining the mother(s) lost in childhood" (Oremland, 1985, p. 422). These images capture the human attempt at undoing "early maternal losses" by fusing with her rather than being the "abandoned child" (Oremland, 1985, p. 422). Psychoanalytic literature has witnessed many assertions in support of such primal fusion. Freud (1905/1953) recognises that all of us are constitutionally bisexual, that masculine and feminine elements coexist in everyone. Additionally, Jung wrote widely about anima and animus, the concepts which primarily communicated that we cannot attain spiritual health by neglecting either one of these elements (as cited in Kast, 2006).

Figure 2
Shiva as Ardhanarishvara. Reprinted from "Michelangelo's Ignudi, Hermaphrodism, and Creativity," by J. D. Oremland, 1985, *The Psychoanalytic Study of the Child, 40*, 399-433. Copyright 1985 by The Psychoanalytic Study of the Child.

Similarly, tantric cosmology maintains that the universe is built with and sustained by masculine–feminine principles of Shiva and Kali; and, in certain traditions, Shiva and Kali are also known to be eternally conjoined (Mookerjee, 1988). In this union, the feminine principle aspires unity whereas the masculine principle, "with each thrust" (Mookerjee, 1988, p. 41), invariably causes separation. Therefore, the annihilating Kali, depicted standing over Shiva, represents the active, separating, masculine principle met by a feminine, unity-urging Shiva who is lying on the ground (Mookerjee, 1988). The Kali–Shiva union represented as Ardhanarishvara, therefore, a transformation from the 'separating' masculine to a unifying and unified 'feminine'; a shedding of the egocentric male outlook in both men and women to create unity from duality. Neumann (1972) refers to this process as "recovery of the matriarchal consciousness" (p. 366); to form the "ouroboros", the "great round in which the positive and negative, male and female, elements of consciousness, elements hostile to consciousness, and unconscious elements are intermingled" (p. 18).

A particular image I found of Kali and Shiva stands out as a mythological equivalent to these elements. As per Figure 3, Shiva is depicted lying supine with an erect penis and Kali is

standing over him with one of her feet on his chest. Mythological literature identifies that Shiva throws himself on the ground (after their dance) in order to stop Kali's destructiveness; however, an understanding of the purpose of Shiva's erect penis is not offered in literature. In a therapeutic sense, it is plausible that this is symbolic of the willingness to meet with both the patient's love and aggression; emotions recognised as archetypal affects that "must be humanized through vigorous intercourse" (Kalsched, 2013, p. 90). I also associate this aggressive position of Shiva to what Kohut (1972) describes as the "mirroring self-object", the therapist occupying a position that allows the patient to really 'be oneself'; and what Symington (1983) refers to as an "analyst's act of freedom" (p. 283) which is a catalyst for therapeutic change. Kali's aggressive rage is, therefore, met with Shiva's availability, constancy, will (for union), boundaries, and a capacity to enforce limits. Shiva must be available to be trampled upon, but he must not die.

Figure 3

Availability. From The Walters Art Museum (http://art.thewalters.org/detail/10042). Copyright 2001 by Walters Art Museum. Creative Commons Zero: No rights reserved.

Therapists must 'meet with' patients in a similar way; leading with their will and availability, courageously presenting their vulnerability to the patient even though on the other side of

such a position lies a dread of the devouring, engulfing, and annihilating aspects of the Kali-patient (Nitsun, 2014). In literature, such devouring and engulfing elements are associated with the 'sadistic introject' parts of the patient. Courtois (1996) identifies that when a therapist yields to "necessary and sometimes unnecessary demands" (p. 460) which are common in enactments; there is a risk of acting out a masochistic surrender which could give rise to the "sadistic introject", the part of patient that is identified with the abuser. As such, it could be considered that just as Shiva who is 'available to be trampled upon' but 'does not die' in the process, the therapist must also make oneself available to 'meet' the patient's affective demands, serve as a therapeutic container, and survive the raging patient.

Sarkar (1943) interpreted the dreams of a student of asceticism in India. He notes that in the dream, the student was being shown that the way to spiritual contentment was not through aggression toward the father substitute or the father himself who forbids satisfaction of desires, but through absolute submission. This aligns with Hindu philosophy—"he must extinguish all aggression and sexual desire and be born again in a spiritual sense" (Sarkar, 1943, p. 173). Further, in the dream, the student was told, "as long as the penis remains, one cannot be a true ascetic. Under the influence of spiritual practice, the penis will have to not only be controlled but be made to disappear within the body" (Sarkar, 1943, p. 173). Sadhana (restraint of sexual passion) is a Sanskrit term discussing a yogic spiritual resolve to transform the libido, to develop the necessary capacities for spiritual contentment. Sadhus (male Shakta worshippers) are known to practice self-castration because of the penis being perceived as "disturbing" their religious practice (Saini et al., 2009, p. 260). This is a form of sadhana.

Freud (1905) also uses the term "libido" to describe sexual drives, sexual appetite, and all instinctual drives. Like the ascetic's call for transformation of libido, psychoanalytic literature recognises that the "libidinization" of penis (the erect penis) represents the ego; and the erect penis also has "comparable narcissistic values" (Payne, 1939, p. 166). With this in mind, just as the advice received by Sarkar's ascetic student in his dream, it could be said that Shiva (Figure 3) is engaged in an act of transforming the libido. By offering his erect narcissistic phallic-ego (his aggression and his desire), he invites the castrating Kali to a unified state (the womb) once again—to realise broader spiritual goals, to be symbolically born again. I wonder if this act of Shiva is also exemplified in what Rosen (1976) describes as "egocide" or "ego death," a symbolic suicide which allows for contact with "the original psychic state before birth" (p. 213); thus creating opportunity for "rebirth, positive transformation, growth, creativity, and significant spiritual reawakening" (p. 209).

Facing the fear: Ego death and its terrors

I find the following quote by Jung (2014) useful in summarising the actions of Shiva and the therapist (the Shiva-therapist) in the presence of the annihilating Kali-patient:

> For a hero, fear is a challenge and a task, because only boldness can deliver from fear. And if the risk is not taken, the meaning of life is somehow violated, and the whole future is condemned to hopeless staleness, to a drab grey lit only by will-o'- the wisps. (para. 551)

The discipline and skill required on the part of the therapist to achieve such 'ego death' appears to be reflected in tantric texts and practices. These texts call for the yogi to intercourse but not orgasm (Cantlie, 1993). Perhaps, therefore, Shiva's erect penis also refers to such an invitation, one that communicates wilful trust and seeks union despite the risk of death. These qualities (trust and intimacy) form the core therapeutic goals when working with those who have survived trauma (Berghuis et al., 2014; Herman, 2015). Kakar (1992) notes, there is incredible strength in being able to trust completely in this way, and such trust is essential to reach not only therapeutic but also spiritual goals. Alongside trust and courage which enables one to assume such a vulnerable position against the forces of fear, the therapeutic task also entails containment, to bear the aggression and murderousness (Bion, 1959).

Shiva's act of throwing himself on the ground in front of Kali conveys an empathic understanding of her loss (of the womb) and ensuing suffering (from the battlefield of life) and an acknowledgement of the vulnerability in the current situation; as if Shiva were to be saying 'there is much to lose if we continue to dance ourselves into cosmic destruction'. Similarly, empathic suggestions such as, there is "no stance I can take and win" (Roth, 2000, p. 22) in a clinical setting is known to have the capacity to evoke in patients a realisation of the position that one puts the therapist into. It is also recognised that such a response from therapists allow patients to move from experiencing oneself as the victim to observing the "powerful self-protective responses" (West, 2013, p. 88) within them which have the capacity to hurt others. Davies and Frawley (1992) refer to this process as "familiarizing the patient with the sadistic introject" (p. 30).

Death, liberation, and expansion of self

In the face of such therapeutic responses, patients feel as if the ground is "being pulled out from under one's feet" (Curran, 2005, p. 108). An experience similar to death because "elements that until that time had dominated the life of the soul rot away" (p. 108). The fear of death, therefore, comes to the fore once again (as it did during 'separation' from the womb). However, alongside this dread, there is also an identification with the therapist's "will and power" (Ghent, 1990, p. 121) which the patient internalises; the 'will' to lie on the ground to be trampled upon and the 'power' to 'not die' but rather call attention to the inherent vulnerability. Through this, the longing in patients "to be found, recognised, and penetrated to the core so as to become real" can move to the fore once again (Ghent, 1990, p. 121). There is an opportunity to let down the defensive barriers, to achieve "liberation and expansion of the self" (Ghent, 1990, p. 108). The conflict between these two states (i.e., the experience of dread and the prospect of liberation), gives birth to new possibilities; there is an opening to "surrender" (Ghent, 1990).

Ghent (1990) writes of the difference between the West and the East when it comes to surrender. His explanation offers additional insights about Shiva's act of lying down in front of Kali and the opportunity that becomes available for Kali to 'lay down arms.' Ghent notes that while in the West surrender is associated with "defeat"; in the East, surrender is associated with "transcendence" and "liberation" (p. 111). Similarly, Ghent identifies the difference in the term "ego" between the West and the East. He notes, in the West, 'ego' "has meant one's strength, rationality"; whereas "in the East, 'ego' means maya (dream, the

illusion of one's self)" (p. 111). Moloney (1954) proposes that when an individual "relaxes in his inner struggle, and gives up trying to maintain this armed neutrality", there is then an opportunity to "experience a theophany or kenosis—a blinding flash of inspiration which seems to light the way toward resolution of his inner conflicts" (p. 122). The individual becomes "the vicar of the very authority (the mother) which he originally attempted to offset, defeat, and destroy." (p. 122). Therefore, death, as in Rosen's (1976) notion of egocide (the ego death and the resulting disintegration), which "allows for contact with the Self (the original psychic state before birth)" creating an "opportunity for rebirth, positive transformation, growth, creativity, and significant spiritual reawakening" (p. 209), becomes the "supreme liberation" (Twemlow, 2003, p. 677). Or, as Hillman says, there is an "expansion of consciousness" and "shifting of psychic energies" (as cited in Colonna, 1980, p. 347).

It is, 'as if' with the surrender of his own 'ego defenses', Shiva was able to destroy the ego, both his own and Kali's; destruction of the maya, the illusion of the rage and the entanglement within the dance (enactment) which could have led to cosmic destruction. In addition, it is useful here to recollect myths about Kali and Shiva's maya. Through Kali's maya, people become entangled and imprisoned by worldly pleasures and through her grace, they attain liberation (Campbell & Campbell, 1968); through Shiva's dancing all appearances of maya are destroyed and reintegrated into the 'absolute' (Groom, 1991). Therefore, it could be said, the Kali maya (ego) of the therapist and the patient causes illusion; and dancing like Shiva (his 'tandab nrithya') is necessary to destroy the illusion of both therapist and patient. Furthermore, Twemlow's (2003) view of Shiva supports these discussions in that he associates Shiva with 'Thanatos', the God of death; "guardian of a merciful sleep to end misery" (p. 677). Thus, in light of my understanding of what has been described here, I have come to believe that the title 'God of Surrender' also befits Shiva.

Finally, in the Kali–Shiva myth, the expansion of consciousness and shifting of psychic energy is reflected in Kali's realisation that she had trampled her consort; she "hung out her tongue in shame and stopped" (Kakar, 1989, p. 360). Here, it is relevant to make note of the Chinnamasta form of Kali (Figure 4) who severs her own head. This image speaks to Kali's experience upon the realisation of her actions. The act of severing her own head appears to represent Kali's acknowledgement of 'shame' symbolically. It is also interesting to note that in this image (Figure 4), Kali is also in 'union' with Shiva, perhaps representing the idea that through expansion of consciousness and egocide, she was able to experience shame and realise the much-longed-for union (samadhi). There is much literary evidence that parallels such a process of transformation within a therapeutic setting; with the realisation that terror and aggression was not "out there" but coming from within them, patients become familiar with and take ownership of the abusing parts of their own self (West, 2013). As if, the Kali-patient is able to 'kill off' the annihilating parts of her own self "without annihilating essence" (Twemlow, 2003, p. 677).

Figure 4
Chinnamasta Form of Kali—Egocide. From Wikimedia Commons. (https://commons.wikimedia.org/wiki/File:Chinnamasta_with_Shiva.jpg). Copyright 2017 by Wikimedia Commons.

Conclusion

Kali is the mother Goddess; a representation of the mother, our first love through the act of having been in her womb. It is necessary for mothers, both actual and representational, to make themselves available for a vigorous intercourse ('meet') with Kali-rage and to do so with vulnerability. Through the availability of such a wilful mother, it is possible to lay aggression to rest (egocide) and eventually surrender. In Figure 5 below, Kali is held by Shiva on his lap. It is, as if Shiva and Kali are being supported and nourished by the umbilical cord of Ardhanarishvara. Both this picture and this research extend an invitation to the profession of psychotherapy to strive toward creating a 'hermaphroditic consciousness' in the therapeutic space, a space that transforms from domination of the 'masculine' toward a unified 'feminine–masculine.'

Figure 5

Transformation. From Shakta Wisdom Blog (http://shiva-parvati.blogspot.co.nz/2016/08/why-does-goddess-kali-stand-on-lord.html). Copyright 2016 by Shakta Wisdom Blog.

Contemporary psychoanalytic literature, psychotherapy training, and practice of psychotherapy tends to focus impartially on trauma which has occurred after birth. The Kali–Shiva myth extends this thinking by recognising trauma of birth as being primary and the most painful trauma. This myth also gives credit to the significance of the traumatic experience while in the womb and the ongoing, unconscious wish to return to the maternal womb. Early psychoanalytic writings support the unconscious struggle captured within these myths, the ubiquity and essentiality of the masculine–feminine principle, and the psychic conflicts that underlie such union.

I believe mythological encounters have much in common with psychotherapeutic encounters. Mythology offers the potential to not only usefully hold the interpersonal exchange in the room but also serve as the spine for formulating psychodynamics of patients affected by trauma and those who have experienced a failure in attachment and bonding. I have confidence about the myth of Kali as being a valuable template to relate to the 'aftereffects of trauma.' I also find that hermeneutic philosophy and methodology has elements that are parallel to philosophy and practices of Hindu visionaries and Shakta worshippers.

The Kali–Shiva myth offers a template for the resolution of traumatic enactments, to step outside of the cycle of trauma and the compulsion to repeat trauma. It is my hope that therapists will find such myths as useful templates to survive the violent regressive backlash of patients, and in the process, conceive the raging patient again in the womb of the therapeutic space. The Kali–Shiva relationship could also serve as a scale to measure the ongoing therapeutic relationship against, particularly when working with survivors of trauma. I find this 'Vedic way' of working with patients adds value to my Western psychotherapy training.

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Paper 15 (2018)

Navigating the boundaries of two cultural worlds while re-negotiating a space for self: A Pasifika student's experience in psychotherapy training

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Navigating the two cultural worlds of psychotherapy and Pasifika cultures such as fa'asamoa (Samoan culture/Samoan way) is a continuous discovery of edges and boundaries. It is the intersection of different worlds, how they meet, crash into, or miss each other. This paper reflects on some research into the personal experiences of the first author throughout her psychotherapy training as part of completing a Master's degree and specifically her dissertation, under the supervision of the second author. The use of first-person pronouns ("I", "me", "my") reflects my personal view. In the research I incorporated Pacific (Samoan) research methodologies such as teu le vā and fa'afaletui-tofa sai'li to reflect values within the worldview of the fa'asamoa, which include those of relationships, and seeking wise counsel as part of the collective Pacific framework within which many Pacific people live and work. The research is illustrated with excerpts from my personal journal. Findings from this research expectedly showed experiences of a 'lack of cultural safety' and 'navigating the edges of two worlds' within psychotherapy training. Recommendations are made to provide opportunities to enhance training in psychotherapy for Pacific and other Indigenous communities worldwide.

Introduction

Throughout my psychotherapy training I felt 'on the edge' of different circles of fa'asamoa and psychotherapy. I was the only Samoan person on the psychotherapy course as a student, with no Pacific staff teaching directly in psychotherapy. This raised concern for me about the understanding of Pacific worldviews and cultural values among students and staff from psychotherapy. Consequently, this concern and my experiences in the programme created the platform for a Master's dissertation. Pacific methodologies were used and consultation with key members of the Pacific community, including a Pacific (Samoan) academic as supervisor, were incorporated to ensure that my collective identity would not be compromised during what can appear to be an individual academic journey. Prior to any discussion about the research topic, key Pacific concepts are provided to contextualise Pacific peoples in Aotearoa New Zealand.

Key Pacific concepts

Pacific collective identity

Tagata Pasifika (Pacific people) form 8.1% of the Aotearoa New Zealand population, with seven major Pacific Island ethnicities; Samoa being the largest Pacific ethnic group (Ministry for Pacific Peoples, 2020). Through a Samoan lens, the concept of self is defined in a collective context and the individual exists in relation to others and to their environment (Tamasese et al., 2005). Pasifika and Samoan identity is shared in that it relates to the world in accordance with their spiritual and physical, mental and emotional elements (Tamasese et al., 2005; Tavana, 2002). Tagata Pasifika are a heterogeneous group that share some (but not all) identities, beliefs, and values. As this chapter can in no way provide a full explanation of the Fa'asamoa, we present key areas of the Fa'asamoa relevant to the purpose of this chapter.

Le Vā and the re-negotiated space

The vā is generally defined as a relational space or the "space that relates" (Wendt, 1999, p. 402). Tuagalu (2008) described the vā as the "social and spiritual relations between people" and "an important concept to understand the ways that Samoans relate to each other and the world at large" (p. 108). Tui Atua (2007) defined vā as "the sacred relationship between humans and all things animate and inanimate" (p. 116). It teaches an individual how to conduct the relationship between self and others in personal, physical, social, cultural, and political settings. Mila-Schaaf and Hudson (2009) described the vā as the space that allows people to relate, negotiate, re-create, and play. Notions of the vā being a space that is creative and negotiable opens up the parameters of what the re-negotiated third space can look like. For the purposes of this paper, the vā is defined as the sacred relational space that is social, spiritual, relating, negotiating, and creating. Defining the re-negotiated space is the amalgamation of Mila-Schaaf and Hudson's Indigenous negotiating space, Bhabha's (1990, 1994) third space, alongside Tui Atua's (2007) vā tapu'ia. Bhabha introduced the intervening and breaking away from notions of hierarchy in cultural differences that make a third space, allowing new meaning and cultural hybridity to occur. Tui Atua (2007), however, described the notion of vā as tapu or sacred. It is a concept and a value that is fundamental to the development, design, nurturing, and sustainability of relationships (Ioane, 2022).

Fa'asamoa (Samoan culture)

The Fa'asamoa and Fa'amatai systems govern Samoan society (Fairbairn-Dunlop, 1996). The Fa'amatai is a system based on the designation and bestowment of chiefs (matai) amongst families and villages where they will govern how family and village lives are structured and upheld. Within the family group, each person has a role where duties and obligations are well known. Some of these roles are arguably more sacred and revered than others (Fairbairn-Dunlop, 1996). The Fa'amatai system assigns the family and the village into gendered groups based on status such as genealogical connection and marriage. This is a system based on divisions of power, status, labour, and expectations.

In the Fa'asamoa, a basic value is 'Fa'aaloalo' or respect, seen as a fundamental foundation for keeping good relationships. There are protocols and etiquette that define respectful behaviour and humility towards others, particularly those in authoritative or leadership roles (Lui, 2003; Silipa, 2008). Fa'aaloalo can also be defined as showing reverence, courtesy, and politeness. It is one's respectful actions, words, and appropriate behaviour that are

included according to the social or cultural space or vā (Silipa, 2008). Within an education environment, it is not uncommon for Pasifika students to show fa'aaloalo (respect) to teachers, elders, and authorities through the behaviours of listening to teachers and being guided by their philosophies. It is uncommon to critique or challenge those in authoritative roles, which is where the tension may lie. Education in a secular environment encourages its students to critique, challenge, and/or to provide an alternative to what they are being taught. In a Pasifika (Samoan) worldview, this can and will be seen as being disrespectful. Therefore, it is likely that responses will be limited.

The empirical literature pertaining to Pasifika student experiences in their psychotherapy training is limited. The literature provided extends to published chapters, interviews, and writing of Pasifika psychotherapists', psychologists', and counsellors' experiences in their respective training courses.

As one of the first Samoan psychotherapists, Skipps-Patterson states, "psychotherapy training was one of the hardest journeys of my life—one in which I often felt alone and marginalized" (Berking et al., 2007, p. 136). This sentiment is reflected in McRobie and Agee's (2017) study of Pacific counsellors and psychotherapists who conveyed disempowering experiences encountered in their training including not being culturally valued as Pasifika, not being acknowledged for their Pacific identity, or receiving recognition of the uniqueness of Pacific culture. Many felt that their voice was largely ignored, and their cultural knowledge was not acknowledged or considered throughout their training. Berking et al. (2007) discussed feeling silenced when their culture went unacknowledged or cultural issues were not talked about; "in psychotherapy I just put my culture away in order to survive" (p. 57). Makasiale (2007) further talked about leaving her spirituality outside during training as "being asked to leave an essential part of me out in the corridor" (p. 111).

In an interview with one of the founding members of Pasifikology (a support network for Pacific psychologists and students), Siautu Alefaio-Tugia described forming a network group to connect and support other Pacific psychology students (Coombes & Alefaio-Tugia, 2013). Before long, they identified key issues such as the "lonely journey for each of us" (Coombes & Alefaio-Tugia, 2013, p. 39) that culturally their psychology training was not welcoming or supportive of cultural Pacific values and beliefs. Pacific psychotherapists and counsellors highlight the triggering cultural clashes that occurred for them as Pacific students in a Eurocentric psychotherapy or counselling training. One such clash was feeling uncertain about their cultural knowledge and ways of relating to a client, and having to double-check according to Western models of practicing. McRobie and Agee (2017) reiterated this, recalling the struggle to maintain their Pacific Indigenous practices and learning while undertaking mainstream European counselling training.

The voices of Pasifika psychotherapists, psychologists, and counsellors give some insight into the experience of Pacific students in their respective Western training programmes. Ioane (2017) invited thought and discussion on the two worlds of Pasifika culture and psychology. She reflected on Pacific clients and families being brought into the psychology world and whether clinicians are open to step into the world of Pasifika communities. She highlighted key cultural concepts of engagement such as 'Vā feilo'ai' (respectful space) and how it should be applied in practice. Ioane brings to light the significance of having mindfulness

with Pacific cultures and how culturally aware clinicians must be in their practice. As an Indigenous way of learning, the Samoan cultural way of learning and being is distinct from the expectations of formal Western education. For example, Fa'asamoa teaches Samoan children not to draw attention to themselves or to speak out of turn in formal settings (Tuafuti, 2010). This way of communicating can cause problems in Western academic settings. Kavapalu (1991) noted, "the process of Western education entails questioning, critical thinking and independent expression, all of which conflict with the cultural values of obedience, respect, and conformity" (p. 191). Therefore, the values and practices of Western education may oppose or reject the Samoan way of learning and being.

Some Pacific literature highlights the different educational value systems and looks to revert or reclaim more Indigenous knowledge in formal education. Nabobo and Teasdale (1994) discussed the importance of Pacific cultural knowledge within the Western education systems and called for more of a balance of traditional cultural knowledge and Western education. They claimed the first step must begin from teachers recognising and knowing their own cultural heritage. In this way, they will become more tolerant and understanding of cultural diversity within their classrooms. Smith (1999) stressed the need for decolonising research and allowing a space for Indigenous knowledge. It is with this understanding of Indigenous and Western learning and education in mind that the research is placed into context by drawing primarily on the experiences of the primary author in a psychotherapy training programme in Aotearoa New Zealand.

Psychotherapy training programme

In the Master's programme (2013–2018), psychodynamic psychotherapy was the main therapeutic approach or modality. It is therapy that focuses on the unconscious content of a person's psyche and relies strongly on the interpersonal relationship between psychotherapist and client to foster recovery (Cabaniss et al., 2017). In utilising the therapist–client relationship, the goals in therapy are to change habitual thoughts and behaviours through self-exploration (Shedler, 2006). This is achieved through strong rapport and a relational, supportive, and warm therapeutic environment (McWilliams, 2004). Transference (the sum of feelings that the client has towards the therapist from the present and feelings displaced from the past) and countertransference (the therapist's feelings experienced while with the client) are also used to help both the client and therapist notice the dynamics in the therapy room (Cabaniss et. al., 2017). In this way, the therapist is able to determine recurring patterns and themes that become the source of further analysis (Shedler, 2010). Psychodynamic psychotherapy also focuses on early life events, childhood attachments, and significant occurrences in the past (Holmes, 2001). It examines early attachment and the subsequent stages of development.

At the time in which this training was undertaken, a core paper—Reflexivity and Relational Skills (PSYT712)—was assessed by following learning outcomes:

1. Demonstrate personal and interpersonal qualities associated with effective outcomes in psychotherapy.
2. Demonstrate consistent presence and engagement with self and other, with a focus on patterns of response and understanding the origins of these.
3. Critically examine the implications for psychotherapy practice of individual and

cultural differences within the bicultural context and multi-ethnic diversity of Aotearoa New Zealand.
4. Demonstrate self-awareness, self-understanding, and reflexivity.
5. Present work at the appropriate academic standard. (Auckland University of Technology, 2022).

It is important to note that within a Pasifika worldview, Tagata Pasifika do not operate in isolation or in silos. The Pacific self is integrated in all areas of life—home, family, community, spirituality, work, academia—which ultimately led to this piece of research. The reflexivity paper encouraged experiential learning that focuses on how others experience you and how you make sense of this yourself. This type of self-reflection and reflexivity pushed against core understandings that I had of myself. My sense of being could not be separated from the integral relationships and world around me. This process felt impossible and excruciating as if I was isolating parts of myself to analyse and understand in isolation and not as a whole.

In the psychotherapy course there is an expectation to notice one's own reactions, thoughts, feelings, associations, and express them publicly. This caused conflict as it was a very foreign concept for the primary author. On one hand it was liberating, as psychotherapy culture nurtures freedom to notice and openly express internal processes; on the other hand, it was conflictual as sharing personal stories and feelings feels counter-cultural to me. For many Pasifika people, openly speaking one's mind and sharing private and intimate details of one's life is not appropriate—particularly when you are expected to share with people with whom you have only recently formed student relationships. This impacted deeply on me as one's duties, roles, and responsibilities are seen to be of great value and respect as a way of contributing to one's family and society. As a student, I learnt to adapt to the educational setting and put on a new critical lens to deconstruct my knowledge and understanding of the world such as my personality, patterns of behaviour, defences, culture, family, and ways of being. This expectedly created tension and conflict.

Methodology

Teu le vā research methodology

Three main Pacific research approaches were used in this research. Teu Le Vā is a Pacific research approach to an education framework (Anae et.al., 2010). As noted earlier, Teu Le Vā is based on tending to or maintaining good/sacred relationships (between people, environment, and creator). The original Teu Le Vā approach has been re-framed for this paper (Anae et al., 2010). Second, Fa'afaletui (Tamasese et al., 2005) is blended with the Samoan concept of Tōfā sa'ili (Tui Atua, 2007). Fa'afaletui entails discussion and consultation with many different people of the community (e.g., elders, community leaders, peers) in order to gauge different perspectives. The Samoan concept of Tōfā sa'ili (Tui Atua, 2007) is reaching out or searching for knowledge and wisdom or "reaching out for wisdom, knowledge, prudence, insight, judgement, through reflection, meditation, prayer, dialogue, experiment, practice, performance and observance" (p. 121). Fa'afaletui-Tōfā sa'ili is a

research method to search for knowledge, to inquire and reflect on processes, and search for meanings amongst many different groups or 'fale'.

Adaptation

Principle 1: *Engage with stakeholders in Pasifika health research.*
A collective conversation engaged my experiences as the Samoan learner and researcher with family members, community members, Pasifika university community and members of the psychotherapy department, and past and current university peers.

Principle 2: *Collaborate in setting the research framework.*
As a sole researcher and participant, I consulted with my supervisor (Pacific), other university Pacific academic staff, and Pacific communities in formulating and setting a unique research framework for my study.

Principle 3: *Create a co-ordinated and collaborative approach to Pasifika in psychotherapy and policy-making.*
Formal feedback regarding proposed research at the time highlighted the incongruence between my topic of research from a Samoan perspective and the Western model of heuristic method of inquiry. Pacific research methods were encouraged that fostered a Pasifika perspective in psychotherapy. In addition to Teu Le Vā methodology, the Fa'afaletui-Tōfā sa'ili inquiry method was used in order to reinforce the co-ordination of a collaborative method with Pacific communities that included academic staff and leaders.

Principle 4: *Grow knowledge through a cumulative approach to research.*
Identifying a Pacific methodology that would fit my worldview and philosophy for research was a key issue in this research. In adapting the Teu Le Vā methodology, an outline was constructed that was essential for my Pasifika understanding of research in psychotherapy. The Fa'afaletui-Tōfā sa'ili method reinforced the cumulative style of engagement within different communities. This research attempted to build the knowledge base in psychotherapy for all practitioners and clients and provide an understanding of the use of Pacific (Samoan) research methodologies in psychotherapy.

Principle 5: *Understand the kinds of knowledge used in Pasifika health research and policy-making.*
The principles of Fa'afaletui-Tōfā sa'ili method revolve around the understanding that knowledge can be built from many different sources of knowledge. Peers, supervisors, Pacific academics, and general Pacific community members were consulted on the subject of the two worlds of psychotherapy and Samoan culture. In addition, other Pasifika experiences of training courses in psychotherapy and similar fields of psychology, family therapy, and in educational institutions in general, were researched. This study was completed as a Master's programme requirement and may have implications for future policy-making.

Principle 6: *Engage with other knowledge brokers.*
Engaging with other knowledge brokers included having conversations with experts of both Samoan culture and community and the psychotherapy world such as therapists; supervisors and lecturers; elders, family members, and members of my Samoan community;

and the academic community, oral histories, art and art histories, anecdotes, and other mediums.

Fa'afaletui-Tōfā sa'ili method

Step one: Fa'afaletui—Weaving different parts of the fale together

This step included weekly to fortnightly discussions in class and supervision groups, fortnightly therapy sessions and meetings with current and previous psychotherapy students, monthly conversations with Pasifika and non-Pasifika university academics, and bi-monthly meetings with family and friends. I discussed and consulted with various knowledge sources regarding how I felt in the psychotherapy programme, tensions and emotions I experienced in the course, and how difficult it was to talk about these experiences.

Step two: Tofa-sa'ili—Searching for wisdom

After these discussions I recorded and collected my thoughts, reflections, ideas, words, images, understandings, and narrative through my journal writing during the period of my training. The writings in the journal from January 2016 to July 2017 were the primary source for my research and was followed by Fa'afaletui in which others were consulted for their wise counsel and knowledge.

Journal entries were coded manually by identifying key themes that were most salient from the data. The themes that emerged and occurred repeatedly were grouped together and sorted into sub-categories. Findings from these themes were analysed with the literature on Pasifika student perspectives of their training to explore any consistencies and differences. This was then discussed with my supervisor for further clarity and robustness.

The Teu Le Vā methodology and two-pronged method of Fa'afaletui-Tōfā sa'ili offered a Samoan cultural platform to position myself in my research. Teu Le Vā methodology underpinned my research as it reflected the Samoan values and worldview by which I orient myself. In connecting Fa'afaletui-Tōfā sa'ili as a Samoan tool of research inquiry, a natural alignment occurs with my worldview of Fa'asamoa which highlights the collective approach of Pacific people to discuss and work collaboratively within their own community to ensure both the individual view that psychotherapy promotes, and my embedded collective view of Pasifika are both acknowledged and respected equally.

Themes

Lack of cultural safety

> All psychotherapists will be knowledgeable of culturally safe practices, and familiar with the Treaty of Waitangi and be able to integrate these into their practice in ways that ensure that issues of diversity and equality are valued, upheld and promoted. (Psychotherapists Board of Aotearoa New Zealand, 2011, p. 2)

The above quote from the psychotherapist core clinical competencies establishes a commitment to safe cultural practice and development in psychotherapy practice and

training. It also becomes the foundation to a comprehensive cultural conduct guide for developing psychotherapists. As a result, it gives definitions of culture and explains the standards of cultural competency such as attitude, awareness, knowledge, and skills. The following extract from my journal illustrates my early thoughts of cultural safety and what it looked like for me at this time.

> *The definition of cultural safety that I like is that whenever two or more people meet from different cultures, worldviews, values, whether from the bigger majority group or the minority group. That both or all cultural values are held equally. Side by side. One is not higher or better than the other.* (June, 2016)

My experiences in the course questioned to what degree the importance of culture and diversity were being held in the community. The following journal piece was entered after a community kōrero meeting (a weekly large group process) where I was asked by another colleague from a different year level "where are you from?"

> *A student asked directly "Where are you from?" My rage filled my body and beamed out through my eyes and face as I was deeply offended and hurt at being blatantly 'othered'. I realised then that cultural safety was something that I alone would have to guard vigilantly for myself.* (July, 2016)

To put this journal entry into context, I had spoken in class about my struggle to voice myself in the previous community meetings. The conversations in community meetings predominantly revolved around Māori and Pākehā biculturalism in Aotearoa, so my position as neither Māori or Pākehā put me into the non-Māori Indigenous, ethnic minority 'other' group. This felt unsafe for me; yet, I did not know how to bring myself into a conversation that, at times, felt binary. I felt unsafe addressing my cultural difference as an ethnic minority student. Yet, I was encouraged to engage with the conversation of critical awareness of power dynamics, culture, bi-culturalism, and multi-culturalism in the context of therapy and Aotearoa. However, this was not reflected among staff who were not always present in community meetings where these crucial conversations were held. This reinforced the feeling of cultural unsafety when those teaching the course were not present to engage in the discussion. I began to query how safe my cultural boundaries were in the training course.

I wrestled during the course with these ideas, and my expectation regarding cultural safety was that my values, norms, beliefs, and identity as I determined them would be upheld alongside others.

> *Despite feeling culturally unsafe a number of times I was still encouraged (by lecturers and peers) to bring my korero of difference to the community. At times I struggled extensively to contain my rage yet I was revered by many for sharing. Therefore, I became stuck in an uncertain limbo that felt painful and still continued to push through, always going back for more.* (August, 2016)

This journal passage acknowledged my internal struggle and difficulty of expressing my cultural diversity in the training context. Tuafuti (2012) described silence as an active part of Pasifika culture and learning, knowing when and where to speak and when to remain silent

in many different contexts. This is important to understanding the struggle that I experienced during the training course and how my cultural knowledge values silence and speaking in a different way.

Navigating the edges of two worlds

In/between edges
and fringes I softly tread
traversing worlds

censor silenced parts
polite rage seething teeth smile
get your ticket. leave.
(January, 2017)

A theme that emerged from the data was navigating the edges of two worlds. In my last year of the training course I was asked by two separate staff members to perform a Pacific prayer and dance. My first response was a reluctant "ok, maybe" but something in me jarred and I felt stuck. An internal struggle had started within me and I was confused and uncertain of why.

> *I was not present at the Marae Noho this year for reasons that I could not fully understand at the time. My cultural values include being respectful of authority and not to show feelings of anger towards them as this is considered deeply disrespectful. Yet, I was angry that I did not have the luxury and space to enjoy the noho as my peers could. Instead, I was asked by different lecturers to perform certain Pacific cultural tasks and this made me feel extremely angry. The feelings of rage and resentment about being the 'exotic' other that represented Pacificness felt token and performance-like.* (July 2016)

My cultural values of being respectful of authority and adhering to their instructions were at odds with the culture of psychotherapy. I felt that I could not openly express my anger towards the staff and this facilitated my decision to withdraw temporarily from the training. I was accustomed to being asked to perform in front of others by my parents and family. However, this felt uncomfortable and forced, and I became angry as it took away my autonomy to choose for myself. The feelings of anger could not be directly expressed or understood as it was disapproved of in my family of origin and in my culture; therefore, it went underground.

The clash of 2 cultures, 2 worlds
- *Pulled in, used*
- *Used for my cultural knowledge*
- *Whose truth matters more/ takes precedent?*
- *Where am I in all this??*

Expectation:
- *That I play my role dutifully*
- *That I adapt*

(April, 2016)

This journal entry was made in the weeks after my temporary withdrawal when I was told that I may fail the practice paper. This was part of my process of trying to work through the thoughts and feelings that I carried. The excerpt shows the questions and reflections of my experience of being asked to perform and having to traverse two sets of truths, values, and knowledge. I was encouraged to continue sharing my feelings and perspectives about my personal processes which helped me acknowledge my tendency to isolate myself when I was feeling overwhelmed or when I did not have support or anyone who would understand me. The Samoan phrase, 'A lafalafa tuna, o le tagata ma lona aiga o le tagata ma lona fa'asinomaga' echoed in my heart. It states that 'In life's journey, one's family is one's guide'; therefore, a person without their family has no guide. In this setting, I turned to my year level peers who were of different ethnic backgrounds from me for support. Despite our cultural differences I felt support in the peer group that was warm and encouraging. In this way I had an avenue to share some of my experiences and still share the angry feelings that I carried.

> *Like an edge-walker that has to dance carefully on the fringes of two worlds while struggling to create a space for myself. I have come to understand some of my angry feelings of rage that live in me. I am allowing a voice for those feelings that have been disavowed for a long time. In this way I strengthen my small voice to become more powerful.* (May-June 2016)

In my attempt to forge a new space for myself I retreated into the safe haven of my room. I took with me the anger and shame that I could not face or share and, in this decision, I passively said 'no'. The training course encourages recognising your own internal processes, emotions, and behaviour. It also encourages you to notice what you are experiencing in the present and how this might be related to patterns in your relationships. It promotes noticing how these are interrelated and that they can be influenced by groups and systems. These ideas conflict with my Samoan cultural education of following instruction from authority and restraining from disclosing personal feelings in public in order to maintain social harmony. Hence, speaking and sharing personal stories and feelings felt counter-cultural to me. Yet, the Western psychotherapy culture nurtures freedom to openly express and notice internal processes. Navigating these two worlds was a journey of learning and understanding this conflict more intimately.

Discussion

> *I'm a child of the edges. The edge of the circle, of society that has been taught so well how to camouflage, how to manage, present, shape shift to fit in… enough.* (November, 2016)

Le isi—Other

The first theme 'Lack of cultural safety' discussed occurrences in the psychotherapy course that made me feel culturally unsafe. My status of Pasifika and ethnic minority in the psychotherapy community and in Aotearoa New Zealand was brought to the forefront during my training. I felt fearful, exposed, confused, isolated, and unsafe for being different; despite being strongly rooted in my cultural identity. I was puzzled as to why these experiences were unsafe for me as I often felt like an outsider that did not belong. DeSouza and Cormack (2009) discussed the minority ethnic migrant group as 'competing other' to

the Indigenous Māori of Aotearoa. They examined the impact of colonialism of the 'white settler' and the relationship with the Treaty of Waitangi and Māori sovereignty that places other ethnic groups outside of this bicultural conversation. I was a part of the ethnic group that was outside the bicultural circle and my attempt to speak about it was met with a reminder that I was on the outside. Nairn et al. (2006) describes the label of 'other' as having colonial beginnings in Aotearoa New Zealand and that Indigenous culture, language, law, and way of life changed to fit the colonisers: "foreign became the natural or normal and the Indigenous, particularly those who did or do not assimilate, became alien" (p. 185). Nairn et al. discusses how Māori had open and positive attitudes towards the new settlers, yet this was not reciprocated. Furthermore, Jackson and Penrose's (1993) work on race construction reveals that those who were from the 'subordinated' cultures and not the dominant culture were labelled as 'ethnic' which demarcated ethnic groups regarding to race and added to differential power relations. This brings to question a possible dynamic in the psychotherapy course of how groups of students and cultural values might be privileged. My experiences as a Samoan student, in general, provided me with an uncomfortable feeling that my Samoan culture continued to be ignored. My identity as a Samoan woman from a collective way of life was not validated and I felt shut down while attempting to voice a narrative of difference within the training.

