The Therapeutic Conversation

Volume I Issue 1 February 2021

ISSN 2981-8532

ANZAP
Australia and New Zealand
Association of Psychotherapy Ltd

PITSIG

ANZAP
Australia and New Zealand
Association of Psychotherapy Ltd

Transitional eBulletin

Summer 2020
Volume 28, No 4

Table of Contents

Editorial

Kia Ora and Welcome

I am delighted to welcome you to this unique publication as it transitions from the former ANZAP eBulletin to an increasingly journal-like publication, The Therapeutic Conversation (TTC).

Members of the Australia New Zealand Association of Psychotherapy (ANZAP) and members of the Psychodynamic Interpersonal Therapy Significant Interest Group (PITSIG) of the UK have been collaborating for several years to establish a joint publication. This collaboration grows out of an earlier one between Bob Hobson and Russell Meares. The Statement of Ambition for The Therapeutic Conversation, contained within, calls for us to write of our clinical experience informed by "themes and ideas emerging out of relational, developmental, neuroscientific, linguistic, philosophical, phenomenological and intersubjective approaches to psychotherapy". This initiative holds great promise for deepening the dialogue between members of our organisations, and perhaps in the future, with others too.

The Therapeutic Conversation is a work in progress. The current edition is structured in two parts. The first part contains papers and a review from our 3 contributing countries; Australia, New Zealand and the UK. The second part retains some of the flavour of the ANZAP eBulletin and aims to give information to ANZAP and PITSIG members about what is happening within our organisations. The shape of The Therapeutic Conversation will evolve according to the Statement of Ambition and to our response to this initiative.

This edition includes a Call for Papers. I encourage you to give voice to your clinical experience by contributing in writing to an ongoing conversation in The Therapeutic Conversation.

Margie Darcy
Editor

A Welcome

by Russell Meares

Robert Hobson (1920-1999) was an eminent Jungian analyst. A warm, compassionate, and idealistic man, he became concerned by the plight of those many people whose illnesses were intractable and considered untreatable. He set up a unit at the Maudsley and Bethlem Hospital, in London, in an attempt to discover a means of treating them. I too had become interested in the problem of intractability, inspired by the treatment of such a case by my father, Ainslie Meares, described in "The Door of Serenity" (Meares, 1958). Hearing of Hobson's pioneering venture, I travelled to London in order to work with him. We became great friends. In 1969 he invited me to collaborate with him in a project to create a new model of psychotherapy, suitable not only for so-called "unanalysable" patients but also for most of those needing psychotherapeutic care. He was to call it the Conversational Model (Hobson, 1985). Hobson wanted a model which was scientifically based and "testable" but also "humanistic". At the outset of the project I stated our position. The statement concluded with the following: "Mental illness is associated with impaired intimate relations. This impairment has been conceived in neurobiological terms, particularly since the notion of attachment has had its fruitful influence. Nevertheless, intimacy and attachment are not the same. Attachment is shown through behaviour, intimacy involves sharing ideas, thought and memories which are usually hidden. Clinical and experimental data must be part of the evidential base" (Meares, 1977). Experiential data might include "a literature which is peculiarly subjective, for it is from sensitive and precise accounts of human experience that any new models of psychotherapy must gain their life" (Meares, 1977, p. 177-178).

Since those early days there have been great developments with a relatively large literature evolving about the Conversational Model with authorship coming from Hobson, myself and colleagues in UK and Australasia. There is no suitable outlet, however, for existential data and the humanistic aspects of the conversational model, which is its life. This journal is welcomed as potentially able to fill a vacancy in the range of publications available to the psychological sciences.

The project can only be furthered by the efforts and creativity of many people working together, whose ideas can be found and developed in a journal. There is therefore a second reason to welcome this journal. It is to be hoped that it can be a means towards unifying the efforts of those working in different countries, all striving to understand and transform the same complexities of existence besetting our patients, all working toward the same end.

Hobson, R.F. (1985). Forms of Feeling. London: Tavistock.

Meares. A. (1958). The Door of Serenity. London: Faber.

Meares, R. (1977). The Pursuit of Intimacy. Melbourne: Nelson.

A beginning: ANZAP and PITSIG introduce The Therapeutic Conversation

For many years now the Conversational Model (CM) has grown from its beginning as a collaboration between Robert Hobson and Russell Meares. To a considerable extent this growth has been carried on independently in Australia, particularly centred in Sydney with outreach to all parts of Australia and New Zealand/Aotearoa. At the same time in a large body of work in the UK, based mainly north of London, the CM has developed and been adapted to suit the requirements of the National Health Service. In the process it has become established as an intervention relevant to across a range of diagnoses and for brief treatments in acute situations as well as for longer term therapy. In Australia, research has centred on Personality Disorder and more recently on working with populations identified as suffering from Complex Traumatic Disorders.

The commonalities of attention to the present moment, to the patient's feeling states and the use of language that facilitates an interpersonal communicative flow mean that there is a coherence and mutual sense of purpose between the groups which have come to represent the CM, the Australian and New Zealand Association of Psychotherapy (ANZAP) and the Psychodynamic Interpersonal Therapy Special Interest Group (PITSIG). After a series of meetings conversation

between the two groups has led to the plan to develop a joint publication, *The Therapeutic Conversation*. This begins with this issue as a re-imagining of the ANZAP Bulletin, now including information and contributions from Australia, New Zealand/Aotearoa and the United Kingdom. For next year we aim to produce a larger volume and plan to introduce a process of peer review, leading to the establishment of The Therapeutic Conversation as a new journal which focuses on the intersubjective processes of exchange contributing to the healing process. As such it will have relevance to situations across the clinical domain, including psychotherapy and CM work but also extending to a more general relevance to recovery from trauma and illness. The statement of ambition appearing below gives an idea of the intent of the publication.

Anthony Korner
Member, Strategic Planning Working Party

Statement of Ambition
The Therapeutic Conversation

The Therapeutic Conversation specifically aims to give expression to clinical experience informed by the convergences of core themes and ideas emerging out of relational, developmental, neuroscientific, linguistic, philosophical, phenomenological and intersubjective approaches to psychotherapy while being open to a broad range of psychoanalytic and non-analytic orientations.

This journal seeks to give voice to the primary experience that clinicians have in working with patients. All clinical work involves an opportunity for therapeutic relationship between clinician and patient, no matter the specific treatment modality. The exchanges that occur in therapeutic conversations contain elements of personal transformation and growth crucial to healing across a wide variety of contexts. This may occur during brief contact or prolonged therapy and may include transformation experienced by the clinician. The phenomenology of change in relationship is in focus.

The core phenomena of clinical relationships involve language and affective exchange associated with perceptual and procedural experience as it occurs during clinical conversation. Psychotherapy refers to meaning exchanges that occur in these healing conversations and can be thought of as applying to situations beyond formally contracted psychotherapy treatments. The term psyche necessarily encompasses both mental and spiritual dimensions of human lives.

Hence the focus in this journal is on language, feeling and relationship rather than a particular theoretical orientation. The scope is broad to capture the art and science of the therapeutic process whilst never losing sight of the boundaries that define clinical practice. There is potential for novel and non-traditional contributions. We therefore welcome work that reflects a variety of theoretical orientations to psychotherapy, the human exchange at the heart of clinical practice. Recognising that pathways to healing come in many forms, including mysterious elements and material dark to consciousness, we encourage clinicians to share the human aspects of the healing journey with its stories of triumph, failure, endurance, adversity, creativity, conflict and resolution. There will be a peer review process that will take into consideration the quality and coherence of writing, its scientific merit and the potential for changing practice. Sometimes this may relate to what the work evokes rather than simply what it represents. Consistent with the journal's scope, the review will also consider contributions that articulate experiences beyond the clinical setting but are germane to therapeutic process. Such contributions we hope will highlight meaningful ways in which broader social and cultural experiences and phenomena feed into the therapeutic conversation and facilitate the healing process.

After more than a century of clinical work and research in psychotherapy, the processes of healing in talking therapies remain largely unknown. By opening the field to the immediacy of the clinical exchange we believe The Therapeutic Conversation will fill a gap in the existing literature and contribute to the illumination of the role of communication in healing. The interdisciplinary point of convergence on conversation highlights what can be thought of as human 'second nature': the myriad of learned adaptations reflected in the singularity of personality and the ways in which language becomes incorporated into personal being.