Fa'amamāsagia ma le lē fiafia—Shame and anger

Cry lava
Exhale heat
Breathe life
Roar
Fanua
Pou.
(November, 2016)

'Navigating the edges of two worlds' ignited intense emotions that I experienced when the edges of two cultural worlds crash. Being asked to perform a Pacific dance and say a Pacific prayer led to intense shame, anger, and internal conflict at having such feelings. My Pacific values and beliefs urged me to nurture the vā with my psychotherapy lecturers and community. As defined above, to nurture the vā is to foster or take care of the vā or the relational space between people and things. In this instance, my Samoan cultural way of being values the maintenance of good relationships and I felt a strong desire to keep the peace by performing the tasks that I had been given. However, I was embarrassed that I alone had been asked to perform Pasifika cultural tasks despite the course having other ethnic minority students that were free of this obligation. I have performed Samoan siva (dance) on numerous occasions with siblings and cousins at family and community cultural events. Yet, in this case, it felt forced, confusing, and angry; and simultaneously I felt the need to retreat in an attempt to work through the internal conflict that I experienced.

On reflection, I felt unfairly singled out, perhaps as a Pacific postcard image of the 'exotic' other (Jones et al., 2000). I felt used for my Pacific identity which did not sit comfortably for me, and I felt disrespected. In an effort to understand my jarring feelings of anger and shame I retreated into the safe haven of my room and chose not to attend the noho.

Afterward I experienced great difficulty and shame returning to the group and speaking openly about the incident in classes.

This incident illustrates the tension that I felt when the two cultural worlds of psychotherapy and Fa'asamoa collided within me. Berking et al. (2007) described the experiences of cultural clashes being Pasifika in their respective psychotherapy and counselling courses. The group learnt to cope with cultural conflicts by putting their culture away despite the internal tensions and feeling invalidated. I resonate strongly with this experience as my experience felt invalidating and caused conflict within me. Therefore, I struggled to find ways to bring my cultural self into the psychotherapy community world, to find a voice to express my struggles, and I felt the strong urge to withdraw from the programme as it seemed easier to "leave it at the door" (Berking et al., 2007, p. 56).

Vā tapuia—Re-negotiated space

> Both are spaces of in-betweenness, both allow for movement. The third space provides a space of fluidity and retreat while staying in relationship, in the vā. Within the vā, there are layers of between-ness and layers of the unseen. (Iosefo, 2016, p. 190)

The re-negotiated space is an intersection of Mila-Schaaf and Hudson's (2009) Indigenous negotiating space, Bhabha's (1990, 1994) third space, and Tui Atua's (2007) description of the vā tapuia. It is this sacred space or vā tapuia that is woven in with the third space that develops the negotiated space and becomes the foundation for negotiated space to be re-negotiated.

The experiences of shame, invalidation, anger, rejection, and feeling unsafe during my time in the psychotherapy course forced me to find spaces and different ways to cope and manage myself. This is the re-negotiating of space that needed to occur for me to continue through the programme while keeping the essence of my values as a Samoan woman intact. Accommodating myself to suit the dominant psychotherapy culture created internal tension, confusion, and conflict that I could not comprehend or work through. Yet, I wanted to continue the course to become a psychotherapist and remain in relationship with others, or to continue to nurture the vā.

The unbalanced cultural perspectives that I experienced align with Mila-Schaaf and Hudson's (2009) model of negotiating spaces. It describes a space that fosters connection and relationship between different cultural knowledge systems and within different models of health care. This model encourages openness to engaging and exchanging knowledge and ideas, to explore and develop, adapt, and retain through "self-determined growth and self-conscious maintenance" (Mila-Schaaf & Hudson, 2009, p. 17). It illustrates a re-negotiation of cultural exchange of knowledge and I felt encouraged as a Pasifika student to interpret and explore my Indigenous ways of healing and learning alongside the psychotherapy training.

I was in constant conflict over my Samoan way of life and culture versus the Western need to express myself as an individual. Traditional cultural norms and values encourage women to be modest and conscious of their social conduct. Therefore, expressing my individual

thoughts and emotions without a filter and openly in front of other students without the consideration of my family and community felt exposing and foreign. Mila-Schaaf (2010) offered the negotiated space again as a place that allows young people to self-determine the ways they can feel like they belong to a group. In this way, I, too, was able to redefine or re-negotiate a space that fit my needs such as confiding in others, reflecting on situations, and physically finding a safe haven. In doing these things I was more able to govern how and when I would fit into the psychotherapy world.

Using Bhabha's (1990, 1994) concept of 'third space' assists in re-negotiating spaces as he described an 'in-between' element of culture. Bhabha examined the limitations of traditional notions of culture and identity to form the 'third space' that is ambivalent, interruptive, reflective, and a space that stimulates new possibility. These components bring to life the re-negotiation of space as the times I felt culturally unsafe, othered, navigating two worlds, and feeling shame and anger. Therefore, I had to retreat, review, consult, ponder, discuss, reflect, and process my experiences. This was an ambivalent process that did not have a straightforward route. Instead, it was back and forth in a rolling motion, like waves that come and go. Many times I was encouraged by supervisors, staff, current and past peers to continue to find a voice for the tension I felt. In the re-negotiated space I was able to draw and write notes and poetry about my thoughts and feelings. In doing so I was fashioning a space to continue the course and uphold my values as a Samoan woman.

O lo'u leo—My voice

Our relational space
we give and take
we share
envelop, develop
fold in
breathe out
stretch and hold. Embrace me.
See me.
O ai oe?
Soothe me in your somber hymn.
Calling to the leo in me.
Hear my call
it is my leo
it is my lament.

Oi aue!
sense me,
mold my spirit,
that yearns e pese atu.

Raw, fresh, untouched, unconscious, depth, sensual, soul, move me.

Self care. While you
climb edges
and build bridges
between worlds.
You have to

shape-shift,
be athletic, nimble, quick to traverse in between.

I am a weaver,
a tailor,
like Nana in her solidness, in her humanness, in her knowingness, her beingness,
her homeliness,
her strength,
her spiritualness.

Say something
Write something
Paint something
Create something
Create a space
Sing a space
Laugh a space
Speak a space
Claim a space
Guard a space

Beyond the mold is fertile
soulful
life giving
life loving
unashamed
powerful
sister keeper
boundary pusher

voice tester

space claimer.
(February, 2018)

The most meaningful impact from this learning journey has been to claim 'Lo'u leo' or my voice. On reflection, the training experiences made me face some uniquely challenging experiences that tested who I was as a Samoan woman and a trainee psychotherapist. In this testing my grapple and struggle with conflicting feelings was invaluable as it gave rise to amplify my leo. The ability to voice my experiences without fear in the psychotherapy world is developing and strengthening.

The experience of being able to voice myself and my experiences was empowering. I am more able to share my understandings and lived experiences with confidence—not fear and apprehension. My leo can speak of my difference as an ethnic minority woman with a rich cultural heritage that, at times, is vastly dissimilar to the psychotherapy world—and that is OK. As the only Samoan student in the course at the time I did not feel culturally safe and supported to voice my concerns. However, my leo is an invitation to be seen in the community with my own views. This has started to form a space within me for reflection,

curiosity, and conversation. It is a developing part of me that is more able to withstand feelings of difference and loneliness while continuing to remain in relationship with others. This journey has constantly reminded me to reflect on the internal conflict of navigating two worlds that are often incongruent. In this way becoming mindful of the importance of re-negotiating a space for myself and claiming my leo.

Recommendations

While this research has highlighted concerns from a Pasifika perspective, we acknowledge the achievements obtained that included registration as a psychotherapist and a Master's degree qualification for the primary author. One of the principles in the fa'asamoa is that of reciprocity; therefore, it is appropriate that recommendations are made to ensure psychotherapy continues to seek ways to enhance its content and delivery so that it authentically responds to the diverse communities in Aotearoa New Zealand.

The most significant issue is awareness of the emotional and cultural struggle of Pasifika students in psychotherapy, as noted from my research, and how these findings may potentially be generalised across other trainings (Berking et al., 2007). This research has provided an inclusion of a Pacific worldview in psychotherapy that may benefit from further ways to promote Pacific in the practice of psychotherapy.

Increasing the Pacific Psychotherapist workforce. Connecting with Pacific communities and within the university to support Pasifika undergraduates from psychology, mental health and counselling to psychotherapy needs a culturally responsive approach. Given that talking therapy is arguably a new concept among Pacific communities, forming a relationship with the Pacific student body at the university may lead to a co-designed/partnered approach to increasing Pacific student enrolments in psychotherapy.

Creating a Pasifika psychotherapy student body for past and present students and affiliates supports Pasifika cultural values and learning. This group may be able to support current Pasifika students culturally and academically through peer supervision and possibly increase the Pacific research and resources in psychotherapy from a practice perspective.

Engaging current university staff in Pasifika cultural training and learning. Includes employment of Pacific staff specialised in cultural training to supervise and support staff learning. This equips non-Pacific staff with support on understanding their Pacific students and providing opportunity to include Pacific content in their curriculum. In this way they are able to meet their Pacific students in culturally appropriate ways and authentically provide a learning space so that all students feel culturally safe to work with Pacific communities.

Conclusion

The findings from this study showed two themes: lack of cultural safety and navigating the edges of two worlds. These themes fostered feelings of anger and shame, as well as not

having my cultural values upheld and being seen as 'other'. It cultivated an awareness of a cultural dis-ease and internal conflict that was experienced during psychotherapy training.

By using Teu Le Vā and Fa'afaletui-Tōfā sa'ili research frameworks, this work introduces an alternative view of psychotherapy training. It offers a voice from a psychotherapy student that is both Samoan and female. It gives a Pasifika perspective that attempts to wrestle with both Western and Fa'asamoa worlds to negotiate and re-negotiate the edges where many people tread. It creates the groundwork for a track that others may traverse to help voice their difference. This is an uncomfortable and painful reality of the edges of the Fa'asamoa and psychotherapy worlds that are raw and tender. Thus, it compelled me to re-negotiate the spaces within the course and within me. This re-negotiation of spaces enabled me to continue to be part of both the two worlds while keeping the integrity of who I am.

Through these worlds' meetings, the tectonic plates of Fa'asamoa and psychotherapy cause friction, pressure, and hot air that can create volcanoes or islands. These are new spaces and lands with fertile soil and a chance for new foliage, growth, and life.

> *A fisaga le matagi, sisi le lafala. Ae a loulouā le tau, sisi le la'afa*.
> When the light breeze blows through, raise the pandanus sail. When the winds blow strong, raise the sennit sail.

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Paper 16 (2020)

Sexual fantasy in sex research—A literature review

Yulia Von and Paula Collens

This paper is derived from research undertaken by Yulia Von (2020), under the supervision of Dr Paula Collens, and explores the question: How is sexual fantasy understood in sex research?

First, a brief definition of key terms is provided. Next, we offer a historical overview of the field of sexology and contributions of pioneer sex researchers to the study of human sexuality. Findings from the review of sex research literature are then presented under the following themes: prevalence of sexual fantasies, most common sexual fantasies, links between sexual fantasy and attachment style, correlation between sexual orientation and object choice in sexual fantasy, and fantasies involving power exchange. The paper closes with a discussion of limitations of the research.

Definitions of key terms

Sexual fantasy: refers to a persistent combination of erotic imagery, thoughts, and sounds that emerge to promote sexual arousal (Kahr, 2007; Leitenberg & Henning, 1995). This study focused on 'conscious' sexual fantasy only, although it is recognised in psychoanalysis that this may derive from unconscious process and 'phantasy' (Spillius, 2001).

Sexology and sex research: refers to the field of multidisciplinary scientific inquiry that addresses human sexuality including sexual interests, sexual behaviours, sexual function, gender identity, and sexual health (Britton, 2005; Crowell et al., 2017; Farmer & Binik, 2005). Sexology and/or sexology research are used as interchangeable terms in this paper, reflecting how these terms were used in the literature (e.g., Crowell et al., 2017).

Sex and gender: sex is a linguistically ambiguous term since it refers to both sexual activity and to the assignment of a 'category' of sex at birth based on biological sex characteristics (Jones, 2018). Gender in social theory refers to a social construct that governs, affords, and constrains particular roles, attitudes, and behaviours which have been associated with biological sex (see Frazer, 2017, for discussion of the construct of gender). It is notable that review of the literature revealed a collapsing of the constructs of gender and sex, generating confusion for readers. In this paper, 'gender' is used with reference to social groupings (e.g., women, men, or trans and gender diverse people). The term 'sex' will be used only when referring to sex assigned at birth (i.e., male, female, intersex) and not to refer to sexual activity. When describing sexual activity, we will use the term 'sexual activity'.

A glossary of terms relating to sexual practices and behaviours that have been used in the literature is provided at the end of this paper.

A brief history of sexology

Sexology is a scientific study of human sexuality that has its roots in the mid-19th century when European physicians, such as Heinrich Kaan, Richard von Krafft-Ebing, Iwan Bloch, Magnus Hirschfeld, Albert Moll, and Havelock Ellis, began writing about human sexual behaviour (Blechner, 2016; Kahr, 2007; Lehmiller, 2017). These early publications reported sexological research that categorised 'normal' and 'aberrant' behaviours; which, at that time, included homosexuality, transsexualism, masturbation, sexual dysfunction, and sexual development (e.g., *Psychopathia Sexualis: A Clinical Forensic Study* by Richard von Krafft-Ebing, 1886; *Homosexuality of Men and Women* by Magnus Hirschfeld, 1914/2000). These first scientific publications marked the beginning of reconceptualising sexuality in terms of medical discourse rather than moral discourse (Lehmiller, 2017).

In the 1880s and 1890s, neurologist and physician, Sigmund Freud, took an interest in sexology and was known to be in correspondence with the sexologists of his time (Blechner, 2016). Sexological concepts of erogenous zones, autoeroticism, narcissism (Ellis, 1898), and sexuality in children (Moll, 1912) influenced Freud's thinking and the development of the theories on infantile sexuality (Freud, 1905/1977). It can be argued that Freud contributed to the advancement of sexology by situating it in the domain of mental/psychological health; and he proposed that sexual fantasies originate in the unconscious mind. Historical convergence of sexology and psychoanalysis laid a foundation for modern sexology research.

A Freudian approach to human sexuality in theory and practice was based on individual case studies. This method had sampling limitations, and in the early 20th century a need for a scientific laboratory study of sexuality began to emerge (Lehmiller, 2017). During the 1940s and 1950s, biologist Alfred Kinsey and his associates undertook a large-scale survey to examine sexuality of Americans. The results of extensive interviews with 5,940 women and 5,300 men were published in two seminal books: *Sexual Behaviour in the Human Female* (Kinsey et al., 1948) and *Sexual Behaviour in the Human Male* (Kinsey et al., 1953). The
impact of Kinsey's findings had a cultural paradigm-shift effect by bringing to light the significant frequency of masturbation (men 92%; women 62%), extramarital encounters (men 50%; women 26%), 'homosexual' activities (men 37%; women 13%), and sadomasochistic desires (men 22%; women 12%) (Farmer & Binik, 2005; Kahr, 2007; Kinsey et al., 1948, 1953; Lehmiller, 2017).

From 1957 to 1965, gynaecologist William Masters and psychologist Virginia Johnson conducted research in which they observed approximately 10,000 complete human sexual response cycles (a four-stage model: excitement, plateau, orgasm, resolution) in the laboratory of Washington University (Lloyd, 2005). The participants (312 men; 382 women) were asked to masturbate or engage in sexual intercourse while connected to equipment monitoring physiological phenomena (Masters & Johnson, as cited in Archer & Lloyd, 2002). Their findings were published (Masters & Johnson, 1966, 1970, 1974, 1979) and have been

credited with transforming sex therapy. The latter is a therapy that focuses on sexual function and sexual relationships. They enhanced couple therapy with interventions such as 'sensate focus', which was reported as helping couples to resolve sexual issues, including erectile dysfunction, premature ejaculation, orgasmic difficulties, and performance anxiety (Berry, 2013).

Contemporary sexology includes researchers from across many disciplines including biology, medicine, anthropology, psychology, psychotherapy, and sociology (Lehmiller, 2017). Sexology, today, aims to increase understanding of all aspects of human sexuality and its expression, including sexual practices in different cultures and different kinds of therapies that address sexual issues (Lehmiller, 2017). The current field of sexology has wide ranging areas of research focus and knowledge including sexual development; sexual orientation; gender identity; intersexuality and transsexuality; sociological, anthropological, and neurobiological aspects of sexual behaviour; sexual function and dysfunction; paraphilia; and relationship and attachment (Friedman & Downey, 2008).

In the next section, findings from a review of sexology research that focused on sexual fantasy will be presented.

Prevalence of sexual fantasies

Review of the literature suggests that sexual fantasy is a prevalent and common human experience amongst adults. A large-scale study in the United Kingdom (UK), involving over 19,000 adult participants, found that on average 90% reported having sexual fantasies (Kahr, 2007). Findings from an American study (Lehmiller, 2018) that gathered data through a 369-question survey and involved 4,175 people, revealed 98% of participants had sexual fantasies. The findings from these two studies are consistent with research findings of the previous five decades. For example, the widely cited literature review of sexual fantasy research conducted by Leitenberg and Henning (1995), found that 95% of respondents fantasised on a regular basis. Findings thus suggest that sexual fantasies are a common experience for adults. However, it should be noted that these results emerge from only two major democratic regions of the world; as such, there are limitations to be considered.

Content of sexual fantasies

It might be argued that human imagination is less constrained by morals, values, beliefs, and prohibitions, and there may be a possibility to create virtually any fantasised scenario. However, empirical literature reveals commonalities across adult fantasies. Thus, there is a high probability of one's unique fantasy has been similarly fantasised by others, no matter how idiosyncratic (Kahr, 2007; Person, 1995). Here, findings from the three largest-scale and most recent studies on sexual fantasies (Kahr, 2007; Lehmiller, 2018; Leitenberg & Henning, 1995) are presented.

The first study (Leitenberg & Henning, 1995) was a review of empirical research conducted between 1953 and 1994. The review was undertaken by two psychologists in the United

States (US). Results revealed the four most frequently identified sexual fantasies: 1) sexual imagery including past, present, or imaginary lovers; 2) sexual power and irresistibility (seduction and multiple partners); 3) forbidden sexual imagery; and 4) submission–dominance scenes with sadomasochistic imagery. The authors commented on the difference in methodologies of the reviewed studies. Sometimes, the data were collected through checklists of different fantasies, and in other studies the data were obtained from written self-reports. Nonetheless, the common findings were apparent across the selected studies.

The British Sexual Fantasy Research Project conducted by Brett Kahr, a psychoanalyst and sexologist in the UK, was undertaken between 2003 and 2007. Data were gathered through 132 interviews (some of which were 5 hours in duration) and 18,167 computer surveys detailing respondents' sexual fantasies, sexual histories, and demographic details. Kahr (2007) presented findings including a thematic index of sexual fantasies from which the first author (Von) generated a rank ordering by percentages of the most to least prevalent (see Table 1).

Table 1
A Thematic Index of British Sexual Fantasies Preferences

Sexual Fantasies	**Percentage (%)**
Sex with regular partner	58
Kissing	43
Sex with someone else's partner	41
Sex with a work colleague	39
Romantic scenes	37
Sex with a stranger	37
Sex with two or more women	35
Vibrator	35
Playing a submissive or passive role during sex	33
Sex with a friend	32
Talking dirty	31
Playing a dominant or aggressive role during sex	29
Sex with someone of same sex	25
Being tied up by someone	25
Underwear	24
Sex with a friend's partner	23
Tying someone up	23
Dildo	22
An orgy	20

Being watched during sex	19
Sex with two or more men	18
Being blindfolded	17
Blindfolding someone else	17
Food items	16
Sex with a man and a woman at the same time	15
Using handcuffs or bondage restraints on someone else	15
Having someone else use handcuffs or bondage restraints or collars on you	14
Being forced to strip	13
Spanking someone else	13
Being spanked	12
Forcing someone to strip	11
Being forced to masturbate	10
Forcing someone to masturbate	9
Stripping off in public	5

Von explored coalescences of types of fantasy outlined by Kahr and re-organised the above under higher-order themes. For example, 'being spanked', 'spank someone', and 'being tied up' were gathered under a higher-order theme of 'dominance, submission, force, and restraints'; and 'sex with someone else's partner', 'sex with a work colleague', and 'sex with a stranger' were grouped under the superordinate theme 'sex with someone outside the relationship'. Table 2 presents these higher and lower order themes. The seven major themes of most common fantasies identified by Von from Kahr's research were: 1) sex with a regular partner; 2) sex with someone outside the relationship; 3) romantic scenes; 4) threesomes and group sex; 5) domination, submission, force, and restraints; 6) sex with someone of the same sex; and 7) voyeurism, exhibitionism, and fetishism.

Table 2

Most Common Sexual Fantasies in the UK

Sex with regular partner
Sex with regular partner
Sex with someone outside of the relationship
Sex with someone else's partner
Sex with a work colleague
Sex with a stranger
Sex with a friend
Sex with a friend's partner
Romantic scenes
Kissing
Romantic scenes
Threesomes and group sex

Sex with two or more women
An orgy
Sex with two or more men
Sex with a man and a woman at the same time
Domination, submission, force, and restraints
Playing a submissive or passive role during sex
Playing a dominant or aggressive role during sex
Being tied up by someone
Tying someone up
Being blindfolded
Blindfolding someone else
Using handcuffs or bondage restraints or collars on someone else
Having someone else use handcuffs or bondage restraints or collars on you
Being forced to strip
Spanking someone else
Being spanked
Forcing someone to strip
Being forced to masturbate
Forcing someone to masturbate
Sex with someone of the same sex
Sex with someone of same sex
Voyeurism, exhibitionism, and fetishism
Vibrator
Talking dirty
Underwear
Dildo
Being watched during sex
Food items
Stripping off in public

A more recent US empirical study by social psychologist and sexuality educator Lehmiller (2018) utilised an online survey of a general population sample of Americans (n = 4,175; aged 18 to 87 years). An extensive questionnaire included a narrative and questions about a favourite sexual fantasy, personality traits, sexual history, and demographic characteristics. The seven most common sexual fantasies, ranked according to frequency were: 1) threesomes and group sex; 2) power, control, and rough sex; 3) variety, novelty, and adventure; 4) forbidden sex; 5) polyamory and swinging; 6) romance, passion, and intimacy; and 7) homoeroticism and gender flexibility.

Findings from across these three large-scale studies reveal there are areas of commonality and synergy in relation to common sexual adult fantasies. Figure 1 presents the major themes from these three studies to foreground some of these synergies. It is notable that themes do not neatly map onto one another; rather, there are convergences and patterns in the findings of these studies. Some of these points are discussed below.

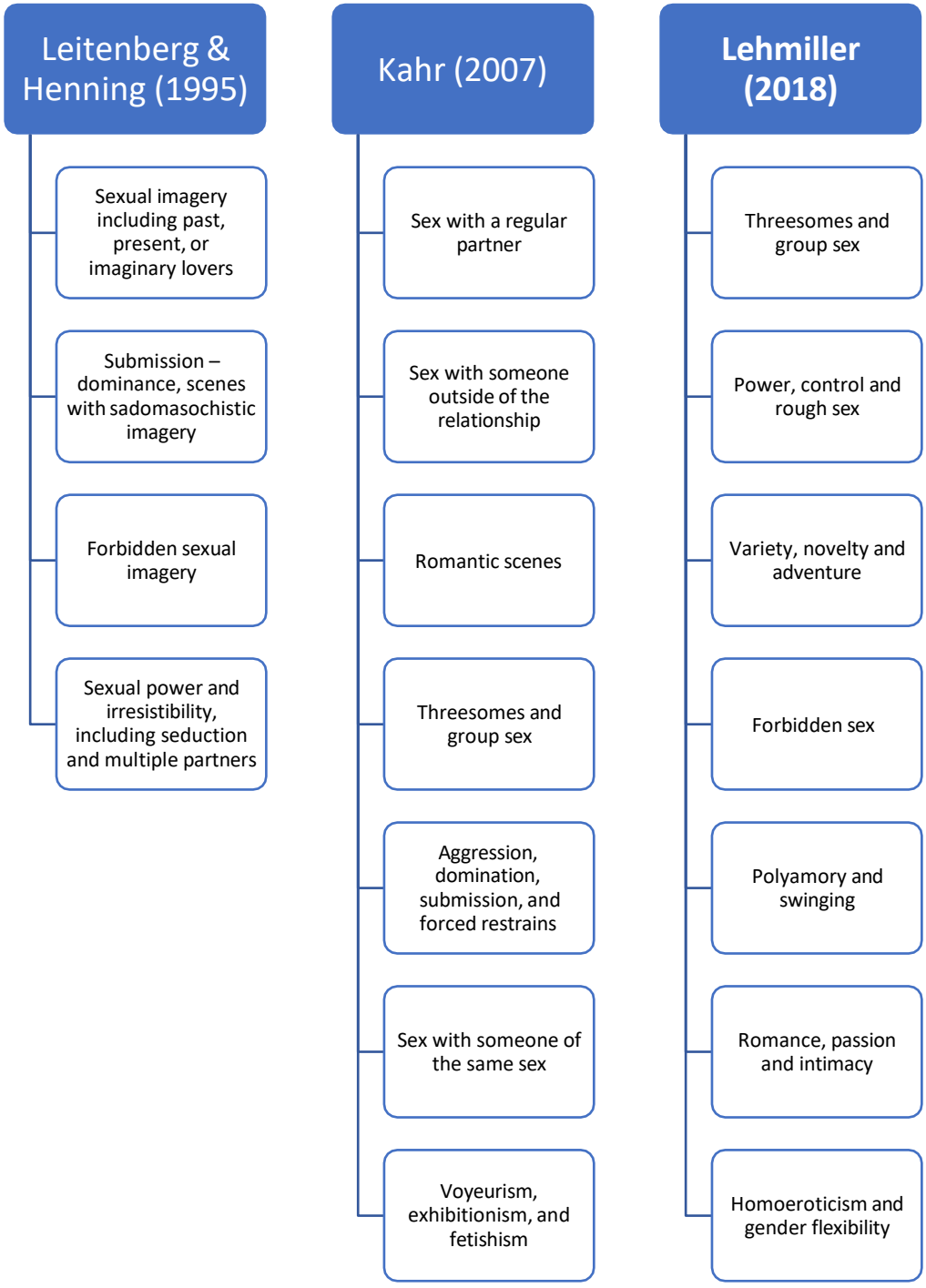
Another common sexual fantasy notable in the above studies relates to scenarios of power dynamics, force, control, restraint, discipline, punishment, degradation, seduction, and rough sex. Such fantasies are named differently by contemporary researchers including submissive fantasies, sadomasochistic fantasies, rape fantasies, forced sex fantasies, and

BDSM—an umbrella term referring to bondage, discipline, dominance, submission, sadism, and masochism (Kolmes et al., 2006; Levand et al., 2019).

Having discussed prevalence and content of the most common sexual fantasies identified in empirical research, we now discuss findings relating to the relationship between attachment style and content of sexual fantasy.

Figure 1

Most Common Sexual Fantasies by Thematic Type/Content



Sexual fantasy and attachment orientation

The reviewed literature indicates that there is a relationship between attachment history and people's sexual fantasies. The attachment system is understood to be the first socio-behavioural system (Cassidy, 1999); thus, it has been argued that it lies at the foundation of the sexual system of an individual (Birnbaum, 2007; Shaver et al., 1988).

Researchers in Israel conducted two studies (Birnbaum, 2007; Mizrahi et al., 2018) that focused on the interplay between attachment orientation and frequency and content of sexual fantasies. Birnbaum (2007) used two samples (n = 176; n = 115) and two different methodologies (20-item sexual fantasy checklist and an open-ended writing method) to reduce methodological biases. Mizrahi at al. (2018) used daily diary questionnaires for 42 days with both members of a 100-couple sample. Findings from both studies revealed that those who were identified as anxiously attached revealed a higher frequency of fantasising and the content of their sexual fantasies often included affectionate and intimate themes. These individuals tended to see themselves as affectionate, caring towards others, and sometimes helpless and cared for, as in submissive fantasies (Birnbaum, 2007). In contrast, avoidantly attached people fantasised less than non-avoidantly attached participants, and the content of their fantasies had limited intimacy and affection themes. Interestingly, attachment avoidance was also associated with submission themes; however, avoidant individuals saw themselves as humiliated and the other as hostile and distant in their sexual fantasies. In addition, a positive correlation was found between attachment insecurities and higher frequency of extradyadic fantasies.

The authors of both studies suggested that sexual fantasies may reflect the relational goals associated with attachment orientation of the fantasiser. Anxiously attached people are preoccupied with worries about their current relationship and the perceived distance of the partner. Reflecting this state, their sexual fantasies consist of scenarios where they feel desired and irresistible. Perhaps, the sense of closeness derived from sexual fantasies of anxiously attached people serves as a soothing function for anxiety stemming from relational insecurity. The relief of such fantasy, albeit temporary, might be related to the higher frequency of fantasising among anxiously attached individuals. In contrast, avoidantly attached people use distancing strategies in real life and in fantasy. For avoidantly attached people, closeness provokes anxiety; thus, the submissive sexual fantasies devoid of romance and affection can provide the route for the fantasiser to experience relief and pleasure bypassing the intimate aspect of sexual interaction.

Similar to Birnbaum's (2007) findings in Israel, Lehmiller's (2018) study in the US also revealed that 'insecure' people (as identified by the author) reported having sexual fantasies with romantic and dominance/submission themes. Lehmiller also viewed submissive fantasies as a route for a fantasiser to escape reality with its relational insecurities. However, in contrast to Mizrahi et al.'s (2018) findings that more insecurely attached people have more extradyadic fantasies, Lehmiller found that insecurely attached people had fewer fantasies involving nonmonogamy. Lehmiller argued that insecurely

attached persons fear abandonment and, therefore, their sexual fantasies would not include plots with potential triggers for jealousy or rejection unless the scenario placed the fantasiser at the centre of attention, as in romantic or submissive fantasies.

Sexual orientation and the object in sexual fantasy

Although most research on sexual fantasies focused on a heterosexual population, two reviewed studies included gay men and lesbian samples with the aim to compare the content of sexual fantasies between gay, lesbian, and heterosexual samples. The findings revealed that cross-orientation fantasies (same-sex fantasies among heterosexual individuals and heterosexual fantasies among those who identify gay or lesbian) were common. For example, Masters and Johnson (1979) interviewed 30 gay men, 30 heterosexual men, 30 lesbians, and 30 heterosexual women. The top five sexual fantasy themes were identified for each group. Cross-orientation fantasies ranked the third most common category for lesbians (sexual encounters with men); third most common category for gay men (sexual encounters with women); fourth most common category for heterosexual men (sexual encounters with men); and fifth most common category for heterosexual women (sexual encounters with women).

However, results from another study (Price et al., 1985) using self-administered questionnaires with 39 gay men, 31 lesbians, 39 heterosexual men, and 33 heterosexual women, revealed a different perspective. Participants in this study reported having sexual fantasies with a partner/s that aligned with their sexual orientation and no cross-orientation fantasies at all. Price et al. (1985) suggested that demographic factors in the samples might explain these different findings. Masters and Johnson's (1979) sample was diverse in terms of social backgrounds, whereas Price at al. recruited a mostly white college student sample. The authors seem to point towards normativity of the sample in relation to their explanation of normative expectations relating to sexual orientation aligning with the object of sexual fantasy. Alternatively, it is possible that difference in data collection methods may account for the difference in findings. Could the immediacy of Masters and Johnson's interview method have facilitated deeper levels of self-disclosure than a self-administered written questionnaire?

In other studies that did not include gay and lesbian populations, same-sex fantasies have been consistently reported by heterosexual people (Couture, 1976; Crepault et al., 1976; Person et al., 1989; Wilson & Lang, 1981), with the higher incidence of same-sex fantasies in heterosexual women than men. Leitenberg and Henning (1995) theorised that this gender difference between women and men may be related to the historical weight of taboo on male homosexuality in Anglo-Saxon cultures.

In 2018, Lehmiller introduced the term 'sexual flexibility' which he defined as the "willingness to deviate not only from our sexual orientation but also from what our culture and society have told us we should want when it comes to sex" (p. 75). Lehmiller used this concept to interpret his findings; his study revealed that 59% of women and 26% men who identified as heterosexual had same-sex fantasies. Echoing Leitenberg and Henning's (1995) explanation of this gender difference, Lehmiller suggested that women have a higher 'sexual

flexibility' and attributed this to social conditioning and historical criminalisation of male homosexuality.

Kahr's study (2007) revealed that heterosexual people who had never had a real-life experience with someone of the same sex, had frequent homoerotic fantasies; and gay men and lesbians who had never had a heterosexual experience had frequent fantasies about heterosexual encounters. Kahr highlighted the complexity of sexual desire and argued that in the realm of sexual fantasy, all the conventions and assumptions about human sexuality are challenged. Referring to 20 years of clinical experience as a marital psychotherapist, Kahr argued that sexuality is a not a "monolithic creation" (p. 154) and questioned if it is possible to have a clearly consolidated sexual identity. In contemporary times, the socio-cultural paradigm shift towards understandings of gender and sexuality constructs as fluid and non-binary destabilises notions of same-sex and heterosex as these are premised on the basis of binary notions of sex and of gender. As such, future research may reveal changes to the above findings, as discourses relating to governing and defining gender and sexualities change.

The findings here suggest that sexual orientation does not necessarily correlate with the object within sexual fantasy, and cross-orientation/sexual flexibility fantasies appear to be common.

Bondage, discipline, dominance, submission, sadism, and masochism in sexual fantasy

This section explores the empirical studies that focused on sexual fantasies containing force, domination, submission, and control. This category of fantasies is one of the most statistically common across the reviewed studies (e.g., Kahr, 2007; Lehmiller, 2018; Leitenberg & Henning, 1995). Therefore, understanding these fantasies can enhance our understanding of sexual fantasy in general.

BDSM fantasies include a diverse range of scenarios, from being blindfolded by a regular partner to a pain-inflicting scene in a dungeon. The intrinsic power exchange seems to be one of the main erotic elements of BDSM fantasies. The diversity of expression of eroticised power is reflected in the unique fantasies reported by participants in the reviewed studies. These include, for example, being forced to masturbate in front of an audience, being held against one's will and raped, or having bodily orifices penetrated by a figure of authority (Kahr, 2007) or being humiliated and used by a group as a sex object (Lehmiller, 2018). These scenarios appear to share an organising principle of power exchange. In this regard, someone is doing something to someone, and this dynamic is sexually arousing for many fantasisers with BDSM sexual fantasies.

Most respondents of the reviewed studies were clear that fantasies of coercion were exciting in fantasy only and were clear this was not to be confused with reality (Critelli & Bivona, 2008; Kahr, 2007; Lehmiller, 2018; Leitenberg & Henning, 1995; Shulman & Home, 2010; Ziegler & Conley, 2016; Zurbriggen & Yost, 2004). A review of over 30 years of research on women's rape fantasies (Critelli & Bivona, 2008) revealed that between 31%

and 57% of women enjoy fantasies of their own rape; and over 99% of women (Laumann et al., 1994, cited in Leitenberg & Henning, 1995) would find an actual rape repellent. Similarly, in Kahr's (2007) study, the experience of rape *fantasies* and the *reality* of rape was clearly differentiated, with only the former being pleasurable. In Lehmiller's study (2018), two-thirds of women and over half the men reported having forced-sex fantasies, but most emphasised the safety, consent, and full control of the fantasiser embedded in the fantasy. It seems that the imaginative aspect of fantasy, no matter how unusual and frightening, provides the safety that is necessary for intense sexual excitement experienced by the fantasisers with BDSM fantasies.

This review revealed that playing a submissive role in fantasy was found to be more common than playing a dominant role (Lehmiller, 2018; Kahr, 2007). Lehmiller (2018) suggested that relinquishing control and the responsibility that comes with it is what lies behind the desire of people to submit in their fantasy, and more people seem to prefer to let go of control than be in control—at least in the fantasy. It can be argued, however, that the submissive in the forced fantasy is actually in control, since they orchestrate the plot and assign the roles—who dominates them and in what way. Perhaps, the need to be wanted, paid attention to, looked at and/or cared for, may underlie a desire to submit, to be tied up, disciplined, restrained, and forced.

Discussion of findings

The findings revealed that sexual fantasy is a common experience for most people; one that often contains scenarios that challenge the dominant heteronormative and mononormative construction of sexuality, and include elements of forbidden and taboo. Sexual fantasies can often cause the fantasiser anxiety, guilt, and shame; and most people do not tell anyone about their sexual fantasies—sometimes not even themselves. Sexual fantasies appear to hold condensed information about a person's unique psychology, attachment history, object relations, and emotional longings and creative imagination; and thus, can be invaluable for psychotherapeutic exploration.

Non-normative and taboo sexuality

People's sexual fantasies often include dynamics and behaviours that transgress normative sexual practices. Sexual fantasy allows people to explore different sexual acts, gender roles, and partnerships that may not be available (or of interest) to them in their actual sexual life. Many respondents of the reviewed studies reported having fantasies that did not reflect their sexuality identity or sexual orientation; fantasies where their own gender identity or expression was changed, and involved a variety of extradyadic sexual relations (threesomes, foursomes, and other group configurations, polyamory, and swinging). Most important is the finding that the most common sexual fantasies transgress normative heterosexual monogamous practices and expectations and, as such, may be thought of as somehow 'taboo' or 'forbidden' for the fantasiser. A high number of reported fantasies included submission, domination, sadism, masochism, voyeurism, exhibitionism, and fetishism—activities often framed as 'taboo' or 'forbidden'. The definition of taboo is constantly evolving, reflecting ongoing changes in socio-medico-legal discourses. Thus, one might anticipate fantasies within specific time periods and cultural contexts to be more or less

forbidden and, therefore, more or less exciting/common. It does seem that 'taboo and forbidden' elements show significant presence in adult sexual fantasies.

In summary, this research suggests that the prevalence of sexual fantasy and the rich and imaginative diversity of scenarios that people employ for sexual pleasure is an ordinary part of human experience.

Is sexual fantasy healthy or pathological?

The pathologising and de-pathologising of sexual desire has been a constant struggle in psychiatry (De Block & Adriaens, 2013) and, historically, the presence of certain sexual fantasies was viewed as a sign of a psychiatric condition (Lehmiller, 2018). It is notable that in the DSM-5 (APA, 2013), presence of specific sexual fantasies appears as one of the diagnostic criteria for the eight paraphilic disorders: 'voyeuristic disorder 302.82 (F65.3)', 'exhibitionistic disorder 302.4 (F 65.3)', 'frotteuristic disorder 302.89 (F65.81)', 'sexual masochism disorder 302.83 (F65.51)', 'sexual sadism disorder 302.84 (F65.52)', 'paedophilic disorder 302.2 (F65.4)', and 'transvestic disorder 302.3 (F65.1)'. This points to the construction of particular sexualities, sexual behaviours, and practices through medico-scientific-psychological discourses and knowledge; and the role of such fields of practice in constituting that which is 'normal' or 'healthy' and that which is considered a mental health disorder. Interestingly, an absence of any sexual fantasy experience has also been viewed as a sign of psychopathology. For example, 'female sexual interest/arousal disorder 302.72 (F52.22)' and 'male hypoactive sexual desire disorder 302.71 (F55.0)' both have absence of sexual fantasy experience as a defining criterion (APA, 2013). Thus, it seems that the presence of particular kinds of sexual fantasy or the absence of any sexual fantasy has been constructed in the psychological and medical discourses as associated with something problematic.