Broadening the horizons of therapeutic conversation around self, trauma, illness and healing and facilitating the access of clinicians to the global

conversation on healing will be core objectives of the journal.

Anthony Korner, Loy McLean, Phil Graham, Andy Groome, Tessa Philips
Journal Committee 2017
.

Part I: Papers

'One impulse from a vernal wood…': Wordsworth, Hobson and the ineffable something… .

Colette Rayment, 2020

My second child, Eric, was a great reader. About five years before his untimely death at 13, he called to me from his bedroom, 'Mum, what's ineffable?' Probably amidst the chopping of onions or potatoes, I replied: 'Well it means it's hard to describe or explain. And it's special, maybe even spiritual.' I was about to go to his room, chat about it, until I noticed the silence enduring. Clearly he was satisfied and going on with his book.

Some time ago, Russell Meares (Emeritus Professor Psychiatry and co-founder of the interpersonal and psychodynamic Conversational Model) suggested a conference on – and here he gestured up to a head high level – and called it, 'you know some kind of hierarchy. Not theology or religion or dogma or faith but..', and again he motioned above his head and I said tentatively, 'transcendence?' 'Yes,' he said.
Ah, I thought, a review of the seekers of some kind of Gnosis of the Divine, a union or at-oneness with the Immanent or the Transcendent. A gloss of the various esoteric ways to Gnosis: Alchemy, Kabbala, Freemasonry, Rosicrucianism, Sufism, and not least the Christian Kabbala, Mysticism and Nature Mysticism.
Later in a paper of Russell's I heard a not quite articulated scorn for all that Alchemical 'mumbo jumbo' (I think Jung's esotericism was somewhere in the picture). Now, I can take a hint as well as the next person and agreed to write on Robert Hobson (the co-founder of the Conversational Model) and his debt to the English Romantic poet William Wordsworth.

Any consideration of Hobson and Wordsworth in the context of spirit and psychotherapy will focus less on their British North country origins and their Cambridge educations, and more on their relationships to the Romantic Movement in literature and psychiatry, respectively. Romanticism, as you know, rebelled against the stronghold of the Enlightenment which privileged only reason. Politically the Romantic movement took its inspiration from the French and American Revolutions and emotionally it emphasised 'an extreme exertion of the self and value of individual experience.' (The Oxford Companion to English Literature, pp. 842-43).

Wordsworth's poetic practice, and, a century later, Hobson's therapeutic duologues, reflect the English Romantics' radical move to simple language. Wordsworth and his friend and collaborator Coleridge introduce revolutionary ideas as to what constitutes appropriate language for poetry of the heart.
Equally fundamental to our discussion is the Romantic and in particular the Wordsworthian pantheistic concept of an Active Universe. A world of Nature interpenetrated with a Divinity that includes it, radiating the individual with divine love, such that he cannot but emanate it to others. Wordsworth's opus is a series of 'RADICAL STATEMENTS OF THE DIVINE SUFFICIENCY OF THE HUMAN MIND IN ITS INTERCHANGE WITH Nature.' (Nicholas Riasanovsky, The Emergence of Romanticism, 1992, p.75). Hobson also confesses to a passion for Nature: in particular for scaling the fells such as Scafell Pike above the Wasdale Valley in Cumbria. An experience he narrates in Forms of Feeling in Wordsworthian language ('recollected in tranquillity') and his own experienced mystical epiphanies more than hinted at.
Additionally, both Wordsworth and Hobson write autobiographically and both value a contemplative stance towards their respective recollections. More of this later. .

In this paper I am searching for what Hobson feels and means by forms of feeling. And in my reveries on the subject I am engaged in some form of contemplation as to how Hobson practices his contemplative attitude towards the stories his patients tell him, towards his thinking about them, and towards his own autobiographical memories.
So, how to paint this 'Night Watch'? sized canvass? How to understand the intersections between these elements found in the poet and the therapist? What kind of theory sustains this kind of endeavour? What, barring any form of theological or religious paradigms, are the terms of reference? What methodology to use; what kind of

language to speak of these things?
It seems to me that, bereft of the language of mystical theology, religion or historically formulated paradigms of esotericism, my only recourse is to stay with the personal, the very personal...

Co-incidental to writing this paper, a year prior I visited the Lake District in Cumbria, UK., homeland of Wordsworth and for a time, Coleridge; and inspiration for much of their best poetry.
Bonnie Zindell, an analyst and colleague from IARPP New York, joined me there. She is also of a literary bent and together we read Wordsworth's poetry in and around the poet's homes and villages. We visited Cockermouth; Derwent Water; Grasmere, the village where he and his sister Dorothy set up Dove Cottage; we noted the inscriptions in the church where he never attended the services of the drunk and mad Rector; sat on the garden seat beneath the yew trees he planted in the churchyard; and read the tomb stones on the graves in which he and his family, including two of his young children are buried.
In Cockermouth we toured the Georgian Town house where the poet was born and where he lived with his father and siblings until orphaned at the age of 13. Alone in the top story sitting room of the house where a pretty oval table was laden with modern editions of the poetry, Bonnie said, 'Let's read something!'
Randomly I picked up a collection of his poems and opened to any old page and read aloud a piece that I had never seen before:.

There was a boy; ye knew him well, ye cliffs

And islands of Winander! – many a time,

At evening, when the earliest stars began

To move along the edges of the hills,

Rising or setting, would he stand alone,

Beneath the trees, or by the glimmering lake;

And there, with fingers interwoven, both hands

Pressed closely palm to palm and to his mouth

Uplifted, he, as through an instrument,

Blew mimic hootings to the silent owls,

That they might answer him.—And they would shout

Across the watery vale, and shout again,

Responsive to his call, -- with quivering peals,

And long halloos, and screams, and echoes loud

Redoubled and redoubled; concourse wild

Of jocund din!

And when there came a pause

Of silence such as baffled his best skill;

Then, sometimes, in that silence, while he hung

Listening, a gentle shock of mild surprise

Has carried far into his heart the voice

Of mountain-torrents; or the visible scene

Would enter unawares into his mind

With all its solemn imagery, its rocks,

Its woods, and that uncertain heaven received

Into the bosom of the steady lake.

This boy was taken from his mates, and died

In childhood, ere he was full twelve years old.

Pre-eminent in beauty is the vale

Where he was born and bred; the churchyard hangs

Upon a slope above the village-school;

And through that church yard when my way has led

On summer-evenings, I believe that there

A long half hour together I have stood

Mute— looking at the grave in which he lies!

Bonnie accompanied me, dissociating I expect, to the house's garden by the banks of the Der-

went. Here we sat for a while and then listened to Wordsworth's earliest memories of his developmental history: the murmuring of the river outside the house as his nurse sang to him.

The next day we visited Dove Cottage in Grasmere. This was William and Dorothy's beloved first adult home.

We found the cottage preserved as they left it: salvaged from an old Inn it was tiny, dark, leaking, smelling of the crude coal fire in the kitchen and the children's bedroom insulated with newspapers. We remained for a time in the small sitting room where one side- board furnished the room. We noticed a single sheet of paper on it, picked it up and noted it was the 'poem' chosen by the Trust's 'volunteer of the month'. Bonnie started to read it out:
There was a boy…. Ye knew him well, ye cliffs
And islands of Winander!
….

She stopped reading, interrupting herself, she said: 'Eric's here'. Overwhelmed, I could only wonder at Bonnie's disclosure of this part of her spirituality. Until then, I had known her kindness and wisdom, but had not known her views on life, death or the universe. There was real solace in her profound response to the incidents we shared and a sense that this was a special moment in our friendship. The rest of our tour of Dove Cottage felt rather 'ho hum'.
Leaving the Cottage, we entered the nearby museum and there it was again, 'There was a boy' in English actorly cadences pealing from the monitors of the main room.

'Significance', as the late Peter Steele, Australian poet, scholar and I'd have to say, mystic, used to say, 'Significance will rise to meet you.'