The inconsistency of viewing sexual fantasy as pathology, on the one hand, and as a sign of psychological health, on the other, is illustrated by the interpretation of one of the main empirical findings by Leitenberg and Henning's (1995) study on sexual fantasy. Findings revealed a correlation between sexual fantasy experience and sexual satisfaction; people with frequent sexual fantasies had more fulfilling sex lives than those who fantasised less. The authors argued that this finding disproved Freudian (1908/1962) theorising about the unhappiness of people who fantasise. Thus, empirical research challenged a traditional understanding of sexual fantasy in psychoanalysis as a sign of deprivation, immaturity, and deficiency. This juxtaposition relates specifically to the ongoing debate in psychiatry about what is considered normal and pathological in a general sense, and what constitutes 'normal sexuality' versus 'abnormal sexuality' (De Block & Adriaens, 2013).

Limitations of this study

In this paper we focused on empirical research on sexual fantasy. Quantitative studies can be methodologically limited by the recruitment and sampling procedures, data interpretation, and generally by demographic composition. The three main studies on sexual fantasies reviewed in this chapter derived data from democratic Westernised regions and cultures of the world—the UK and US (Kahr, 2007; Lehmiller, 2018; Leitenberg &

Henning, 1995). This is likely to constrain and influence research findings, and questions of transferability of these understandings across cultures and regions of the world are to be considered.

Samples from the studies reviewed were also limited in terms of relative lack of inclusion of sex, sexuality, and gender diverse participants. The findings should, therefore, be considered in light of the over-dominance of 'normative sexualities, genders, and sexes' along binary lines within the samples. This may lead to skewed understandings that are not applicable across diversity of sexualities and genders, particularly in relation to that which was understood by researchers to be taboo or forbidden. It may highlight the need for more research to explore the sexual fantasies of those who transgress normativity through their lived experiences of identifying as sex, sexuality, and/or gender diverse.

Conclusion

In this paper we presented a brief historical overview of sexology and discussed themes that were identified in a review of empirical sexology research on sexual fantasies. The studies that were included in this review indicated that 90-97% of people regularly experience sexual fantasies, and sexual fantasies often contain violence, group sex, dominance, submission, voyeurism, and exhibitionism, as well as romantic scenes (Kahr, 2007; Lehmiller, 2018; Leitenberg & Henning, 1995). The review revealed that there may be a connection between attachment style and frequency and content of sexual fantasies, and that the gender of the object of sexual fantasy cannot be assumed to align with the individual's expressed sexual orientation or sexuality identity. The review of literature on BDSM fantasies revealed that the scenarios and content of fantasies containing forced sex, constraints, and control is wide-ranging and unique; and the organising principle relates to exchange and configurations of power. There is clear differentiation between having a coercive fantasy that arouses pleasure and the reality of an unwanted violation of the lived experience of sexual coercion.

We explored how sexual fantasy has been understood and interpreted in the field of sex research, recognising the limitations of this knowledge being derived from Western democratic socio-cultural regions of the world, within a specific period of history, and from samples that are over-represented in terms of normative sexual and gender identities. In the review of the literature, sexual fantasy was found to be an ordinary and common part of human experience, and thus a critical area of awareness for psychotherapists and psychological practitioners. Our hope is that this review may support psychotherapy and other mental health practitioners to understand the significance, diversity, and complexity relating to understandings of sexual fantasy.

Table 3
Glossary

Aberrant	Deviating from the usual or natural type ("Aberrant", n.d.)
Dominatrix	The term refers to a woman who physically or psychologically dominates her partner in a sadomasochistic encounter ("Dominatrix", n.d.)
Exhibitionism	A form of sexual behaviour involving exposure of one's genitals to unsuspecting person ("Exhibitionism", n.d.)
Fetishism	An ability to experience sexual arousal from an animated object, activity, or a part of the body (Kahr, 2007)
Homoeroticism and Gender-Bending	A desire for flexibility with respect to one's gender and/or sexual orientation (Lehmiller, 2018)
Paraphilia	A pattern of recurring sexually arousing mental imagery or behaviour that involves unusual and especially socially unacceptable sexual practices (Merriam-Webster, n.d.a)
Polyamory	A relational paradigm based on consensual, multiple affective, and sexual relationships (Ferrer, 2018)
Swinging	A form of consensual nonmonogamy that involves an exchange or swapping of romantic partners (Lehmiller, 2018)
Voyeurism	The practice of obtaining sexual gratification from observing others" (Merriam-Webster, n.d.b)

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Paper 17 (2021)

Exploring hidden assumptions of culture in child psychotherapy in Aotearoa New Zealand: A hermeneutic literature review

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Child psychotherapists in Aotearoa New Zealand work in diverse settings with children, young people, and families from a variety of cultures. Our nation's colonial history and its impact on society are factors which necessitate a critical perspective of how culture influences every aspect of our work. International research has identified an urgent need for the child psychotherapy profession to consider the implications of cultural difference carefully, while in the Aotearoa New Zealand context, concerns have been raised about the dominance of Western-based models of practice to the exclusion of other approaches. Failure to meet the needs of Māori clients and practitioners was one of the risks associated with psychotherapy remaining "monocultural", according to Hall et al. (2012); a view echoed by Professor Keith Tudor who said, "to realise the value of psychotherapy in New Zealand, we need more Indigenous knowledge, social-cultural analysis and diversity in the workforce" (AUT, 2019). The question I (the first author) set out to explore in the dissertation on which this paper is based (Cadogan, 2021) was: How do assumptions about culture influence therapeutic practice in child psychotherapy in Aotearoa New Zealand? A natural starting point seemed to be a critical evaluation of the origins of child psychotherapy. This paper presents firstly this evaluation, and secondly an alternative to the Western perspective.

The origins of child psychotherapy: Classical psychoanalysis

When I consider the cultural tradition and background of child psychotherapy in Aotearoa New Zealand, I visualise a waterway, beginning with a single river. The single river originates in Europe in the late 1800s and early 1900s, where Sigmund Freud laid the foundations of psychoanalysis in what became known as "classical psychoanalysis" (American Psychological Association, 2015) or "Freudian classical theory" (Ahmed, 2015). Psychoanalysis is considered the theoretical and clinical discipline that underpins child psychotherapy (Likierman & Urban, 2009). Although it started out with the classical theories of Freud, psychoanalysis quickly developed into a series of tributaries, sometimes deviating, sometimes coming together to join other tributaries, at times enriching each other with their theoretical and clinical findings, at times challenging each other for supremacy, resulting in contemporary psychoanalysis which has several streams. However, it is primarily the classical psychoanalysis of Freud with which I am concerned, and to which I refer, in this research, as its influence on child psychotherapy training in Aotearoa New Zealand remains prevalent.

Amongst other intellectuals of his time, Sigmund Freud offered a secular alternative to the world view previously dominated by religion. Freud drew attention to aspects of human nature such as sexual desire that had hitherto been problematic for Christianity, and went so far as to suggest that lifting of sexual repression would make society a better place (Freud, 1917/1963). Freud saw psychoanalysis as an empirical discipline, a science, which could provide a trained analyst with the means to access the inner workings of the mind (Mitchell & Black, 1995). Freud referred to psychoanalysis as "the dissection of the psychical personality" (Freud, 1933/1964, p. 57), where the primary subject of study was unconscious mental activity. Through his clinical work, Freud realised the intensity of the needs and wishes of children, something that previously had not been acknowledged. Freud was able to identify the child's powerful desire for love and satisfaction of bodily instincts, and he recognised how these needs were met or otherwise could have a significant impact on mental wellbeing throughout the lifespan.

Freud's work occurred against the backdrop of Europe's imperial and colonising enterprises around the world, and the anthropological studies of new populations returning from the new colonies. These European encounters with new peoples were imbued with elements of a discursive framework grounded in European ideals about humanity and the nature of human society, including terms such as "savage" and "primitive" (Brickman, 2017). One of the major criticisms of classical psychoanalysis is that colonial and imperial narratives of Western superiority, and the resulting derogatory racist projections, are inescapably embedded in its internal structures and working assumptions (Brickman, 2017; Frosh, 2013; Mattei, 2011).

For example, near the beginning of his paper on "Totem and taboo", Freud (1913/1950b) writes:

> There are men still living who, as we believe, stand very near to primitive man, far nearer than we do, and whom we therefore regard as his direct heirs and representatives. Such is our view of those whom we describe as savages or half-savages; and their mental life must have a peculiar interest for us if we are right in seeing in it a well-preserved picture of an early stage of our own development. (p. 1)

Frosh (2013) argued the common use of the terminology "primitive" in classical psychoanalytic language highlights and reproduces a colonial division between primitive and civilised, suggesting that psychoanalysis equates Western culture with progress and rationality. Frosh also proposed that colonialism and racism remain deeply embedded in psychoanalytic thinking and language, and impact contemporary theory and practice in ways that are not necessarily apparent.

Diverging from psychoanalysis

Following on from the prolific and pioneering work of Sigmund Freud, some of the main early contributors to psychoanalytic work with children were Anna Freud and Melanie Klein. Both had their own unique perspective about child development and psychic functioning, and both played significant roles in developing psychoanalysis for children based on the

platform established by Freud. In the period between 1942 and 1944, growing divergence in ideas about theory and technique led to the branching of classical Freudian psychoanalysis into three main tributaries or schools. One school followed Anna Freud becoming known as the "Freudians"; one followed Melanie Klein becoming the "Kleinians"; and the middle group, who came to be known as the "Independent" group, were made up of others, eventually including Winnicott (see Hernandez-Halton, 2015, for a contemporary summary of these events). The first child psychotherapy training was established at the Tavistock Clinic in London, England, in 1948 by John Bowlby and Ester Bick, and became a new profession within the British National Health Service (Rustin, 1999). Bowlby had links to Kleinian and Freudian influences, as well as those outside psychoanalysis, and his research and practice while working at The Tavistock Clinic eventually led to attachment theory. For her part, Ester Bick pioneered infant observation, which remains a cornerstone of child psychotherapy training (Sternberg, 2005), as part of her role in leading the first child psychotherapy training programme established in 1948.

Training programmes in Aotearoa New Zealand for child psychotherapists have had a rocky history, with stops and starts creating a discontinuous supply of professionals for the workforce. The orientation of the training has experienced fluctuations and variations, with incorporations of international theoretical developments from over the past two to three decades. Despite the fluctuations, many of the orthodox, classical psychoanalytic foundations have been retained (Tischler, 2009). So, what are some of the broader, ontological, epistemological, and ideological aspects of the Western tradition?

Revealing the "Western" in child psychotherapy

To unmask what Western culture is, and how it influences orientation to practice, it is necessary to start at the metaphysical level. How we conceive of ourselves, relationships with others, society, the natural and spiritual worlds, all determine how we perceive and act in relation to those with whom we work. Diverse cultural groups hold vastly different views about what constitutes a person, and the extent to which that entity exists, or not, in relation to the wider fabric of society, the environment, and the cosmos. One of the doctrines deeply entrenched in the Western worldview, and its associated knowledge system, is positivism.

Positivism and science

Positivism is a philosophical theory which asserts objective "things" exist in the world prior to and separate from individual humans, who, in turn, exist prior to, and separate from, society (Dalal, 2011). Positivism presumes that with sufficient objectivity, rigour, and experimentation, value-free observers can uncover facts and data, which are then equated with truth and knowledge (Grant & Giddings, 2002). In a positivistic framework, scientific verification is considered the gold standard for deducing knowledge, theory, and practice; and science is the only way to find truth.

As we have already seen in relation to the classical psychoanalysis of Freud, there was a desire to empirically investigate, and dissect in an almost surgical way, the contents of the mind. Freud came from a medical background; he trained as a neurologist and had a wish to

create a scientific psychology or, in his words, "to furnish a psychology that shall be a natural science" (Freud, 1950b, p. 295). Although much has changed since the early days of classical psychoanalysis, much has stayed the same. The contemporary push for "evidence-based practice" models in psychotherapy and other disciplines exemplifies the continued dominance of the positivist paradigm. A few treatment modalities utilised in some child psychotherapy settings such as Cognitive Behavioural Therapy (CBT) and mentalisation-based treatments have followed the scientific path, generating many empirical studies and resulting in research that lays claim to evidence-based practice. Cognitive behavioural therapy, in particular, has developed a dense evidence base, which is now being critiqued for its hyper-rational take on human suffering and denial of its own cultural embeddedness (Dalal, 2018). Dalal (2018) asserted "CBT has joined forces with the pharmaceutical industry and psychiatry in their project or medicalizing ordinary human suffering and then selling (patented) treatments for that suffering" (p. 7). The research that contributes to the evidence base has also been criticised for neglecting 95% of the world's population; and it has been argued that psychological research focuses on American subjects who make up only 5% of the world's population (Arnett, 2009).

Positivism also pervades the Western perspective of human subjectivity, which I will refer to simply as subjectivity for simplification. It is not something we necessarily give much specific thought; but, it plays a critical role in how we conceptualise ourselves, our clients, and the therapeutic process.

Subjectivity

Western societies typically view human beings in an atomistic way—as discrete, physically bounded entities. The following description by Geertz closely captures what my Western cultural heritage has impressed upon me about the nature of selfhood and how our subjectivity is conceived:

> The person as a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic centre of awareness, emotion, judgement and action organized into a distinctive whole and set contrastively against other such wholes and against its social and natural background. (as cited in Christopher, 1999, p. 142)

While this approximates my own, personal experience of Western subjectivity, it has been stated that "subjectivity is no timeless, cultureless essence of personhood, but a cultural artefact that mutates over time" (Taylor, 2012, p. 195). The notion of an inner self, as expressed above, has been deemed a construction of Western modernity, and contrasts with a pre-modern "extensive" self, which was rooted in communal life (Taylor, 2012). In the Western world, modernity also brought with it a new fascination with the internal, deep interior of persons—the realms of private, psychological subjectivity. Freud was part and parcel of the surge of interest in the hidden marvels of the human mind, a renewed focus on interiority. However, more recently, within the domain of psychoanalysis, the assumption that an individual "self" exists and interacts with other discreet individual selves has been called "the myth of the isolated individual mind" (Stolorow & Atwood, 1994, p. 233). It is noted:

> Invariably associated with the image of mind is that of an external reality or world upon which the mind entity is presumed to look out. Here too we encounter a reification, in this

> case one involving the experience of the world as real and existing separately from the self. (Stolorow & Atwood, 1994, p. 236)

The concept of a discrete inner self is a Western notion, at odds with the perspectives of many diverse cultural groups, prompting Cushman (1990) to warn that ignoring the ethnocentric discourse of the current Western conceptualisation of self, would be to participate in "culturally disrespectful and damaging psychological imperialism" (p. 599).

Individualism

Individualism is a term that has been used to describe the tendency for Western psychology to view the individual as the primary reality, a self-possessive entity with responsibility for its thoughts, emotions, and behaviours (Ingle, 2018). Dalal (2016) highlighted that individualism tends to be the prevailing outlook in almost all psychotherapies, placing the intra-psychic world of the individual at the heart of assessment and treatment which is focused primarily on the individual. Individualism has also been deemed the dominant cultural outlook in a range of other disciplines spanning many decades (Christopher, 2001; Christopher & Smith, 2006; Roland, 1996; Sampson, 1977; Taylor, 2012; Waterman, 1981).

Christopher (1996) has suggested that individualism confers what the self is, and what it should become, concluding that individualism is a "moral vision" for Western culture and Western approaches to counselling. As a moral vision, Christopher asserted that individualism makes assumptions about what constitutes a good or healthy person in a psychological sense. Wellbeing is associated with "autonomy, environmental mastery, positive relations with others, purpose in life, personal growth, self-acceptance, happiness and the freedom to live life as one sees fit" (Christopher, 1999, p. 149). These moral visions are then implicated consciously or unconsciously in our practice (Christopher, 1999). Moreover, Roland (2006) suggests Western therapists "are often unaware of deeply embedded cultural assumptions of individualism in their psyches and in psychoanalytic and psychological theories and norms" (p. 454).

Western developmental perspectives

From Sigmund Freud's body-based sequential unfolding of instinctual drives to Mahler's (1971) model of separation-individuation, ideas and concepts about child development and links to psychopathology pervade psychoanalytic theory and practice (Fonagy & Target, 2003). Each school has its own meta-psychological perspective about the nature of mind and subjectivity, how psychological functions and structures are established, and the mechanisms that contribute to "normal" or "abnormal/atypical" development. Roland (2006) has asserted that "psychoanalytic norms of development and functioning are more Western-centric than most analysts realize regardless of their psychoanalytic orientation" (p. 456).

Freud's earliest theory of development was a "psychosexual" stage model, where the maturing body was viewed as the predominant driver of mental life. Within this model, a central feature of psychological development was the "Oedipus complex", the successful resolution of which was one of the key psychological tasks of childhood. The Oedipus complex involves a hypothetical triadic relationship between parents and a child, which Freud (1909/1950a) once described as a "family romance". However, almost every aspect of

the Oedipus complex, as described by Freud, has been challenged; and the concept, its viability, and cross-cultural relevance remains a subject of debate (Bhugra & Bhui, 2002; Fellenor, 2013).

Following Freud, some of the early models and ideas about development stemmed from work with children who had been separated from parents in Britain during World War II. In particular, the works of John Bowlby and Mary Ainsworth had a significant impact on child psychotherapy; in part, because Bowlby was one of the founders of the Tavistock child psychotherapy training programme in Britain.

Drawing on a diverse range of disciplines such as ethology, biology, animal behaviour, and psychoanalysis to create an over-arching model describing how our earliest relationships are established and maintained, the partnership between John Bowlby and Mary Ainsworth led to the body of knowledge we now know as attachment theory (Ainsworth & Bowlby, 1991). Attachment theory introduced the idea that there are different patterns of relating—such as "secure" and "insecure"—to principal caregivers (Ainsworth et al., 2015). The concept of the attachment figure as a "secure base" from which children could venture out to explore and return was also introduced as part of attachment theory, the concept credited to Mary Ainsworth (Bowlby, 2005). Bowlby (2005) also applied the secure base concept to the role of the therapist, saying one of the key functions of the therapist was: "to provide the patient with a secure base from which he can explore the various unhappy and painful aspects of his life, past and present" (p. 156). Attachment-based interventions for young children have been used extensively in child psychotherapy, historically and today, including "Child Parent Psychotherapy" (Lieberman & Van Horn, 2008), and "Circle of Security" (Cooper et al., 2013). Interventions building on attachment theory have also been developed, including a range of "mentalisation" based treatments, where secure attachment is viewed as the developmental and therapeutic context for reflection about mental and emotional states (Fonagy et al., 2002; Midgley et al., 2017; Midgley & Vrouva, 2012).

However, attachment theory has been criticised for emphasising Western ideals of autonomy, individuation, and exploration; and being generally "laden with Western values and meaning" (Rothbaum et al., 2000, p. 1093). Keller et al. (2017) argued that attachment theory holds a distinct conceptualisation of infants, which they refer to using the acronym "WEIRD", to describe the "Western, educated, industrialized, rich, democratic" people often used as research subjects. Other authors, such as Morelli et al. (2017), suggested that by omitting the critical dynamic interplay between socio-cultural and ecological processes in the attachments that children develop, attachment theory fails to recognise the profound differences in child care around the world. Dalal (2006) has submitted that "each cultural system will generate its own forms of attachment, which legitimate different ways of being together" (p. 143).

This assertion has been supported by research on attachment patterns in different settings. For example, Rothbaum et al. (2000) found fundamental differences in conceptualisations of maternal sensitivity and child security between Japanese and American cultures. Adult attachment pattern ideals have been found to differ between Taiwanese and American cultural contexts (Wang & Mallinckrodt, 2006). In our own local context—Aotearoa New Zealand—the importance of connections beyond the interpersonal have been highlighted in

Māori attachment systems (Fleming, 2016, 2018). For a summary of research that has demonstrated cultural variations in attachment, see Rothbaum and Morelli (2005).

Other models of development that are prevalent in child psychotherapy training and practice have also been subject to scrutiny. A critique by Cushman (1991) of Daniel Stern's (1985) theory of infant development highlights some of the ways Stern reinforced contemporary Western discourse and ideas about the nature of self and the extent to which his theories and observations could be applied to other contexts. Cushman argued that Stern had preconceived ideas about the nature of the self, suggesting that Stern's "ontological frame of reference causes him to see the masterful, bounded self wherever he looks. He is accustomed to seeing it because it is in the cultural clearing. He sees it before it is constructed" (Cushman, 1991, p. 210). Furthermore, Cushman argued that due to the popularity of Stern's psychological theory with psychotherapists and parents, the theory itself was influential in actively constructing the Western notion of self.

The tendency for human development theories to become popular based on the extent to which they resonate with existing cultural beliefs has been examined in compelling commentary by Kirschner (1990). Kirschner suggested the theories that become "classics" are those which adhere to and expand existing cultural ideals about personhood. Specific "Anglo-American" ideals are identified, namely self-reliance, self-direction, and verbal expression; and Kirschner showed how these attributes are emphasised in the three main schools of psychoanalytic thought at the time. Kirschner pointed out that Margaret Mahler's highly influential theories about child development (Mahler, 1963, 1971) were not finding favour in Vienna, and it was only when Austrian-born Mahler began working in America that her ideas gained support and backing. This is attributed to themes of individuation, independence, and self-direction found in Mahler's work which mirrored some of the existing cultural ideals of personhood present in American society and favoured by her American colleagues due to their own "ingrained ethnopsychological concerns" (Kirschner, 1990, p. 856). Cross-cultural comparisons show American and Japanese mothers encouraging opposing ends of the individuation/independence continuum with their 20- to 23-month-old toddlers, with Japanese mothers encouraging dependence rather than independence, indicating a culturally patterned style of relationship rather than one that is universal across cultures (Roland, 1996).

Despite the continued provision of psychodynamic accounts of child development with titles such as "*Normal Child & Adolescent Development: A Psychodynamic Primer*" (Gilmore & Meersand, 2014), which claim to be consistent with contemporary scientific thinking, others suggest that development follows diverse trajectories, is profoundly shaped by culture, and, therefore, that child mental health cannot be addressed separate from the context of their families and wider communities (Guzder & Rousseau, 2010). Furthermore, it has been pointed out that complex power dynamics that lead to inequality should be factored into psychological development models (White, 2006). Some authors propose that psychoanalytic development theories need to embrace non-linear, dynamic paradigms to remain relevant and useful (Galatzer-Levy, 2004; Gilmore, 2008).

Alternatives to the Western perspective

A frequent critique of Western knowledge systems that underpin the child psychotherapy framework in Aotearoa New Zealand is that phenomena pertinent to the therapeutic relationship (e.g., self, other, wellness, distress) are decontextualised, individualised, and wider relationships and connections ignored. An alternative perspective to the positivistic one that pervades Western society began emerging during the course of my research, one that drew on social constructionism and cultural constructivism.

In psychology, social constructionism emerged in the work of Gergen (1973), although it is credited with having a multidisciplinary background as an overall theoretical orientation (Burr, 2015). In contrast to positivism, social constructionism asserts that we construct our own versions of reality, that the principles and concepts we use to make meaning of the world are not universal but are culturally and historically specific (Burr, 2015).

Cultural constructivism was a term used by Gaines (1992a) as a means to contrast his own perspective from other anthropological approaches that critiqued Western medical knowledge and theory. Gaines (1992a, 1992b) asserted that psychiatry and psychiatric systems were culturally constructed, an idea I will pursue later in this chapter.

These two related perspectives—social constructionism and cultural constructivism—provide a lens through which the taken-for-granted assumptions about Western culture can be revealed and examined in a more critical light as they relate to the theory, training, and practice of child psychotherapy in Aotearoa New Zealand.

The tendency of Western psychotherapies to view the psychological subject in individualistic and decontextualised terms has been mentioned previously (Ingle, 2018). However, according to Dalal (2002), "minds do not exist in isolation, they exist with other minds in psycho-social contexts" (p. 129). Drawing on the work of Norbert Elias, Dalal explained how individuals cannot exist outside societies and the inherent power relation, and how the psyche and society are joined in a union where they simultaneously and mutually construct each other.

Similarly, Woodard (2008) suggests that the concept of self "is as much a socio-political construct as it is an internal experience" (p. 58). In addition, Bowden (2000) proposes that the notion of a distinct individual psyche is problematic for psychotherapists in our local context, because for many Māori there are inextricable links to the group, society, and other cultural features which cannot be separated from an individual's psychological state. The following quotation reinforces this position:

> Māori people would regard someone who is independent and directed by his or her own thoughts and feelings as a person in a very bad way. Independent living and feeling, and regarding yourself as sufficient as an individual is very unhealthy in Māori terms. (Durie & Hermansson, 1990, p. 112)

In relation to Māori, it has been observed by Smith that "the individual was not considered to be the chief agent determining his 'own' life, nor was he considered to be altogether

responsible for his experience" (as cited in Sampson, 1988, p. 17). Similarly, Woodard (2008) suggests that the concept of an Indigenous self can be better represented as ecological "selves" which are "co-created through interconnected, symbiotic relationships with the land and other physical resources" (p. 28).

Both Gilgen (2016) and Woodard (2008) connect the colonising process in Aotearoa New Zealand to the way in which self has been constructed, or rather re-constructed, for the Indigenous peoples of Aotearoa since the arrival of European settlers. Woodard states, "the Western notion of self was used to subjugate and oppress Indigenous populations for exploitation. The unthinking continuation of these models via psychotherapeutic relationships facilitates the ongoing oppression of Indigenous Peoples of Aotearoa" (p. 59). Woodard described how the colonising ideology disrupts the experience of indigenous "selves", creating an objectified "Other" which is internalised. The result is an objectified and divided self. Woodard suggests that, at some level, "conceivably all psychological issues for Māori stem to some extent from an objectified and divided self" (p. 57), asserting that whakamā and mate Māori are manifestations of the experience of the alienated and divided/fragmented sense of self which results from the internalisation of the objectified "other".

Wellbeing, distress, and healing in cultural context

The critical constructionist/constructivist perspectives counter the reductionist and essentialist tendencies of Western biomedicine and psychology, arguing that there are no universal principles underlying human nature, human behaviour, wellbeing, and distress; and that our understandings are simply products of our culture and place/time in history (Burr, 2015). For example, common Western psychological concepts such as "wellbeing" are not necessarily transferrable cross-culturally, and have been criticised for their assumption of universality and focus on the individual while negating more holistic aspects for indigenous peoples, including Māori (Cram, 2014; Durie, 2006). Māori-specific measures of wellbeing, outlined by Durie (2006), included the need to consider multiple levels of wellbeing, including the individual, whānau, and population. Māori psychotherapy practitioners have also conveyed that the rights and needs of the individual are inseparable from those of the whānau, hapū, and iwi (Hall et al., 2012). Although Whānau Ora has been firmly established as a revolutionary social policy innovation aimed at improving wellbeing of Māori (Boulton, 2019), historically there has been little attention given to essential aspects of Māori mental health in counselling and psychotherapeutic theory and practice (Durie & Hermansson, 1990). Some of these key ingredients of wellbeing, such as Mauri, are culturally based concepts that Western, reductionist approaches can work against (Durie & Hermansson, 1990).

A similar incongruence arises where Western systems deem certain behavioural phenomena associated with distress "psychopathology", while the same constellation of behaviour may be deemed rational and in keeping with the specific worldview for other cultural groups. For example, in our own local context, mainstream explanations for suicidality favour biomedical or contextual factors (e.g., depression, inter-personal relationships etc.). But for some Māori, suicidal behaviour can be linked directly with unresolved collective grief

following cultural trauma (Lawson Te-Aho, 2013). Within a Kaupapa Māori framework, suicide has been viewed as a manifestation of disconnection, an outcome of colonisation, the loss and discontinuity of whakapapa, as "a physical end to spiritual suffering" (Lawson Te-Aho, 2013, p. 64). The Māori youth suicide rate is almost three times that of non-Māori (Snowdon, 2017) and this is not a recent or isolated finding. High Māori suicide rates are framed as the result of the trauma of colonisation transmitted through generations (Farrelly et al., 2006). It has been argued that for Māori, suicide cannot be conceptualised at an individual level, because collective trauma at the group level is indistinguishable from trauma at the individual level (Lawson Te-Aho, 2013).

This belief is consistent with the growing body of international knowledge around what are termed "collective soul wounds" (Duran et al., 2008), historical or intergenerational trauma. These terms relate to the damage done to the physical, spiritual, and psychological lifeworld of a group of people due to historical events including colonisation. Distress and the impact of trauma can transfer from one generation to the next; in imperceptible ways, "images and fragments of traumatic and violent scenarios are transported from one generation's unconscious to that of another, leading to cycles of repetition and retaliation, restricting one's freedom to imagine alternatives and inhabit alternative positions" (Auestad & Treacher Kabesh, 2017, p. 1). While trauma-informed care and trauma-based interventions are flourishing in psychotherapy and other modalities, trauma is generally still conceived of at an individual level, despite growing research on collective trauma on a wider scale (Brave Heart & DeBruyn, 1998; Duran, 2006; Duran & Firehammer, 2016; Duran et al., 2008; Grayshield et al., 2015). Furthermore, targeting therapeutic work at the level of the individual tends to overlook factors such as prejudice, discrimination, and disparities in health, education, and employment (Sue et al., 2019).

As the problematic nature of a monocultural, ethnocentric approach to health becomes more apparent, calls are mounting for Western counselling and psychotherapies to embrace and integrate the wisdom of Indigenous healing traditions (Bojuwoye & Sodi, 2010; Sue et al., 2019). Non-Western Indigenous healing traditions tend to have a more holistic approach to health and wellbeing which favours the interrelatedness of spirit, mind, and matter; and where persons are not separated from the group, the environment, or the cosmos (Sue et al., 2019). These traditions have been in place since the beginning of time, with all societies and cultures developing their own conceptual models of illness, distress, and healing (Gone, 2010; Solomon & Wane, 2005). Examples from our local environment illustrate how collaboration between Indigenous and Western traditions can work well for children and young people (Bush & NiaNia, 2012; NiaNia et al., 2017). Caution is needed, however, so that Indigenous knowledge and healing is not also colonised by Pākehā understanding (Bell, 2007; Jones, 2001).

Child, childhood, and adolescence as cultural constructions

Just as understandings of wellbeing, distress, and healing have been cast as social and cultural constructions, the classification and sub-classification of children themselves (e.g., neonate, infant, child, adolescent) in Western society and institutions can also be viewed as social constructions. Notions of "child", "childhood", and "adolescence", and the associated

values, are so ingrained in Western vernacular that we do not stop to question the extent to which they represent universal phenomena. The physiological immaturity of children may be considered undeniable; however, the way this immaturity is understood and dealt with by communities has been deemed a "fact of culture" (Prout & James, 1997, p. 7). Extensive research and literature from sociology and anthropology, in particular, has shown the extent to which cultural difference determines our conceptualisations of children, with a suggestion that "the idea of a universal child is an impossible fiction and that children's lives are influenced as strongly by their culture as by their biology" (Montgomery, 2008, p. 15). The way childhood is conceptualised has changed radically, even in the last 100 years, with many authors suggesting that the Western concept of childhood is socially, politically, and historically constructed (James & Prout, 2014; Maitra & Krause, 2015; Timimi, 2010) and, therefore, liable to change across time (Prout & James, 1997). Ideals and expectations about how children should develop; be socialised; what constitutes "good" care versus what might be deemed harsh, harmful, or abusive, are all facets of cultural context.

For example, the term "adolescence" or "adolescent" may seem uncontested to those of Western origin, as adolescence and teenagers are familiar concepts to us; however, one does not have to look very hard to discover that this position is not universal. For example, Tupuola (1993) found that youth living in Aotearoa New Zealand who had been born in Samoa were unfamiliar with Western conceptualisations of "adolescence", as one participant described:

> I believe the concept adolescence is a European concept as many palagi generally do things individually and they have the opportunity to live on their own and choose what they want to do without interference of other people and are not bonded to care for their elders. (p. 308)

Another participant explained that in Samoan culture, young people are not treated as an adult until they are deemed responsible enough, until they have proved themselves; hence adolescence as an arbitrary phase between childhood and adulthood "is foreign to our culture" (Tupuola, 1993, p. 311).

Tupuola (2004) found young women of Samoan descent were critical of models of adolescent identity that were linear in terms of cultural and personal identity development. For these young women, adolescent identity status was not a matter of reaching a particular point in a stage-like model; rather, it was felt adolescent identity was more a "sociocultural and political construction that is temporary and transient in nature" (Tupuola, 2004, p. 96). New technologies and research of the 20th century have been applied to childhood and influenced our thinking about children contributing to what has been deemed "a growing imposition of a particularly Western conceptualization of childhood for all children" (Prout & James, 1997, p. 9).

Emotional experience as a cultural construction

Literature also suggests emotional experience and emotional socialisation are culturally constructed (Mesquita et al., 2016, 2017). Emotions have been described as phenomena

that derive their meaning from cultural models of being a person and being in relationship to another (Mesquita, 2007), and it is suggested that we "do emotions" in culturally normative ways that promote acceptance and belonging (Mesquita et al., 2017). For example, Western cultures typically view emotions as a personal, internal thing, something that takes place within the individual—we sometimes speak of "having" emotions (Mesquita, 2007). Some collectivist cultures, however, see emotions in a more relational sense, as belonging to the self–other relationship rather than to the individual per se (Mesquita, 2001).

Literature also revealed that the emotional socialisation process is context specific; different environmental contexts require children to adapt and survive in different ways and, therefore, require different skills, competencies, or strategies in child rearing (Ogbu, 1981). We can easily label behaviours, those of a parent or a child, in ways that fit our preferred theoretical frameworks. For example, using the attachment framework, descriptors such as controlling, hostile, confrontational, constricted, submissive, disruptive, dis-engaged, passive, and punitive are all used in relation to a particular classification of attachment style (Solomon & George, 2011). We may attribute these descriptors to patterns of behaviour, and then plan interventions aimed at "correcting" the problematic features in line with the model. However, Ghosh Ippen (2018) points out that some behaviours evolve as adaptive, protective features to suit particular environments, particularly those where racism, prejudice, discrimination, and oppression are features. He proposed that challenges in contemporary therapeutic work between parent and child, and parent and service provider, often stem from historical trauma and what we may perceive as challenging or difficult behaviours may have developed as survival mechanisms that have adaptive functions (Ghosh Ippen, 2018). Therefore, any attempt to uncritically alter such behaviours may be problematic.

We also need to be aware of potential differences in how emotion is expressed in different cultures and contexts. One of the key therapeutic functions of the child psychotherapist is "naming affects and inner states that have previously been unlabelled and disavowed so that the child can re-integrate more modulated versions of split-off aspects of self" (Meersand & Gilmore, 2018, p. 326). However, for many cultures, direct expression of emotion is not necessarily desirable, and verbalisation may have culture-specific norms or patterns/rules that are unfamiliar to Western professionals (Sue et al., 2019).

Durie and Hermansson (1990) highlight that for Māori, emotions are an inherent part of the whole-body experience and cannot be separated; so the idea that feelings should be verbalised is "a fairly strange way of looking at things" (p. 111). They suggest the need to verbalise feelings in order to validate the feeling is an artificial dichotomy for Māori, and "the idea of talking about feelings is a foreign one" (Durie & Hermansson, 1990, p. 111). While they provide a useful clarification, and something to consider as practitioners, we also need to guard against the tendency to homogenise culture, recognising that Māori identities, and cultural identities in general, are far more nuanced than commonly thought (Durie, 1995; Moeke-Maxwell, 2012).

Development in context—Working with tamariki Māori

While child psychotherapy continues to utilise Western models of child development, other disciplines, including sub-disciplines of psychiatry, have conceded that culture profoundly shapes developmental trajectories and have begun to explore this territory in journals such as *Transcultural Psychiatry*, devoting entire issues to cultural aspects of child mental health (Guzder & Rousseau, 2010). Some of the critiques of attachment theory have already been discussed, including the assertion that it is infused with Western concepts, ideals, and values. Fleming (2016) has determined that Māori knowledge and concepts of attachment have been obscured by the dominant Western paradigm in therapeutic processes in Aotearoa New Zealand. This means concepts central to therapeutic practice with tamariki Māori also largely remain invisible. This is a significant finding considering how pervasive Western attachment theory is in many mental health settings, including, but not limited to, child psychotherapy.

Fleming (2016) suggests core Māori attachment concepts that need to be factored into therapeutic encounters include an exploration of past and present connections with whenua, wairua, whānau, and tūpuna. Fleming explains how collective, multi-levelled, and dynamic caregiving systems within whānau, hapū, and iwi are integral to protecting and nurturing child development. The importance of whakapapa knowledge to link children to living family members and ancestors; as well as to wider attachment relationships such as mythology, legend, and tikanga, are emphasised. Concepts such as wairuatanga, wairua, whangai, and whanaungatanga are discussed by Fleming in respect to their place in a Te Ao Māori perspective of attachment.

When core features of Te Ao Māori are missing, families and practitioners may experience mainstream services as alienating and oppressive. Dr Diane Kopua, an Otago University Māori health academic and Head of Psychiatry at a District Health Board, suggests “it’s almost like mental health services are way of colonising people again. You come in, you’re disconnected from your land, your culture, and your language. You can’t articulate values that are part of your ancestry” (Duff, 2018). Within Dr Kopua’s practice, a mother, Erena, comments on her experience of mainstream mental health services prior to meeting Dr Kopua. Erena notes that after her four-year-old son disclosed that he had been sexually abused “I was referred to a lot of people, but I was getting the run around… I wasn’t allowed in the room with my son when he was doing his art therapy. He was getting taken away from me and I felt like I was being treated like I was the abuser” (Duff, 2018, para. 33). In response to the lack of appropriate services for Māori youth, Dr Kopua and her husband Mark have established “Mahi a Atua”, a narrative therapy that uses Māori creation stories as the basis for healing from the trauma of colonisation (Rangihuna et al., 2018). The whole family are involved in the process, and Erena says her son, who was previously withdrawn and angry, has made more progress in five sessions with Dr Kopua and her team than in the previous five years. Erena explains, “my son loves it. He says, ‘I love getting told the stories mum, I understand my feelings’” (Duff, 2018, para. 35).

Te Ao Māori narratives provide tamariki Māori with metaphors that can serve as guidance for daily life and for mapping their pathways in life (Rau & Ritchie, 2011). Narrative methods, such as “pūrākau”, feature in the literature as examples of how insights can be

gained into Māori experience in the therapeutic setting (Hall, 2013). A recent study encouraged psychotherapists to engage with and apply the knowledge of pūrākau as a means to deepen understanding of child development and wellbeing (Amopiu, 2020). It is suggested "understanding the taonga embedded in the pūrākau has the potential to inform, educate and influence the future psychotherapists that engage in healing practices with mokopuna Māori" (Amopiu, 2020, p. 56). Pūrākau are also being used as a research method in a study on healthy attachments within Māori social systems (Mikahere-Hall, 2020).

In the context of mokopuna Māori traumatic brain injury, Dr Hinemoa Elder has developed a whānau-based approach called "Te Waka Oranga" designed to enhance recovery outcomes (Elder, 2013). Whānau are conceptualised as the functional unit of healing within the framework, rather than the individual child who sustained the brain injury. This flies in the face of the dominant, biomedical healthcare paradigm where it is the individual patient/client who is at the centre of the treatment. Te Waka Oranga brings whānau knowledge into partnership with clinical resources, relying on joint participation between professionals and whānau, who each hold their distinct knowledge system. Clinicians occupy one side of the waka, whānau occupy the other. Together, they are considered a "kaupapa whānau", a group brought together for a common purpose. This approach allows joining together and reciprocity, while acknowledging the difference in worldviews (Elder, 2013).