But why am I telling you this? Well, the points of intersection between Hobson, Wordsworth and my story have much to do with the same human state – and that is the state of longing; longing to escape loneliness and wishing for and questing for, and then receiving, a response from the other, a response that, as you know, makes the difference between an experience of intimacy and I would call it love, on the one hand, and one of alienation or a form of exile from human kind, on the other. But this longing can also be seen as a kind of spirituality or way of the mystic. And anyone can be a mystic and in particular in our therapeutic work any therapist can take a contemplative stance towards his/her listening and understanding. This is my theme.

In tracing the Wordsworthian influence on Hobson and the pertinence of this genealogy to spirituality and psychotherapy, we are really engaged in a series of stories about a particular kind of relating, (saying and responding)that we are of course all too familiar with: Wordsworth's verse stories about rural folk, Hobson's about his patients' stories, their stories, my stories.

Now to come to the points of intersection between Wordsworth and Hobson. The first is in the domain of language:

LANGUAGE:
In another forum I have presented my ideas as to how the innovative poetics of Coleridge gave rise to his *Conversational Poems*. This literary nomenclature was not lost on Hobson as he named the model which he and Russell developed: *The Conversational Model*. Coleridge can be seen as having a substantial influence on Hobson's understanding of language; conversational intimacy; and Imagination as the therapeutic means to work with his patients.

Without repeating that work it's important to note that Coleridge was Wordsworth's one time soul-intimate and co-contributor to the Lyrical Ballads. It is the Preface to the *Lyrical Ballads* a collection of the poetry of Coleridge and Wordsworth that Hobson takes for his own *Epigram to Forms of Feeling: the Heart of Psychotherapy*:

This is Wordsworth:

> The principal object, then, which I proposed to myself … was to choose incidents and situations from common life, and to relate or describe them throughout, as far as was possible, in a selection of language really used by men …. (*Lyrical Ballads*, 1805 p. xi).

This is Hobson's manifesto, he says, adopted in 1949:

> If there is any truth in this book it is embodied in the stories written in a selection of language really used by men and women. (Hobson, *Forms of Feeling: the Heart of Psychotherapy*, p. Xv).

More importantly Hobson recommends this passage from *The Prelude* to every student of psychotherapy as itself, a truth not to be forgotten: 'a clarion call to all psychotherapists'. He continues:

> A psychotherapist … cannot avoid trying to be a kind of artist. His task is to assist in discovering a precise expression for personal feeling, for a 'felt-meaning' in, between, himself and his client. (ibid. p. 28)

According to Hobson language is dynamic. It grows and expands and becomes discarded as new forms are needed in and between the speakers: 'Perhaps, he says, we approach a language of feeling (ibid. p. 52).'

Overall in *Forms of Feeling* Hobson cites Wordsworth about 25 times and there are as well numerous unacknowledged Wordsworthian references such as 'recollected in tranquillity' and 'intimations' of something – which any first year undergraduate would recognise as pure Wordsworthian language. But I am now taking you wider into the opus so that you can hear and feel the broad sweep of Hobson's inheritance. Listen to the simple language and intimate tone of **The Fountain: A Conversation':**

POEM B

'The Fountain: A Conversation'

We talked with open heart, and tongue

Affectionate and true,

A pair of friends, though I was young

And Matthew seventy-two.

Another conversational poem **'Expostulation and Reply'** proceeds with the same kind of simple language and tone as the speaker chides the young William for sitting about meditating on Nature instead of reading his books; and William responds with the defence that he learns from more meditation.

POEM C

Expostulation and Reply.

Why William, on that old grey stone,

'Thus for the length of half a day,

'Why William, sit you thus alone,

'And dream your time away?'

'Where are your books? That light bequeath'd

'To beings else forlorn and blind!

'Up! Up! And drink the spirit breath'd

'from dead men to their kind.

One morning thus, by Esthwaite lake,

When life was sweet I knew not why,

To me my good friend Matthew spake,

And thus I made reply.

'The eye it cannot chuse but see,

'We cannot bid the ear be still;

'Our bodies feel, where'er they be,

'Against, or with our will.

'Nor less I deem that there are powers,

'which of themselves our minds impress.

'That we can feed this mind of ours,

'In a wise passiveness.

'Think you, mid all this mighty sum

'Of things for ever speaking,

'That nothing of itself will come,

'But we must still be seeking?.

'-Then ask not wherefore, here, alone,

Conversing as I may,

I sit upon this old grey stone,

And dream my time away.'

We will return to the theme of this interchange later. For the moment it serves to move us along to the second area of influence from the poet to the therapist.

The second point of intersection between poet and therapist pertains to

AUTOBIOGRAPHY

More than once Hobson intimates that *Forms of Feeling* is autobiographical:

> This book is very personal …. I have attempted to re-write my autobiography as a psychotherapist in such a way as to formulate a method, a Conversational Model…
>
> When I speak of an 'autobiography' I mean the development of ideas, attitudes, and meanings which have arisen and been transformed through joy, sorrow, chaos, and relative tranquillity in a journey of forty years…. (p. xii).

Hobson prises self-knowledge even as he takes us through the transcripts of patient, Freda, and her declared inability to cry. At the same time he gives us one of his most lucid explanations of what he means by forms of feeling. This is Hobson:

> [In face of Freda's 'I just can't cry.] I remember when I was not able to weep, and scenes from the past are joined together in complex shapes with profound feelings of loss and guilt. (p. 22)

AND THERE IT IS – A CLEAR echo of Wordsworth's 'Shapes' of feeling.

In a poem called 'Yew Tree.' Wordsworth says that:

POEM D

Yew-Trees.

… ghostly Shapes

May meet at noontide— Fear and trembling Hope,

Silence and foresight – Death the Skeleton

And Time the Shadow, - there to celebrate,

…

United worship; or in mute repose

To lie, and listen to the mountain flood

Murmuring from Glaramara's inmost caves. (p172. Lines 25-33)

These lines succeed in delineating in all its complexity the structure and diversity of the speaker's state.

Of course the Romantic psychiatrists set in motion this passion for autobiography and even for writing histories of their patients' biographies. And remember, Hobson was analytic, Jung's autobiographical writing was also a history of ideas, feelings, dreams. But despite these powerful influences, Hobson's major precedent for introspective autobiography is Wordsworth's *Prelude*, the 13 book-long autobiographical poem revealing startling self-analysis of the poet by himself. Hobson cites The Prelude several times in his book, but never so strongly as in the context of asking himself apropos patient, Joe, 'What is it like to be him now?' and, with respect to another patient, George, Hobson ponders 'knowing myself and [patient] George as a whole' (p. 136)

Wondering about staying with his sense of himself and trying to 'intimate something about those occasions when I am in touch with, and speak from my middle in response to the language of another', Hobson declares that 'there are times when it seems appropriate to speak of knowing, acting, and relating as a whole'. (p. 137) Then with a particular stanza from *The Prelude* in mind, Hobson formulates:

> Symbols, such as moving metaphors, can intimate or disclose a whole. Poetry is one form of language which can suggest how a process of feeling can progressively combine units of experience into new wholes. (ibid)

and immediately after, cites these verses from *The Prelude*:

POEM E

from The Prelude

'Dust as we are, the immortal spirit grows

Like harmony in music; there is a dark

Inscrutable workmanship that reconciles

Discordant elements, makes them cling together

In one society. How strange that all

The terrors, pains, and early miseries,

Regrets, vexations, lassitudes interfused

Within my mind, should e'er have born a part,

And that a needful part, in making up

The calm existence that is mine when I

Am worthy of myself!