Te Waka Oranga bridges a divide which I am often acutely aware of when working with people who may not share dominant culture perspectives of individuals and families. I often wonder: who is the client in child work? Or, as Elder (2013, 2017) put it, who or what is the "unit of healing" in child psychotherapy? In Aotearoa New Zealand, we know that the wellbeing of tamariki Māori is indistinguishable from the wellbeing of whānau (Māori Affairs Select Committee, 2013), and Fleming (2016) has indicated that child-centred approaches are contrary to Māori attachment concepts. So, is child psychotherapy, as it exists today, a contradiction in terms for Māori—can a child or young person be delineated from their wider connections in an intervention that honours Te Ao Māori and Te Tiriti?

It is in pondering questions such as this that we are able to challenge monocultural theories and approaches to training and practice. In doing so, the hope is that we minimise harm and avoid colluding with existing power structures that perpetuate our nations undeniable health and social disparities.

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Paper 18 (2021)

How novel interactions in parent–infant psychotherapy can contribute to change in a depressed relationship between mother and infant: Reflections from a hermeneutic literature review

Monique Hiskens and Kerry Thomas-Anttila

I (Monique) first became interested in this topic while working with a mother and her infant within a psychiatric ward. My role at the time had involved supporting mother with her attachment to her son whilst they were admitted to the unit for the purposes of providing psychological input alongside psychiatric treatment. My stance was informed by psychoanalytic infant observation and wider psychotherapy principles. Over the course of my work with mother and infant, a particular moment between the dyad stood out as unique and, as such, invited further enquiry. In the dissertation I wrote in my final year of the psychotherapy Master's programme at Auckland University of Technology, I sought to investigate the 'ingredients' that had contributed to this moment, in order to better understand what had occurred between us in the room.

This paper is inspired by my dissertation research, which took the form of a hermeneutic literature review. It does not, however, serve as a complete summary of the ideas available in the literature. It is, instead, a reflection upon a key learning from the literature reviewed for the dissertation, alongside a reflection of how this learning has since informed my clinical practice. I begin with reflections from my clinical work with the mother and her infant. Identifying details have been disguised to protect their privacy.

Origins

At the time that I first met the mother infant pair, they had experienced significant environmental disruption which appeared to precipitate mother's eventual mental health crisis and the lack of formation of an effective attachment relationship. Mother described a perpetual inability to think, indifference towards her infant, chronic exhaustion, deep despondence, and acute suicidality. The infant presented with many medical difficulties and at seven months of age interacted in a lifeless, empty, gaze-avoidant manner. In sessions with the dyad, the predominant countertransference responses I experienced involved debilitating helplessness, loneliness, impotence, and low-grade nausea in the pit of my stomach. I often stumbled over my words and frequently lost my own ability to concentrate on either mother or child, slipping into a similar formless dissociation that appeared to present in the infant. Our sessions together frequently involved a painful witnessing of mother and infant taking turns in their rejection and indifference toward each other, and I felt unable to helpfully assist the dyad.

Finding a way to hold them in mind as they struggled had felt impossible, and I became aware of a strong aversion to being together that seemed present within the three of us. This also appeared to frequently echo within the wider teams (i.e., paediatrician, dietitian, nursing staff, occupational therapists) that worked with this dyad, who often endeavoured to offset this discomfort by insisting on ways the mother and infant should alter their interactions with one another. This came in the form of giving instruction, advice, or making demands about how and when things such as feeding, holding, settling to sleep, or communicating should be done. There were many opinions about what this dyad 'needed'. At times, this was experienced by the family as forceful and confusing due to the conflicting information which pushed and pulled the family in different directions. It also resulted in both mother and infant being unwittingly reminded of how dysfunctional things between them had become, as those around them sought to consistently alter them. There was a realistic driver to these interventions; it was clear that the infant was failing to thrive both in his physical and social development. However, the unfortunate and unexpected side effect of the consistent encouragement to do things differently was the perpetuation of the distance between mother and son.

In the instances where mother attempted to employ aspects of the advice given by health professionals, she would reach out to her child through song, touch, or eye contact. He would respond by drifting away, appearing to slip into a frozen, limp state as though his connection to the world dissolved in that moment. When observing these interactions, I experienced mother as inauthentic—trying to force jumpstart a liveliness that was not present within her nor between them. This appeared to have a repelling effect, despite mother's best intentions and the best intentions of those encouraging mother to interact with her baby in this enthusiastic manner. These moments felt heartbreaking and sad, due to the truth that mother took from this each time; he does not need me, nor does he want me, and why should he? Similarly, there were very few instances where I witnessed the infant spontaneously signalling to his mother to have his needs met. It was, in fact, quite difficult to ascertain what his needs were due to his general under signalling. However, there were moments where he demonstrated his social capacity with his au pair, turning towards her voice with a brief sense of animation. This, too, would serve as a painful injury to mother, who also noticed his ability to show interest in the au pair. We continued in this manner for many sessions.

The moment

The phenomenon I chose to research arose in an interaction which seemed to precede several relational improvements for the dyad. The interaction itself had left me feeling emotionally stirred as I felt both touched and upset by what I had witnessed. After a tense beginning to our session, mother and baby appeared to be predictably restless, uncomfortable, helpless, and exhausted by their ongoing hospital stay. Mother became tearful in our session and manoeuvred her baby to face her on her lap. He was often physically uncomfortable while being held and would fight off being cradled by arching his back or squirming. I reflected to mother some of her baby's body language and recognised the ways she was trying to adjust her holding to allow him more comfort. I wondered aloud what the infant may be making of her upset today and how he might have experienced

some of the preceding events that day. I described some of the ways he was responding and moving in the session, attempting to create links with the affect present in the room. Mother looked down upon her baby for some time and spoke to him in a tone I had not heard. It was not the faux-joyous, baby-whisper I had come to expect from her; nor was it the hopeless, helpless adult voice she often used when she spoke to me. She sounded resigned, almost pained, and told him how sorry she was. Her eyes welled with tears. “It feels so hard to love you. I really want to try but this is so, so hard”.

His body slowed and he turned toward his mother. Their eyes met, and a calmness fell over the room. Mother was sad. This information was not new; but it seemed that for the first time the infant had entered directly into the conversation with us. She was speaking to him about the two of them together. The hairs on the back of my neck stood up. The silence felt taut and fragile. Their connection had a similar quality. As quickly as it occurred, it broke again, and they looked away from each other. However, something in the atmosphere had changed and felt worth noticing. During my research, I referred to this interaction as ‘the original moment’; it was always present in my mind as I searched and read the literature for resonances and understanding.

On authenticity

Infants can be thought of as possessing a wide range of communicative tools and goals, propelling them towards active participation in communication (Banella & Tronick, 2019; Baradon et al., 2016; Music, 2017; Salomonsson, 2017; Tronick & Beeghly, 2011). It appears that the infant’s communicative apparatus is finely tuned to a range of non-verbal aspects of communications, suggesting a nuanced ability to decipher what is occurring emotionally at any given time regardless of the spoken dialogue. One of these non-verbal aspects—the authenticity or emotional congruence of the adult—appeared to illuminate itself repetitively in the literature (Arons, 2005; Bollas, 2017; Lieberman & Harris, 2007; Magagna, 2012; Norman, 2001; Salomonsson, 2007, 2017). I endeavoured to look more closely into this specific aspect of non-verbal communication. This aspect appeared to relate to my research topic; investigating the ways in which parent–infant psychotherapy can facilitate authentic communications in the context of maternal distress.

When first wondering about what had occurred in that moment between mother and infant, I had considered the idea that the infant was able to receive something of mother’s words which felt familiar or reassuring, allowing them to connect. At first, I pondered what of mother’s lexical content the infant was able to understand and thought perhaps this is where the key communicative difference lay. My wondering initially focussed on the words used by mother in this original moment. Yet, what appeared to be emerging in the research was a noticing of the way in which the infant was impacted less by the verbal content and instead by the moment of authentic, emotional communication which aligned with the infant’s internal experience. Within this, something of the communication from a containing presence appeared to be received and translated more effectively. There was somehow more to this dynamic, however, as mother had been authentically sad and distressed many times before in other sessions which had not appeared to permeate with the infant in the same way this moment had. Authenticity was identified as one key feature in the original

moment, but it felt pertinent to examine what other parts had contributed. I was drawn towards literature that discussed the process of psychotherapeutic change, as three key articles had continued to illuminate themselves throughout my engagement with the hermeneutic process.

Something more than interpretation

The Boston Change Process Study Group comprises psychoanalytic infant researchers who seek to investigate more closely what elements of psychoanalytic treatment contribute toward meaningful change. The group observed that "something more" (Stern et al., 1998, p. 903) than interpretation appears to happen in the analytic situation which contributes towards change. They attempted to detail what this "something more" comprises. The group observed great parallels between what occurs in the infant–parent relationship and the client–therapist relationship. This felt as though it aligned with my emerging observations of infant research. The parallel was particularly noticeable when considering the way in which implicit relational knowing accounts for patterns that form in intimate relationships and how shifts in those implicit knowings appear to contribute toward meaningful growth and change.

Recognition was given to the asymmetrical nature of the client–therapist intersubjective space, which also applies in the infant–parent relationship. Both participants can be considered active in the co-construction of relational patterns. However, there is a structural, necessary imbalance in terms of whose emotional needs are being attended to, who possesses a greater range of ability, and who is able contribute more towards scaffolding the shared understandings (Morgan et al., 1998). In the client–therapist relationship, we would imagine that it is the client bringing their unconscious content to be worked upon. However, there remains an unavoidable component of the relationship which the therapist contributes to in their own way via the countertransference. This is a theoretical development which moves beyond the classical psychoanalytic approach in which the therapist is assumed to be at all times objective and emotionally neutral (McWilliams, 2011). In the infant–parent relationship, we would imagine that the parent takes predominant responsibility for most of what occurs in the relationship, as the cognitive driver of familial patterns. However, the infant brings their primitive self and uniquely participates in the construction of the relationship.

Types of change

The contributions of the Boston Change Process Study Group can be broadly grouped by several concepts which require clarification before proceeding. The first is the distinction between types of knowledge; declarative and procedural. Declarative knowledge is described as explicit, able to be represented symbolically and verbally. Transference interpretations attempt to make conscious, alter, and adjust declarative knowledge (Stern et al., 1998). Procedural knowledge is a non-symbolic, implicit form of knowledge which informs our more automatic ways of operating yet is not necessarily considered dynamically

unconscious as it is not defensively excluded (Stern et al., 1998). The procedural knowledge that informs ways of being with others is constructed in the earliest life stage through initial experiences in relationship and is termed here “implicit relational knowing” (Lyons-Ruth et al., 1998, p. 284).

A distinction can be made between implicit relational knowing and internalised object relations to emphasise the co-constructive process which occurs in the intersubjective and individual forming of implicit relational knowledge as opposed to the sense of taking in from the outside, as in the case of object relations (Lyons-Ruth et al., 1998). Evidence of implicit relational knowings have been observed in young infants within their expressions of anticipation of specific relational patterns from a known caregiver, distress when these expectations are violated, and generalisations of interactive patterns (Banella & Tronick, 2019; Cohn & Tronick, 1983; Field et al., 1988; Stern, 1985; Stern et al., 1998; Tronick et al., 1978).

> Implicit relational knowing encompasses normal and pathological knowings and integrates affect, fantasy, behavioural and cognitive dimensions. Implicit procedural representations will become more articulated, integrated, flexible, and complex under favourable developmental conditions because implicit relational knowing is constantly being updated and ‘re-cognized’ as it is accessed in day-to-day interaction. (Lyons-Ruth et al., 1998, p. 285)

These concepts emphasise the uniqueness of all relationships. That is, we can observe that there are some generalisable ideas about the ways relationships are formed or participated in which can offer useful structure in understanding where a dyad’s struggle may be developmentally located. However, alongside remains a web of unique implicit relational knowings which continuously inform all relationships and contribute to a messy co-constructive process within the therapy. Psychotherapy with infant–mother couples invites us to acknowledge that "at the base of relational uniqueness are inherently sloppy microtemporal communicative processes expressing relational intentions, affects, and knowings that are then further elaborated, repaired, and apprehended by co-creative processes” (Tronick, 2003, p. 478). Cooper (2015) describes the juxtaposition of both relational singularity and the often repeated generational themes: “Relationships have a level of plasticity, uniqueness, and an embedded indeterminacy, even as one braces for one’s tendencies for repetition” (p. 337).

The normal developmental process is described in great detail as a model for effective therapeutic contact, suggesting that the accuracy and specificity of the caregiver’s micro-recognition of the infant’s ever-shifting states will contribute toward a greater degree of internal coherence for the infant (Tronick, 1989). This requires an ability to repetitively and persistently tolerate the parenting experiences of “struggling, negotiating, missing and repairing, mid-course correcting, scaffolding” (Stern et al., 1998, p. 907) interactions with the infant in the general process of “moving along” (Morgan et al., 1998, p. 325).

In the case of a depressed mother and her infant, however, the ability to accurately and continuously persevere in this often exhausting process may be significantly compromised. The effect of failed reparation upon the infant involves an ongoing state of wariness in their

sense of self and disorganisation which compromises their meaning-making ability, complexity, and internal flexibility (Banella & Tronick, 2019; Tronick & Beeghly, 2011). There is a need to assist mother and infant to re-find their ability to continue moving along. This involves a reformulating of the difficult moments as part of a necessary process, feeling able to approach these moments with curiosity and resilience as opposed to experiencing them as a devastating confirmation of hopelessness.

In this sense, perhaps by deepening an understanding of what is occurring in effective mother–infant moments of contact, the therapeutic process can become more able to assist mother–infant dyads in reconnecting with a developmentally responsive, personalised flow of reciprocal communication. This concept provides a framework in which the gradual, repetitive, difficult aspects of infant–parent treatment can be regarded as contributing toward a slow return to the 'moving along' process, for the purposes of renegotiating negative implicit relational knowings. As the communications from mother (and infant) appear to be supported to become less contradictory, it seems a gradual, developmentally paced process of locating one another can resume.

The co-creation of a depressed relationship

The discussions of implicit relational knowledge also appear to encapsulate a necessary acknowledgement of the infant's active (though lesser) participation in the 'depressed relationship'. Both mother and infant's implicit understandings and expectations of one another can become increasingly more fixed and locked over time in the absence of intervention. Acknowledging the process of co-creation in the depressed relationship was a helpful learning, as it supported my observations of this mother and infant in which the infant himself participated in the depressed style of interaction. In my own interactions with the infant, I had found myself often tempted to rouse him from his depressed, limp state due to the discomfort it produced in me. Alone with this infant, the countertransference felt empty and bleak. Unable to access natural bonds through playfulness and interaction, I found myself feeling distant in our relationship as though he had become wholly unwilling and uncurious about the world around him. This dynamic certainly appeared to reflect in the relationship between mother and infant, as in her moments of attempting to connect with him she often found herself feeling disappointingly rebuffed. Between them both, the pattern of helpless interaction continued. This perhaps accounts for some of the 'stuckness' I feel I am consistently facing when working clinically with unwell mothers and their infants.

By coming to understand that the infant, too, unwittingly participated in this relational style, he (and mother) could begin to be approached compassionately. Counteracting the predominant senses of helplessness, hopelessness, and stuckness, the therapist can hold in mind a faith that gradual alterations to implicit relational knowing can contribute to change in the therapeutic relationship. Importantly, for infant work, and unexpectedly, for myself, this appears to consist of predominantly non-verbal aspects; "implicit relational knowledge becomes the arena for the occurrence of changes outside the semantic sphere" (Morgan et al., 1998, p. 328). The continual and sometimes painful experience of moving along, can be conceptualised as an important foundational time in which the therapist is coming to understand the background of the dyad's subtle implicit relational knowings. There is space

within this for the therapist to find a way to accept the mother and infant as they are, to join with them from the point at which they are beginning. With a depth of understanding from this viewpoint, the therapist can begin to observe occurrences of tenuous novelty; the creaking open of a door to let in new light.

How novelty invites new relational space

When considering the process of therapy, several components are described to locate the areas of change as distinct from the usual therapeutic proceedings. 'Moving along' has been briefly described, and appears to encapsulate the more gradual, everyday processes of infant–parent work with depressed mothers; encouraging and demonstrating an ability to mentalise the infant's expressions, observing baby in free play or communication, acknowledging the parents' past experiences and exploring how this may be impacting the current relationship, thus gradually creating a therapeutic alliance with the family. However, I felt I had experienced with my mother and baby dyad a moment more significant than that of the foundational moving along process. A moment of definitive shift, uniqueness, tension, presence. It felt distinct from other witnessed instances with other mothers and babies in loving reverie; and yet, the quality of connection was in some way similar. Furthermore, it appeared to spur on some internal, novel, open space that allowed for the possible introduction of new experiences such as mother's wish to bathe baby for the first time the following day. I looked again toward the literature for assistance on understanding this moment.

Stern et al. (1998) and the Boston Change Process Study Group further detail ways in which shifts in implicit relational knowing are experienced and the relevance this may have upon further relational change. They propose that a "moment of meeting" (Morgan et al., 1998, p. 325) in which a newly altered intersubjective environment is ushered in, precipitates change for both individuals involved. The moment of meeting is comprised of co-constructed understanding, spontaneous individual contribution, and "specific recognition of the other's subjective reality" (Lyons-Ruth et al., 1998, p. 286). There is an active, intense, authentic presence of all involved within a moment that is uniquely singular, spontaneous, fleeting and, perhaps, unremarkable. Emotional congruence between those involved is in ascendance, as what is being communicated is absorbed and understood with mutual fittedness. There is a sense of joint understanding of shared past experiences existing alongside a present acknowledgement of "what is happening, now, here, between us" (Stern et al., 1998, p. 908). Work or interaction is able to then continue, albeit with new depth. As Stern (2004) notes, *"*after a successful moment of meeting, the therapy resumes its process of moving along, but it does so in a newly expanded intersubjective field that allows for new possibilities*"* (pp. 370–371).

Similarly, Lachmann and Beebe (1996) note three principles of salience which contribute significantly toward effective regulation, representation, and internalisation which are based upon infant research with further applications to adult treatments. These are: ongoing regulations, disruption and repair, and heightened affective moments. The three aspects listed have been identified as the key modes of dyadic regulation. It could be suggested that 'ongoing regulations' relates to the concept of moving along (Morgan et al.,

1998), whilst 'disruption and repair' appears to correspond with Tronick's (1989) writings about the necessity for continuous reparation between mother–infant as well as Stern's (1985) concepts of negotiating and tolerating relational struggles. The variance in terms which appear to describe the same or similar concepts was noted by the authors.

The third principle, 'heightened affective moments', however, is described as moments in which a "powerful state transformation" (Beebe & Lachmann, 1994, p. 147) can occur, referring to changes in arousal, affect, and cognition (Lachmann & Beebe, 1996). This concept was first introduced by Pine (1981) in which he described "affectively supercharged" (p. 24) moments in which the infant experiences a sense of gratifying merger and heightened arousal following the satisfying experience of hunger being effectively satiated. Conversely, the supercharged moment may also occur in the instance where similarly intense negative arousal occurs in the absence of such gratification. Pine suggests that these polarised experiences of momentary positive or negative arousal states in the infant have a lasting developmental impact. Beebe and Lachmann (1994) expand these ideas, suggesting that a heightened affective moment is only able to occur within the context of "ongoing regulations" (p. 128) and "disruption and repair" (p. 129). This provides a foundation in which the dramatic experience of a heightened affective moment can appear as a novelty within an established relational framework.

Lachmann and Beebe (1994) echo Pine's (1981) proposal in the assertion that the heightened affective moment can produce the experience of either a disruption or repair. This expands the view that the heightened affective moment is limited to the experience of satisfaction from hunger by mother. Instead, they suggest that the heightened affective moment can include moments which usher in a broader relational scope and new experience of shared intimacy. There is a psychical feeding that takes place, similar to an experience of satiation.

Links to the original moment

The descriptions of heightened affective moments and moments of meeting certainly fit my experience of the original moment. The moment in itself was unremarkable if not for an awareness of the emotional impact that had occurred within it. Through an observation of my own countertransference experience, the moment could be recognised as singularly novel in its affect, highlighting itself as a moment of meeting. My wonderings about this time have included a consideration that without the prior experiences of the painful "moving along" of the therapy, made up of the many empty and fruitless interactions that had preceded it, this moment could have been easily missed. The therapy, in many ways, resumed its normal process of moving along, with many more difficult interactions to follow. However, an organic hopefulness had entered my mind as the therapist, with a witnessing of this authentic connection where both mother and infant attuned to each other in a painfully touching way. Reflecting upon this moment now, I am struck with an image of the first delicate wisps of smoke rising up from a fire as attempts are made to kindle it with the repetitive, frustrating rubbing together of two sticks. This moment certainly did not indicate a lit fire, but instead gave the participants a brief moment in which

the fire could all at once be imagined again as a real prospect.

There is a concentration upon authenticity rooted in this concept. Morgan et al. (1998) detail the way in which moments of meeting must occur within the context of a "real relationship" (p. 325). However, this concept relates more to the way in which the moment of meeting occurs only in the case of shared, authentic experience as opposed to relational contact dominated by past representations. There is an acknowledgement that in adult therapeutic settings, contact can arguably never be devoid of past influences. Gotthold and Sorter (2006) describe the frightening implications of the term real relationship in a therapeutic context, concluding that this pertains more to the sense of "authentic engagement" in an "operative form of implicit relational knowing" where it is possible to access a "profound sense of knowing and being known" (p. 112). There is also an emphasis on the movement forwards in time, in which therapeutic interactions are less dominated by ghosts of the past. Instead, there is a concentration upon the affect in the present moment. Those involved in the therapy are able to operate within implicit relational knowings they have constructed together.

> What is experientially prominent in the here and now is the past that the patient and therapist share together, rather than the past they share with other people... the therapeutic exchange is a dialectic between transference influenced interactions and real relationship interactions. (Morgan et al., 1998, p. 326)

In terms of my clinical work with the given mother–infant example, the idea of bringing their relationship into the 'here and now' as a therapeutic step felt particularly valuable. In previous sessions with this mother and infant, we had spent considerable time discussing their surrounding context; what had occurred prior to and throughout conception, pregnancy, birth, and early infancy. These contextual details were entirely relevant in the process of building an effective therapeutic alliance as well as deepening my own understanding of the presenting family. However, the "moment of meeting" appeared to occur in a brief encounter in which mother and infant were in some ways freed of this external narrative, now concentrating upon one another in the present moment. Despite the necessary acknowledgement of their, and our, shared past, there was a sense that the three of us were able to acknowledge "what is happening now, here, between us" (Stern et al., 1998, p. 908).

This perhaps also accounts for my own countertransference experience in the moment as if the affect of the room was fragile or delicately balanced in time. It felt as though the breaking out of this connective moment could happen at any time. I remembered a sense of goosebumps travelling over me, and felt aware that I was in the presence of something unique. Although much of what was being verbally communicated was arguably sad or painful, it was indeed authentic and emotionally accurate at that point in time. I wondered about whether or not what I had witnessed and taken part in was an experience of maternal reverie (Bion, 1962) in an alternate form. I had certainly not witnessed the clinical prototype for this; the warm, containing mother gazing into her cradled infant's eyes. Yet, there was an unmistakeable loving, connective quality within this moment, reminiscent of a moment of reverie, in which mother appeared to authentically communicate her desire for connection, opening avenues for this to further occur.

Taking these concepts forward

Since undertaking the initial dissertation research, I have maintained an interest in recognising moments of meeting, as well as accessing an internal sense of patience whilst navigating the initial stages of the moving along in therapy. This has served as a kind of antidote to my repulsion of stuckness, allowing me to remain in paced step with a family or dyad throughout these early stages of therapeutic engagement. It is not to say that the natural repulsion present when bearing witness to disconnect between mother and infant is no longer in existence. Rather, I allow myself to take some reassurance in this broad categorisation of the movement of therapy; now more able to map our travels with both an individual openness to the intersubjectivity alongside a sense of vague direction.

Finding myself trapped in the relational stuckness of a family in which unhelpful patterns continue to be acted out no longer feels as though we are drifting directionless through space. Instead, I am grounded by the idea that we may very well happen across a moment of meeting in which something different enters the therapy. This reassurance assists me in resisting the temptation to fly into action or suggest interventions or exercises we could try to stimulate their attachment. The drive to 'do something' was present throughout my work with this family (and other families), as I was aware of the very present risk posed to the infant's social, emotional, and physical wellbeing as he attempted to develop within this emotionally barren landscape. The idea of remaining as a bystander to the possible effects upon him was utterly unbearable. However, colluding with this hopelessness was no more reassuring as it perpetuated mother's own suicidality.

Although there may be times where direct intervention is useful, my sense with this family was that they were often bombarded by the perspectives of health professionals, leaving no room for mother's instinct or desire to emerge. All aspects of feeding, sleeping, and interacting had been already colonised by myriad other well-meaning health professionals. Mother, in turn, felt utterly spare to the equation. Her utterances of "these are not my babies", alongside her felt inability to think, could be well understood in this context. I would suggest that this mother was not left with any sense that her relational contribution with this infant had felt 'good enough' in the Winnicottian sense (Winnicott, 1965). Instead, what pervaded was the prominent idea that she must find ways to do more, do differently, and interact in a way which felt incongruent with the emotional reality of their situation at the time.

In the original moment, however, the shift witnessed had involved an authentic recognition of the difficulties in their relationship. Mother had been able to recognise negative feelings within herself and name these accurately in the present moment. Furthermore, she was able to accurately express her wish to remedy their connection. In a sense, this was the authentic, loving component of the communication which perhaps prevented the moment from being altogether overwhelming for the infant. The good mother can be described as a mother who is able to acknowledge and tolerate her feelings of hatred and aggression within herself (Parker, 2005). Margot Waddell (2018) writes:

> Those experiences that make sense do so because they are underpinned by emotional authenticity. They are therefore the ones that can be learnt from. Those experiences which do not make sense have to be either artificially accommodated in the personality or extruded elsewhere, coming to hinder rather than to foster growth. (p. 42)

The chapter invited me to investigate closely the unique contribution offered by psychotherapy in the field of parent–infant work. The observational lens allowed me, as a practitioner, to look beyond the initial painfulness of the moment to understand in greater depth what had occurred. As Bion (1962) aptly described, the work involves a transformation of unthinkable beta-elements into more cohesive alpha-elements which can be reflected upon or integrated more effectively.

The co-creation of relationship between infant and mother has been described as an ongoing, messy process formed continuously through the give and take of affect and expression (Banella & Tronick, 2019). The contemporary relational approach advocates strongly for a co-constructive therapy process in which there is an emphasis upon the progression of intersubjective discovery within therapeutic relationships (McWilliams, 2011). The particular strength of psychotherapy, in this sense, is the recognition of the uniqueness of relationships due to implicit relational knowings, as well as the ongoing momentariness of relational states. This applies to both client–therapist and infant–mother. Psychotherapy invites the gathering in of both joyous and difficult moments of connection present in all forms of relationship. Regarding each of these types of interaction as potentially significant invites a unique process of moment-to-moment discovery. That is to say, there is every likelihood that this clinical moment could have been missed, dismissed, altered, or impinged upon in another time or setting.

As I take these ideas forward into my work with children, adolescents, and their parents, I find myself patiently open in different ways to what is bought into the therapy room. Most notably, I find myself interested in moments of spontaneous novelty, in which something within the countertransference, the dialogue, or the affect is felt to be moving into a territory not yet explored. The need for spontaneity is perhaps accounted for in the discussion of authenticity. That is to say, the spontaneous action must be underpinned by an emotional authenticity to allow for effective correspondence between the perceived need and the response activated. If a response is carried out by a mother due to the external direction from another (i.e., when she is given instructions), it could be understood as in some way incongruous or inauthentic within her—she had neither perceived her infant's need nor constructed the response to give. However, in the spontaneous action, something within mother occurs authentically, prompting her salient response.

By viewing spontaneous, authentic novelty as an important ingredient of change, I have found myself in practice to be more receptive to locating the moments in which it seems to occur. A clinical example includes a time of feeling more able to receive feedback from a previously people-pleasing adolescent. Their criticism of the therapy sessions and of me as their therapist had been unexpected. Yet, on reflection I found myself feeling more able to view this painful feedback as an important movement forward in this young person's ability to state their own needs and expectations. Another example includes an adoptive parent admitting to me that their relationship to their adopted child felt distinctly different to their

relationships to their biological children. I had experienced a level of grief upon hearing this; and yet, it appeared to free both parent and child from a burdening expectation which had prevented the authentic development of their unique relationship. In each of these moments I had experienced an initial level of uncertainty which had also been present in the original clinical moment centred in this paper. There was a clear sense that we were, all at once, navigating something different which existed outside of our therapeutic norm and that had been constructed over the preceding sessions.

Conclusions

In this paper, I have reflected upon psychoanalytic literature which draws understandings from psychotherapeutic work with clients as well as observations of the infant–parent relationship. What is suggested is that facilitating effective, co-created, meaningful change involves at first establishing a moving along process, in which the therapist comes to understand, in a felt sense, the subtle and specific ways an infant and their parent interact together. There is a concentration upon the implicit relational knowings at play. Following, maintaining an open receptivity to authentically spontaneous or novel moments invites the couple to move gradually beyond their stuckness. In the context of some established emotional safety within the therapeutic relationship, there becomes room to step beyond the established way of interacting. There is a sustained concentration upon "what is happening now, here, between us" (Stern et al., 1998, p. 908). I feel that this delicately put phrase by Stern encapsulates, with both simplicity and depth, the attentiveness to the ongoing experience of relationship held within this form of psychotherapeutic work.

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Paper 19 (2021)

The experience of the young child bereaved by sibling stillbirth in Aotearoa New Zealand: An account of hermeneutic methodology and method

Nicola Jackson and Margot Solomon

Stillbirth has a devastating impact on family and whānau. The experience of bereaved parents is often, understandably, foremost in our minds and hearts. But the loss of an infant, before or after birth, has life-long consequences for the entire family. Siblings of the dead infant, often barely out of infancy themselves, have been called “invisible mourners”, since their loss is often unacknowledged.

The first author (who writes this paper in the first person), undertook to see those unseen siblings in her research, with the supervision of the second author. Jill Buchanan also supervised the early stages of the project (Jackson et al., 2021). The project used a psychoanalytic developmental orientation to expand understandings of the experience of young children (aged 2- to 6-years-old) affected by stillbirth in Aotearoa New Zealand.

Understanding stillbirth is like trying to resolve the unresolvable; or make tangible the intangible. Stillborn children make imprints upon our lives. They are woven into the universe; yet they are nebulous and hard to grasp, slippery and ethereal. A research methodology and method that can hold these qualities might seem impossible to find depending on where we look.

In my study, I used a hermeneutic literature review. Like the art of psychotherapy, I found the approach was dynamic and contextual (Smythe & Spence, 2012), and embraced the complexity of human experiences—the ultimate of which is, arguably, when birth and death occur together. The hermeneutic literature review enabled me to be in the subjective reality of the young child, the place of fairy tales and pūrākau, where we can recognise our dead in different forms and shapes.

In this paper, I attempt to elucidate the dynamics of the relationship between methodology, method, the researcher, and the researched, as I observed them unfold during my study. As Giddings and Grant elucidate (2002), the choice of methodology needs to fit with the research topic and the researcher. As both an example of and an extension to that proposition, this paper draws the connection between the research methodology and the research results and additionally to the praxis of the developing psychotherapist.

Research whakapapa

My research had its origins in my own experience as a bereaved young sibling. In this way, my research is a kind of re-search of something that has already made a claim on me, something I have already known but forgotten (Romanyshyn, 2020). My research also has its roots, and perhaps its branches, in my work as a child and adolescent psychotherapist for bereaved children.

A review of the academic literature showed that previous attempts to understand my research phenomenon were relatively few and tended to either pathologise or describe the child's experience without acknowledging the author's own prejudices or lens. As I write this, I am aware that a key unacknowledged prejudice is in fact that the authors are all adults. This perhaps reflects the experience of surviving siblings themselves as "forgotten" (Crehan, 2004).

Concurrently, I thought about the features of young childhood that make it worthy of special consideration. I found that fantasy, play, and a vivid emotional life were facets of the way the young child conceptualised their experience of their preschool or "magic years" (Fraiberg, 1950). This observation led me to wonder if I could research my phenomenon in a way that privileged the subjective reality of the young child. The hermeneutic methodology is a type of playing with symbols, with play at its heart, through which one can enter the natural habitat of the young child.

My academic education as a child and adolescent psychotherapist took place over six years at Auckland University of Technology (AUT) starting in 2016 and was mainly based in a Euro-centric view of childhood. During this time, and for many years before, themes of colonisation, questions of place and time, and how to think about and practice child and adolescent psychotherapy in Aotearoa New Zealand were highly active in the psychotherapy community and beyond. These themes form part of my research whakapapa and contributed to my choice of methodology.

All research conducted in Aotearoa New Zealand concerns Māori. Kaupapa Māori was once, and still is, for some, ordinary and normal (Came, 2013). The hermeneutic methodology offers an opportunity for dialogue with Māori writers. I wanted to broaden my horizons and stimulate thinking in ways and directions that respected mana whenua of the land in which I live and practice psychotherapy. I wanted to research as a sixth generation Pākehā—as me.

All of these considerations led me to choose a hermeneutic methodology which enabled me to fully embody my research and contextualise it in the time and place of my life, and my clients' lives. Most importantly, it has enabled me to see clearly its relevance to my psychotherapeutic practice.

The hermeneutic philosophy

In the 19th century, hermeneutic studies aspired to capture the original meaning as intended by the author. However, German philosophers, Heidegger [1889-1976] and his student

Hans-Georg Gadamer [1900-2002], advocated that hermeneutic study could offer more than original meaning. Gadamerian hermeneutic philosophy, on which this study is based, was the result of Heidegger and Gadamer's collaboration. It recognises that we each have pasts, presents, and futures into which we are interwoven, inseparably, with our history and culture (Smythe & Spence, 2012).

The hermeneutic philosophy allows us to research as ethical agents, as fully human as we can be, because it can accommodate our unique realities as human researchers (Nixon, 2017). The hermeneutic methodology requires that the researcher thinks about, acknowledges, and embraces the power of their own prejudices. Prejudices are created by each researcher's unique blend of factors such as their whakapapa, history, culture, experience, and education.

The texts that we interact with in hermeneutic studies are anything that stimulates a thoughtful encounter in the researcher (Smythe & Spence, 2012). When we interact with a text, what is induced in us has a message for us about our research question. We might have thoughts, feelings, bodily sensations, desires, urges, dreams, actions, and conversations in response to each text. We might not even link them to the text at the time, or we might make obvious spontaneous connections. Sometimes, it takes the course of almost the entire research journey to realise the message. These messages in response to texts determine how we answer, or do not answer, our research question. Slowly, the messages come together to form an understanding that we then offer to our own readers; who, in turn, have their own responses.

The way that we interact with texts in the hermeneutic research is like a conversation. We take in something from the text and respond in kind, and then are prompted again by our continued interaction with the text. Gadamer framed hermeneutic study as a dialogue between researcher and the text, and through the researcher, between texts. He contended that the texts, from their own socio- historical and cultural standpoints, would have something to say to the researcher from their own standpoint, and vice versa. He proposed that the hermeneutic process would change the researcher's understanding of a topic by prompting the researcher to be "thought-full" (Smythe & Spence, 2012) and to think about something in a new way.

We can see, therefore, an influential factor in hermeneutic research is the researcher's relationship with their own selves, with their previous experiences, worldview, culture, and other contextual elements. This is the way that we make meaning, and which enables understanding. Through this process, we realise our full human potential (Nixon, 2017). If the research deliberately includes the effect of the researcher's own subjectivity, they can contribute fresh insights and create new knowledge.

We live in the whisper of the page

As mentioned earlier, the hermeneutic philosophy is usually associated with Gadamer and his teacher, Heidegger. However, during my research I found inspiration for my approach in

a surprising range of different unrelated texts which did not refer to Gadamer. Nevertheless, they helped me understand what I was doing, what to listen to, and what was important.

Rev Māori Marsden [1924-1993] was an indigenous tohunga, scholar, writer, healer, and philosopher. His thoughts about the nature of the universe speak to my research paradigm, which represent my nature of reality and what I value as knowledge.

In the introduction to Marsden's book, "*The Woven Universe*", Te Ahukaramū Charles Royal (2003) acquaints us with the "the woven universe", where the world is a "kahu (dress), a fabric comprising of a fabulous mélange of energies" (Te Ahukaramū Charles Royal, 2003, p. xiii). Te Ahukaramū Charles Royal credits his brother Haunui Royal with highlighting the importance of language. Reo (language) is a way to weave people and all things together into a fabric of whanaungatanga and relationships. This weaving is the work of the tohunga whakapapa (genealogist) (Te Ahukaramū Charles Royal, 2003). Arguably, it is also an important aspect of the hermeneutic literature review.

Another writer who captures the essence of the hermeneutic methodology is Whiti Hereaka (Ngāti Tūwharetoa, Te Arawa). Whiti is a playwright, novelist, screenwriter, barrister, and solicitor (Hereaka, 2019). In her prologue to a collection of pūrākau, she writes that words and stories enable us to live in the past, present and future within endless and countless lives: "We are creatures of words. We are creatures of imagination. We live on the edges of dreams and the margins of thought. We live in the whisper of the page" (Hereaka, 2019, p. 27).

Te Ahukaramū Charles Royal and Whiti Hereaka tell us to concern ourselves with how our universe is woven, the nature of our place within it, and that we can find ourselves in words, imagination, and dreams.

We live with uncertainty

Hermeneutic methodology uses the power of words, symbols, metaphors, and unspoken messages to create new understanding in the researcher. Romanyshyn (2020) describes the work of the researcher as someone who "is attuned to the gap between what is said and what is always left unsaid, the gap between conscious and unconscious, which is bridged by the symbol as the expression of the transcendent function" (p 220). Using this approach, the poem "*We Look with Uncertainty*", by Anne Hillman, symbolised for me some of key ideas of Gadamerian hermeneutic philosophy, especially the movement from one horizon to another (Hillman, 2020).

> We look with uncertainty
> beyond the old choices for
> clear-cut answers
> to a softer, more permeable aliveness
> which is every moment
> at the brink of a death;
> for something new is being born in us
> if we but let it.
> We stand at a new doorway,
> awaiting that which comes….
> daring to be human creatures,

Vulnerable to the beauty of existence.
Learning to love.

This poem was read to me by Hilary Foged at Te Wahi Ora Women's Retreat at Piha in May 2020. The context was a women's writing weekend and the recent emergence from the first lockdown imposed by COVID-19 in Aotearoa New Zealand; the first of four lockdowns while I was undertaking this study. Like Hillman conveys in her poem, Gadamer was clear that we cannot take for granted the knowledge that we think we have about something, and fall into the complacency, passivity, or security that it offers us. Instead, we must be actively questioning, challenging ourselves and our understanding. In hermeneutic research, the researcher approaches the work with an openness to what may be found, and a willingness for the findings to be different to what Hillman calls "old choices"; "old choices" perhaps synonymous with Gadamer's "prejudices".

The poem also speaks to accepting that sometimes in research the answers are not obvious or delineated or simple. Such a methodology can seem difficult to up-hold in Western cultures where positivism is deeply embedded and has greatly influenced assumptions about what knowledge is by emphasising the importance of objectivity, systematisation, observation, and verification (Giddings & Grant, 2002).

Pertinent to my topic of study, the poem references birth and death. During research there is a gestation and creation of something unique. The researcher allows their body and mind to become the vessel, sustenance, and driver of growth so that "something new" can be birthed and offered to humankind in the service of development of humankind and the evolution of culture.

Finally, the poem speaks to the value of not acting or doing which, although it may be hard for some of us, including me, is sometimes necessary. For it is through the moments of stillness that the mist can clear, or the ideas can catch up with our racing minds and be able to find and connect with us. In hermeneutic research, there are periods of immersing oneself in a topic, trusting the process and awaiting the thought, which is integral in hermeneutic research (Smythe & Spence, 2012).

The literature review as hermeneutic method

Gadamer considered that method was a problem and emphasised instead the importance of the question. He even taught that "method" could obscure the "truth" (Gadamer, 2004), and that the way of hermeneutic practice is determined by the phenomenon being studied and not the method (McCaffrey & Moules, 2016). Gadamer (1960/2004) emphasised the importance of play, its "to-and-fro movement that is not tied to any goal that would bring it to an end" (Nixon, 2017, p. 32). Hence, the nature of hermeneutic research is that there are few rules to follow; rather a way to be attuned (Smythe & Spence, 2012). Nevertheless, for research purposes, there needs to be some way to operationalise Gadamer's philosophy, which necessitates a research method.

I chose to operationalise the hermeneutic methodology by way of a literature review, which required me to engage with texts and to listen for both the explicit and implicit, conscious and unconscious, messages they had in response to my research question. Austgard (2012) and Boell and Cecez-Kecmanovic (2014) attempt to systemise an approach of interpreting texts using hermeneutic philosophy. I adopted the approach of Austgard, of breaking the work into four parts; and appreciated the support provided for systemisation by Boell and Cecez-Kecmanovic. In my study, I found that I moved backward and forward between Austgard's parts, while maintaining a general momentum from part one to part four. The parts were: 1) working out the hermeneutic situation; 2) identifying my fore-understanding; 3) hermeneutic dialogue with the text; and 4) fusion of horizons.

For much of my study I found that sometimes the four parts were separate and sometimes they merged and were in dialogue with each other. For the purpose of the paper, I will try to separate and describe each section.

Working out the hermeneutic situation

I propose that working out the hermeneutic situation is about the development of the research question, which starts with an attraction between the researcher and the researched. The research question can be regarded as the frame that forms "the new doorway", as Anne Hillman (2020) refers to in her poem, where we "tarry" and "loiter" as part of our hermeneutic process.

The question arises from the soul of the researcher, the hermeneutic methodology, the tradition of the researcher, the motivation of the researcher, and the requirements for an argument that contributes to a body of knowledge (Austgard, 2012; Boell & Cecez-Kecmanovic, 2014; Romanyshyn, 2020).

My research question was: What is the experience of the young child bereaved by sibling stillbirth? I refined my research question as I understood more fully the story that was being jointly constructed by myself and my texts. In my original question, I started by considering all sibling bereavements. I eventually came to narrow that down as I became aware of the unique nature of stillbirth loss compared to other types of sibling loss; even other types of perinatal loss and the different experiences of siblings born before and after the loss.

I excluded texts about children born subsequent to perinatal loss, often called "replacement children" such as those described by Beaumont (2011) and Donoghue (2017). It was clear from preliminary readings that children born after sibling stillbirth have a different experience than those born before. I only included data about children who were aged between two- and six-years-old at the time of stillbirth, because I wanted to capture the effect of sibling bereavement by stillbirth at this particular developmental stage.

Identifying my fore-understanding

This part of the research was about identifying the prejudices that I brought to the research, and what understanding I thought I already had about my questions. Exercising this reflective capacity is a key part of the psychotherapy training and practice, and can be refined in the student through the research process. I find that even after submitting my dissertation I discover new prejudices that I was not aware of previously.

To lay out some of the influences on my prejudices; I am a sixth-generation Pākehā New Zealander. My ancestors came to Aotearoa from England, Ireland, and Denmark. I am a daughter, sister, and mother of three children. I am cisgender, heterosexual, feminist, educated, an able-bodied woman. I am also a child and adolescent psychotherapist working in the community from my practice 'Child in Mind'.

Hermeneutic dialogue with the text

Undertaking a hermeneutic study entails the researcher being open to provocation wherever they may be. My sources spoke to me via academic literature, pūrākau, poetry, novels, visual art works, and dialogued with my lived experience.

The way that the research is developed during the hermeneutic process can be regarded as circular and iterative (Boell & Cecez-Kecmanovic, 2014). For example, in the process of going back and forth between what the researcher sees and their interpretation of the text, they broaden their horizons and gain new awareness which enables them to see beyond their own prejudice. The hermeneutic circle shows itself through the continual revision of understanding. As I engaged with new texts, I found that the texts I had already read developed new meaning.

What I thought I knew about my topic influenced what I read first, which was psychoanalytic authors with whom I was already familiar, as well as new ones found by searching the PsycINFO database—a specialist database of psychological literature.
I became attuned to how I was responding to those psychoanalytic papers, and I paid attention to what interested me most, what gave me strongest responses, and I was curious about what that meant about my research question. Donald Winnicott [1896-1971], one of the most pre-eminent psychoanalytic authors, writes that "the written words of psychoanalytic literature do not seem to tell us all that we want to know" (Winnicott, 1971, p. 142). The hermeneutic methodology allows that to be true and encourages us to look beyond what we know.

Having started with psychoanalytic literature, I invited other contributors to the conversation as I came across them. In the following examples of the hermeneutic circle, I hope to show how my understanding was developed iteratively by dialogues with a multitude of voices. Over the course of my research I found that the most rich and powerful responses to my research question came from cultural artefacts. I think in many cases they stimulated me to think about the psychoanalytic readings in new ways, and vice versa.

In my first example, I found a co-locateur on a family trip to the art gallery. "*For of such is the Kingdom of Heaven*" (Bramley, 1891) is said to be one of the most popular works in the Auckland City Art Gallery Toi ō Tāmaki (Auckland City Art Gallery Toi ō Tāmaki, 2021). The oil on canvas painting depicts a young girl in a funeral procession. The setting is a road beside the sea, in England—my ancestors' homeland—and was painted in 1891 (see Figure 1).

The girl walks with other girls in front of a group of women carrying a small coffin. The size of the coffin, the costumes, hymn books, and demeanour and composition of the group suggest it is a family group mourning their dead child and sibling. What is striking about the painting is the apparent loneliness of the little girl, perhaps a bereaved sibling. She walks alone and stares straight into the eye of the viewer. Her expression is hard to read but it could be described as serious, plaintive, sad, and searching. The artist has captured well some of the experiences of the young child bereaved by stillbirth that I found in academic literature. I notice that the five young children of the procession lead the way and are not accompanied by adults, have no source of parental comfort or reassurance as they walk their way past onlookers. Another character stares straight at us as well. She is presumably the mother of the infant, and her expression is blank and numb. It seems the bereaved sister has very definitely been weaned and separated from her mother and conveys exclusion, loneliness, and, maybe, bewilderment. These were all themes of young childhood as expressed by psychoanalytic writers (Waddell, 2002).

Figure 1
For of Such is the Kingdom of Heaven by Frank Bramley (Bramley, 1891). *Permission to use image granted by the Auckland Art Gallery Toi o Tāmaki.*

My second example, the pūrākau "*Born.Still*" by Māori contemporary writer, Briar Grace-Smith (Ngā Puhi, Ngāti Hau), was one such story. It encouraged me to contemplate the enduring relationship between a surviving sister (six-year-old Hina) and her stillborn sibling (Grace-Smith, 2019). The title of the story "*Born.Still*" invites us to reconsider the meaning of the word 'still' in 'stillborn'. In 'stillborn', 'still' seems to mean 'lifeless', 'silent', 'at rest'. But in "*Born.Still*", 'still' could mean 'enduring', 'in spite of everything', 'even so'; maybe referring to the enduring bond between sister and stillborn sibling and validity of the birth, life, and death of the infant, despite the circumstances. Indeed, a theme of the story is Hina's relationship with Māui. This theme became the key finding of my study—that the stillborn sibling becomes a lifelong constant companion for the bereaved child.

Hina's story is that takes place in the transitional space while also being about the transitional space. The story could also be seen as a story about transitional space between Hina and her mother, and how it is enriched with symbols that Hina uses to have a relationship with her dead brother. Through the relationship with Hina's mother, her mother's provision and sharing of the rituals of cutting her hair and making the basket, and together throwing Māui into the sea, provide a story and meaning for Hina about her brother, and underpin her enduring relationship with him. The setting of the story in an apocalyptic future, when the sea and the land are dead, speaks to our past, present, and future. It is not strange that an ancient legend is set in the future because in certain abstract places, the past is happening at the same time as the present in a kind of transitional space.

During my study I went away for a few days to an inner-city apartment to progress my dissertation and found myself in such a space. I read academic papers during the day and researched my family tree far into the night, looking for dead children, bereaved siblings, my mother's lost biological family and immigration stories. The academic work during the day could best be described as part three, hermeneutic dialogue with the text. The work during the night was my 'dream work' and spoke to me about my fore-understanding (part two of Austgard's model) as well as how I was interpreting the texts (part three) and how the texts spoke to me (part four). This 'dream work' was like an inner fusion of understanding, interpretation, and application, the hallmarks of hermeneutic tradition (Austgard, 2012).

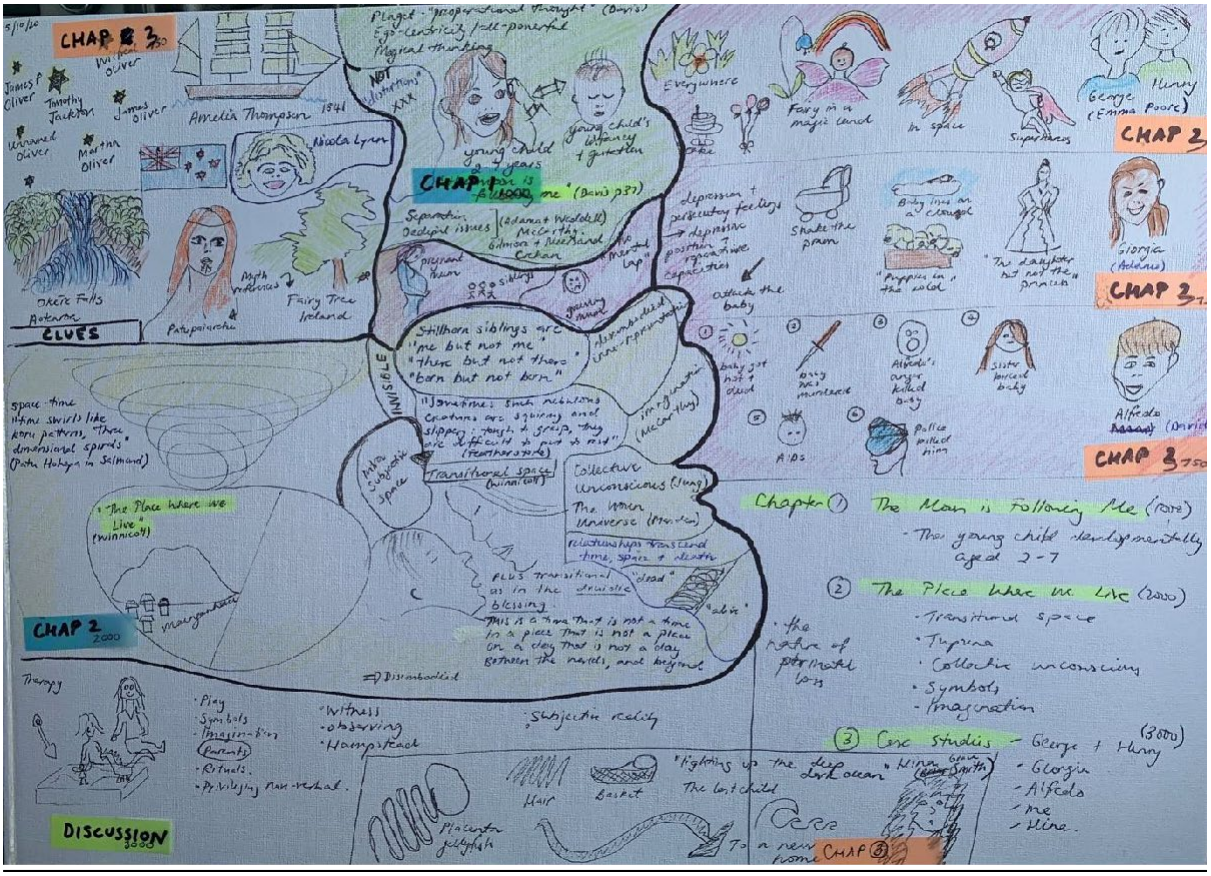
Fusion of horizons

As a result of the texts talking to each other, and to me as the researcher, gradually ideas came together and I conceived new ones. I became impregnated by the work and something new was born in me, as in Anne Hillman's poem. Romanyshyn (2020) describes this creative "birth" process, as bringing a feminine presence to the art of understanding.

When I had finished my data collection, I drew on a piece of A3 paper what symbols were most enduring for me from my foregrounding, dialogue with the texts, and my own experience of immersing myself in the study. This is how I became consciously aware of how the texts talked to me and to each other. From looking at the drawing, I could see how my dissertation should be divided up and how each text and section might relate to the other.

Due to Jill Buchanan's resignation from AUT, she supervised me up to when I was started writing my data chapters and just after I completed my picture of my work (see Figure 2).

Figure 2
Fusion of Horizons



I worked with Dr Margot Solomon as my supervisor for the remainder of my study. During this time, my ideas took on shape and structure. I started the writing process and wrote and rewrote as my understanding of my research phenomenon flexed and grew. My key finding is that we can regard the dead sibling as a lifelong constant companion for the surviving child. The dead sibling is present for the young child, and the grown-up young child, and can have a significant lasting influence.

Outcomes

While my research outcomes are not the subject of this paper, I would like to mention the findings I specifically attribute to the hermeneutic methodology. I attribute them to the methodology because I became aware of them mainly through the creative experience of engaging with texts as distinct from absorbing the content of the texts. That is not to devalue what I learned from absorbing content; rather, to highlight how the process of the researching hermeneutically can yield meaningful results in its own right. The application of my findings to the practice of psychotherapy with bereaved children can be found in the dissertation (Jackson et al., 2021).

An important finding was that young children use symbols and play to process and express the experience of bereavement by sibling stillbirth. Through play, the young child has an evolving relationship with their sibling. I experienced this myself through doing this research. Art-based research validated these examples by showing that children connect with and integrate the sibling into their lives through art, poetry, dance, and music (Jonas-Simpson et al., 2015).

Another finding was that stillbirth is a beginning with no ending. Still babies are born, but into a different realm. They are not biologically defined. Instead, they are our constant companions, and they are with us all the time. For indigenous cultures, such as Te Ao Māori, this is an ordinary way of experiencing reality.

I propose that for young children the daily presence of their dead sibling is also quite ordinary. The young child inhabits, for a part of their time, a different realm; the imaginative magic realm. This the realm, created between therapist and child, is created during psychotherapy with young children, as it is between parent, whānau, and child. The adult has access to this realm through engaging in culture, narrative, the visual arts, and the written word. This realm is where our dead live. Karlo Mila (2020) suggests in her poem that we sense our dead too within our own bodies.

Finally, the experience of sibling stillbirth in young childhood draws us to whakapapa. The idea of "whakapapa etched on faces before birth" (Broughton, 2016, p. 193) suggests that through life and death we are simultaneously tūpuna (grandparents or ancestors) and mokopuna (grandchildren or descendants). The presence of the dead baby is passed from generation to generation through the transitional or transpersonal space that each generation shares with the one before. Losses experienced generations before, either earlier deaths or losses due to colonisation or immigration, can be extenuated and refreshed by a stillbirth in the family.

Strengths and limitations

This study has focussed primarily, but not exclusively, on healthy young children located within a nuclear family of European culture, living in Aotearoa New Zealand. The nature of hermeneutic research is that it relies on the researcher's prejudices and life experience. Due to my personal limitations and prejudices, combined with those of a mainstream training programme in an academic institution, this research is a version of "mainstream", where Kaupapa Māori is not "normal" (Hudson et al., 2010). This is a limitation of my research. Further research could address the experience of Māori whānau and tamariki, perhaps using a Kaupapa Māori methodology.

Further research could also look into the role of nature in a young child's bereavement experience. I hypothesise that dialogue with the natural world would provide a stimulating response to my research questions. A strength of my research is that I have been able to draw on my own experiences as a young child bereaved by sibling stillbirth. This could also be considered a limitation because it is more difficult to envelop experience of the research

phenomena that differs from my own. However, the hermeneutic methodology welcomes acknowledged prejudices.

Conclusion

Although my dissertation is complete, the claim remains on me. In the timeless intergenerational meeting place that is the space between client and therapist, I encounter my research topic in all its richness. I have described my research process and given some examples of how I engaged with texts such as Frank Bramley's (1891) painting "*For of such is the Kingdom of Heaven*" and Grace Briar Smith's (2019) pūrākau "*Born.Still*".

The hermeneutic methodology privileges the use of the symbol, playing, and the use of the cultural and even the spiritual experience, which are all features both of the developmental stage of young childhood and my psychotherapy practice with young children.

Through the use of the hermeneutic methodology, I acknowledged my prejudice as an adult and attempted to privilege the subjective reality of the young child. Being able to take this approach was fundamental to my research aim of exploring the young child's experience.

This approach also enabled me to place my research question in contemporary Aotearoa New Zealand. I engaged with ideas and authors from the psychoanalytic community based in America, England, and the Commonwealth, on which the tradition of child and adolescent psychotherapy is based. Concurrently, I dialogued with authors and artists from Aotearoa New Zealand and the Pacific. This was important to me as a researcher and speaks to the research whakapapa, the history of child and adolescent psychotherapy in my country. It is my attempt to respond to the question of how practitioners in colonised countries think about the practices and traditions of their European contemporaries and its application in their own place and time.

Finally, the hermeneutic methodology contributed to my development as a psychotherapist. The transpersonal is the spiritual encounter between people where the mysteries of life can be held and felt, and do not need to be resolved. It is said to be an aspect of the therapeutic relationship (Clarkson, 1999). Research with the "soul in mind" (Romanyshyn, 2020, p. 3) can also be a feature of the research endeavour based on the hermeneutic methodology. For as does the young child bereaved by stillbirth, the researcher and the therapist hold life and death simultaneously. There is no resolution. There is neither a beginning nor an ending. But the mysteries of life can be held and felt.

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Paper 20 (2021)

The art of mourning: Exploring the impact of artistic creation on the psychotherapist

Jessie McCall and Margot Solomon

The realm of artistic creation has long captivated thinkers within the psychotherapeutic sphere. A rich lineage of theoretical contributions considers the origin, nature, and process of creativity through a psychoanalytic lens, yet fewer contributions consider the significance of therapist as artist. My training and practice as a psychotherapist sit alongside my work as a freelance dance practitioner and choreographer—these two practices interlacing within my own experiential understanding. Through the intimate methodology of heuristic inquiry, I undertook an 18-month investigation into the potential impacts of experiences of artistic creation upon the psychotherapist. This contribution to psychotherapeutic research is evidently driven by an autobiographic interest, and yet "with virtually every question that matters there is also a social—and perhaps universal—significance" (Moustakas, 1994, p. 17). Heuristic methodology explores the nature and meaning of phenomena through the embodied and personal lens of internal self-search processes (Douglass & Moustakas, 1985), and it is from this deeply subjective place that I feel I have met meaningfully with concepts and phenomena that, intriguingly, map onto established theoretical frameworks in both confirming and disruptive ways.

This research has unearthed the significance of loss in my creative and therapeutic experiences. Mourning and the facilitation of integrative inner representations have been revealed as processes integral to transformative change in both artistic and psychotherapeutic domains. My research findings presented here comprise an embodied proposition: that opening toward loss through personal artistic practice may facilitate a radical recalibrating of self—a process vitally resonant with the psychotherapeutic endeavour.

Self-inquiry—The heuristic method

The fundamentally embodied and experience-near nature of the psychotherapeutic endeavour is pertinently mirrored in heuristic research methodology. As corroborated by Rose and Lowenthal (2006), the relational quality of heuristics facilitates an apt exploration of "the lived experience of psychotherapy" (p. 133). As depicted by artistic researcher Julian Klein (2017), the ability to see oneself "from outside a frame and simultaneously enter into it", perhaps equally describes the therapeutic and artistic task, in which "perception becomes present to itself" (para. 9). My methodology aptly called me to engage this same meta-awareness—a perception of my evolving perception as researcher.

Following the heuristic method, my research unfolded over six distinct yet interlinked phases (Moustakas, 1990). The first phase (initial engagement) comprised the selection and refinement of an area of both personal and societal interest (Sela-Smith, 2002). The second phase (immersion) invited the "critical beginning" of self-dialogue in relation to both lived artistic experience and psychotherapeutic theory, through free-form personal reflection notes that allowed my internal responses, curiosities, and felt senses to percolate (Moustakas, 1990). The third phase (incubation) facilitated a retreat from "intense and focussed attention on the question" (Kenny, 2012, p. 8), allowing the emerging phenomena to digest on an unconscious level. The fourth stage of the heuristic method (illumination)—the "breakthrough into conscious awareness" of new realisations—was scattered intermittently throughout my study (Moustakas, 1990, p. 29), resonating with Sela-Smith's (2002) depiction of "waves of awareness over time" (p. 67). In the fifth phase (explication), I began making sense of the layers and vertices of meaning emerging in my findings through an active examination and classification of key themes. These were able to "take up residence in the researcher", eventually calibrating into a "new whole" in the sixth phase (creative synthesis), culminating the research process (Sela-Smith, 2002, p. 68).

Established frameworks—A psychoanalytic lens on creativity

That art might allow reality and fantasy to reconcile is a foundational theoretical seed in the psychoanalytic conceptualisation of creativity; a seed sown by Freud (1995) despite his reservation that "whence it is that the artist derives his creative capacity is not a question for psychology" (p. 187). Meeting the frustrations of reality, yet unwilling to forsake instinctual satisfactions, the artist is proposed to mould their phantasies "into truths of a new kind" (Freud, 1911, p. 244). However, a lack of comprehensive theory underpins this suggestion of artistic sublimation, with Adams (1994) declaring it one of the most tenuous concepts in classical analysis. In the middle of the 20th century, a vital and vitalising turning point in the rendering of creative impulse was provided by the work of Austrian-British psychoanalyst Melanie Klein (1949, 2002). Klein's formative concept of the depressive position and its relationship to symbolisation—furthered by the work of Hanna Segal (1980)—heralded the notion that the creative act ultimately seeks to provide symbolic relational repair: to "put together what has been torn asunder, to reconstruct what has been destroyed, to recreate and to create" (p. 75).

Many have used this Kleinian arc as an intriguing jumping off point for complementary renderings, such as Maizels' (1996) conception of a post-depressive "spiritual position" (p. 148). However, others, such as Meltzer (1988) and Likierman (1989), posit earlier creative beginnings than the infantile depressive stage. Seemingly akin to Bollas' (1978) theory of personal idiom, in which the infant's experience of the mother's style of care is "the first human aesthetic" (p. 386), Likierman (1989) writes that the "initial reaction of our sense impressions to the world" (p. 133) heralds our later brushes with beauty and artistic imagination. Amplifying the implicit involvement of art in the building of the self, Bollas (1978) asserts that "unintegrations of self" find assimilation through the form of aesthetic objects. This perhaps echoes Winnicott's (1953) transitional object: something that feels to be both of-the-child and yet not-the-child—this "covenant between fantasy and reality"

(Spitz, 1982, p. 62) helping the child (and I would venture, consequently the artist) to bridge their inner and outer world.

Artmaking is also suggested within the psychotherapeutic literature to be innately entwined with our connection to life and death. Rank (1989), following some of the conceptual trails of Rickman (1940) and Stokes (1955), explores this terrain while pushing adamantly against Freud's conception of the death instinct: the innate wish to return to a state of complete rest. He posits that while such self-destructive internal forces may be present, they are vitally counterbalanced by a spirit of creative overcoming. Rank felt that the forward reaching "need to go beyond" quality of artistic creativity allowed one to survive the "ever-expanding and ever-contracting, space between separation and union" (p. 86) that life-fear and death-fear: a fear of individuating and a fear of losing one's individuality respectively, pose.

Plato's (1924) renowned suggestion that invention occurs when the "mind is no longer in" the artist (p. 502), nods to the widely held premise that unconscious psychic material holds a central role in art making. Ernst Kris (1952), an art historian and psychoanalyst, suggests that productive contact with material beyond the conscious mind constitutes "a regression in service of the ego" (p. 177). Comparable perhaps to Schafer's (1958) adaptive regression, the creative process is proposed to liberate the artist from the "fetters" of rational Aristotelian logic (Arieti, 1976, p. 51). This is thought to allow closer contact with unconscious insight, implying that indeed "they who dream by day are cognizant of many things which escape those who dream only by night" (Poe as cited in Galloway, 1986, p. 243). Regression toward unconscious material—something often relegated to pathology—is seen to emerge within the creative process as "an innovating power" (Arieti, 1976, p. 52). Arieti (1976) reminds us, however, that some level of co-ordination between primary processes (primitive pleasure-oriented impulses) and secondary processes (rational moderation of these impulses) is vital to allow creativity, rather than schizophrenia, to result from such regression. Segal (1991) seems to corroborate this in her assertion that the ability to stay connected to the reality of the external world is "essential to [the artist's] feeling of a completed reparation" (p. 96). Accordingly, Niederland's (1976) proposal that the artistic product "albeit rooted in and influenced by the primary process" (p. 189) is oriented toward reality, is echoed by McCully's (1976) assertion that profound discoveries across history have stemmed from the application of rational thought to a non-rational inspiration. Here the literature seems to converge on the premise that to be creative rather than destructive, artistic process necessitates a marriage of the conscious and unconscious spheres.

Losing it

Across the research process I felt I was constantly undertaking the work of beginning again. The "dissolving wholes into parts and reconstituting new integrations again and again" that Rose (1993, p. 504) describes of creative work, was becoming increasingly evident in the artistic pursuits I was examining and in the very process of examining them. Just as I was documenting constant, painful forfeitures of established choreographic material as new ideas were introduced within the rehearsal process, constantly reapproaching the meaning of the unfolding documentations themselves meant dismantling much carefully-ordered

thinking, and painstaking writing. In both spaces, loss seemed to experientially permeate a movement toward the new. This consistent gravitation towards loss within a study of something so apparently generative—artistic creation—enlivened my understanding of Thomas Ogden's (2000) description of mourning.

Mourning is not simply a form of psychological work; it is a process centrally involving the experience of making something, creating something adequate to the experience of loss. What is "made" and the experience of making it—which together might be thought of as "the art of mourning"—represent the individual's effort to meet, to be equal to, to do justice to, the fullness and complexity of his or her relationship to what has been lost (p. 66).

That the palpable experience of loss I was brushing up against in these generative spaces might be conceived of as mourning—the creation itself arising out of an underlying processing of loss—ushered me back to a significant turning point in the conceptualisation of creative impulse. Melanie Klein's (1949, 2002) formative concept of the depressive position refers to a developmental location at which a growing capacity to see objects as multidimensional wholes replaces a previous protective splitting of objects into all-good and all-bad parts. Klein (1949) asserts that such "vital advances in the infant's emotional and intellectual life" (p. 3) give rise to feelings of mourning and guilt—namely a guilt that one may have damaged or destroyed their objects whilst in the hateful grip of the earlier split (paranoid schizoid) state. Whilst deeply pertinent to vast psychoanalytic territories, this concept is foundational to creativity in that the guilt engendered and accompanying need to mourn the feared loss are functions fundamental to the capacity to symbolise. An internal world left devastated by depressive realisations drives the artist to seek symbolic repair, to create it anew: "this is what every major artist does—creates a world" (Segal, 1991, p. 86).

Holding on

I began reckoning with the idea that perhaps the loss I was encountering was not just unavoidable in creative process but was indeed its foundation. And yet, leaning into the loss—opening towards a depressive recognition of the damaged multidimensional reality of things—was certainly not the only dynamic I was witnessing across the research process. Close examination of the ebbs and flows of my choreographic practice also revealed a conspicuous quality of rigidity that seemed to swoop in at times—one prone to a clinging to rights and wrongs, to certainties and indelibility. Artist-psychotherapist Marion Milner's descriptions of a phenomenon within her own writing process that she terms 'blind thinking' resonated acutely with my experience:

> In addition to this inability to see all the facts, blind thinking also showed a tendency to distort those facts it did see. I found that its judgements were hardly ever moderate. It liked 'either-or' statements, wanted everything to be all good or all bad. Gradually I became aware how frequently it tried to bolt to extremes. (Milner, 1934, p. 95)

This same jarring flip between assurance and insecurity, the cleaving apart of good and bad, of Milner's and my own experience of 'blind thinking', seems to meet inherently with Klein's (1940) notion of the paranoid schizoid position in which benevolent objects and persecuting objects are kept protectively distanced in the mind. This universal experience in which

“aggression is contained in the hateful relationship with the bad breast, safely distanced from the loving relationship to the good breast” (Mitchell & Black, 1995, p. 94), is initially occupied in our first few months and returned to continually throughout life—a return that I seemed to be making at distinct points within my creative process.

This hope of apparent, albeit illusory, ‘safe distance’, might explain why such a positioning, a defensive splitting, remains so tempting across our lives—and palpably so within a creative endeavour. Whilst the generative forward-reach of creativity requires a painful grappling with loss, grasping onto ‘blind thinking’ promises us that we can avoid loss, can hold on to all-that-is-good by bracketing it off and clinging to it categorically. This hope to create a lossless system acutely reminded me of certain anxious stages of choreographic process. Rather than allowing ideas to arise and subside, in this mode each new thought is met with an urgent jotting down, producing screeds of often uninterpretable ideas. This fear of losing essential parts has arisen too within clinical work. A client once brought to me her fear that if she did not notate everything from our sessions precisely, the insights would simply evaporate—our time together reduced to a sort of nothingness. Her concern stirred a curious dread in me, bringing to mind the propensity for my own clinical note taking to become overworked, as if some essential insight might slip away if not fastened to the chronological terrain of my notes.

Coming and going

Yet so much indicates that the nature of knowledge is not this brittle. Freud’s (1899) suggestion, in *The Interpretation of Dreams*, that “in the unconscious nothing can be brought to an end, nothing is past or forgotten” (p. 576), proposes that if an idea moves out of our immediate awareness, it may be simply resting in another crevice of the psyche. Indeed, my own felt experience or understanding often follows a sort of shuffling in and out of availability—insights arising and becoming obscured again, not lost but submerged as they shift to a new position in a changing whole. Within this research, the very concept of mourning and its significance to my query seemed to slide, in this manner, in and out of explicit awareness—striking me almost anew each time it arose. As with Rose’s (1993) description of “reconstituting new integrations again and again” (p. 504), the illumination phase of both creative process and heuristic research has accordingly occurred for me as a cyclical phenomenon, in which established understandings have often emerged anew, and novel discoveries felt deeply familiar.

Leaning away from protective grasping and into a trust that passing material will make its own way back, feels deeply relevant to the psychotherapeutically significant notion of negative capability. Brought into the psychotherapeutic realm by Wilfred Bion (1995), and notably enriched by Jessica Benjamin (2004), the concept of negative capability aptly originates from poet John Keats, who describes it as the capability of “being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason” (cited in Hebron, 2014, para. 2). During the early devising stage of a dance work that ran simultaneous to the research process, I noted that “the urge to know exactly what the unfolding content means has disappeared behind some sort of intentional suspension, an uncertainty that feels somehow truer than any specific understanding”.

The experience of seeking a hospitable relationship with uncertainty, of attempting to hold doubt with the same care as understanding, bridges my experience of sitting with an artwork and sitting with a client. In both settings the holding of space for what might emerge, uncluttered by pressure to understand, allows the task to take place. Ehrenzweig (as cited in Milner, 1987) suggests that the creative state appears as an emptiness of consciousness, but only because its fluid content cannot be gripped by the fixed perceptions of the surface mind. As Milner (1987) attests, the depth mind—the tacit understanding that I sought to prioritise in this research, and that seems vital to my artistic process—can only be accessed by this sort of "absent-minded watchfulness" (p. 195).

Yet, as revealed in the evident return to 'blind thinking', this is not always an easy place to dwell. Assurances from both psychotherapeutic and creative theory that such free-floating uncertainty is an acceptable part of the plan can dissolve alongside other "reason" once immersed in the unknown. The boundless doubt invited in negative capability can, for me, masquerade, viscerally, as barrenness. Perhaps it is the content of my own mind that I so fear losing—the rational thoughts that I have been encouraged by a largely positivist family and society to recognise as the essential evidence of myself.

Let's pretend

So how does one keep making? How is this anxious hurdle cleared repeatedly across a career of artistic projects in which new things are created; and thus, utter uncertainty and the potential for loss necessarily borne? Akin to Schafer's (1958) concept of adaptive regression, perhaps the artistic frame helps to excuse makers from the "fetters" of the rational, certainty seeking mind (Arieti, 1976). Lombardo's (2007) thinking around conventions supports this wondering; the "entries into a special frame of mind" that he suggests are akin to a child's "let's pretend" (p. 365), bring the frameworks and scaffolds of my own choreographic practice to mind. The bounds of the studio space, rules of style and genre, relationships with forerunning artistic lineages, adherence or subversion of familiar techniques, etc., each, indeed, signal a fundamental separation from everyday reality.

Kris (1952), Arieti (1976), and Rank (1989) each attest that such artistic conventions free up a certain psychic vigilance—this energy then available for a state of play with the newly permissible material. Freed to recognise potentially disturbing feelings and granted a protected space to relate to them, a malleable collection of symbols can be newly juxtaposed and, thus, newly understood without the feared 'real life' ramifications of their enactment. Considering the function of artistic convention in this way brings the potentially parallel role of the therapeutic frame to mind—the boundaries and conditions of the therapy encounter that distinguish the "play space" of the therapy from the "reality world" outside (Stern, 2016, p. 128). As with artmaking, access to something experientially true seems to be facilitated within the therapy by a suspension of immediate reality. As Winnicott (2005) writes in *Playing and Reality*, the very fact that a symbol of the breast is not the breast itself "is as important as the fact that it stands for the breast" (p. 6). In the same sense, I conceive that the fact that life-as-represented-in-therapy is not the client's

real life, is essential in allowing it to effectively stand in, symbolically—and thus malleably—for the client's real life.

This returns me to the role of loss in the creation of the symbol. Perhaps the temporary loss of the real (through the 'as if' or 'let's pretend' of therapy or art making) necessitates the rich creation of symbols to reform this lost reality—symbols which then allow a reworking and reconsideration of previously untouchable; and thus, concretised experience. As Segal (1952) states, "every situation that has to be given up in the process of growing, gives rise to symbol formation" (p. 203). Symbols are born as stand-ins for things lost in reality. Any ability to create and manipulate symbols when creating artworks, or to verbally image experience in the therapy room, has stemmed from the letting go of something real. Paralleling creative and therapeutic conventions in this way breathes new life into my understanding of Winnicott's (2005) assertion of the essentially paradoxical nature of the analytic encounter: it being both real and illusory.

Considering the symbol in this way illuminates my experiential finding that despite the necessary unreality of a creative process, in the wake of one I feel more real. My personal reflections are peppered with reports of feeling more in possession of myself amidst an artistic project. Integrating Bion and Winnicott's stances, Eigen (2004) emphasises that for something to feel real, it must undergo unconscious processing. Perhaps the unconscious, dream-like, and indeed symbolic logics of artistic process, counterintuitively provide a sense of enhanced reality. Symington (2003) offers the evocative metaphor of painting pictures inside the self as a means of coming to know one's experiences. From the chaotic impulses and sensations within us "we create a series of pictures that we dare to call our mind" (Symington, 2003, p. 13). Perhaps in making art I am adding paintings of denied or simply unregistered losses to the gallery of my mind, making realer to myself what I have already really experienced—who I already am.

Transformer

What has emerged as a primary feature of this research—comprising perhaps its greatest limitation and revelation simultaneously—is the encounter with my evidently ambivalent relationship to transformation. As Sela-Smith (2002) describes of the heuristic method, "once access is made through feeling experiences, wholes that were formed out of limited or flawed awareness can be reconstructed" (p. 62). Through this reconstruction, the meanings underpinning our experience can be transformed. Initiating meaningful change through enhanced access to affect equally sits at the heart of psychotherapy. Jung (1933) stressed that in the meeting of two personalities, akin to that of two chemicals, "both are transformed" (p. 49). As the therapist's involvement in the intersubjective field of psychotherapeutic work has become increasingly acknowledged within analytic theory, it has become even clearer that meaningful therapeutic process affects the analyst as well as the patient (Jaenicke, 2011).

This study has brought to the fore the significance of this same principle in the context of artistic creation. My findings suggest that through creative process I am both expressing self-experiences and engaging in the continued modification of them. Alongside allowing

something of myself to be seen, the art-making process also appears to be acting upon the revealed parts—refashioning them via the formation and manipulation of the symbols that stand in for them. Perhaps this modification process is what Turco (2001) refers to when he says that in artmaking the "contents of the inner world interpenetrate the reality ego" (p. 547). Put simply, the creative act seems to change the artist by giving them a clearer view of themselves (Oppenheim, 2005). To me, this evokes the psychoanalytic concept of the intersubjective third: a triangular space between therapist and client unconsciously occupied "for the purpose of freeing themselves from the limits of whom they had been to that point" (Ogden, 2004, p. 189). Winnicott's (2005) notion of potential space: a hypothetical space between self and object, might be another means of imaging this—a space where "identity can be suspended in creative play, in the absorbed exploration of potential" (Metcalfe & Game, 2008, p. 21) mapping aptly onto the crucial 'let's pretend' offered by the frame of artistic convention. It seems that my relationship to artmaking involves such a third dimension: a space in which the meeting of I-as-subject and me-as-object might bring about a change in the experiencing self.

Ogden (2004) asserts that the process of having oneself "given back" via such a third dimension is "not a returning of oneself to an original state; rather, it is a creation of oneself as a (transformed, more fully human, self-reflective) subject for the first time" (p. 189). The hope of this transformation seems central to my engagement with both art making and therapy. It is the hope of finding new ways of bearing and, indeed, embracing loss in the welcoming of the new. Analogously, in placing the self of the researcher at the centre of the heuristic inquiry, research discoveries fundamentally become self-discoveries. As Moustakas (1990) writes, "while understanding the phenomenon with increasing depth, the researcher also experiences growing self-awareness and self-knowledge" (p. 9).

And yet, as much as this research has elucidated my hope for transformation across these spheres, it has equally revealed my evasion of it. Flights into intellectualisation and pre-emptive control that pledged to keep me in the known, the unchanging, evidently intervened at various stages of both the creative processes I was documenting, as well as the research process of documenting them. In the immersion phase I noted that "reading the first few lines of the article, there is a burning interest that turns my head, literally, away from it". Yet, despite the potential to impede my engagement, this tension within the research process itself has served to augment a central theme of the emerging data: that my lived experience of therapy and artmaking appear to be fundamentally connected by the same dialectic—the paradoxical hope for, and fear of, change.

Catastrophic creation

Near the end of the research process, I came across printmaker Sybil Archibal's red and purple monotype *Windows*, accompanied by the caption "Is this a sunrise or sunset? I wasn't sure until I realized it is both, one way of being is ending as another is coming into form" (Archibald, 2020). The peaceful nature of Archibald's language, the smooth "one way of being is ending", felt pointedly at odds with a rather more chaotic sense of destruction that I was encountering around change. A notable letter from Winnicott to Klein brings their thinking closer than ever in this area, with Winnicott (as cited in Groarke, 2003) making

reference to the “irreducible link between destruction and creativity” (p. 486) that Klein herself vehemently fostered. I find Peters’ (1961) contributions in this area particularly evocative in his conception of artistic creation as destruction by incorporation, comparing the destruction inherent in the creative act to that of eating—food violently destroyed and yet assimilated into oneself.