(*The Prelude*, Book I, "Introduction - Childhood and School-Time")

Wordsworth has delved into his own inmost cave (of Glaramara) to discover at last, an inner wholeness that he knows was not always available to his troubled, longing youth and young manhood. This wholeness is the goal of Hobson's therapeutic conversations. He takes great pains to explain how he sets about working towards it by means of a practice of taking a symbolical attitude or 'silent expectation'. Which brings us to the third point of intersection between poet and therapist:

A third intersection between Wordsworth and Hobson pertains to

SILENT EXPECTATION OR SYMBOLICAL ATTITUDE, [FEELING AND PRESENTATIONAL SYMBOLISM]

You may remember Hobson's account of patient Steven: having exhausted his repertoire of techniques to engage the boy, he gives up. And he allows himself a reverie about the sun on the cricket pitch and playing cricket. He mutters to himself: 'It's bloody!' The rain? The ruined cricket? The boy's pained silence? The impasse between them? Most probably he has in mind all of these meaning-in-feelings. Suddenly he lights on the idea of playing a drawing game with his patient. The game tropes Hobson's symbolical attitude: it is also a metaphor for us who read Hobson, watching him wait, dream, respond: 'Let's play together and see what comes out of it,' Hobson says. This play he writes, 'suggests a symbolical attitude.' (p. 10) Later He comments on this successful connection with the boy as due to his stopping trying too hard; letting the tension fall away; being able to let things happen; a capacity for new openness and patience to wait with, he says, St John of the Cross's loving attentiveness. (p. 14) Even if Hobson had not named John of the Cross, there it is – a symbolical attitude is a contemplative stance, and it is a stance with an expectation that something will happen.

And what happens has to do with:

3B Feeling and presentational symbolism.

Presentational Symbolism' is non-discursive and untranslatable. (p. 710) It is unique and it is what it is, and means what it says. (pp. 71-72). Moreover, in the case of Hobson's patient, Joe, Hobson says:

> A description of Joe as a patient made from outside is very different from the form in which Joe presents or discloses himself in a conversation. Person-language or 'knowing', entails presentation whereas thing-language, 'knowing about' is discursive.

Later in his book, Hobson ironizes his attempts to make distinctions between discursive thinking, imaginative thinking and fantasy thinking. Almost throwing in the towel on the subject, Hobson seems to realise that his (or is it Jung's) distinction between signals, symbols, discursive symbolism, discursive thinking, imaginative thinking and fantasy-thinking are constructs, useful up to a point, but ultimately arbitrary and artificial. (p. 75) What Hobson does next, when he finds himself in this cul-de-sac of theorising, is to cite Wordsworth's Prelude on just such abstruse thinking. Wordsworth speaks of the young man that he was:

POEM F

His intellect by geometric rules,

Split like a province into round and square?...

In weakness, we create distinctions, then

Deem that our puny boundaries are things

Which we perceive, and not which we have made.'
(*The Prelude*. Book II, "School-Time")

Later in *Forms of Feeling* Hobson seems to reap the fruit of these technical endeavours to theorise about language. He seems to come into a clearer view of what he wants to present. [Is he (consciously? unconsciously?) modelling what happens in a therapy?]

What he means by presentational symbolism is a language (72) of feeling used to express COMPLEXITIES OF meaning in an all-at-once manner. It is unique, untranslatable and only grasped as a meaningful whole. An example of a presentational symbol is a moving metaphor which is the currency of a language of feeling. These he says are shapes of feeling as in works of art. (72)

Hobson does not cite Wordworth's 'I wandered lonely as a Cloud,' but it is a good example of forms of feeling experienced and then re-experienced when recollected later in tranquillity; its conclusion conveying a delightful all-at-onceness of pleasure:

POEM G

'I wandered lonely as a Cloud'

I wandered lonely as a Cloud

That floats on high o'er vales and Hills,

When all at once I saw a crowd

A host of golden Daffodils;

Along the Lake, beneath the trees,

Ten thousand dancing in the breeze.

The waves beside them danced, but they

Outdid the sparkling waves in glee:-

A Poet could not but be gay

In such a jocund company;

I gazed – and gazed – but little thought

What wealth the shew to me had brought:

For oft when on my couch I lie

In vacant or in pensive mood,

They flash upon that inward eye

Which is the bliss of solitude,

And then my heart with pleasure fills,

And dances with the Daffodils.

Which verse bring us to the fourth intersection between the poet and the therapist:

The fourth intersection between poet and therapist has to do with:

FRESH MEANING AND SPECIAL EXPERIENCES

The poet's 'daffodil' experience, recollected later on his sofa, brings us to consider what Hobson calls 'rare moments of personal meaning (138)'. Those 'times of intense experience which stand out in relief against the more usual uniform background of our lives (138)'. These, Hobson says, citing the poet, '…when recollected in tranquillity, charge our existence with special meaning and significance. (p. 138).

Such special experiences, such 'moments of vision', Hobson says, frequently occur alone. This granted, Hobson insists that although experienced alone, 'there is … a quality of personal relatedness and, .. something of the intimate look and gaze between mother and baby (ibid)' Here is Wordsworth aged thirty-something, formulating in a personal way his own early attachment theory in verse:

POEM H

from *The Prelude*

…blest the Babe

Nursed upon his Mother's breast, who when his soul

Claims manifest kindred with an earthly soul

Doth gather passion from his Mother's eye! (*Prelude*, Book II, "School-time" p. 270)

and a few lines later:

No outcast he, bewildered and depressed:

Along his infant veins are interfused

The gravitation and the filial bond

Of nature that connect him with the world.

The motherless and then fatherless poet seems to know exactly what deficit the Active Universe supplies for him. Wordsworth knows what seems to be happening in (what Hobson comes to call) special experiences or moments of personal meaning. (Forms of Feeling p. 139) [Hobson finds it hard to name the process, as we all do in any rational forum. He calls on the struggles of William Blake, the Hebrew Prophets, and Wordsworth to attempt to explain these 'glimpses of a visionary gleam which … we 'half-perceive and half create'-- (Hobson p. 139 from Wordsworth,) the highly emotionally charged visionary experiences of an individual life.

William James, Evelyn Underhill and Gershom Sholem in their variously distinctive ways play a safe part in that they collect and classified the

visionary and numinous experience of others without disclosing much about themselves. Patrick White and Chaim Potok, to name two novelists, are able to endow their characters with esoteric Christian and Kabbalistic mystic experiences respectively and at the same time remain authorial and aloof from these realities themselves. Wordsworth and Blake and Rilke being poets, are more likely to reveal their hands and declare their special experiences. Hobson would also like to do so but acknowledges the difficulty:

> All men are faced with the problem of making sense of moments of vision.
>
> The discourse-language of art, of stories employing presentational symbolism is most appropriate for intimating ineffable and paradoxical experiences. An attempt to describe by talking about is fraught…. (Hobson p. 139).

And yet Hobson perseveres in talking about such experiences. What ultimately is his point?

I think that Hobson regards the therapeutic insight, that moment of gnosis about the self, as being in the same class of experience as the visionary experience of the mystic, the artist, an even, the lover.

Let's turn to two of Wordsworth's accounts of a special experience of his own'. The first is from the ***Two Part Prelude***

POEM I

Two Part Prelude

Thus did my days pass on, and now at length

From Nature and her overflowing soul

I had received so much that all my thoughts

Were steeped in feeling; I was only then

Contented when with bliss ineffable

I felt the sentiment of being spread

O'er all that moves, and all that seemeth still,

…

…wonder not

If such my transports were, for in all things

I saw one life, and felt that it was joy.

One song they sang, and it was audible,

Most audible then when the fleshly ear,

O'ercome by grosser prelude of that strain,

Forgot its functions and slept undisturbed.

And the second is from Wordsworth's Lines Written a Few Miles above Tintern Abbey and it is, as we shall see, well known to Hobson:

Lines Written a Few Miles above Tintern Abbey

Though absent long,
These forms of beauty have not been to me,
As is a landscape to a blind man's eye:
But oft, in lonely rooms, and mid the din
Of towns and cities, I have owed to them,
In hours of weariness, sensations sweet,
Felt in the blood, and felt along the heart….
And passing even to my purer mind
With tranquil restoration:-- feelings too
Of unremembered pleasure; such perhaps,
As may have had no trivial influence
On that best portion of a good man's life:
His little, Nameless, unremembered acts
Of kindness and of love.

…Nor less, I trust,
To them I may have owed another gift,
Of aspect more sublime; that blessed mood,
In which the burthen of the mystery,
In which the heavy and the weary weight
Of all this unintelligible world
Is lightened: that serene and blessed mood,
In which the affections gently lead us on,
Until, the breath of this corporeal frame,
And even the motion of our human blood
Almost suspended, we are laid asleep
In body, and become a living soul:
While with an eye made quiet by the power
O harmony, and the deep power of joy,
We see into the life of things.

Hobson cites these lines and declares:

> If ... poems work their magic, hitherto disparate images are brought together, and out of the tension of their relation a greater whole is disclosed. Separate experiences are united in such a way as to intimate a groundswell of pre-conceptual experiencing which enlivens a new pattern of meaning. We see the minute particulars of distinct objects, ideas and feelings; we bring them together and, in a new synthesis with echoes from our middle, we see beyond – into 'the life of things'. There is a new vision and a new way of seeing. That is insight. (Hobson *Forms of Feeling* p. 81).

Pronouncing poetry not an activity divorced from everyday living, Hobson sees that his patients' metaphors, AND I CITE, 'carry experience forward ... and disclose a meaning which is beyond or prior to conceptual thoughts and formulated words. The significance for the patient is in the poet's words, 'Felt in the blood and felt along the heart'.

5A LONELINESS, LONGING AND ALONENESS-TOGETHERNESS

I have left what is perhaps Hobson's lasting debt to Wordsworth to this fifth position: a recognition of the intensity of individual longing.

The Wordsworth of The Prelude longs to see the daughter he conceived before fleeing the Napoleonic Wars; he longs for his youthful apprehension of the world: the 'radiance taken from [his]sight' which was once so bright [but which] Be now for ever taken from [his] sight', and in a very short piece 'Surprised by Joy' he longs to tell his deceased child something of a momentary transport of joy that he feels.

Imagine a grieving father coming to Hobson unable to voice the complexity of his decades of grief, his guilt that, for a few minutes recently, he felt a special experience: an alleviation of that pain. He felt himself in a cocoon of joy and in that moment of joy has feelings of great love and in particular love for his child. Full of remorse and contrition, he tells Hobson that momentarily he turned lovingly to share this joy with the child, only to be

bowled over again in the flash of re-realisation that the child is long and forever dead. He returns to a devastation of grief and longing.

And so, I invite you to imagine that as he sits with this man, Hobson might attentively apprehend the man's feeling, not of course in this Wordsworthian form which is the artistry of the poet, but in the complexity and truth achieved by this form and communicated to us by this form:

POEM K

Surprised by Joy

Surprised by joy- impatient as the Wind

I wished to share the transport – Oh! With whom

But Thee, long buried in the silent Tomb,

That spot which no vicissitude can find?

Love, faithful love recalled thee to my mind—

But how could I forget thee! – Through what power

Even for the least division of an hour,

Have I been so beguiled as to be blind

To my most grievous loss? – That thought' return

Was the worst pang that sorrow ever bore,

Save one, one only, when I stood forlorn,

Knowing my heart's best treasure was no more;

That neither present time, nor years unborn

Could to my sight that heavenly face restore. (ibid. p. 171)

And the fifth intersection is:

5B) LONELINESS TRANSFORMED TO ALONE-TOGETHERNESS

This concept is so much a part of how we practice the Conversational Model that it needs no amplification. (We respect the individual and accompany him or her on the therapeutic journey). Rather I ask myself how Hobson regarded this transformative process in light of his Wordsworthian inheritance and his own spirituality? After all he refers to all of Donne, Blake, Coleridge, Rilke and even St Paul to find help.
Hobson in his 1974 paper, '**Loneliness**' asks:

> How to penetrate to the core of loneliness in each person and speak to that and yet not intrude upon his (her) creative aloneness?

Hobson cites Bertram Russell's belief that 'the loneliness of the human soul is unendurable'; and that nothing can penetrate it except the highest intensity of the sort of love that religious teachers have preached; whatever does not spring from this motive is harmful, or at best useless.' Russell adds that it follows that … in human relations one should penetrate to the core of loneliness in each person and speak to that.'

How Hobson does that is by means of the special Moment as it becomes available to the therapist in conversation with his patient. And his inspiration is Wordsworth's *Prelude*:

POEM L

from *The Prelude*

There are in our existence spots of time,

That with

distinct pre-eminence retain

A renovating Virtue, whence..

.. our minds

Are nourished and invisibly repaired.

(*The Prelude*, Book II, XII ii 208-210 and 214-215)

.

> My central theme, (Hobson writes), is this harmony of the outward and inward eye by the imaginative act of loving insight. We make new sense of loneliness in a Moment as it emerges in conversation. (p. 72).

> Psychotherapy happens ... when a passionate new look at, with movement into, the world, accompanies an emergence from a static loneliness into a moving tender aloneness-togetherness shared by two or more persons. (p. 74).

> And he says this calls 'for ... ways of speaking the language of love.'

Now I have obediently eschewed the tenets of religion and mystical theology. But here is **Hobson** showing **his** hand vis a vis his relation to mysticism as he parodies the verses on love by that biblical mystic, St Paul, (p. 80) (I remind you that you will have heard similar rhythmic verses at many a wedding).

> Though I speak with the tongues of Freud, Jung and Skinner and understand all mysteries, yet have no love, my interpretations or reinforcement schedules become as a sounding brass or a tinkling cymbal. (p. 80)

Hobson draws on the unchurched spiritual tradition of received love (from contemplation of the Transcendent or the Immanent or Nature – it doesn't matter) – and imparts it to people in his world. The mystic who receives this love on the mountain top always descends the mountain to the market place or the consulting room. We heard the conversational tones of the poem on meditation and nature entitled *Expostulation and Reply* where the older man, Matthew, chides young William for meditating instead of reading; but the poet playfully writes a second piece on the same subject in which as its title declares It ends like this:

POEM M

The Tables Turned

One impulse from a vernal wood

May teach you more of evil and of good;

Than all the sages can.

Sweet is the lore which nature brings;

Our meddling intellect

Mis-shapes the beauteous forms of things;

- We murder to dissect.

-

- Enough of science and of art;

Close up these barren leaves;

Come forth, and bring with you a heart

That watches and receives.

Romanticism saw the pairing of collaborators in innovative work: Wordsworth and Coleridge, Wordsworth and Dorothy; Wordsworth and his Active Universe, Shelley and Keats, in our own field, Freud and Jung,... and in our own day Hobson and Meares; Meares et al and each of us; each of us and our patients; you listening to me; soon me listening to you; my American colleague Bonnie and I; my deceased son and I.

'Eric's here' was Bonnie entering my longing and loneliness when reminded of his death by the boy in the Winander poem, her voice was the **response** I needed at that moment – it was the 'halooing' of my owls and my Hobsonian Moment where **alone** became aloneness-togetherness in friendship and love.

Psychodynamic-Interpersonal Therapy for Self-Harm.

Else Guthrie, Cathy Brennan, Kate Farley and Cara Sass.

Leeds Institute of Health Sciences
Worsley Building
School of Medicine
University of Leeds, UK.

Correspondence to e.a.guthrie@leeds.ac.uk.

Abstract

Self-harm is a major mental health and public health problem across many parts of the world. The results of recent systematic reviews suggest that psychological treatment may be beneficial both in terms of improving psychological distress and reducing self-harming behaviour. However, there is no definitive study. This paper describes two recently funded large trials which plan to evaluate psychological treatments for self-harm. One will focus on people who have multiple self-harm and the other on people with acute self-harm (3 or less prior self-harm episodes). Both trials include psychodynamic -interpersonal therapy as one of the psychological treatments that will be evaluated. The trials and the adaptation of psychodynamic-interpersonal therapy for self-harm will be briefly described.

Introduction

Self-harm is a major mental health and public health problem. There are over 200,000 hospital attendances for self-harm per annum in the UK[1] and approximately 100,000 acute hospital admissions [1], at an estimated cost of between £133-162 million per year [2, 3]. In Australia, the overall age-standardised incidence of hospital-treated self-harm events (not individuals) for 2010–2011 was 117/100,000/year (95% CI = [116, 118]); rates of self-harm were higher among females 148.0/100,000/year (95% CI = [45.7, 150.3]) than males 87.0/100,000/year (95% CI = [85.3, 88.7]), and considerably higher among aboriginal people[4]. For comparison, the incidence of hospital-treated self-harm in England over a similar time period (2000–2007) ranged from 310 to 510 per 100,000/year [5]. The rates of self-harm in both countries are gross underestimates, as the trends in self-harm have increased over the last 10 years, and most people who self-harm do not attend hospital.
The costs to society of self-harm have been estimated to be at least 10 times higher than health service costs, mainly through lost productivity [6, 7]. The recent Adult Psychiatric Morbidity Study in the UK reported that 62% of people following self-harm received no treatment [8], and the most socially disadvantaged people are least likely to receive help following self-harm [9].