Beyond the essential fact of destruction: the necessity of making room for the new via the demolition of the old, I have found that my particular orientation to this demolition matters significantly. My presence to the loss, my capacity and position in bearing witness to it, appears to impact the nature of the change that it heralds. Bion (1984, 1995) and Goldberg’s (2008) thinking resonate with this noticing, in their suggestion that the very process of grappling with change is an indispensable aspect of psychic growth. Levine’s (2016) assertion that “at the moment of change, you look into the abyss” (p. 36), evokes the abysmal unknowns that mourning (and its inherent change) entails. Connecting transformation and mourning in this way perhaps speaks to Segal’s (1980) observation that it is depressive negotiations that bring a “radical alteration in [one’s] view of reality” (p. 73).

Perhaps it is this radical alteration that is simultaneously dreaded and courted within therapeutic and artistic pursuits. Bion’s (2014) notion of catastrophic change and, in a retrospective sense, Winnicott’s (1974) notion of fear of breakdown, both highlight this dread of encountering emotional truth: truth that might disastrously alter the self. Though “catastrophic” has been branded by some authors as melodramatic, I feel the word aptly captures the “real dangers” of the existing personality intersecting with “some mysterious unknown force which may be either developmental or destructive” (Harris Williams, 2012, p. 3). In Maizels’ (1996) description of catastrophic change as a “quivering” (p. 7) between paranoid-schizoid and depressive positions, mourning is again implied as a key component of radical self-alteration, due to its essential role in any movement between these positions. It is not surprising then that the inextricable connection of mourning and creativity is paralleled in the relationship between catastrophic change and creativity, with Harris Williams (2012) asserting that the “capacity to think creatively is the same as a capacity to tolerate catastrophic change” (p. 2). I find myself wondering if indeed they could be seen as different conceptualisations of the same phenomenon: catastrophic change viewing as an event what mourning renders as a process. Or perhaps catastrophic change might name a particular transformative moment embedded within the wider transformative process of mourning.

Inner artworks—Artistic creation and the psychotherapist

As Cooper (2016) notes, how therapists experience and work with “our own sense of incompleteness, our own grief” (p. 3) during the therapy is essential to its progress (p. 3). This research has revealed my artistic process to be an arena in which I test and develop this essential ability to face into my own grievances and fallibility. As the primary vessel of both therapeutic and artistic work is the self, I carry these capacities between spheres.

My experience of the artmaking process appears to mirror the therapeutic process in the provision of a third dimension that facilitates me being ‘given back’ to myself. In both spaces

this ‘giving back’ has proved to involve change: a recalibration of aspects of the self in response to emotional truth revealed by the third perspective. Such change, even when growthful, fundamentally involves the integration of loss; a mourning process that can feel catastrophic in the movement from known to unknown. Reflecting closely on these processes in my artmaking has clarified my motivation and orientation towards my therapeutic work by revealing a similar hope—to embrace growth in the self (mine and the client’s) by coming into closer relationship with the mourning it requires.

All self-knowledge acquired by the therapist has an inevitable impact on their therapeutic work. Jung (1933) saw it as the most critical aspect of the therapeutic relationship. As such, whilst any self-knowledge generated in this research process will have some bearing upon my work as a clinician, the particular understanding generated around my own relationship to change seems potent in its relevance to potential processes in the client. Many clients I have worked with have arrived to therapy hoping for change in their lives; and yet, often work, on varying levels of consciousness, to disallow such a change to take place. Various clinicians write of patients’ tendencies to both desire and resist change, with Strupp (1982) reiterating that undesirable ways of being always have their own highly convincing “raison d'être” (p. 250). The likelihood that my clients will themselves be navigating a conflictual relationship with self-alteration increases the importance of my own self-reflexivity in this sphere. I wonder whether the potential identification with a conscious belief in the beneficial possibilities of change might impair therapists’ recognition of their own trepidation of it. An increased awareness of my resistance of transformation surely allows me to better navigate the potential intermingling of this with my clients own potentially ambivalent relationship to self-alteration.

The ability to symbolise challenging experience is a therapeutic capacity that my findings suggest is honed within artistic practice. As a developing therapist, I am endeavouring to grow my proficiency in signifying the affect moving in the interpersonal field. Segal (1952) makes clear that to create art the artist too must learn to symbolise depressive experience, necessitating that they “accept the reality of death for the object and the self” (p. 206). Alongside the process of symbolising, the therapist must develop the ability to contain the psychic content of the other. This process of allowing the mind to expand without being destroyed is one which Harris Williams (2012) believes is also developed by learning to “tolerate the aesthetic conflict” (p. 6) in artistic creation. In this sense, processes of artistic creation show potential to assist in the development of a flexible, robust container for the therapist and client’s psychic contents, as well as the enhanced potential to come to know these contents through the symbolic function.

The potential for core therapeutic capacities to be developed within the artistic experience including the negotiation of depressive anxieties, furthering of self-knowledge, ability to contain and symbolise material, and fostering of negative capability, stirs important considerations for psychotherapeutic training. In my experience within the sole post-graduate psychotherapy course in Aotearoa New Zealand, the development of these capacities was fostered almost entirely within talk-based environments. Beyond the absence of artistic or other non-verbal experiential spheres for generating psychotherapeutic competencies in the curriculum itself, the density of academic demands and assessment meant that space for personal artistic engagement was often meagre. This

seems concerning in light of research suggesting academic components to be distinctly secondary to experiential learning in their value to the developing therapist (Orlinsky et al., 2001). Considering the solo sample-size of this study, I am not proposing that specific artistic engagement should be mandated within psychotherapeutic training. However, it appears that offering both time and encouragement for trainees to engage in extracurricular creative modalities would likely see these become invaluable adjunct spaces to further the embodied learning that is so deeply relevant to trainees' emerging clinical capability.

Whilst artistic processes evidently have meaningful bearings upon me as a therapist, it feels important to distinguish that it is not the artwork per se that makes this impact. The act of making dance material, for instance, does not itself innately strengthen negative capability or the capacity to mourn. The outer artwork cannot integrate splits in the internal world; rather, it is the inner artwork, an internal representation, that integrates. The conventions of the outer artwork aid a facilitative suspension and malleability of reality that may foster such a representation to manifest. It is this tacit image, rather than the framing conventions, that symbolises the loss—that allows it to be represented in the self. As Symington (2003) wrote, "at the moment when a representative image is created the pain is embraced" (p. 14). This understanding reinforces my sense of the role of the therapeutic frame in my work as a psychotherapist—technique and convention being fundamentally facilitative, yet change itself arising from the internal objects of myself and my client (Harris Williams, 2012).

Conclusion

"One has to posit I think that there is something in the personality that surges to represent, to paint a picture, of the sensations which bombard us both from within and from the outside" (Symington, 2003, p. 12). In my own life, I have responded to this urge to represent sensation via both artistic creation and therapeutic engagement. Levine (2016) writes candidly about how "a mutual survival of destructiveness" (p. 36) can be a source of passionate and creative change for therapist and client alike. This study has affirmed that my acknowledgement, representation, and survival of such destructiveness might itself underlie my creativity in my artistic and therapeutic practices. Facing into the disastrous loss and the hope of the new that catastrophic change heralds, appears crucial to the creative transformation sought in each sphere.

While the work of integration is never done, therapeutic and artistic practice appear to constitute major pillars of my own "sustained and yet never completed effort" (Arieti, 1976, p. 182) to accept the wholeness of things and the transformative potential of loss. The enhanced understanding of parallel resistances, hopes, and challenges across each realm has itself offered integration; allowing me to bring together my sense of these apparently separate pursuits into a more holistic endeavour for, and resistance of, transformative change. The mind, said Oliver Wendell Holmes (2015), once "stretched by a new idea or sensation… never shrinks back to its former dimensions" (p. 266). Whilst indeed a radically destabilising process, opening toward change through artistic creativity offers the psychotherapist embodied experiences of vital relevance to the psychotherapeutic endeavour: each reaching toward a radical recalibrating of who we find ourselves to be.

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Paper 21 (2021)

It takes two: Ruptures and repairs in the therapeutic relationship with adolescents

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This paper, which is based on the Master's research conducted by the first author under the supervision of the second author, considers the ruptures that occur in the therapeutic relationship with adolescents, as well as the repairs, with a specific focus on these processes in telepsychotherapy.

The therapeutic relationship

The therapeutic relationship is one of the most researched concepts in psychotherapy; Freud (1912/1958) began to refer to it in his early writings and understood that it was important for treatment success. With the development of child psychotherapy, Anna Freud (1946) noted that an affectionate attachment between the analyst and the child is a requirement for subsequent work in child therapy. She differentiates this relationship from eagerness for connection to fulfil an interpersonal void in the child's life, which was noted as a less developmentally mature way of relating.

Bordin (1979) defined the *working alliance* as involving both an emotional bond and an agreement between therapist and client on the treatment tasks and goals. The first generation of alliance-focused research sought to clarify the association between a strong alliance and positive treatment outcomes (Nof et al., 2019). Safran and Muran (2000) conceptualised ruptures and repairs in their work inspiring the second generation of this type of research, focusing on what makes the alliance itself therapeutic.

Safran and Muran (2000) highlighted the continuous process of an intersubjective to-ing and fro-ing between therapist and client which involves moments where the quality of the therapeutic relationship increases in tension and/or deteriorates, known as ruptures, and moments where this tension is focused on to be resolved, known as repairs (Eubanks-Carter et al., 2015). Ruptures in the relationship are common and unavoidable events in the therapeutic process, and working through them can function as a corrective experience and encourage interpersonal growth (Safran et al., 2011). Blatt and Behrends (1987) discuss how ruptures are crucial when working with adolescents to allow a process where they can express their needs of identity, separation, and individuation. The social, historical, and cultural backgrounds of the client and therapist shapes how each negotiates their relationship, usually outside either person's awareness.

Adolescence

> Only the most courageous, perhaps the most foolish therapists are willing to treat adolescents, for they are the most difficult group of children with whom to work. (Spiegel, 1989, as cited in Blake, 2021, p. 130)

Adolescence is a time of great developmental change and is often compared with the rapid growth seen in utero. Anna Freud (1958) described this stage in life as "an interruption of peaceful growth which resembles in appearance a variety of other emotional upsets and structural upheavals" (p. 267). The transition into adolescence can introduce a certain amount of disruption to family relationships (Chen-Gaddini, 2012). In therapy with adolescents, ruptures are important to allow a process where young clients can express themselves and their needs (Blatt & Behrends, 1987). Muran and Eubanks (2020) explained that within the rupture experience lies a dialectical tension between the drives to pursue autonomy and connection at a time when adolescents are going through a second individuation phase (Blos, 1967). Ogden (1994) also speaks of this in the therapeutic process of experiencing the dialectic of *oneness* and *twoness*.

Anecdotally, teenagers have been bestowed the negative reputation of being a problematic population to deal with and this has extended to discourses in mental health. Young people have the right to receive care for all aspects of health and, typically, many mental health difficulties become more prominent during adolescence (The Partnership for Maternal, Newborn and Child Health, 2020). Recent evidence proposed that teenage mental health continues to be neglected while often being highlighted as an essential issue (Azzopardi et al., 2019). The growing research on creating and maintaining a working, therapeutic relationship has positive potential in the treatment of youth and adolescents, as well as the lack thereof likely leading to premature ending of therapy (Garcia & Weisz, 2002; Zack et al., 2015).

New Zealand adolescents are a unique group, encompassing multiple cultures and attitudes towards emotional wellbeing and help-seeking. They also have high rates of mental health problems, particularly depression, anxiety, substance use, and suicide (Ministry of Health, 2019), with Māori rangatahi (youth) among the most affected. Appleby and Phillips (2013) contend that in New Zealand treatment rates are low as many adolescents with mental health needs do not often connect with a child and adolescent mental health service, and they discuss engagement as an essential aspect of effective treatment.

Research on rupture

Ruptures can vary in frequency, intensity, and duration and can manifest through disagreement of treatment goals, lack of collaboration on tasks, or strain in the emotional bond (Eubanks et al., 2018). Repeated misunderstandings can damage the alliance and be detrimental to the therapeutic process (Safran et al., 1990). Pinsof and Catherall (1986) stress that the dynamic nature of the therapeutic alliance means it can, and does, differ depending on who the client is, who the therapist is, the therapeutic orientation(s) being used, and the length and quality of the relationship experienced.

While research has largely focused on adult populations, there has been increasing evidence of the role of the therapeutic alliance as significant in facilitating positive therapeutic outcomes for teenagers, indeed it appears to be a more crucial factor for youths than adults (Bhola & Kapur, 2013). Safran et al. (1990) argued that the presence of ruptures (and subsequent repairs) in the relationship in the treatment process seem to be more effective in terms of treatment outcomes compared with therapies without ruptures.

Ruptures leading to dropout

Dropout is defined as the termination of treatment involving the client making the unilateral decision of leaving whilst the therapist or treatment team perceive this decision as premature and ill-advised (Kazdin, 1996). Ruptures are unlikely to appear uniformly, and when unresolved by the end, they appeared to be linked with higher rates of dropouts with teenagers, however this is relatively unexplored in the literature.

O'Keefe et al. (2020) researched whether rupture and repair markers were associated with different types of endings with treatment of depression for adolescents (n = 35) through observational measures. They defined *markers* or signs of ruptures under two categories: confrontation and withdrawal. Confrontation markers appear as direct or hostile anger or dissatisfaction, while withdrawal markers appear as verbal or nonverbal expressions of disengagement or avoidance. Muran and Eubanks (2020, p. 69) outlined examples of rupture markers as shown in Table 1.

Table 1

Rupture Markers as Therapist Interpersonal Markers

Withdrawal ruptures
Movements *away* from other or self
Efforts towards *isolation* or *appeasement*
Pursuits of *communion* at the expense of *agency*
Examples
- Silences (confusion and mind-wandering)
- Shifts in topics or focus (avoidance)
- Too much or abstract talk (psychobabble)
- Overly protective or accommodating
Confrontation ruptures
Movements *against* other
Efforts towards *aggression* or *control*
Pursuits of *agency* at the expense of *communion*
Examples
- Pathologising patient (blaming and belittling)
- Coercions to conform to a theory or due to empathic failure
- Microaggressions against cultural identity
- Coercions regarding mutuality versus asymmetry

O'Keefe et al. (2020) focused on "dissatisfied dropouts"—clients who voice that treatment is not helpful, and "got-what-they-needed dropouts"—clients who express not needing to continue therapy when the therapist may not agree. They examined these groups along

with “completers”—those who ended therapy with the agreement of their therapist. Confrontation ruptures were rarely observed in all three groups, a finding which aligns with other research suggesting that teenagers will regularly avoid expressing negative experiences of therapy to their therapist (Gibson & Cartwright, 2013; Henkelman & Paulson 2006). Dissatisfied dropouts had more confrontation and withdrawal ruptures apparent in late sessions and experienced more unresolved ruptures from early in treatment compared with the other groups. Ruptures were usually resolved in sessions with completers and got-what-they-needed dropouts (O’Keefe et al., 2020).

The influence (or lack thereof) of the therapist in contributing to the therapeutic relationship breaking down was of interest. Therapists contributing to higher proportions of ruptures identified in early sessions were rated 50% for dissatisfied dropouts; (14%) for completers; and 0% for got-what-they needed dropouts (O’Keefe et al., 2020). Therapists being perceived as passive and unresponsive were the most common factors identified as negatively impacting the relationship, causing and worsening ruptures experienced by participants. Adolescents who were able to verbalise feeling uncomfortable and not knowing what to say often responded in a more withdrawing manner when their therapist was silent or seemed passively unreceptive to their concerns. Muran and Barber (2010) suggest looking for withdrawal early on and when dissatisfaction is expressed indirectly by exploring avoidance and making sense of the adolescent’s wish that they are struggling to articulate.

O’Keefe et al. (2020) discuss how a rigid focus on interventions can lead to shutting down the emotional experiences of the client and further ruptures. This focus on a therapeutic activity at the expense of what is pertinent for the teenager can contribute to ruptures. This may involve making interpretations that do not fit with the client, challenging the client’s processes, or focusing on practical goals and issues. Winnicott (1965) talks about adolescents having a “fierce intolerance of the false solution” (p. 210), alluding to adults offering responses, often in a problem-solving manner, to what is apparent on the surface regarding perceived difficulties. In O’Keefe et al.’s (2020) study, participants were observed to disengage by withdrawing from or rejecting therapeutic tasks.

Finally, focusing on risk can conflict with the overt wishes of clients in treatment and strain the relationship. Adolescents often present with risk concerns. Gibson et al. (2016) conducted a thematic analysis on data from young people (n = 63) aged 13–18 years to highlight what New Zealand youth would need to access psychological support. Their findings showed participants voicing need for autonomy and control with engagement, not having parents overly involved, a relationship different from a friendship, the experience of being listened to, and flexibility of services to meet the lives and needs of youth. They also considered how a focus on risk and confidentiality, presumably while missing out other aspects of major difficulties, can contribute to ruptures and dropouts for adolescents. Risk behaviours are not associated with severe psychopathology and are understood to ease the tensions of aggressive and sexual impulses while lessening internal unconscious guilt (Waddell, 2002). Therapists must balance keeping the client safe and maintaining the relationship. Ruptures are inevitable when there are major risk-taking, care, or protection issues present.

Therapists' view of ruptures

Morán et al. (2019) conducted semi-structured interviews with eight clinical psychologists who had experience working with teenagers to gather subjective experiences of moments of ruptures in psychotherapy with their young clients. They used an interpretive phenomenological research methodology to glean thematic findings from the collected data and arrived at four categories, three of which relate to reflections of the understanding of ruptures for the individual clients.

The first was the failure to recognise the adolescent's experience, whereby participants noted their difficulty maintaining awareness of the client's experience whilst applying rigid interventions that felt unconnected. They identified youths being sensitive to the therapeutic context and being drawn to exert their autonomy and respond to any perceived errors by the therapist. This can have the impact of therapists experiencing blame and feeling ineffective for the client who is withdrawing.

The second category is the intense affective experience of adolescence in psychotherapy, namely how it is expressed and felt within the therapeutic relationship. Participants talked about their need to regulate their own internal processes and their vigilance to safeguard the rights of their young clients when high distress and safety are involved. They found that acting on the urge to respond in a controlling manner can contribute to the rupture which can be experienced as confrontational. This can exacerbate feelings of fear, anguish, and confusion for both client and therapist with a lack of containment.

The third is the presence of therapeutic boundaries as an articulator of the purpose of therapy, regarding which participants discussed their assumptions about the adolescents' understanding of the therapy process. If the therapist's role and purpose are unclear for the client, in combination with the client's low motivation, lack of trust, and expectations to engage in psychotherapy, this can present significant barriers in establishing a bond.

Morán et al. (2019) suggest special focus is needed on the occurrence of ruptures. The therapist's role is to consider the relevance of attending to the thoughts, feelings, and intentions of the teenage client to unpack the forming ruptures in order to understand the deeper, relational nature of these in any therapeutic dyadic situation with youths. Failure to do so can contribute to further ruptures.

Menzies (1961) explains that the therapist's defences are activated to avoid disturbing identifications from, and excessive emotional investment in, the young person and family. Subsequently, the therapist can display resistance and unwillingness in the relationship which can further distance the adolescent client. The defences of individual practitioners can reflect wider systemic defences of mental health services that face enormous pressures to meet the needs of increasing numbers of people presenting with more and more complex issues with short-term interventions. This situation continues to put pressure on therapists' capacity to acknowledge and address ruptures in the relationship with teenagers. In Aotearoa New Zealand, there is still unmet need reported for mental health services for young people with some services reporting times when they are at capacity and cannot see more rangatahi (Malatest International, 2016).

Ruptures in telepsychotherapy

Virtual therapy presents some unique challenges and considerations. Withdrawing in the therapeutic process became complicated for therapists meeting with clients online to ensure safe physical distancing during the global COVID-19 pandemic that began in 2020. Some researchers were already exploring tele-health options including for delivery of psychotherapy (Carpi Lapi et al., 2018; Dolev-Amit et al., 2020; Hartman, 2011; Monthuy-Blanc et al., 2013). Hartman (2011) speaks about psychotherapists being unable to ignore the impact of new and evolving technologies on social and interpersonal relations and how these might impact the therapeutic relationship for the adolescents.

Therapists might feel remote and frustrated having to connect through a computer screen and may confuse their feelings with an actual rupture (Monthuy-Blanc et al., 2013). Dolev-Amit et al. (2020) discuss technical difficulties that challenge the identification of ruptures, such as limited observations of nonverbal language and body cues, unclear facial nuances, inadequate sound quality, or video lags which may mask silence length. Clients can also avoid the therapeutic work by not being visible on camera, talking with other people in their surroundings, or attending to other distractions during the session.

Technology can also function as a psychic retreat (Steiner & Schafer, 1993) from the external world. Carpi Lapi et al. (2018) discuss how technology can be utilised as a defence against mental pain, creating a literal and metaphorical barrier between people. Talking through a screen may avoid the intimacy of being with someone else. The use of devices and technology can offer a different kind of boundary, represented by the screen, that divides therapist and client and creates a contemporary *transitional space* for the expression of one's internal world (Carpi Lapi et al., 2018). Verheugt-Pleiter (2008) discusses how the online therapist might facilitate a space between phantasy and reality to make sense of the client's experience and guide a sense of a coherent self for the client.
Finally, it is worth noting that therapists may have to name that the therapy is not working and there can be potential risks and harm with continuing ineffective treatment (Wolpert et al., 2018).

Research on repair

Every relationship is at risk of moments of frustration and mismatch whereby repair is sought to overcome further weakening or breaking of our ties with others. Early mother–infant studies highlighted the natural occurrences of relational ruptures as seen from early life (Beebe & Lachmann, 2015). Most of the time it was observed that the mother and child were not attuned with one another or meeting each other psychically; however, approximately 70% of those misattuned periods appeared possible to be repaired within *two* seconds (Tronick & Cohn, 1989). These repairs, or coming together again, are associated with optimal development involving self-efficacy and coping capacity for the child (Tronick, 2007).

Regarding therapy, there are no consistent guidelines on how practitioners should intervene or work with ruptures in the therapeutic relationship. Muran et al. (2021) offered their most recent overview of the strategies for rupture-repair to recognise the client's needs (Figure 1). This overlaps with a stage-process model that occurs between the client and therapist around rupture resolution (Figure 2).

Figure 1
Strategies for Rupture-Repair (Muran et al., 2021, p. 4; designed by Rachel Small, 2019)

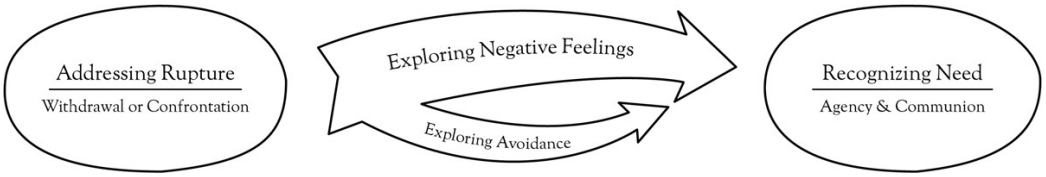
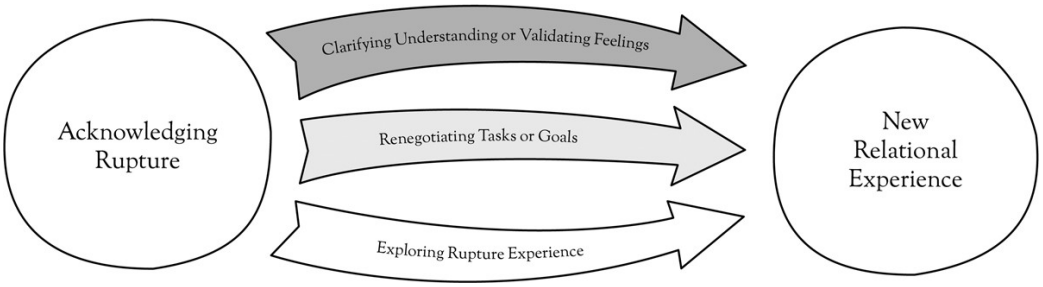


Figure 2
Stage-Process Model (Muran et al., 2021, p. 4; Safran & Muran, 1996; designed by Rachel Small, 2019)



Muran et al. (2021) discuss strategies for attending to the rupture as soon as it is identified. The first involves alliance building whereby goals and misunderstandings are clarified, as well as validating any anxious and difficult to tolerate feelings; and the second includes renegotiating changing of focus, tasks, or goals. These strategies can promote significant change through the client having new experiences and different outcomes to their expressed wishes; for example, shifting negative expectations of the other being withholding, intrusive, or not nurturing. The third strategy of exploring the rupture experience looks at attending to the internal states and behaviours of both the therapist and client that may have contributed to the rupture. The focus is on highlighting any underlying conflicting needs. Often there is ambivalence between moving towards independence and regression towards dependence (Winnicott, 1965).

The use of this approach to expand awareness of what is occurring around the ruptures makes it possible to exit a vicious circle of enactments. The therapist can inquire into the here and now. Muran et al. (2010) explain that one must be within the rupture dynamics to know how to get out of it and suggest thinking with the client about "what is happening between us right now?" This *therapeutic meta-communication* is the essential technical principle to guide the approach to ruptures and repairs which has potential for shared

emotional regulation and expanding awareness of the subjective experience of self and other.

Repair and attachment

Bowlby (1988) conceptualises attachment as a guiding framework for clinical practice and implications for conducting and adapting therapy. He suggests that the psychotherapist may become a temporary attachment figure for the client by becoming a reliable and trustworthy person in the patient's exploration of their experiences. In the therapeutic relationship, attachment histories of the therapist and client can intersect and might inform different ways of approaching rupture and repair.

The need for repair can be understood through attachment theory; people are fundamentally relational from the moment they exist in the world. Central to this theory is the notion that individuals from a young age seek connection with their caregiver or attachment figure and that a secure attachment involves experiences of regular and warm availability and responsive care (Bowlby, 1988). When this happens, children learn to use their attachment figure(s) as a *secure base,* that is they are willing to turn to them in times of need and can be comforted by them in a way that allows them to feel better and return to other activities and exploration. Experiences of attachment influence future patterns of relationships in an individual's life.

A part of healthy functioning involves reliance on secure attachment relationships in times of danger, vulnerability, or illness by bolstering against stress and uncertainty. According to Bowlby (1980):

> Intimate attachments to other human beings are the hub around which a person's life revolves, not only when he is an infant or a toddler, but throughout his adolescence and his years of maturity as well, and on into old age. (cited in Wallin, 2007, p. 13)

Straus (2017) explains that some attachment strategies that develop from difficulties in relying on others can interfere with developmental tasks for children. In adolescents, aggressive and dismissive behaviours towards others can function as a strategy to be in relationship while maintaining control, distance, and self-reliance. This can involve ignoring one's needs and avoiding negative emotional experiences; for example, attachment-based feelings of fear, anger, disappointment, hurt, and loneliness. This can disrupt tasks of developing emotional regulation, adaptive help-seeking, information processing, communication, and sense of self (Straus, 2017). The role of the therapeutic relationship can help to promote an increased sense of inner security as well as enhancing understanding of behaviours that may have been influenced by unmet attachment needs.

Zack et al. (2015) examined how the attachment histories of a group of adolescents (n = 100) in residential care in the United States might moderate the alliance relationship. Participants were aged between 11 and 25 years and the majority were male (68%) and Caucasian (84%). All participants had a primary substance dependence diagnosis. Attachment histories were assessed using the Inventory of Parent and Peer Attachment (IPPA; Armsden & Greenberg, 1987). Those with insecure attachments prior to treatment needed more

emphasis on rapport building and rupture resolution while, interestingly, those who reported more secure attachments did not appear to be associated with use of the relationships and symptom reduction (Zack et al., 2015).

Repair strategies

Nof et al. (2019) proposed a Child Alliance Focused Approach (CAFA) model of treatment or adjunct to therapy designed for practitioners to identify and repair ruptures in the alliance with young clients aged 6–17 years. This is based on the framework introduced by Safran and Muran (2000) in psychotherapy with adults whereby the aim is to open "an interpersonal space of reflection and negotiation, in which a mutual recognition and relational change can occur" (Nof et al., 2019, p. 46). It is thought that such a framework is relevant for work with adolescents (Nof et al., 2019).

It is difficult to resolve ruptures in the therapeutic relationship if they are obscured by strong affect, or if they are not identified at all. CAFA's first phase outlines how therapists can attend to rupture dynamics with adolescents by first regulating their own emotional responses. Instead of continuing treatment as normal, the therapist must be able to successfully manage their own intense feelings. Not doing so and continuing treatment as normal can lead to further ruptures (Eubanks et al., 2018).

The therapist should make sense of what type of rupture is occurring and reflect internally on the underlying communication of the client. This involves mentalisation as to the thoughts, feelings, and intentions of the young person at the moment of rupture in order to make sense of the behaviours observed; commonly linked with signals of distress and longing around protection and safety (Bowlby, 1988; Harel et al., 2006). Nof et al. (2019) suggest four questions to guide reflection (see Table 2).

Table 2

RNRN Questions to Guide Therapist's Reflection of Ruptures with Young Clients

Reason	What preceded the rupture?
Needs	What did the child need from the therapist?
Reaction	How did the child react to the rupture?
Non-adaptive pattern	Is the rupture part of the general vicious cycle?

With youth, therapists should be wary of going along with the client's tendency to withdraw, to relate to others inauthentically, and to fail to assert their needs (Safran & Muran, 2000). The deliberate use of pausing should be in response to a noticeable shift in the young client's behaviour or an experience in the room observed through the therapist's countertransference. Pausing can help with noticing the rupture and display respect in the therapeutic relationship by showing the young person an earnest attempt to face the rupture in a different, manageable way.

The second phase involves therapists verbally highlighting the rupture in the alliance and associated reactions; for example, noting, "I can see you tapping your fingers on your leg". The focus should be on what has been done rather than what was not done (e.g., "you are

not listening to me"). Accurate mirroring helps build the therapeutic relationship and bolster the client's more adaptive and realistic self-schema (Ackerman et al., 2010).

CAFA's third phase focuses on the therapist taking responsibility for the rupture in a non-judgemental style, which can aid young clients to assert their emotional needs without fear of the relationship falling apart (Safran & Muran, 2000). The therapist can explain that their approach or decision was not appropriate for the client and articulate that they made a mistake. Reiterating the rupture as the young person's attempt to signal their distress or discomfort should also be highlighted (e.g., "you let me see that this explanation is not helpful for you").

The final phase directs therapists to use meta-communication to ask permission to talk further about sensitive material brought into sessions and be open to such a request being rejected. Nof et al. (2019) offer a narrative approach to speaking about the rupture and including content of the young client's interests as well as their emotional words and descriptions. Normalising statements can promote self-acceptance of desires (Misch, 2006); for example, voicing to the client that 'all young people want to be listened to without expectations for something else'. Recapping the therapist's role in helping contain unbearable feelings in the therapy space, as opposed to outside in the young person's day-to-day life, is essential in upholding the relationship.

Repairs over telepsychotherapy

Practitioners who have utilised telepsychotherapy can assume that technology can interfere with the development of the therapeutic relationship and rupture resolution (Monthuy-Blanc et al., 2013). There can also be a belief that clients are not motivated to engage in therapy remotely (Deen et al., 2013). Empirical studies outlined that clients' ratings of the therapeutic alliance with telepsychotherapy are at least as robust as those formed in traditional face-to-face treatment across a range of diagnostic groups (Backhaus et al., 2012; Germain et al., 2010; Simpson & Reid, 2014). These findings suggest that therapists were also able to develop skills around managing ruptures and repairs virtually.

Carpi Lapi et al. (2018) discuss the use of countertransference in therapeutic relationships with adolescents when meeting virtually. They make a distinction between "digital native" teenagers and "digital immigrant" adults who approach communication through technology differently. Therapists are warned to confront their prejudices and unconscious feelings about meeting virtually as being artificial and getting in the way of establishing a therapeutic relationship. In contrast, adolescents use the internet as a genuine way of connecting with others. Subsequently, not being able to meet in the real world and to test that reality may lead to false knowledge whereby boundaries and identities become confused (Seligman, 2011).

Dolev-Amit et al. (2020) propose a four-step model for dealing with withdrawal ruptures in telepsychotherapy (common with adolescents) given they appear more subtly over digital means of communication. Firstly, the therapist should make the necessary preparations for the client before switching to the online setting through practical setup of technologies (e.g., equipment, across locations, programmes) and advising the client to be in a quiet,

private space without distractions. Secondly, during the first online meeting the therapist should take time to comment about the change in the usual environment and initiate a conversation about possible difficulties. Therapists must be aware that the setting might influence how the client is engaging in telepsychotherapy and any ruptures arising, for example, whether family members are present around the home. Therapists need to be more active and take charge of virtual sessions so that the client can feel their presence more strongly to compensate for lack of the acquainted therapeutic space and reassuring physical presence.

In the third step, the therapist should try to determine whether a rupture occurred. This will be based on cues such as facial expressions, eye contact, acoustic changes, and the therapist's own countertransference feelings. Special attention should be given to acoustic measures such as reduced responsiveness, change in speech rate, unsteady voice quality, or longer silences (Dolev-Amit et al., 2020). Lastly, the therapist can attend to the rupture directly or indirectly; either by assuming responsibility or by revisiting the goals and changing tasks of treatment due to the transition to telepsychotherapy. Alternatively, the therapist can choose to attempt to fulfil the client's unspoken wish with indirect supportive techniques, such as showing genuine interest in the patient or pointing out the client's strengths and gains in dealing with their difficulties, especially during stressful times. Therapists are guided to show their clients that they believe in their resilience and to work together with the client as a team toward better self-understanding (Book, 1998).

When ruptures are repaired

Schore (2003) explains how the repair of misattunements or ruptures nurtures the area of the brain (namely the right hemisphere) that is involved with receiving, expressing, regulating, and communicating emotions, which impacts the sense of the developing self. For Schore (2012), this interactive psychobiological regulation can occur in a therapeutic context in which the client is empowered to describe, and eventually regulate, their inner experience with an empathic therapist who provides a safe relational space, rather than just insight alone. The therapist needs to be able to tolerate negative affect and countertransference and be willing to remain in relationship with the client, and to shape their interactions to approach repair where ruptures have occurred.

A sufficient therapeutic relationship can counter stress reactions, or the fight–flight–freeze response, and "the experience of feeling cared about in a relationship reduces the secretion of stress hormones and shifts the neuroendocrine system toward homeostasis" (Adler, 2002, p. 883). Bromberg (2006) observes that processing in psychotherapy becomes "safer and safer so that the person's tolerance for potential flooding of affect goes up" (p. 79). In other words, the social bonds of attachment embedded in the therapeutic relationship build resiliency towards stress and intolerable affects.

Talking through ruptures towards repair in the therapeutic relationship solidifies the moment of both the therapist and the client overcoming a relational hurdle and gaining a sense of being seen and understood. If therapists can allow themselves to know their client through the ongoing intersubjective field they both share, an act of recognition takes place

in which words and thoughts come to symbolise the experience instead of being substitutes for it (Bromberg, 2006).

Conclusion

This paper has offered an overview psychotherapists' understandings of ruptures and repairs in the therapeutic relationship with adolescent clients. The findings across the literature show that rupture–repair processes in therapy are clinically significant and commonly occur multiple times, including in the work with teenagers. Research has investigated and guided practice in thinking about when there is tension in the therapeutic relationship with youth, and collaboratively finding a way back into connection through repair.

Ruptures can and do occur regularly with adolescent clients in nuanced ways that can be easily dismissed as noncompliance and unreadiness for therapy. Experiences of ruptures can feel highly conflictual, reflecting the level of tension between the need to assert oneself and be cared for which is developmentally appropriate with teenagers. Ruptures can also arise from therapists not being attuned to their client and not being mindful of their own reactions and interactions with the young person. Resolution of such ruptures, such as outlined above, becomes a meaningful experience of being able to communicate and be understood in a different way by both the therapist and the client. This in turn potentially creates new possibilities in relationships, and subsequently life itself.

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Appendix

A list of theses and dissertations in the Master of Psychotherapy programme(s) supervised by staff in the Department of Psychotherapy & Counselling (2000–2021)

Compiled by Keith Tudor

This Appendix lists all the dissertations and theses associated with the Master's programme(s) in psychotherapy at the Auckland University of Technology (AUT) in the 21 years since its inception. I use the plural (programmes) as, over the years, there have been a number of such Master's programmes. When the university was incorporated in 2000, what had previously been a diploma programme became a Master's, initially as a recognised but unnamed pathway within the Master of Health Science (MHSc) (AK3485), recognised that is by the Committee on University Academic Programmes, which approves all qualifications awarded at New Zealand universities. From 2004, psychotherapy became a named pathway within the MHSc, thus, the Master of Health Science in Psychotherapy (also AK3485). Finally, in 2012, a separate qualification, the Master of Psychotherapy (MPsychotherapy) (AK3920) was established and recognised (see Table 1). At this point the Master's programme became a 2-year degree, though preceded by the Graduate Diploma in Health Science (AK1289) or the Graduate Diploma in Psychotherapy Studies (AK3920). From 2018 the Master's degree included a specialisation in child and adolescent psychotherapy, thus: the Master of Psychotherapy (Child and Adolescent Psychotherapy) (also AK3920). Although the dissertation paper is the same for the two degrees, this distinction has been acknowledged in a separate Table (22.2) in 2021, the first year that saw graduates from this specialisation. Each of the Master's degrees carried or carry honours (abbreviated to 'Hons' after the degree) for those students awarded first- or second-class degrees. As the book is honouring and focused on the Master's programmes based in the Department, I have not included theses supervised as study towards the university's higher degrees, such as the Master of Philosophy, Doctor of Philosophy, and Doctor of Health Science.

Also, over the years and in the different iterations of these Master's degrees, the written research component has changed both in title (from thesis to dissertation) and in points value (from 120 and 60 to 45), details of which are also summarised in Table 1. The points allocation to a paper or a course represents a tariff of an expected number of hours of study, thus 60 points = 600 hours, and 45 points = 450 hours.

Table 1. A summary of the Master's degrees in the field of psychotherapy at Auckland University of Technology (2000–2021)

Year	**Title of Degree** (with or without Hons)	**Programme Code**	**Research Paper/Course**	**Paper/Course Code**	**Points value**	**Percentage of degree**
2000	Master of Health Science (MHSc)	AK3485	Thesis Dissertation Dissertation	588690 588869 588666	120 60 40	50% 25% 16.67%

From 2004	Master of Health Science (MHSc) in Psychotherapy	AK3485	Dissertation	588869	60	25%
From 2012	Master of Psychotherapy	AK3920	Dissertation	588869 HEAL901 HEAL996	60 60 45	25% 25% 18.75%
From 2018	Master of Psychotherapy (Child and Adolescent Psychotherapy	AK3920	Dissertation	HEAL996	45	18.75%

This Appendix lists all the Master's theses and dissertations (2000–2021), their dates, titles, the author (student), and the supervisor(s). Where the date on the lodged version of the thesis or dissertation differs from that in the student's record or the Library catalogue, I have put this as the (later) date of the Library catalogue. Where possible, and in the spirit of wanting to make more students' work in this field more accessible to the profession and the public, I have given a link to an accessible version of the thesis or dissertation. The only exceptions to this are some early theses and dissertations which have not been digitalised (but which may be read on site at AUT), and those that were and/or are (still) embargoed. There are five levels of access to this material:

1. Open access—for which the uniform resource location (url) provided here takes you, the reader, directly to the thesis or dissertation.
2. Restricted access, i.e., to AUT staff and students—for which the url provided here takes you to the catalogue, but not to the thesis or dissertation.
3. Further restricted access, i.e., to a psychotherapist or psychotherapy student with the permission of the Head of the Department or, in some cases, the Associate Dean (Postgraduate)—for which the url provided here takes you to the catalogue, but not to the thesis or dissertation.
4. Temporarily restricted access, i.e., those theses and dissertations that are embargoed for a limited period—for which we provide the date by which the thesis or dissertation will be accessible.
5. Permanently restricted access, i.e., those theses and dissertations that are embargoed permanently—for which the url provided here takes you to the catalogue, but not to the thesis or dissertation.