A recent systematic review found that >80% of people who self-harm have a recognised mental disorder [10] with depressive and anxiety disorders being the most common. One in 25 people who present to hospital following self-harm will kill themselves within the next 5 years, and approximately half of all people who die by suicide have previously self-harmed [11]. In the UK, 30% repeat self-harm within 6 months[12] and 50-60% in the next 5-6 years [11, 13].

In terms of treatment approach, it is useful to distinguish acts of self-harm that are a response to recent stressors and are associated with acute distress, and multiple (repeated) acts that are associated with longer-term more complex psychological problems. For the purposes of this paper the former group will be referred to as people with 'acute self-harm' and those people who repeatedly self-harm as 'multiple self-harm'. The recent Cochrane review of psychosocial interventions for self-harm in adults [14] and NICE guidance for self-harm [15] make this distinction between people with multiple self-harm who require intensive sustained psychological treatment, while those with 'acute self-harm' require an acute solution to their current distress, a distinction reflected in NHS clinical practice.

Reported pooled results from trials of psychological treatment for self-harm from two recent systematic reviews and meta-analyses suggest that psychological treatment leads to a reduction in repetition of self-harm at six and 12 months post-index episode in comparison with controls[14, 16]. The Cochrane review focuses upon 'cognitive behavioural therapy (CBT)' brief treat-

ments, a term that included psychodynamic therapy and problem solving [14]. A review by Hetrick and colleagues cites CBT and psychodynamic-interpersonal therapy as having the best evidence for effectiveness [16]. Cochrane also provides evidence for the benefit of psychological treatments for depression, suicidality and hopelessness.

A more recent systematic review, focused on psychodynamic treatments for self-harm, identified 12 relevant trials and concluded there was evidence of a reduction in self-harm at 6 months for psychodynamic therapies versus control conditions[17]. Included in these reviews is a previous exploratory trial comparing psychodynamic-interpersonal therapy plus usual care to usual care alone for people who attended hospital after an acute episode of self-harm [18]. This study showed promising results with a reduction in self-harm at six months for psychodynamic-interpersonal therapy vs comparator.

Psychodynamic-interpersonal therapy (PIT), or conversational model therapy, addresses interpersonal difficulties which underpin psychological distress. Over 88% of people present with self-harm because of interpersonal difficulties including: relationship problems with partner, family and others, bullying, and bereavement[19], and 93% have a pressing life problem[20]. The main purpose of brief psychodynamic-interpersonal therapy is to improve interpersonal functioning and interpersonal support, both of which have been shown to buffer the negative impact of stressful life events on self-harming behaviour [21], and may reduce suicidal thinking and behaviour post self-harm [22]. Two key linked diathesis-stress, theoretical models of suicidal behaviour - the interpersonal theory of suicide [23] and the integrated motivational-volitional model of suicide [24]postulate that certain psychological constructs (thwarted belonging, perceived burdensomeness on others, acquired capability for suicide, and defeat and entrapment) are linked to suicidal behaviour. Such constructs are associated with loneliness, trauma and rejection, factors which a recent network analysis has shown are linked to suicidal thinking in people post self-harm [25].

NICE Guidance for self-harm [15] is currently being revised, however, current guidance calls for further research to establish the clinical and cost-effectiveness of therapy for people who self-harm. This paper describes two studies (SAFE-PIT and FRESH-START) which have recently been funded (approximately £5 million) by the National Institute of Health Research in the UK to a) determine the cost-effectiveness of a low intensity intervention for people with acute self-harm (SAFE) and b) the cost-effectiveness of a moderately high intensity intervention for people with multiple self-harm (FRESH-START). The two studies both include evaluations of psychodynamic-interpersonal therapy and share similar outcome measures, which include repetition of self-harm, mental health outcomes and quality of life. They will provide comprehensive and coherent answers regarding response to psychological treatment for these disadvantaged client groups, using appropriate therapies, high intensity (for multiple self-harm) and low intensity (for acute self-harm), that have been developed and used in NHS real world settings. Both studies are in the pre-start-up phases and are due to start recruitment in 12 months' time.

Two other trials of psychodynamic-interpersonal therapy for self-harm are also being conducted in the UK. Psychodynamic-interpersonal therapy is currently being evaluated as a treatment for self-harm in prisons (WORSELF-HARMIP II-ISRCTN18761534) after a successful pilot study, and a variant of psychodynamic-interpersonal therapy (psychodynamic-interpersonal therapy with elements of cognitive analytic therapy) is being evaluated in a pilot trial for people with depression and self-harm in primary care (COPES project based in Liverpool). These two other studies will not be described in this paper.

SAFE-PIT) HTA 19/102-NIHR131334

A total of 770 adult people who attend ED with an acute episode of self-harm (3 or less prior episodes of self-harm) will be randomised 1:1 to receive psychodynamic-interpersonal therapy plus best care, or best care alone. Primary outcome data will be obtained objectively from hospital records a minimum of 12 months post-randomisation.

A nested qualitative study will explore a) experiences of therapy and b) the process of implementation of the therapy within existing services. This

work aims to provide a broader perspective on the impact of therapy to support the interpretation of trial results and to explore the potential patient level, therapist level and service level factors which may be important for understanding success or the barriers to implementation.

Secondary outcomes include: self-reported self-harm; psychological distress as measured by CORE-OM [26]; proportion of people with clinically significant improvement (and deterioration) on CORE-OM; anxiety as measured by the Generalised Anxiety Disorder-7 (GAD-7) [27]; hopelessness as measured by the Beck Hopelessness Scale (BHS) [28] ; interpersonal function measured by the Inventory of Interpersonal Problems (IIP-32) [29]; predictors, moderators and mediators of outcome; quality of life as measured by the Recovery Quality of Life Scale (ReQoL) [30]; health care use; participants' experiences of PIT service managers' and therapists' experiences of participating in the trial and delivering treatment and what are the wider organisational implications of embedding and sustaining the intervention and its impact on other aspects of service delivery.

PIT will be delivered by liaison mental health nurses who are familiar with managing risk and helping people who present with self-harm. Training involves a three- day course plus a further 8 weeks of weekly supervision on 2-3 training cases, followed by ongoing weekly supervision during the trial. Treatment is delivered over 4 x 50 minute sessions either weekly or 2 weekly. All sessions are audio-recorded. PIT is manualised and tailored for self-harm. Intervention fidelity will be maintained by clinical supervision, self-rating of fidelity by therapists, and independent rating of randomly selected audio-recordings. Appropriate social distancing measures and/or remote working will be utilised, if necessary.

The FRESH START Trial RP-PG-1016-20005.

The FRESH START trial is part of a programme of research about multiple self-harm (lifetime history of 3 or more episodes of self-harm), of which, the final part of the programme is a multi-centre randomised controlled trial of psychological therapy plus best care versus best care alone. A total of 630 adult people who attend ED with multiple self-harm will be randomised 1:1 to receive psychological therapy plus best care, or best care alone. The psychological therapy arm will contain the possibility of being randomised to one of three therapies: psychodynamic-interpersonal therapy, cognitive behavioural therapy or acceptance and commitment therapy. There is an assumption that all three therapies will have broadly similar outcomes, so can be included in the same trial arm. Primary outcome will be determined by scores on the CORE-OM outcome measure. Secondary outcome data will include data from hospital records a minimum of 12 months post-randomisation and patient reported outcome measures will be obtained at 6 and 12 months post-randomisation. Participants who meet the criteria for multiple self-harm (greater than 3 prior episodes of self-harm) will include a broad range of people with a diverse range of mental health problems, including a small proportion of people who meet criteria for borderline personality personality disorder (BPD). The trial however is not focused on people with BPD, but instead on the much larger group of people who self-harm three or more times, for whom there are very few treatment pathways. PIT will be delivered by liaison mental health nurses who are familiar with managing risk and helping people who present with self-harm. Training involves a three day course plus a further 8 weeks of weekly supervision on 2-3 training cases, followed by ongoing weekly supervision during the trial. Treatment is delivered over 12 x 50 minute sessions either weekly or 2 weekly, with an option of 2 further sessions (i.e. maximum 14).

Psychodynamic-interpersonal therapy for self-harm.

We have designed the interventions to be delivered by liaison mental health nurses who undertake much of the self-harm work in acute hospitals. At present, very few services in England offer psychological treatment for people who have self-harmed, so it is difficult for people to access psychological treatment. Those people who meet criteria for borderline personality disorder may be able to access specific treatments for this condition, but they represent a tiny proportion of the overall number of people who self-harm. By training liaison nurses who work in a setting that has recently received investment from NHS England,

we can expand the 'therapist pool' without taking away therapists from other services. .

We have used this model in the NHS in Manchester and Liverpool to develop and run self-harm services over many years. We have found it is easier to train nurses who are familiar with managing risk to deliver therapy than it is to train 'therapists' to see clients who are deemed to be at high risk of suicide or further self-harm. Practice varies a little by locality, but many psychological services do not accept referrals of people who are self-harming because they are considered to be too risky. Liaison nurses are also embedded within acute services, are familiar with referral pathways and can access support from a Consultant Liaison Psychiatrist.

There is also a high turnover of staff in acute services, so it is more efficient to provide a brief training course with on-going supervision from an experienced therapist than invest in a lengthier training intended to produce independent practitioners. Some of the nurses become extremely skilled and can then deliver training and supervision themselves. The recent pandemic has meant that most of the training has been adapted to be delivered remotely.

The PIT Components

PIT components involve natural aspects of human relating and some of the them constitute core aspects of common therapeutic behaviour (e.g. picking up cues). Attending to these basic skills can result in a dramatic improvement in therapists' overall practice; all therapists, no matter their previous experience, can improve this part of their work.

There are ten components of PIT for self-harm, which when used together offer a powerful way of empathizing with and deepening the collaborative work with the client. The first seven help the therapist to focus upon how the client is feeling 'here and now' in the session, not how the client felt last week or yesterday but right now. Feelings are brought alive and shared, rather than talked about in an abstract way. This is a very powerful tool to get to the heart of the client's problems in a rapid but supportive and collaborative fashion.

The last three components of the model specifically focus on interpersonal issues and developing a therapy rationale (Box 1) .

Box 1

The ten PIT components used in PIT-SAFE and FRESH START .

1. Using statements rather than questions
2. Picking up cues
3. Using a negotiating style
4. Understanding hypotheses
5. Metaphor
6. I and we
7. Focusing on feelings
8. Exploring feelings re interpersonal relationships
9. Exploring patterns in interpersonal relationships to bring about change
10. Therapy rationale

These components have been described previously in many publications and more recently in the manual section of a recent book on PIT [31].

Adaptations for self-harm

A key approach in PIT for self-harm is to use the components of the model to focus upon the last time the client self-harmed. In particular, to try to bring the feelings associated with the self-harm alive in the session. There are several reasons for doing this. First, by re-experiencing the feelings (albeit in a less intense form) with the therapist, rather than talk about them, they are shared and faced, without the need to self-harm. Second, the purpose or function of the self-harm is much easier to understand, if the feelings are alive and not talked about in a distant, detached fashion. Third, by staying with the feelings that precipitate self-harm, thoughts, images or prior experiences associated with those feelings, can be explored and elaborated into a complex form: a form of feeling.

Below is an example of the first ten minutes of a first session with a client called Sarah. The different components of the model are shown in italics (Box 2).

Box 2

An example of the opening dialogue between a therapist and client using PIT.

T: Hi Sarah. It's good to meet. I don't know very much about you, but I do you have self-harmed.

S: (nods)
T: It's a bit odd coming to see someone like me. We've not met before. (therapist gestures with hand) This room……
S: yeah
T: Perhaps we could start, if it's ok with you, if you could say something about the self-harm. I'd like to know as much about it as you can tell me (statements).

S: Um I took some antidepressants about a week ago…
T: Ok…..so…. you took some antidepressants (statement)
S: yes
T: I'd like to know as much as you can tell me…….if that's ok. (statement; negotiating style)
S: I took more than I should have took, quite a lot more……the whole thing…I did it on purpose..(long pauses between each phrase, then a longish pause)
T: It's quite hard to talk about ..(pause) so there was some intent…..and I wonder what was going through your mind (picks up cue; understanding hypothesis)
S: I wanted things to stop, I just wanted out (becomes tense)
T: And as we talk there is some of that upset her now…….I wonder if we could stay with that… this feeling…..like when you took the tablets (picks up cue;I and we; focus on feelings)
S: Trapped……hopeless….I don't know
T: A feeling of being trapped…like being in an awful bind…….an awful place (picks up metaphor)
…….and you say you wanted out when you took the tablets…..a wanting to die
S: Just to stop,,,,,,,stop feelings…….I guess it was…..I phoned my friend…..I started panicking and phoned a friend.

T: So more trying to stop these awful feelings….these feelings of being trapped….. (statement; metaphor)
S: Lots of things……(pauses)
T: Feels like you are coping with lots of difficult things (understanding hypotheses).

S: I'm all on my own. Lots of things going through my mind.

T: alone……I wonder with this feeling… anything goes through your mind (picks up cue;focus on feeling).

S: I remember when I was younger I had my dad…..someone to give me a cuddle..my dad died when I was 15….

T: So you would have been very young then……..(statement).

S: ….pause
T: you miss him…..there's no one else (statement; exploring feelings in interpersonal relationships).

S: No (tearful). No
T: Um…….loss……alone……and also you said trapped….as if you are in some terrible thing you can't get out of…. (brings up metaphor of being trapped again).

S: I made a really big mistake ..I don't know what to do….there's nothing I can do……
T: It feels it's really hard to talk about,,,,,have you talked about it with anyone….(nods no) …really tough…I wonder if it's possible to tell me a little about what's troubling you (I and we: statement: picks up cue).

S: We have been trying for a baby……me and my husband….we haven't had any success…but I slept with someone else and then I got pregnant…then I had a miscarriage….. then……
T: You lost the baby……(statement).

S: Tearful…just been awful…..

T: You've been through an awful lost……lost your dad when you were 15 and then the baby (picks up cue of loss).

S: I can't tell him……it's not his…..I can't tell him…I can't talk to anyone……..

T: You've been holding with awful inside you (statement, picks up cue).

S: He's been upset about losing the baby as well. I have felt so guilty. He wants to try again We were going to have tests and things done, before `I got pregnant.

T: You're wondering if he can't have children (statement).

S: Nods. He's been married before and they couldn't have any children.
T: This is such an awful thing to have to shoulder by yourself. You haven't been able to tell anyone (exploring feelings in interpersonal relationships).

In this example, by focusing on the feelings associated with the self-harm, these feelings are brought into the session and experienced in the 'here and now'. The therapist picks up the metaphor of 'feeling trapped' and this enables Sarah to share the dilemma about her husband, that she had been unable to tell anyone about previously and had been holding her inside her. The feelings driving her self-harm are also understood as being linked to loss of her father and the lack of someone to support her, making her feel more isolated and vulnerable.

Assessment of risk and safety planning

In the first session, the therapist seeks to establish a strong bond with the client and identify a focus for the remainder of the therapy. The therapist also, however, has to carry out an assessment of risk of further self-harm or suicide at some point in the initial session. As all the liaison nurses are experts in this area, the degree of time they apportion to the risk assessment is flexible and tailored to the client's individual circumstances. If there is little apparent risk, then the assessment can be relatively brief, however, if the therapist picks up that the client has worrying suicidal thoughts with plans to act upon them, a detailed assessment would be conducted and acted upon, if the risk was considered high.

Therapists can choose whether to conduct the risk assessment in PIT-mode or switch out to utilise their normal style of questioning. Most prefer to switch to their usual approach, which involves asking a series of questions about various aspects of risk. A small number (those who are most confident in using the model) use a PIT approach, which relies much less on questions. Below is an example of a risk assessment conducted in PIT mode (Box 3).

Box 3

Example of the key elements of a risk assessment for suicide using PIT components.