Where a student and a staff member published an article from the thesis or dissertation, this is noted within the relevant entry, including those that are included in this book. I have done my best to ensure that this list is accurate. It's been quite a journey as I quickly discovered when I began this particular piece of detective work 7 years ago, there was—and still is—no one list! Fortunately, like Sherlock Holmes, I have had a band of Irregulars. These have been, first and foremost, Dr Margot Solomon who held—and, indeed, still holds—much of the history of the Department, and Dr Susan Shaw, former Associate Dean (Academic) in the Faculty of Health & Environmental Sciences, who did and does the same for the Faculty—tēnā kōrua e hoa mā. In finalising and checking various lists over the years and, more recently, for this publication, I also acknowledge the input of Carole Popman, Administrator for these programmes for many years; Andrew South, Liaison Librarian, and a good friend to the Department and its staff and students over many years; Rudy Bin Mahli, Scholarly Communications Librarian; and Fen Su, Liaison Librarian: all at AUT; Dr Shoba Nayar, formerly of AUT and now Research Officer; and Angie Strachan, former Library Engagement Advisor at AUT and now Research Assistant—tēnā koutou katoa e hoa mā. I, of

course, take responsibility for any omissions, to whit, if any reader knows of any other Master's theses or dissertations in psychotherapy or resulting publications from them which are not noted here, I'd be grateful if you would let me know (at keith.tudor@aut.ac.nz) for future revisions and/or publications and/or revisions.

2000

Table 2. Master of Health Science – Theses (Paper 588690) (120 points) 2000

No	Title	Student	Supervisor(s)
1	*Dissociative identity disorder (DID): A grounded theory study of connecting.* https://librarysearch.aut.ac.nz/vufind/Record/1110459	Gudrun Frerichs-Penz	Jonathan Fay, Peter Greener, & Ondra Williams
	Frerichs-Penz, G. (2001). The three phases of connecting: A New Zealand study of the treatment of dissociative identity disorder. *Forum*, *7*, 43-64.		
2	*The lived experience of women who have undergone long-term psychotherapy: A phenomenological inquiry.* https://librarysearch.aut.ac.nz/vufind/Record/1126862	Jen Green	Liz Smythe & Jonathan Fay

2001

Table 3.1. Master of Health Science – Theses (Paper 588690) (120 points) 2001

No	Title	Student	Supervisor(s)
3	*Filling a hole: The experience of being deaf in psychotherapy with an interpreter.* https://librarysearch.aut.ac.nz/vufind/Record/1108577	LaVauney Harris	Deborah Spence

Table 3.2. Master of Health Science – Dissertations (Paper 588869) (60 points) 2001

No	Title	Student	Supervisor(s)
4	*A qualitative case study of psychotherapeutic relationship.* https://librarysearch.aut.ac.nz/vufind/Record/1119178	Simon Lee Seung Wook	Andrew Duncan
5	*Projective identification and the therapist: Identification with the client and the developing therapeutic relationship: A case study.* https://librarysearch.aut.ac.nz/vufind/Record/1119169	Kyle A. MacDonald	Andrew Duncan
6	*The dance of the therapeutic relationship: A psychoanalytic case study of a woman with bulimia nervosa.* https://librarysearch.aut.ac.nz/vufind/Record/1119182	Kellie Payne	Margot Woods
7	*Towards a new epistemology in psychotherapy research: An action research case study.* https://librarysearch.aut.ac.nz/vufind/Record/1136128	J. Blair Schulze	Stephen Appel
8	*Putting Ogden to work.* https://librarysearch.aut.ac.nz/vufind/Record/1119174	Leon Tan	Stephen Appel

2002

Table 4. Master of Health Science – Dissertations (Paper 588869) (60 points) 2002

No	Title	Student	Supervisor(s)
9	*In search of true-self: a shared journey: A qualitative case study of a therapeutic relationship.* https://librarysearch.aut.ac.nz/vufind/Record/1109283	Lee P. Buckingham	Anne Gommers, Gael Rowntree, & Claire Cartwright
10	*How does the therapeutic relationship contribute to the healing of a client with both a mental health disorder and a substance addiction: A qualitative case study.* https://librarysearch.aut.ac.nz/vufind/Record/1108537	Julie Matheson Crosland	Sue Joyce & Claire Cartwright

11	*Countertransference issues in the treatment of anorexia nervosa: A psychotherapeutic case study: A veritable feast in the context of famine.* https://librarysearch.aut.ac.nz/vufind/Record/1153931	Anna Hedley	Peter Greener
12	*The unmentionable countertransference: Critical feelings in the therapy room: A systematic literature review with clinical illustrations on the definition and use of critical countertransference.* https://librarysearch.aut.ac.nz/vufind/Record/1141912	Anoushka Mohammed	Andrew Duncan
13	*Discovering the names of tears: A case study of a therapeutic relationship with a client suffering from major depressive disorder: A psychotherapeutic and qualitative inquiry*	Linda A. Poynton	Andrew Duncan
14	*Beginning therapy: A qualitative case study of a therapeutic relationship*.	Sarah C. W. Smith	Stephen Appel

2003

Table 5.1. Master of Health Science – Theses (Paper 588690) (120 points) 2003

No	Title	Student	Supervisor(s)
15	*Managing disequilibrium: A grounded theory study of therapists working in groups with people with eating disorders.* https://openrepository.aut.ac.nz/handle/10292/11315	Robyn Brinkman	Margot Solomon
16	*Embodied relationships: The therapist's experience.* https://openrepository.aut.ac.nz/handle/10292/11290	Josie Goulding	Margot Solomon & Liz Smythe
17	*Doing and being: How psychotherapists balance the impact of trauma: A grounded theory study.* https://openrepository.aut.ac.nz/handle/10292/11243	Anita Wacker-Thielke	Margot Solomon

Table 5.2. Master of Health Science – Dissertations (Paper 588869) (60 points) 2003

No	Title	Student	Supervisor(s)
18	*Expressive arts therapy techniques in psychotherapy to facilitate the expression of early developmental issues understood as transitional phenomena: A Winnicottian perspective.* https://librarysearch.aut.ac.nz/vufind/Record/1146763 [In the dissertation itself, the submission is noted as for the Master of Health Science in Psychotherapy]	David Coomber	Brigitte Puls
19	*The use of empathic tools in the treatment of clients who dissociate: A systematic review with clinical illustrations of therapeutic relationships*. https://librarysearch.aut.ac.nz/vufind/Record/1143026	Anna Aleida Drijver	Stephen Appel
20	*Disorganised attachment reclaiming a buried self.* https://librarysearch.aut.ac.nz/vufind/Record/1143231	Catherine Healy	Stephen Appel
	Appel, S. & Healy, C. (2005). The heritage of disorganised attachment. *Forum*, *11*, 49–72.		
21	*Towards a Māori psychotherapy: The therapeutic relationship and Māori concepts of relationship: A systematic literature review with case illustrations.* https://librarysearch.aut.ac.nz/vufind/Record/1201745	Margaret Poutu Morice	Stephen Appel & Cabrini Makasiale
	Mikahere-Hall, A., Morice, M. P., & Pye, C. (2019). Waka Oranga: The development of an Indigenous professional organisation within a psychotherapeutic discourse in Aotearoa New Zealand. *Ata: Journal of Psychotherapy Aotearoa New Zealand*, *23*(1), 23–34. https://doi.org/10.9791/ajpanz.2019.04		
22	*When there are no words—Bodies communicating in therapy: A systematic review of the literature related to an aspect of the therapeutic relationship.* https://librarysearch.aut.ac.nz/vufind/Record/1117586	Ingrid Nagl	Brigitte Puls

23	*Cultural matching and the psychotherapeutic relationship*. https://openrepository.aut.ac.nz/handle/10292/11289	Seilosa W. Patterson	Philip Culbertson
24	*Countertransference guilt: The therapeutic relationship: A literature review with clinical illustrations*. https://openrepository.aut.ac.nz/handle/10292/11288	Helmut M. Rudolph	Andrew Duncan & Stephen Appel

Table 5.3. Master of Health Science – Dissertations (Paper 588666) (40 points) 2003

No	Title	Student	Supervisor(s)
25	*Walking between two cultures: The process of identity formation in resettled refugee adolescents and the place for psychotherapy.* https://librarysearch.aut.ac.nz/vufind/Record/1145640	Janet Brady	Evelyn Baker-Sander

2004

Table 6.1. Master of Health Science – Theses (Paper 588690) (120 points) 2004

No	Title	Student	Supervisor(s)
26	*The lived reality of men who have been violent/violated*. https://openrepository.aut.ac.nz/bitstream/handle/10292/24/BryantJ.pdf	John Bryant	Liz Smythe
	Bryant, J. & Tudor K. (2022). Violent men: The lived reality of men who have been violent/violated. In K. Tudor & E. Green (Eds.), *Psyche and academia: Papers from 21 years of the Auckland University of Technology psychotherapy Master's programmes*. Tuwhera Open Access Publications.		
27	*Growing through adversity: Becoming women who live without partner abuse: A grounded theory study*. https://openrepository.aut.ac.nz/bitstream/handle/10292/245/GilesJ.pdf	Janice R. Giles	Margot Solomon & Helen Curreen

Table 6.2. Master of Health Science – Dissertations (Paper 588869) (60 points) 2004

No	Title	Student	Supervisor(s)
28	*The therapist's difficult emotional experience and racism: A modified systematic literature review*. https://openrepository.aut.ac.nz/handle/10292/11313	Carlyn Abels	Philip Carter
29	*Nonverbal therapy techniques emphasising art in psychotherapy with abuse and trauma clients: A modified systematic literature review with clinical illustrations of a research question related to the psychotherapeutic relationship.* https://openrepository.aut.ac.nz/handle/10292/11252	Norma Alexis	Robyn Brinkman & Andrew Duncan
30	*The wounded self: Anorexia nervosa and pathological narcissism: How the daughter may be used as a parental selfobject and how this may impact upon her development of self and may predispose her to the development of Anorexia Nervosa and implications*. https://openrepository.aut.ac.nz/handle/10292/11285	Rhonda Bliss	Brigitte Puls
31	*Surrender to the drama: The enacted process in the psychotherapeutic relationship: A systematic literature review with clinical illustrations*. https://openrepository.aut.ac.nz/handle/10292/11312	Jo Chetwynd-Talbot	Sonja Goedeke
32	*The unconscious influences of developmentally arrested symbol formation on the therapeutic relationship with a client diagnosed with borderline personality disorder: A Kleinian perspective*. https://openrepository.aut.ac.nz/handle/10292/11272	Kitt Klitgaard Christiansen	Anita Wacker
33	*The complexities of working with adult clients who have histories of severe childhood trauma: A systematic literature review with clinical illustrations*. https://openrepository.aut.ac.nz/handle/10292/11343	Loretta Clarke	Liadan Cotter

34	*Suicide: A dying shame: A literature review of the therapeutic relationship*. https://openrepository.aut.ac.nz/handle/10292/11273	Susan P. Goldstiver	Stephen Appel
35	*When doing your best is the best you can do: Understanding how moral influence is mediated in couple therapy*. https://librarysearch.aut.ac.nz/vufind/Record/1152348	Sue Joyce	Margot Solomon
	Joyce, S. (2022). When doing your best is the best you can do: Understanding how moral influence is mediated in couple therapy [K. Tudor, Ed.). In K. Tudor & E. Green (Eds.), *Psyche and academia: Papers from 21 years of the Auckland University of Technology psychotherapy Master's programmes*. Tuwhera Open Access Publications.		
36	*Understanding and working with complicated grief. The therapeutic relationship: A literature review with clinical illustrations*. https://openrepository.aut.ac.nz/bitstream/handle/10292/667/MarksA.pdf	Amanda Marks	Andrew Duncan & Gudrun Frerichs
37	*How is play relevant to the teaching and learning of psychotherapy?* https://librarysearch.aut.ac.nz/vufind/Record/1152552	Anne McDermott	Andrew Duncan
38	*Serious illness in the psychotherapist: Denial, disclosure and the therapeutic relationship: A review of the literature*. https://openrepository.aut.ac.nz/handle/10292/11305	Christopher D. Mitchell	Brigitte Puls
39	*Psychotherapy with men: Masculine gender roles and emotional expressivity impacting on the therapeutic relationship*. https://openrepository.aut.ac.nz/handle/10292/11244	Stefan Nägler	Liadan Cotter & Andrew Duncan

Table 6.3. Master of Health Science in Psychotherapy – Dissertations (Paper 588869) (60 points) 2004

No	Title	Student	Supervisor(s)
40	*Grief and the therapist: How the therapist manages personal grief while maintaining safety for both self and the client within the therapeutic relationship: A modified systematic literature review with clinical illustrations*. https://openrepository.aut.ac.nz/handle/10292/11280	Jane Hinds	Anita Wacker
41	*The therapeutic relationship: A literature review with clinical illustrations: A Foucaultian view of power within masculinity and psychotherapy.* https://openrepository.aut.ac.nz/bitstream/handle/10292/11152/WilsonJ.pdf	Julian Wilson	Gudrun Frommherz

2005

Table 7.1. Master of Health Science – Theses (Paper 588690) (120 points) 2005

No	Title	Student	Supervisor(s)
42	*Envy amongst psychotherapists in a psychotherapeutic community: A hermeneutic inquiry*. https://openrepository.aut.ac.nz/bitstream/handle/10292/169/LandC.pdf	Crea M Land	Margot Solomon
43	*Knowing reality: Psychotherapists' and counsellors' experiences and understandings of inexplicable phenomena while working with clients*. https://openrepository.aut.ac.nz/bitstream/handle/10292/110/RosenbergL.pdf	Linde Rosenberg	Stephen Appel
	Rosenberg, L. (2005). Uncanny phenomena in psychotherapy: Loving messages, quantum locality or madness? *Forum*, *11*, 187–201.		

44	*How a childhood experience of involvement in a psychotherapy cult shapes life stories after leaving: A narrative inquiry study.* https://librarysearch.aut.ac.nz/vufind/Record/1171709	Elizabeth St. Claire	Brigitte Puls & Jan Wilson

Table 7.2. Master of Health Science – Dissertations (Paper 588869) (60 points) 2005

No	Title	Student	Supervisor(s)
45	*Sibling transference and tele in the peer group: The road less travelled.* https://openrepository.aut.ac.nz/handle/10292/11253	Raywyn Brinsden	Philip Culbertson & Jonathan Fay
46	*Bulimia nervosa and self psychology.* https://librarysearch.aut.ac.nz/vufind/Record/1228561	Kate Casey	Stephen Appel
47	*Countertransference: A phenomenon that enriches the therapeutic process: A literature review with clinical illustrations.* https://openrepository.aut.ac.nz/handle/10292/11275	Rachel L. Cox	Robyn Brinkman
48	*Cultural identity in the child psychotherapy environment: A Maori perspective.* https://openrepository.aut.ac.nz/bitstream/handle/10292/523/HallA.pdf	Alayne Hall	Philip Culbertson
49	*Does attachment theory apply to working with pornographic addiction in men?* https://openrepository.aut.ac.nz/bitstream/handle/10292/1037/HarrisJ.pdf	Jane Harris	Andrew Duncan & Helen Packard
50	*Dreams as an experience: An exploration of meaning-making.* https://openrepository.aut.ac.nz/handle/10292/11281	Deborah Heays	Margot Solomon
51	*Building into the dark: Psychoanalytic explorations into psychosis, dream and cinema.* https://openrepository.aut.ac.nz/handle/10292/11307	Emma Ladd	Stephen Appel
52	*Who needs who? Therapist dependency and its impact on the therapeutic relationship: A modified systematic review with clinical illustrations.* https://openrepository.aut.ac.nz/handle/10292/11306	Meg McMillan	Helen Packard
53	*Understanding Ogden: Projective identification, the analytic third and reverie.* https://openrepository.aut.ac.nz/handle/10292/11287	Sandra Russell	Stephen Appel
54	*Turning against the self: A literature review with clinical illustrations.* https://librarysearch.aut.ac.nz/vufind/Record/1189952	Lynley Williams	Josie Goulding & Andrew Duncan

Table 7.3. Master of Health Science in Psychotherapy – Dissertations (Paper 588869) (60 points) 2005

No	Title	Student	Supervisor(s)
55	*How Buddhist meditative principles may enhance psychotherapeutic efficacy*	Gaylene Jakicevich	Andrew Duncan
56	*The wounded healer in psychotherapy: A systematic literature review concerning an issue related to the psychotherapeutic relationship interspersed with illustrations from clinical practice.* https://openrepository.aut.ac.nz/handle/10292/11286	Shizuka Torii	Brigitte Puls & Andrew Duncan

Table 7.4. Master of Health Science in Psychotherapy – Dissertations (Paper 588666) (40 points) 2005

No	Title	Student	Supervisor(s)
57	*Exploring the potential usefulness of mother-infant interventions in the infant's first year of life: A systematic literature review with clinical illustrations.* https://openrepository.aut.ac.nz/handle/10292/11293	Jude Gilroy	Kerry Gibson

58	*Which edge to work: The use of interpretation in short-term child psychotherapy: a systematic literature review with clinical illustrations.* https://openrepository.aut.ac.nz/handle/10292/11292	Helen Lane	Kerry Gibson
59	*The impact of losing a parent to sudden death on six to eleven year old children.* https://openrepository.aut.ac.nz/handle/10292/11328	Jayne Fiona Locke	Brigitte Puls
60	*Understanding the impact of prematurity on attachment.* https://openrepository.aut.ac.nz/handle/10292/11340	Elizabeth Wilkinson	Brigitte Puls

2006

Table 8.1. Master of Health Science in Psychotherapy – Dissertations (Paper 588869) (60 points) 2006

No	Title	Student	Supervisor(s)
61	*Gay men, internalised homophobia and therapy: Working with internalised homophobia in gay men using a gay-affirmative model: A systematic literature review.* https://openrepository.aut.ac.nz/handle/10292/11276	Steven Colligan	Andrew Duncan
62	*Countertransference and projective identification: What is the relationship between them, and how useful are they as a way of understanding the emotional nature of the therapeutic relationship?* https://openrepository.aut.ac.nz/handle/10292/11274	Amanda Cox	Margot Solomon
63	*The changing place of 'holding': From Winnicott to contemporary relational psychoanalytically informed psychotherapy.* https://openrepository.aut.ac.nz/handle/10292/11254	Malcom Robert Idoine	Brigitte Puls
64	*A conversation beyond words: Exploring somatic countertransference when working with alexithymic clients*. https://openrepository.aut.ac.nz/handle/10292/11304	Gabriela Mercado	Josie Goulding
	Mercado, G. (2022). A conversation beyond words: Exploring somatic countertransference when working with alexithymic clients. In K. Tudor & E. Green (Eds.), *Psyche and academia: Papers from 21 years of the Auckland University of Technology psychotherapy Master's programmes*. Tuwhera Open Access Publications.		
65	*Can religious belief be a pathological defence? A modified systematic literature review concerning an issue related to the psychotherapeutic relationship interspersed with case illustrations from clinical practice*. https://openrepository.aut.ac.nz/bitstream/handle/10292/11159/MorrisJ.pdf	Julian Morris	Andrew Duncan
66	*Self-destruction: Clinical implications of the death instinct.* https://openrepository.aut.ac.nz/bitstream/handle/10292/11154/NyemeczM.pdf	Monique Reina Nyemecz	Stephen Appel
	Nyemecz, M., & Appel, S. (2007). The death instinct: Suppression of emotions, physiology, and illness. *Forum*, *13*, 7–23.		
67	*The therapist's love*. https://openrepository.aut.ac.nz/bitstream/handle/10292/11157/Thomas-AnttilaK.pdf	Kerry Thomas-Antilla	Kerry Gibson
	Thomas-Anttila, K. (2022). The therapist's love. In K. Tudor & E. Green (Eds.), *Psyche and academia: Papers from 21 years of the Auckland University of Technology psychotherapy Master's programmes*. Tuwhera Open Access Publications.		
68	*Drowning the judge: The connection between addiction, trauma, and the superego*. https://librarysearch.aut.ac.nz/vufind/Record/1172262	Lisa Zimmerman	Andrew Duncan

	Zimmerman, L, & Duncan, A. (2007). Drowning the judge: Addiction, trauma and the superego. *Forum*, *13*, 76–91.

Table 8.2. Master of Health Science in Psychotherapy – Dissertations (Paper 588666) (40 points) 2006

No	Title	Student	Supervisor(s)
69	*The impact of terminal illness and sibling death from cancer, on the latency-aged brother or sister*. https://openrepository.aut.ac.nz/handle/10292/11291	Lorna Wood	Evelyn Baker-Sander

2007

Table 9.1. Master of Health Science – Theses (Paper 588690) (120 points) 2007

No	Title	Student	Supervisor(s)
70	*Dance and stillness: A phenomenological hermeneutic inquiry into the experience of stillness: Presented through the medium of dance performance and written exegesis*. https://openrepository.aut.ac.nz/bitstream/handle/10292/179/DeLeonJ.pdf	Jennifer De Leon	Josie Goulding & Liz Smythe
	De Leon, J. (2009). Dance, stillness and paradox. *Dance Therapy Collections*, *3*, 192–199. http://dtaa.org.au/wp-content/uploads/2017/03/deLeonJ2009Dance-Stillness-and-Paradox.pdf		
71	*The alchemy of love: Recent graduates' lived experiences of psychotherapy training: A hermeneutic study*. https://openrepository.aut.ac.nz/bitstream/handle/10292/10/MorganM.pdf	Marilyn Morgan	Margot Solomon
72	*The forgotten feminine*. https://openrepository.aut.ac.nz/bitstream/handle/10292/422/SleemanL.pdf	Lauren Sleeman	Margot Solomon & Lynne Giddings
73	*A phenomenological study of the experience of psychotherapists who meditate*. https://openrepository.aut.ac.nz/bitstream/handle/10292/44/SolomonP.pdf	Paul Solomon	Peter Greener
74	*What is the meaning of supervision for mental health support workers? A critical hermeneutic inquiry*. https://openrepository.aut.ac.nz/bitstream/handle/10292/88/SutcliffeR.pdf	Robin Sutcliffe	Margot Solomon

Table 9.2. Master of Health Science in Psychotherapy – Dissertations (Paper 588869) (60 points) 2007

No	Title	Student	Supervisor(s)
75	*Contemplating silence: A review of understandings and clinical handling of patient silence in psychoanalytic psychotherapy*. https://openrepository.aut.ac.nz/bitstream/handle/10292/691/DaviesA.pdf	Amber Davies	Stephen Appel
76	*The role of relationship in the treatment of autism: perspectives from relationship development intervention and psychotherapy*. https://openrepository.aut.ac.nz/bitstream/handle/10292/705/EmmensC.pdf	Colleen Emmens	Anne McDermott
77	*The animal-human bond in the psychotherapy relationship: As a bridge towards enhanced relational capability*. https://openrepository.aut.ac.nz/bitstream/handle/10292/657/EmmensJ.pdf	Joanne Emmens	Andrew Duncan
78	*Mind those tears: Thinking about crying in the therapeutic relationship*.	Emma K. Harris	Sue Joyce

	https://openrepository.aut.ac.nz/bitstream/handle/10292/700/HarrisE.pdf		
	Harris, E. (2022). Mind those tears: Thinking about crying in the therapeutic relationship. In K. Tudor & E. Green (Eds.), *Psyche and academia: Papers from 21 years of the Auckland University of T Technology psychotherapy Master's programmes*. Tuwhera Open Access Publications.		
79	*The influences of being an adopted person on the psychotherapeutic relationship from an object relations perspective: A modified systematic literature review with clinical illustrations*. https://openrepository.aut.ac.nz/bitstream/handle/10292/696/HyltonJ.pdf	Jennifer L. Hylton	Andrew Duncan
80	*Psychotherapy with Chinese clients: The effects of cultural assumptions such as filial piety on the working relationship*. https://openrepository.aut.ac.nz/bitstream/handle/10292/704/LiuB.pdf	Benjamin Liu	Paul Solomon
81	*To disclose or not to disclose: Is that the question? Therapist self-disclosure – understandings, types and influences*. https://openrepository.aut.ac.nz/bitstream/handle/10292/708/LowryJ.pdf	Jayne Lowry	Linde Rosenberg
82	*The therapeutic relationship: A modified systematic literature review with clinical illustrations: Hope: Therapeutic friend or foe? Psychoanalytic perspectives on the development and transformation of hopes within the therapeutic relationship*. https://openrepository.aut.ac.nz/bitstream/handle/10292/707/MercierM.pdf	Mark Mercier	Andrew Duncan
83	*Languages of psychotherapy: The therapist's bilingualism in the psychotherapeutic process*. https://openrepository.aut.ac.nz/bitstream/handle/10292/514/SkulicT.pdf	Tomislav Skulic	Anne McDermott & Stephen Appel

2008

Table 9.1. Master of Health Science – Theses (Paper 588690) (120 points) 2008

No	Title	Student	Supervisor(s)
84	*Stepping through different realities: A phenomenological hermeneutic study of psychotherapists' spiritual experience*. https://openrepository.aut.ac.nz/bitstream/handle/10292/64/RyanK.pdf	Kay Ryan-Manton	Margot Solomon & Linde Rosenberg

Table 9.2. Master of Health Science in Psychotherapy – Dissertations (Paper 588869) (60 points) 2008

No	Title	Student	Supervisor(s)
85	*How does the quality of the mother-infant relationship influence the baby's capacity to be alone and develop play?* https://openrepository.aut.ac.nz/bitstream/handle/10292/660/BuchananJ.pdf	Jill Buchanan	Anne McDermott
86	*Things fall apart, the centre cannot hold: An exploration of depression in infancy*. https://openrepository.aut.ac.nz/bitstream/handle/10292/544/DAlmeidaJ.pdf	Jennifer D'Almeida	Margot Solomon
87	*Escaping the 'monkey trap': How might psychotherapists utilise Buddhist approaches towards cultivating non-attachment within psychotherapeutic practise?* https://openrepository.aut.ac.nz/bitstream/handle/10292/682/DillonJ.pdf	Jacqueline Dillon	Paul Solomon

88	*Insecure attachment and the therapeutic relationship: Relational dynamics between therapist and addicts in psychotherapy*. https://openrepository.aut.ac.nz/bitstream/handle/10292/808/EkamparamG.pdf	Gaytri Ekamparam	Stephen Appel
89	*Boredom: Uncovering feelings from beneath a psychic fog*. https://openrepository.aut.ac.nz/bitstream/handle/10292/645/FentonRM.pdf	Rae-Marie Fenton	Paul Solomon
90	*To the analyzing instrument and beyond: Reconstructing evenly hovering attention*. https://openrepository.aut.ac.nz/bitstream/handle/10292/496/GuptaR.pdf	Rajan Gupta	Margot Solomon
91	*Conversion therapy versus gay-affirmative therapy: Working with ego-dissonant gay clients*. https://openrepository.aut.ac.nz/bitstream/handle/10292/11160/KirbyA.pdf	Andrew Kirby	Stephen Appel
92	*The therapist's container in practice*. https://openrepository.aut.ac.nz/bitstream/handle/10292/11151/SolovievaN.pdf	Natalia Petrovna Solovieva	Stephen Appel
93	*The forgotten parent: The father's contribution to the infant's development during the pre-oedipal years*. https://openrepository.aut.ac.nz/bitstream/handle/10292/772/StoneD.pdf	Dorothea Kay Stone	Paul Solomon
94	*Dissociation or psychosis?: What is the difference and what impact do these different diagnoses have on treatment?* https://openrepository.aut.ac.nz/bitstream/handle/10292/11158/TroyG.pdf	Giselle Troy	Linde Rosenberg
95	*Silence in psychotherapy: Therapists' difficulties in using silence as a therapeutic technique*. https://openrepository.aut.ac.nz/bitstream/handle/10292/11161/WarinT.pdf	Tarsha Warin	Sue Joyce
96	*Working with parents and carers within psychodynamic child and adolescent psychotherapy*. https://openrepository.aut.ac.nz/bitstream/handle/10292/502/WidgeryC.pdf	Camilla Widgery	Josie Goulding
97	*Entering the void: Exploring the relationship between the experience of colonisation and the experience of self for Indigenous Peoples of Aotearoa, and the implications for clinical practice*. https://openrepository.aut.ac.nz/bitstream/handle/10292/500/WoodardW.pdf	Wiremu Woodard	Andrew Duncan & John O'Connor
	Woodard, W., & O'Connor, J. (2019). Entering the void: Exploring the relationship between the experience of colonisation and the experience of self for Indigenous peoples of Aotearoa, and the implications for psychotherapeutic clinical practice. *Ata: Journal of Psychotherapy Aotearoa New Zealand*, *23*(1), 89–112. https://doi.org/10.9791/ajpanz.2019.09		

2009

Table 10.1. Master of Health Science – Theses (Paper 588690) (120 points) 2009

No	Title	Student	Supervisor(s)
98	*A Heideggerian hermeneutic study of the meaning of living with prostate cancer.* https://openrepository.aut.ac.nz/bitstream/handle/10292/909/VasconcelosRE.pdf	Rosana Eteia Vasconcelos	Margot Solomon

Table 10.2. Master of Health Science in Psychotherapy – Dissertations (Paper 588869) (60 points) 2009

No	Title	Student	Supervisor(s)
99	*A leadership intervention perspective on the creation, monitoring and maintenance of the group therapeutic relationship: A modified systematic literature review with clinical illustrations.* https://openrepository.aut.ac.nz/bitstream/handle/10292/713/DefibaughC.pdf	Christopher Defibaugh	Andrew Duncan
100	*Ghosts at the banquet: Moving towards aliveness: The anorexic client.* https://openrepository.aut.ac.nz/bitstream/handle/10292/683/EwenS.pdf	Sue Ewen	Sue Joyce
101	*What are the therapeutic implications of psychoanalytic conceptualisations of God when working psychoanalytically with Christian clients?* https://openrepository.aut.ac.nz/bitstream/handle/10292/902/FlorenceH.pdf	Helen Jane Florence	John O'Connor
102	*The effectiveness of psychodynamic psychotherapy with schizophrenic psychoses: A modified systematic literature. review.* https://openrepository.aut.ac.nz/bitstream/handle/10292/946/JosiasM.pdf	Moira Josias	Paul Solomon
103	*Impaired self-soothing, sexualisation and avoidant attachment: Are these significant precursors to male sexual addiction?* https://openrepository.aut.ac.nz/bitstream/handle/10292/951/RowlandsD.pdf	David Lindsey Rowlands	Andrew Duncan
104	*Why food?: An exploration of the psychodynamics of the use of food in eating disordered clients and the implications for treatment.* https://openrepository.aut.ac.nz/bitstream/handle/10292/753/RuangsriT.pdf	Tassya Ruangsri	Josie Goulding
105	*The parentified child in a child psychotherapist: A systematic literature review of the parentified child, exploring its effects on the countertransference process in child psychotherapy.* https://openrepository.aut.ac.nz/bitstream/handle/10292/885/TamO.pdf	Oi Kuen Wong Tam	Margot Solomon
106	*The psycho-social impact on hearing children of deafness in their primary caregiver.* https://openrepository.aut.ac.nz/bitstream/handle/10292/900/WardA.pdf	Anna Ward	Margot Solomon

2010

Table 11.1. Master of Health Science – Dissertation (Paper 588869) (60 points) 2010

No	Title	Student	Supervisor(s)
107	*Inner journeys: Psychodynamic perspectives on immigration, identity and cross-cultural adaptation.* https://openrepository.aut.ac.nz/bitstream/handle/10292/1000/KerriskC.pdf	Cian Michael Kerrisk	Margot Solomon

Table 11.2. Master of Health Science in Psychotherapy – Dissertations (Paper 588869) (60 points) 2010

No	Title	Student	Supervisor(s)
108	*Beneath our feet: An exploration of the ways psychotherapists think about the human-nature relationship, and the clinical implications of this in Aotearoa-New Zealand.*	Michael Apathy	Brigitte Puls

	https://openrepository.aut.ac.nz/bitstream/handle/10292/1218/ApathyM.pdf		
109	*The psychological birth of a psychotherapist: What are the parallels, if any, between becoming a mother and becoming a psychotherapist?* https://openrepository.aut.ac.nz/bitstream/handle/10292/1122/ClarkeV.pdf	Victoria Clarke	Carol Shinkfield
	Clarke, V. (2022). The psychological birth of a psychotherapist: What are the parallels, if any, between becoming a mother and becoming a psychotherapist? In K. Tudor & E. Green (Eds.), *Psyche and academia: Papers from 21 years of the Auckland University of Technology psychotherapy Master's programmes*. Tuwhera Open Access Publications.		
110	*Putting poetry back into the mind: How can therapeutic writing benefit clients of psychodynamic psychotherapy?* https://openrepository.aut.ac.nz/bitstream/handle/10292/948/DeedB.pdf	Bronwyn Gaye Deed	Birgitte Puls
111	*Psychoanalytic feminism: A systematic literature review of gender.* https://openrepository.aut.ac.nz/bitstream/handle/10292/905/McIverV.pdf	Victoria McIver	Josie Goulding
112	*How public understandings of psychotherapy are influenced by film and television portrayals of psychotherapists and some of the implications for clinical practice.* https://openrepository.aut.ac.nz/bitstream/handle/10292/1213/TimpsonS2.pdf	Suzanne Timpson	Keith Tudor

2011

Table 12. Master of Health Science in Psychotherapy – Dissertation (Paper 588869) (60 points) 2011

No	Title	Student	Supervisor(s)
113	*Does temperament influence the parent-child attachment relationship?* https://openrepository.aut.ac.nz/bitstream/handle/10292/1225/ButlerJ.pdf	Julie Karen Butler	Carol Shinkfield
114	*From one person to two person psychotherapy: Considerations and practicalities for including the partner in the treatment.* https://openrepository.aut.ac.nz/bitstream/handle/10292/2480/HayJ.pdf	Jonathan Hay	Stephen App
	Hay, J., & Appel, S. (2013). Why consider the client's partner in psychotherapy? *Ata: Journal of Psychotherapy Aotearoa New Zealand*, *17*(1), 55–64. https://doi.org/10.9791/ajpanz.2013.04		
115	*Growing up in a Western country: How applicable is the theory of second individuation to second generation Chinese youths? Implications for psychotherapeutic practice.* https://openrepository.aut.ac.nz/bitstream/handle/10292/4475/WongCCH.pdf	Christine Chi Hang Wong	Birgitte Puls

2012

Table 13.1. Master of Health Science – Dissertation (Paper 588869) (60 points) 2012

No	Title	Student	Supervisor(s)
116	*What are the risk factors in the abuse and maltreatment of children with disabilities?* https://openrepository.aut.ac.nz/bitstream/handle/10292/5325/WyberJ.pdf	Jenny Wyber	Keith Tudor

Table 13.2. Master of Health Science in Psychotherapy – Dissertation (Paper 588869) (60 points) 2012

No	Title	Student	Supervisor(s)
117	*Death, freedom, isolation and meaninglessness and the existential psychotherapy of Irvin D. Yalom.* https://openrepository.aut.ac.nz/bitstream/handle/10292/4611/Berry-SmithS.pdf	Stephen Frederick Berry-Smith	Stephen Appel
118	*Was Freud right? Is intensive psychotherapy needed to harness the brain's natural plasticity?* https://openrepository.aut.ac.nz/bitstream/handle/10292/6191/BradleyR.pdf	Ruth Bradley	Stephen Appel
119	*What impact, if any, does profound deafness have on the formation of the attachment relationship between the profoundly deaf infant and hearing mother?* https://openrepository.aut.ac.nz/bitstream/handle/10292/4109/HughesGM.pdf	Geraldine Monina Hughes	Carol Shinkfield
120	*How early attachment experiences effect how an individual relates to a Christian God and how this manifests in later life to his or her image of the God he or she believes in.* https://openrepository.aut.ac.nz/bitstream/handle/10292/5712/StewartV.pdf	Victoria Stewart	Keith Tudor

2013

Table 14.1. Master of Health Science in Psychotherapy – Dissertations (Paper 588869) (60 points) 2013

No	Title	Student	Supervisor(s)
121	*Menopause in psychotherapy: A thematic analysis*. https://openrepository.aut.ac.nz/bitstream/handle/10292/5939/HintonM.pdf	Margot Hinton	Keith Tudor
122	*Inhibition of anger in the child psychotherapist: Examining its effects on the therapeutic process*. https://openrepository.aut.ac.nz/bitstream/handle/10292/7347/XharraBatesH.pdf	Hana Xharra Bates	Paul Solomon

Table 14.2. Master of Psychotherapy – Dissertations (Paper 588869) (60 points) 2013

No	Title	Student	Supervisor(s)
123	*I'm torturing myself: A thematic analysis of psychoanalytic literature on the internal persecutory experience*. https://openrepository.aut.ac.nz/bitstream/handle/10292/5699/BoughenK.pdf	Kiersten Boughen	Stephen Appel
124	*What are the themes in the psychoanalytic literature on assisting people with a terminal diagnosis? A thematic analysis*. https://openrepository.aut.ac.nz/bitstream/handle/10292/5718/DeaneB2.pdf	Barbara Deane	Brigitte Puls
125	*Spontaneous images in the mind: A thematic analysis of psychoanalytic literature on psychotherapists' unbidden visualizations*. https://openrepository.aut.ac.nz/bitstream/handle/10292/5640/GrossCB2.pdf	Claudia Gross	Stephen Appel
126	*The use of sandtray approaches in psycho-therapeutic work with adult trauma survivors: A thematic analysis*. https://openrepository.aut.ac.nz/bitstream/handle/10292/5592/KosankeG.pdf	Garjana Claudia Kosanke	Brigitte Puls

	Kosanke, G. C., Puls, B., & Feather, J. (2015). Sandtray work with adult trauma clients: Creating safety, facilitating communication and fostering healing. *Australian and New Zealand Journal of Arts Therapy*, *10*(1), 59–65. https://tinyurl.com/38hydutw		
127	*Exploring the relevance of attachment theory to therapeutic communities for addictions: a critical review of the literature.* https://openrepository.aut.ac.nz/bitstream/handle/10292/7221/SmithJ.pdf	Jyoti Smith	Stephen Appel & John O'Connor
128	*How has surrender been written about in psychoanalytic psychotherapy? A thematic analysis*. https://openrepository.aut.ac.nz/bitstream/handle/10292/5606/SouthwellG.pdf	Graham Southwell	Stephen Appel
129	*Homoerotic countertransference in psychoanalytic literature: A thematic analysis*. https://openrepository.aut.ac.nz/bitstream/handle/10292/5693/TusonJ.pdf	Jane Tuson	John O'Connor
	Tuson, J., & O'Connor, J. (2022). Homoerotic countertransference in psychoanalytic literature: A thematic analysis. In K. Tudor & E. Green (Eds.), *Psyche and academia: Papers from 21 years of the Auckland University of Technology psychotherapy Master's programmes*. Tuwhera Open Access Publications.		

2014

Table 15.1. Master of Health Science in Psychotherapy – Dissertation (Paper 588869) (60 points) 2014

No	Title	Student	Supervisor(s)
130	*Exploring team dynamics in psychotherapeutic milieux and their impact on clinical outcomes: A critical review of the literature*. https://openrepository.aut.ac.nz/bitstream/handle/10292/8551/BlacklockK.pdf	Karen Blacklock	John O'Connor

Table 15.2. Master of Psychotherapy – Dissertation (Paper 588869) (60 points) 2014

No	Title	Student	Supervisor(s)
131	*The body as a resource in psychotherapy*. https://openrepository.aut.ac.nz/bitstream/handle/10292/8919/BeeverR.pdf	Rosemary Beever	Paul Solomon
	Beever, R. (2022). The body as a resource in psychotherapy. In K. Tudor & E. Green (Eds.), *Psyche and academia: Papers from 21 years of the Auckland University of Technology psychotherapy Master's programmes*. Tuwhera Open Access Publications.		
132	*The eco-friendly therapist: An Interpretative literature review of obstacles and solutions to practicing ecotherapy*. https://openrepository.aut.ac.nz/bitstream/handle/10292/7785/ClareS.pdf	Selina Clare	Keith Tudor
	Clare, S., & Tudor, K. (in press). Ecotherapy: Perceived obstacles and solutions, positions and experiences. *Transactional Analysis Journal, 53*(1).		
133	*From one body to two bodies: Psychoanalytic perspectives on the therapist's body as the analytic object. a hermeneutic literature review*. https://openrepository.aut.ac.nz/bitstream/handle/10292/8882/CroweP.pdf	Pautia M. Crowe	Margot Solomon
134	*Problem gamers' perceptions and experiences of therapy: A thematic analysis*. https://openrepository.aut.ac.nz/bitstream/handle/10292/7726/DriverJ.pdf	James Driver	Stephen Appel
	Driver, J. (2015). A very human need: Understanding the motivations that lead to gaming addiction. *Ata: Journal of Psychotherapy Aotearoa New Zealand*, *19*(2), 137–144. https://doi.org/10.9791/ajpanz.2015.13		

135	*What is the experience of being both Māori and Pākehā? Negotiating the experience of the hybrid cultural object*. https://openrepository.aut.ac.nz/bitstream/handle/10292/7710/GrennellN.pdf	Niki Grennell	Keith Tudor
	Grennell-Hawke (Ngai Tahu, Ngai Mutunga), N., & Tudor, K. (2018). Being Māori and Pākehā: Methodology and method in exploring cultural hybridity. *The Qualitative Report*, *23*(7), 1530–1546. https://doi.org/10.46743/2160-3715/2018.2934		
136	*Themes in the countertransference when envy is experienced by the client in psychotherapeutic work: A thematic analysis*. https://openrepository.aut.ac.nz/bitstream/handle/10292/9276/HoldingF.pdf	Fiona Holding	Josie Goulding
137	*What is the relationship between psychodynamic psychotherapy and the 12 steps of Alcoholics Anonymous? A heuristic enquiry*. https://librarysearch.aut.ac.nz/vufind/Record/1288024	Phoebe Hunter	Margot Solomon
138	*The psychodynamics of anxiety in organisations*. https://openrepository.aut.ac.nz/bitstream/handle/10292/8872/LangleyC.pdf	Catherine Louise Langley	Margot Solomon
139	*Winnicott's theories on the influence of an infant's early environment on the development of anti-social tendencies in adolescence*. https://openrepository.aut.ac.nz/bitstream/handle/10292/7722/PretoriusN.pdf	Nicky Pretorius	Keith Tudor
140	*Marion Milner and creativity: A thematic analysis*. https://openrepository.aut.ac.nz/bitstream/handle/10292/8740/PuckeyJ.pdf	Jane Elizabeth Puckey	Stephen Appel
141	*The perceived benefits of equine assisted therapy: A thematic analysis based on small scale study interviews of equine assisted psychotherapists and counsellors*. https://openrepository.aut.ac.nz/bitstream/handle/10292/7988/TiptonA.pdf	Aimi Tipton	Keith Tudor
142	*What are the meanings of the mātauranga Māori concept of mana and what might this concept contribute to the understanding and practice of psychodynamic psychotherapy*? https://openrepository.aut.ac.nz/bitstream/handle/10292/7863/ReidyJ.pdf	Joanne Reidy	John O'Connor

2015

Table 16. Master of Psychotherapy – Dissertations (Papers 588869, HEAL901) (60 points) 2015

No	Title	Student	Supervisor(s)
143	*Exploring the conscious and unconscious processes of internalised racism in the therapeutic relationship: a thematic analysis.* https://openrepository.aut.ac.nz/bitstream/handle/10292/9832/EllisE.pdf	Emma Ellis	Margaret Poutu Morice
	Ellis, E. (2018). Internalised racism: In the client, the therapist, and the therapeutic relationship. *Ata: Journal of Psychotherapy Aotearoa New Zealand*, *22*(1), 85–102. https://doi.org/10.9791/ajpanz.2018.07		
144	*The effectiveness of therapeutic communities in the treatment of addicts with antisocial personality disorder: A critical review of the literature*. https://openrepository.aut.ac.nz/bitstream/handle/10292/8947/HerathM.pdf	Senanayake Mohan Herath	Stephen Appel
145	*Seeking understanding of the young adult and their experience of psychodynamic psychotherapy: A hermeneutic literature review*.	Jacqueline Jane Petter	Joanne Emmens

	https://openrepository.aut.ac.nz/bitstream/handle/10292/9873/PetterJ.pdf		
146	*The "other-other" perspective: Perceptions and experiences of non-Maori ethnic-minority psychotherapists practicing in the bicultural context of Aotearoa New Zealand*. https://openrepository.aut.ac.nz/bitstream/handle/10292/8925/SalpitikoralaM.pdf	Mihili Salpitikorala	Stephen Appel
	Alexander, M. (2022). The "other Other" perspective: Reflecting on encounters of bicultural Aotearoa New Zealand as experienced by non-indigenous ethnic minority psychotherapists. *Ata: Journal of Psychotherapy Aotearoa New Zealand*, *26*(1), 39–51. https://doi.org/10.9791/ajpanz.2022.03 Alexander, M., & Tudor, K. (in press). The experiences of non-indigenous ethnic minority psychotherapists residing and practicing in New Zealand. *Culture & Psychology*.		
147	*Cultural humility: A hermeneutic literature review*. https://openrepository.aut.ac.nz/bitstream/handle/10292/9616/WaltersT.pdf	Tatjana Walters	Keith Tudor
148	*Women's responses to their child's disclosure of sexual abuse.* https://openrepository.aut.ac.nz/bitstream/handle/10292/9833/WareT.pdf	Tania Anne Aroha Ware	Jonathan Fay & Jackie Feather

2016

Table 17.1. Master of Health Science – Thesis (Paper 589690) (120 points) 2016

No	Title	Student	Supervisor(s)
149	*Therapists' experiences of shame: An heuristic study*. https://openrepository.aut.ac.nz/bitstream/handle/10292/10186/HammondM.pdf	Marian Hammond	Margot Solomon & Keith Tudor

Table 17.2. Master of Health Science in Psychotherapy – Dissertation (Paper HEAL901) (60 points) 2016

No	Title	Student	Supervisor(s)
150	*Love after incest. How does father/daughter incest impact survivors' attachment and later developing romantic love relationships and how can the therapeutic relationship assist in helping survivors heal from maladaptive love patterns? A hermeneutic literature review*. https://openrepository.aut.ac.nz/bitstream/handle/10292/10624/OliverY.pdf	Yasmine Lorraine Oliver	Stephen Appel & Joanne Emmens

Table 17.3. Master of Psychotherapy – Dissertations (Papers 588869, HEAL901) (60 points) 2016

No	Title	Student	Supervisor(s)
151	*A psychotherapist's experience of grief: An heuristic enquiry*. https://openrepository.aut.ac.nz/bitstream/handle/10292/10424/AlleyneB.pdf	Bronwyn Alleyne	Keith Tudor
	Alleyne, B., & Tudor, K. (2022). A psychotherapist's experience of grief: An heuristic enquiry. In K. Tudor & E. Green (Eds.), *Psyche and academia: Papers from 21 years of the Auckland University of Technology psychotherapy Master's programmes*. Tuwhera Open Access Publications.		
152	*"Our Māori connection": The impact of colonisation on one southland whanau*. https://openrepository.aut.ac.nz/bitstream/handle/10292/10225/ArmstrongV.pdf	Verity Armstrong	Wiremu Woodard
	Armstrong, V., & Woodard, W. (2022). "Our Māori connection": The impact of colonisation on one Southland whanau. In K. Tudor & E. Green (Eds.), *Psyche and academia: Papers from 21 years of the*		

	Auckland University of Technology psychotherapy Master's programmes. Tuwhera Open Access Publications.		
153	*How twins experience their twinship, with implications for therapy: A systematic review of qualitative interviews*. https://openrepository.aut.ac.nz/bitstream/handle/10292/9901/BeggK.pdf	Karen Begg	Margot Solomon & Stephen Appel
154	*Gender in psychotherapy: How does the literature portray the power dynamics in a female therapist-male client dyad?* https://openrepository.aut.ac.nz/bitstream/handle/10292/10155/DumitracheA.pdf	Adina Dumitrache	Brian Rodgers
155	*Ngā Tāpiritanga: In what ways are indigenous Māori perspectives on attachment similar to and different from Western psychoanalytic perspectives on attachment and what are the implications for the practice of psychotherapy in Aotearoa New Zealand? A kaupapa Māori critical literature review*. https://openrepository.aut.ac.nz/bitstream/handle/10292/10510/FlemingA.pdf	Anna Fleming	John O'Connor
	Fleming, A. H. (2018). Ngā tāpiritanga: Secure attachments from a Māori perspective. *Ata: Journal of Psychotherapy Aotearoa New Zealand*, *22*(1), 23–36. https://doi.org/10.9791/ajpanz.2018.03		
156	*The therapist's experience of working with the anorexic client*. https://openrepository.aut.ac.nz/bitstream/handle/10292/9869/GreenE.pdf	Emma Green	Margot Solomon
	Green, E., & Solomon, M. (2020). The body responds. *Ata: Journal of Psychotherapy Aotearoa New Zealand*, *24*(1), 29-42. https://doi.org/10.9791/ajpanz.2020.03		
157	*From shame to self-acceptance: A hermenetuic literature review*. https://openrepository.aut.ac.nz/handle/10292/10270	Bogumila Greenwood	Brian Rodgers
158	*An interpretive review of psychoanalytic literature on empathy in the therapeutic relationship*. https://openrepository.aut.ac.nz/bitstream/handle/10292/10567/KistasamyK.pdf	Kumeshni Kistasamy	Julia Ioane & Keith Tudor
159	*The addicted narcissist: How substance addiction contributes to pathological narcissism with implications for treatment*. https://openrepository.aut.ac.nz/bitstream/handle/10292/10217/LaurenceK.pdf	Kim Laurence	Paul Solomon
160	*A double life: The psychological being of heterosexually married men who have sex with men. A thematic analysis*. https://openrepository.aut.ac.nz/bitstream/handle/10292/9913/LeeSP.pdf	Seng Poh Lee	Joanne Emmens
161	*Eye to eye: A hermeneutic literature review of eye contact and the gaze in psychoanalytically informed psychotherapy*. https://openrepository.aut.ac.nz/bitstream/handle/10292/10459/MalcolmO2.pdf	Outi Malcolm	Brigitte Puls
	Malcolm, O., & Puls, B. (2017). Seeing and being seen: Eye contact and psychotherapy: Findings from a hermeneutic literature review. *Ata: Journal of Psychotherapy Aotearoa New Zealand*, *21*(2), 133–147. https://doi.org/10.9791/ajpanz.2017.13		
162	*Does Melanie Klein's concept of internal objects relate to Samoan writings on internal structures of the self? A phenomenologically-oriented heuristic enquiry*. https://openrepository.aut.ac.nz/bitstream/handle/10292/10098/MameaK2.pdf	Karlene Mamea	Peter Slater & Julia Ioane
	Mamea, K., Ioane, J., & Slater, P. (2018). A Samoan sense of self: An exploration. *Ata: Journal of Psychotherapy Aotearoa New Zealand*, *22*(1), 103–113. https://doi.org/10.9791/ajpanz.2018.08		
163	*What are the theories, methods and techniques underpinning vocal psychotherapy? An interpretive hermeneutic literature review*.	Rebecca Elizabeth Wright	Brigitte Puls

	https://openrepository.aut.ac.nz/bitstream/handle/10292/10058/WrightR.pdf		

2017

Table 18.1. Master of Psychotherapy – Dissertations (Paper HEAL901) (60 points) 2017

No	Title	Student	Supervisor(s)
164	*To be seen and heard: The lived experience of Pasifika students participating in psychotherapy training in Aotearoa, New Zealand an interpretative phenomenological analysis*. https://openrepository.aut.ac.nz/bitstream/handle/10292/10638/Stewart-FolauA.pdf	Ambyr Folau	Paula Collens & Julia Ioane
165	*"Nature and I", an ecotherapy journey: A heuristic inquiry into nature's role in healing, from a psychotherapy perspective*. https://openrepository.aut.ac.nz/bitstream/handle/10292/11009/FranklinM.pdf	Marie Franklin	Jonathan Fay
166	*Seeking understanding on the issue of happiness: A hermeneutic literature review*. https://openrepository.aut.ac.nz/bitstream/handle/10292/10983/PetersenM.pdf	Matthew Petersen	Joanne Emmens
167	*Clinical understandings of a mother's murderous rage towards her infant: A hermeneutic literature review*. https://openrepository.aut.ac.nz/bitstream/handle/10292/10531/ShawA.pdf	Angela Jayne Shaw	Peter Slater
	Shaw, A., & Lummis, D. (2022). Clinical understandings of a mother's murderous rage towards her infant: A hermeneutic literature review. In K. Tudor & E. Green (Eds.), *Psyche and academia: Papers from 21 years of the Auckland University of Technology psychotherapy Master's programmes*. Tuwhera Open Access Publications.		
168	*Exploring the impact of millennials' use of social media on their attachment experiences, and its possible implications for psychotherapy: A thematic analysis*. https://openrepository.aut.ac.nz/bitstream/handle/10292/10634/ViljoenB.pdf	Brigitte Viljoen	Joanne Emmens
169	*The therapist's experience and understanding of their client's secrets: A hermeneutic phenomenological inquiry*. https://openrepository.aut.ac.nz/bitstream/handle/10292/10608/WilkinsonJ2%281%29.pdf	Joanne Mary Wilkinson	Paula Collens
170	*A therapist's journey from naivete to knowing*. https://openrepository.aut.ac.nz/bitstream/handle/10292/11012/YatesM.pdf	Michelle Yates	Jonathan Fay

Table 18.2. Master of Psychotherapy – Dissertations (Paper HEAL996) (45 points) 2017

No	Title	Student	Supervisor(s)
171	*A hermeneutic literature review exploring the intersection of video gaming and psychotherapy*. https://openrepository.aut.ac.nz/bitstream/handle/10292/10875/MunroF.pdf	Fraser Munro	Brian Rodgers
172	*A path towards wholeness: Identifying the experiences of clinicians who practice psychotherapy and Nichiren Buddhism*. https://openrepository.aut.ac.nz/bitstream/handle/10292/10504/ShiraiS.pdf	Seiko Shirai	Wiremu Woodard
173	*What does the psychotherapeutic literature reveal about therapist's experiential responses to working in psychotherapy with trans- clients?*	Sally-Anne Thomson	Paula Collens

	https://openrepository.aut.ac.nz/bitstream/handle/10292/10987/ThomsonSA.pdf		
174	*How do second generation immigrants experience immigration? Understanding the impact of the immigration process on second generation immigrants through the lens of psychoanalytic thinking.* https://openrepository.aut.ac.nz/bitstream/handle/10292/11437/XieX.pdf	Xiaoyin Ariel Xie	Joanne Emmens

2018

Table 19.1. Master of Psychotherapy – Dissertations (Paper HEAL901) (60 points) 2018

No	Title	Student	Supervisor(s)
175	*Criminality and psychotherapy in forensic mental health: A hermeneutic exploration of the literature around the metaphor monster in relation to the violent offender (meeting the monster).* https://openrepository.aut.ac.nz/bitstream/handle/10292/11801/AjayiO.pdf	Olakunle Ajayi	Brian Rodgers
	Ajayi, O., & Rodgers, B. (2022). The violent offender: Human, monster, or both? In K. Tudor & E. Green (Eds.), *Psyche and academia: Papers from 21 years of the Auckland University of Technology psychotherapy Master's programmes*. Tuwhera Open Access Publications.		
176	*Regarding intuition: An heuristic journey into a psychotherapist's experience of intuition*. https://openrepository.aut.ac.nz/bitstream/handle/10292/11506/Schorr-KonCJ.pdf	Christa Juliet Schorr-Kon	Margot Solomon
177	*The therapist's experience of disbelief in working with dissociative identity disorder* https://openrepository.aut.ac.nz/handle/10292/11521	Susie Thomas	Margot Solomon

Table 19.2. Master of Psychotherapy – Dissertations (Paper HEAL996) (45 points) 2018

No	Title	Student	Supervisor(s)
178	*Yoga psychotherapy: Which yoga postures can be used to balance which emotions, in the context of psychotherapeutic treatment?* https://openrepository.aut.ac.nz/bitstream/handle/10292/11916/BatalhaC.pdf	Catia Batalha	Wiremu Woodard
179	*Psychological perspectives on narrative and storytelling*. https://openrepository.aut.ac.nz/bitstream/handle/10292/11553/BeachmanL.pdf	Lisa Beachman	Paul Solomon
180	*Equine facilitated psychotherapy: From a neuropsychoanalytic perspective, how can the horse-human bond assist the repair of early relational trauma that has led to insecure attachment? A hermeneutic literature review*. https://openrepository.aut.ac.nz/bitstream/handle/10292/11615/BentleyA.pdf	Andrea Bentley	Paul Solomon
181	*The connection between the infant's development of dimensionality and the adult's capacity to dream*. https://openrepository.aut.ac.nz/bitstream/handle/10292/11501/BlythS.pdf	Susan Blyth	Paul Solomon
182	*Facing personal adversity while dealing with the pain of others: A hermeneutic literature review*. https://openrepository.aut.ac.nz/bitstream/handle/10292/11672/Dissertation%20Final%20John%20F.pdf	John Francis	Kerry Thomas-Anttila
	Francis, J., & Thomas-Anttila, K. (2002). Facing personal adversity while dealing with the pain of others: A hermeneutic literature review. In K. Tudor & E. Green (Eds.), *Psyche and academia: Papers from 21 years*		

	of the Auckland University of Technology psychotherapy Master's programmes. Tuwhera Open Access Publications.		
183	*Working (it) out: An heuristic enquiry into exercise and psychotherapy*. https://openrepository.aut.ac.nz/handle/10292/12011 [Embargoed until November 2024]	Daniel Harrison	Keith Tudor
	Harrison, D., & Tudor. K. (2020). Working (it) out: An heuristic enquiry into psychotherapy and exercise. *Advances in Mind-Body Medicine*, *34*(2), 14–23.		
184	*Can a psychotherapy student authentically grow under academic demands: A heuristic inquiry*. https://openrepository.aut.ac.nz/bitstream/handle/10292/11620/LohJ.pdf	James Loh	Jonathan Fay
185	*Kali, Shiva, and psychotherapy: A hermeneutic literature review*. https://openrepository.aut.ac.nz/bitstream/handle/10292/11633/MahanteshVG2.pdf	Vijay Gurumurthy Mahantesh	Wiremu Woodard
	Mahantesh, V. G., & Woodard, W. (2022). Kali, Shiva, and psychotherapy: A hermeneutic literature review. In K. Tudor & E. Green (Eds.), *Psyche and academia: Papers from 21 years of the Auckland University of Technology psychotherapy Master's programmes*. Tuwhera Open Access Publications.		
186	*A beginning psychotherapist's journey into anger and aggression: A heuristic enquiry*. https://openrepository.aut.ac.nz/handle/10292/11531	Brodie Morgan	Kerry Thomas-Antilla
187	*Better silent than silenced: Searching for the words of sibling suicide bereavement.* https://openrepository.aut.ac.nz/bitstream/handle/10292/11582/RoydenL.pdf	Leah Royden	Brian Rodgers
188	*The dream themes of the suicidal unconscious*. https://openrepository.aut.ac.nz/bitstream/handle/10292/11918/StJohnV.pdf	Victoria St. John	Joanne Emmens
189	*Navigating the boundaries of two cultural worlds while re-negotiating a space for myself: My journey as a Samoan woman in the AUT psychotherapy course*. https://openrepository.aut.ac.nz/bitstream/handle/10292/11996/TapuTuitahiA.pdf	Athena Tapu Tu'itahi	Julia Ioane
	Tu'itahi, A. T., & Ioane, J. (2022). Navigating the boundaries of two cultural worlds while re-negotiating a space for myself: My journey as a Samoan woman in the AUT psychotherapy course. In K. Tudor & E. Green (Eds.), *Psyche and academia: Papers from 21 years of the Auckland University of Technology's psychotherapy programmes*. Tuwhera Open Access Publications.		
190	*Paranoia and sexual orientation: A hermeneutic literature review*. https://openrepository.aut.ac.nz/bitstream/handle/10292/11487/WilsonP.pdf	Paul Murray Wilson	Paula Collens

2019

Table 20.1 Master of Psychotherapy – Dissertations (Paper HEAL996) (45 points) 2019

No	Title	Student	Supervisor(s)
191	*My experience of being present. A heuristic self-search inquiry.* https://tinyurl.com/ynb4yzf3	Nick Brown-Haysom	Garjana Kosanke
192	*Dance into the unknown. A heuristic inquiry.* https://openrepository.aut.ac.nz/bitstream/handle/10292/12523/ChristophersJ.pdf	Jane Christophers	Margot Solomon
193	*To speak or not to speak: The experience of disclosing and concealing my obsessive-compulsive disorder – a heuristic enquiry.* https://openrepository.aut.ac.nz/bitstream/handle/10292/12490/Dissertation%20Chris%20Lorigan.pdf	Chris Lorigan	Garjana Kosanke

194	*How have we silenced the everydayness of our mental dis-ease, in mainstream Aotearoa New Zealand?* https://openrepository.aut.ac.nz/bitstream/handle/10292/12450/PlayerBishopL.pdf	Louise Player-Bishop	Brian Rodgers

2020

Table 21.1. Master of Psychotherapy – Dissertations (Paper HEAL996) (45 points) 2020

No	Title	Student	Supervisor(s)
195	*First person accounts of psychotherapy for psychosis.* https://openrepository.aut.ac.nz/bitstream/handle/10292/13439/CoyleP.pdf	Philippa Coyle	Joanne Emmens
196	*The therapist's experience of the (non-)establishment of therapeutic alliance in couple therapy.* https://openrepository.aut.ac.nz/bitstream/handle/10292/13354/Dissertation%20Helen%20Creagh%20HEAL996PdF.pdf	Helen Creagh	Garjana Kosanke
197	*The use of art therapy in work with adult survivors of childhood sexual abuse trauma: A thematic analysis.* https://tinyurl.com/2js7vnkn	Limor Fybish	Mariana Torkington & Margot Solomon
198	*Breathing and relating: Exploring a therapist's heuristic experience.* https://openrepository.aut.ac.nz/bitstream/handle/10292/13157/HuxtableC.pdf	Cordelia Huxtable	Margot Solomon
	Huxtable, C., & Solomon, M. (2020). Breathing and relating: Exploring a therapist's heuristic experience. *Body, Movement and Dance in Psychotherapy*, *15*(4), 236–250. https://doi.org/10.1080/17432979.2020.1813808		
199	*Sensing home: A thematic analysis of psychoanalytic texts.* https://tinyurl.com/232jdz59	Hayden Mark Isaac	Garjana Kosanke & Wiremu Woodard
200	*Sexual fantasy: A hermeneutic literature review.* https://openrepository.aut.ac.nz/bitstream/handle/10292/13432/VonY_Sexual%20Fantasy.pdf	Yulia Von	Paula Collens
	Von, Y., & Collens, P. (2022). Sexual fantasy in sex research. In K. Tudor & E. Green (Eds.), *Psyche and academia: Papers from 21 years of the Auckland University of Technology psychotherapy Master's programmes*. Tuwhera Open Access Publications.		

2021

Table 22.1 Master of Psychotherapy – Dissertations (Paper HEAL996) (45 points)

No	Title	Student	Supervisor(s)
201	*The role of language in therapy: The therapist's bilingualism in the countertransference experiences*. https://openrepository.aut.ac.nz/bitstream/handle/10292/14440/AmiriM.pdf	Mina Amiri	Wiremu Woodward
202	*A modified systematic literature review examining current support provided for young people to manage stress.* https://openrepository.aut.ac.nz/bitstream/handle/10292/14297/BattsP.pdf	Poppy-Louise Batts	Elizabeth Day
203	*Falling into the abyss: A heuristic self-inquiry into a psychotherapist's experience of abrupt endings*. https://openrepository.aut.ac.nz/bitstream/handle/10292/14790/ChueD.pdf	Dana Chue	Keith Tudor
204	*In defence of a manic defence: A therapist's experience of humour in psychotherapy*. https://openrepository.aut.ac.nz/bitstream/handle/10292/14499/CiurlionisC.pdf	Craig Ciurlionis	Keith Tudor

205	*A psychotherapist's experience of self-disclosure, when practising in the digital era: A heuristic self-study*. https://openrepository.aut.ac.nz/bitstream/handle/10292/14202/LongleyH.pdf	Hannah Longley	Joanne Emmens
206	*In two minds: A heuristic enquiry into my experience of ambivalence*. https://openrepository.aut.ac.nz/handle/10292/14532 [Embargoed until 24th September 2024]	Deborah Lyn Lyons	Keith Tudor
207	*The art of mourning: Exploring the impact of artistic creation upon the psychotherapist*. https://tinyurl.com/2s46e9fn	Jessie McCall	Margot Solomon
	McCall, J., & Solomon, M. (2022). The art of mourning: Exploring the impact of artistic creation upon the psychotherapist. In K. Tudor & E. Green (Eds.), *Psyche and academia: Papers from 21 years of the Auckland University of Technology psychotherapy Master's programmes*. Tuwhera Open Access Publications.		
208	*"The vibrating red muscle of my mouth": What has happened to the diagnosis of hysteria?* https://openrepository.aut.ac.nz/bitstream/handle/10292/14460/WoodsJ.pdf	Jenny M Woods	Margot Solomon

Table 22.2. Master of Psychotherapy (Child and Adolescent Psychotherapy) – Dissertations (Paper HEAL996) (45 points) 2021

No	Title	Student	Supervisor(s)
209	*Exploring hidden assumptions of culture in child psychotherapy in Aotearoa New Zealand: A hermeneutic literature review*. https://openrepository.aut.ac.nz/bitstream/handle/10292/14678/CadoganN.pdf	Nicky Cadogan	Wiremu Woodard
	Cadogan, N., & Woodard, W. (2022). Exploring hidden assumptions of culture in child psychotherapy in Aotearoa New Zealand: A hermeneutic literature review. In E. Green & K. Tudor (Eds.), *Psyche and academy: Papers from 21 years of the Auckland University of Technology psychotherapy Master's programmes*. Tuwhera Open Access Publications.		
210	*Moving on from childhood trauma: The remedial potential of body-centered psychotherapy for children*. https://openrepository.aut.ac.nz/bitstream/handle/10292/14423/EngelbrechtAM.pdf	Anna Maria Engelbrecht	Mariana Torkington
211	*Weathering the storm: How parent-infant psychotherapy can facilitate transformative communications of maternal distress. A hermeneutic literature review*. https://openrepository.aut.ac.nz/bitstream/handle/10292/14143/HiskensM.pdf	Monique Hiskens	Kerry Thomas-Anttila
212	Hiskins, M., & Thomas-Anttila, K. (2022). Weathering the storm: How parent-infant psychotherapy can facilitate transformative communications of maternal distress. A hermeneutic literature review. In K. Tudor & E. Green (Eds.), *Psyche and academia: Papers from 21 years of the Auckland University of Technology psychotherapy Master's programmes*. Tuwhera Open Access Publications.		
213	*The experience of the young child bereaved by sibling stillbirth*. https://openrepository.aut.ac.nz/bitstream/handle/10292/14519/JacksonN.pdf	Nicola Jackson	Margot Solomon & Jill Buchanan
	Jackson, N., & Solomon, M. (2022). The experience of the young child bereaved by sibling stillbirth. In K. Tudor & E. Green (Eds.), *Psyche and academia: Papers from 21 years of the Auckland University of Technology psychotherapy Master's programmes*. Tuwhera Open Access Publications.		
214	*It takes two. Ruptures and repairs in the therapeutic relationship with adolescents: A hermeneutic literature review.* https://openrepository.aut.ac.nz/bitstream/handle/10292/14522/WongK.pdf	Kirsten Wong	Mariana Torkington
	Wong, K., & Torkington, M. (2022). It takes two: Ruptures and repairs in the therapeutic relationship with adolescents. A hermeneutic literature review. In K. Tudor & E. Green (Eds.), *Psyche and academia:*		

In reading and reviewing this list, I particularly wish to acknowledge the work of Dr Margot Solomon (née Woods) who supervised 32 Master's theses and dissertations in the discipline of psychotherapy between 2001 and 2021. This remarkable record represents not only a major contribution to those students who have subsequently become practitioners, but also an important legacy to the discipline and the profession—tēnā koe, rangatira.

Editors' and Contributors' Biographies

Editors

Emma Green, PhD, is a registered psychotherapist living and working in Tāmaki Makaurau, Aotearoa (Auckland, New Zealand). She has taught in the Department of Psychotherapy & Counselling at Auckland University of Technology in the undergraduate and Master's programmes. She now works in private practice where she works with individuals, couples, and groups. Her research interests include culture, gender, and sexuality; whiteness; transformational social change; and feminist theory and psychotherapy, including Jungian theory. She has a special interest in poetic inquiry and qualitative methodologies that attend to different ways of knowing.

Keith Tudor is Professor of Psychotherapy at Auckland University of Technology and currently Co-lead of the AUT Group for Research in the Psychological Therapies. He was programme leader of the Master of Health Science (in Psychotherapy) (2009–2012) and of the Master of Psychotherapy (2010–2012 and 2014). Originally trained in gestalt therapy and transactional analysis in the UK, he is a Teaching and Supervising Transactional Analyst and currently co-President of the Aotearoa New Zealand Association of Transactional Analysis. He was co-editor of *Ata: Journal of Psychotherapy Aotearoa New Zealand* (2012–2017), and editor of *Psychotherapy and Politics International* (2012–2022). He is a well-published author, and enjoys encouraging colleagues to research, write, and publish.

Contributors

Olakunle Ajayi is a forensic mental health practitioner in New Zealand. In his work, he offers psychotherapy treatment, supervision, mentorship, and education. His interests are in the visible and hidden dynamics that occur in forensic and mental health contexts. Olakunle loves nature and sports, with a keen interest in football.

Bronwyn Alleyne is a psychotherapist working in private practice in Auckland. Bronwyn has worked for many years in grief organisations and also in a hospice setting, and now primarily specialises in working with the dying and the bereaved, as well as individuals and couples in private practice.

Verity Armstrong – Ko Takitimu, ko Hikaroroa kā mauka, ko Aparima, ko Waikouaiti kā awa, ko Uruao, ko Ataiteuru, ko Takitimu kā waka, ko Tahu Pōtiki te takata, ko Kāti Huirapa me Kāi Te Ruahikihiki kā hapū, ko Takutai o te Tītī, Ko Waihōpia, Ko Kāti Huirapa ki Puketeraki kā marae, ko Kāi Tahu, Kati Mamoe kā iwi, ko Kuini Goodwillie toku tupuna, ko Joan Hartley toku mama, ko Ivan Armstrong toku papa, ko Verity Armstrong toku ingoa.

Rosemary Beever (Te Āti Awa, Ngāti Toa, Ngāti Mutunga, Pākehā) works in a trauma service in South Auckland, and has a small, central, private practice specialising in bioenergetics and somatic psychotherapy. She loves dance and movement practices and being in nature.

John Bryant has practiced psychotherapy and counselling for over 25 years. This includes private practice, teaching, and clinical supervision in a variety of different settings including Segar House, Massey University, and Help. He has lectured in violence and trauma studies at Manukau Institute of Technology and AUT. John draws on both his own life experience and his professional training in psychodynamic psychotherapy, Gestalt, interpersonal therapy, and mindfulness-based CBT, as well as his understanding of brain/body science and psychotherapy to work collaboratively with individuals and couples with relationship problems, anxiety, depression, stress, and anger problems.

Nicola Cagogan is a graduate of the Master of Psychotherapy programme.

Victoria Clarke is a Child and Adolescent Psychotherapist. She has worked in a community abuse and trauma agency and a Child and Adolescent Mental Health Service. Victoria is now a lecturer in the AUT Psychotherapy Master's programme and is an AUT doctoral student with an interest in child telepsychotherapy.

Paula Collens, PhD, Senior Lecturer at AUT, teaches on both psychotherapy and counselling psychology programmes. Areas of teaching, research, and clinical specialism include working with sexuality and relationship diversity and integrating the arts in therapy. She is a Chartered Psychologist (BPS), Counselling Psychologist (UK HCPC), and full member of the New Zealand Psychological Society.

John Francis is a psychotherapist in private practice and a research officer at AUT. His research interests include the subjective experience of psychotherapists, experiences of hair loss, depression and anxiety, and marginalised communities. He is a graduate of the AUT psychotherapy programme and calls Auckland home.

Emma Harris graduated from AUT in 2007. She went on to do further post grad studies at AUT in Mindbody Healthcare and brings a whole person approach to her psychotherapeutic work. She works fulltime in private practice in West Auckland.

Monique Hiskens is an Auckland-based child psychotherapist.

Julia Ioane, DClinPsych, began her academic career at AUT in 2015 in the Department of Psychotherapy & Counselling before moving to Psychology, although she still supervised students in the psychotherapy programme. She now teaches in the clinical psychology programme at Massey University, where she is an Associate Professor, and continues to practice as a clinical psychologist. As Samoan, born and raised in Aotearoa New Zealand, she is an advocate of Indigenous and Pasifika psychology and practice in this country, and continues to promote the inclusion of Indigenous research models and methodologies to ensure psychology is inclusive of the communities it serves.

Nicola Jackson is a seventh generation Pākehā New Zealander living in Tāmaki Makaurau with her partner and three children. She works as a child and adolescent psychotherapist in her community practice Child in Mind, where she sees bereaved children in her work with the charity Kenzie's Gift.

Sue Joyce (née) Mannion was born in Ireland. In 1959, aged two, she and her family emigrated to New Zealand. She held a BA (Philosophy) from Auckland University and, from AUT, a Postgraduate Diploma in Health Science (Clinical Supervision) and a Master of Health Science (Hons). She joined the staff at Auckland Institute of Technology in 1999. She was a Council member of the New Zealand Association of Psychotherapists from 2006 and Chair of its Ethics and Professional Standards Committee from 2007 until her death in 2009, aged 52, from injuries received in a motor vehicle accident in Bali. She is survived by her husband, three children, (and now) five grandchildren.

Dianne Lummis is a child and adolescent psychodynamic psychotherapist who has practised in Aotearoa for 30 years. Her interests included working with tamariki and their whānau. Her specialism is working with children who have experienced severe trauma. Currently she is Programme Leader of the Master of Psychotherapy (Child and Adolescent Psychotherapy).

Vijay Mahantesh spent his early life in the spiritual city of Varanasi on the banks of the holy river Ganges, where he was exposed to, and was part of, various festivities, rituals, and rites. Through these events, Vijay gained knowledge of traditional myths, epics, and lore and developed a keen interest in the human psyche. Vijay moved to Aotearoa and has been in the helping professions in Tāmaki Makaurau since 2005. He currently leads a team of family therapists and is a psychotherapist in private practice.

Jessie McCall is a psychotherapist currently based in private practice in Titirangi, West Auckland, New Zealand, where she grew up. Jessie is also a queer movement artist who is interested in the uncanny ways that psychological and emotional experiences can be evoked through the interaction of body, space, and object.

Gabriela Mercado is a psychotherapist, sex therapist, and supervisor. She works in private practice in Auckland. Gabriela has worked at The Burnett Foundation Aotearoa, previously New Zealand AIDS Foundation, and at Auckland Sexual Health Services. An active member of the New Zealand Association of Psychotherapists, she has been a Council member for six years. Gabriela is a regular guest lecturer on the AUT Master of Psychotherapy programme.

John O'Connor is a Jungian Analyst and Psychotherapist with extensive experience with patients with complex relational histories, in group psychotherapy, clinical supervision and education, and working cross culturally. He is Chair of the New Zealand Association of Psychotherapists' Advanced Clinical Practice psychotherapy training pathway and is co-editor of *Ata: Journal of Psychotherapy Aotearoa New Zealand*.

Brian Rodgers, PhD, is the programme director for the counsellor education programmes at the University of Auckland, Aotearoa New Zealand. Brian has supervised numerous Master's student dissertations and theses including at the University of Auckland, Auckland University of Technology, the University of Queensland in Brisbane, and the University of Strathclyde in Glasgow.

Angela Shaw is a psychodynamic psychotherapist in private practice in Tāmaki Makaurau Auckland. She has an interest in the intersection of the internal world, external

place or environment, and theory. She is skilled in working with expectant and new mothers experiencing depression and anxiety. Angela particularly enjoys couples therapy.

Margot Solomon, PhD, taught for 26 years on the psychotherapy Master's programmes in the Department of Psychotherapy & Counselling at AUT. She has a passion for research methodologies that are a fit for psychotherapy, especially hermeneutics and heuristic self-study. She currently works as a psychoanalytic psychotherapist and group analytic psychotherapist in private practice. She is a member of Group Analysis International, the New Zealand Association of Psychotherapy, the Australian Association of Group Psychotherapy, and the International Association of Relational Psychoanalytic Psychotherapy.

Athena Tapu Tu'itahi is a psychotherapist, who is registered with both the Psychotherapists Board of Aotearoa New Zealand and the Accident Compensation Commission, and a lecturer at Auckland University of Auckland. She has experience working in Pasifika mental health services at Auckland and Waitemata District Health Boards and Adolescent and Children Mental Health Services. She has worked in the community at Auckland City Mission—Te Whare Hīnātore, and at St Vinnies Charitable Trust as well as community wellbeing programmes such as Dressed in Confidence.

Kerry Thomas-Anttila, PhD, MHSc (Psychotherapy) (Hons), MA (Hons), is a Senior Lecturer and Programme Leader of the Master of Psychotherapy in the Department of Psychotherapy & Counselling, Auckland University of Technology, Aotearoa New Zealand. She teaches and supervises in the Department and also works as a psychoanalytic psychotherapist in private practice.

Mariana Torkington is a member of staff in the Department of Psychotherapy & Counselling at AUT.

Jane Tuson trained as a psychodynamic psychotherapist at AUT. She currently works with adults in private practice and is based in Auckland, New Zealand. She is also completing her PhD, researching how the training and practice of psychotherapy impacts the psychotherapist's significant others.

Yulia Von is a psychotherapist in private practice in Auckland. Her clinical work is informed by her continuous study of psychotherapy and sexology. Yulia works with individuals and couples experiencing concerns in the areas of sexual desire, sexual function, sexual orientation, gender identity, and non-monogamy.

Kirsten Wong is a third generation Chinese New Zealander and Child and Adolescent Psychotherapist living in Tāmaki Makaurau. She is currently working in a Child & Adolescent Mental Health Service and has an interest in therapies informed by attachment, child development, family systems, mentalisation, and psychodynamic theories.

Wiremu Woodard is Tuhoe and an Indigenous therapist, father of four, activist, environmentalist, and sometimes contemporary dancer and artist. Wiremu is committed to reducing health disparities for Māori and promoting social justice. He is a graduate of the

Master's programme at AUT, and a former member of staff. He currently works in community practice at Kereru. Wiremu is a founding member of Waka Oranga, a group of dynamic Indigenous Māori practitioners committed to emancipatory freedom.