T: So I wonder if I can take you back to last Saturday…….you said you were all alone in the flat…your friends had gone out……you started to drink a bit…but not a lot……you felt very down……and alone…..

C: Yeah…..

T: I'd like us to get back to that time……if we can…….as if it is happening now……(gestures with hand)
C: I felt so alone……..it hurt…….it hurt……
T: You are feeling that a bit now……with me… (focus on feelings; I and we)
C: Yeah……. I'd just texted my mum …..well I'd texted her a few hours earlier and she hadn't replied. I knew she had read the text but she just ignored it…..I had texted that I was feeling a bit down…..I then rang her but she didn't answer…
T: Um……very tough……for you……..you felt alone and…… rejected almost…I am not sure……(understanding hypothesis, negotiating style).

C: Yeah
T: As if she doesn't care…….(understanding hypothesis).

C: She doesn't care…..she's only interested in herself……always has been..

T: That's very painful…..I think (understanding hypothesis)
C: Yeah. (looks upset)

T: I wonder if we can stay with that feeling…….alone……wanting your mum …but she doesn't respond……(focus on feeling).

C: tearful……..it just hurts…….I feel useless ……she doesn't care…..

T: a bit unloved……not sure (understanding hypothesis, negotiating style, feelings about relationships).

C: she doesn't love me…. No one really cares……..about me…..(anger in her voice)… .I might as well be dead…..

T: That feeling on Saturday …….here now…….very painful…(focus on feeling)
C: Even if I had killed myself…..I don't think she would mind that much…….well maybe a bit…..

T: You want her to care for you though….I'm not sure I have that right (understanding hypothesis, feelings about relationships).

C: Yeah….(crying)……
T: and when you actually cut your wrists quite deeply…….you wanted to ……(statement)
C: Not die…..not really……I wanted to stop feeling…….

T: stop feeling …these awful feelings……and frustration ..? (understanding hypothesis).

C: Yeah….I feel so angry with her…..

T: Um …….you hurt yourself……cos these angry, hurt feelings are difficult …….so difficult to bear (statement)
C: Yeah…….(screws up face)
T: and I guess these feelings, these feelings now with me……..they come at times
C: they come and go……I can't predict
T: They come at you left field
C: (Nods)
T: When they are really bad……I wonder….. really at their worst…..I wonder whether you have thoughts of ending your life.. .(statement)
C: No …..I just want the pain to stop…..

T: So if we think about the week, a couple of weeks ahead….you have no plans to end your life….it's about trying to stop the pain..(statement)
C: No……..

T: Ok …I have to check that….and I need to know if it changes…….I need you to let me know….to tell me
C: Yeah….

T: and thinking back, you were saying, you've harmed yourself many times…..I wonder if any of those times, you've wanted to end your life…..

C: At times I wish I was dead, that I would be better off dead, but I've never actually tried to kill myself.

T: um…..it seems when you harm yourself, it's a way of almost keeping you safe, by turning off these unbearable feelings……feelings at the moment that just become too much at times….and you have no other way to manage them….

C: Yeah…..yeah…..when I cut….there's a relief……a numbness…..it all stops….

T: Ok ….there are some other things we routinely ask all people……about any thoughts to harm others…
C: No
T: and in terms of contact with mental health services before….I was wondering if you have had any prior treatment…..(The therapist goes on to complete the other aspects of the formal assessment).

Using PIT-mode enables the client's feelings prior to the actual self-harm to be brought 'alive' into the session. A clear picture of their intent can be established and the therapist is able to assess the suicidal intent at the time of self-harm, any current and future plans about suicide and any past thoughts and intent regarding self-harm. This is sufficient to establish that the client is 'safe' to continue in therapy and no additional action is required.

Therapists also spend time in the first 1-3 sessions helping the client develop a safety plan, if they do not already have one. This involves setting out in a

structured format, what actions the client can take, were they to become suicidal. It usually includes a list of contact numbers of professional organisations, named people they can phone, and certain behaviours that may be helpful.

In the FRESH START trial, therapists are also expected to explore possible functions of the self-harming behaviour, as prior work in the research programme, identified particular common underlying functions of self-harm in this client group. Many of the functions (e.g. protection from suicide) have a protective or positive element for the individual. The focus on function(s) in PIT enables links between the self-harming behaviour and key interpersonal relationships or dilemmas to be explored.

The therapeutic relationship

PIT places great emphasis (as do all psychodynamic models) on the therapeutic alliance between therapist and client. A positive alliance is one of the best predictors of good treatment outcome. We encourage nurse therapists to regularly consider the following questions:

- How close and connected do you feel with the participant?
- How much of the session has been spent working in the 'here and now'?
- Has it felt as if no connection has been made at all?
- Has the participant begun to open up and share feelings but then backed off? If so, what provoked the participant to withdraw?
- Are you behaving in such a way as to deter the participant from beginning to share feelings?
- How do you feel towards your client?

As therapists become more experienced in working with this model of therapy, it is this aspect of the therapy, the connectedness between client and therapist, which assumes central importance, particularly in the 12 as opposed to the 4-session model. Many of the PIT components help facilitate the development of a strong bond between the client and the therapist, and through that, the development of new ways of resolving dilemmas and difficulties. As the therapeutic relationship deepens and the conversation between the therapist and the participant develops, links between the therapist/participant relationship and other important relationships in the participant's life may become more apparent.

Developing a rationale

Developing a rationale for treatment is an important component of all therapies and has been shown to predict outcome. It's important towards the end of the first session to discuss with the client a rationale for the therapy based upon the kinds of difficulties and problems that have been discussed between the therapist and client. Below is an example of the rationale offered to Sarah the client in the first example in this paper (Box 4).

Box 4.

Example of a therapy rationale.

T: So we have been through a lot today ….. and there's an awful lot here…and obviously you've been through a lot and you took those tablets…. But also the loss of your dad, the miscarriage and all the stuff with your husband …..in this kind of therapy we try to help people understand and manage their feelings around self-harm and any kinds of things to do with relationships which may be important. It's obviously a very difficult situation you find yourself in …..with your husband and what to do about that really..I suppose with this kind of treatment……we try to talk about things,,,,…you said you are scared of him…. and it's a difficult position ….and taking the tablets is I guess a way of helping you manage how you feel…. And we find that with self-harm…..it's an important thing…important at that moment to cope with those dreadful feelings……so we want to talk more about all these things…..how to help manage your feelings…. And try and find a way through…I know you can't see that at the moment…but there usually is a way through…..so I wonder if that makes sense…..

.

Meta and micro understandings

As the therapy progresses from the initial sessions, the emphasis remains upon working in the 'here and now'. PIT puts much greater emphasis on micro-understandings that arise from feeling moments than meta understandings that arise from cognitive conceptualizations. These micro understandings can be understood as small building blocks of the self that clump together to gradually form a bigger picture. The repeated exposure to feelings experienced in the 'here and now' that are shared and contained, generalises to other areas of the client's life, making feelings more bearable when they are alone, so it becomes possible for the client to begin to share their experience with trusted others.

PIT formulations start with these micro understandings, which gradually develop into a more coherent form as the therapy progresses. A focus on the form of feelings i.e. the multiple connected images, memories, experiences that arise from particular, unique, feeling states help shape these micro-understandings.

Most people try to search for a meta understanding of their problems in therapy, and this can be helpful, if it is not intellectualised, but tiny connections linked to feelings that 'run deep' often lead to new understandings and a re-framing of the meta-understanding. .

If the therapy progresses well, more and more links should be made between, feelings and relationships. This can be done in the form of linking hypotheses, explanatory hypotheses, relating change to therapy and patterns in relationships. The function that self-harm plays can become an important part of the client's understanding. It is often better to see the' bigger picture' emerging as it is built up from 'micro moments' rather than starting with a 'formulation'.

Testing solutions

As the therapy progresses, different ways of responding to events and feelings should emerge. The therapist must understand that even very small changes can be very difficult for the client. The therapist should use the client's growing awareness of their feelings and patterns in relationships to consider alternative responses to difficult relationships/feelings such as walking away from conflict rather than becoming embroiled in an argument, talking to someone rather than keeping things to themselves, finding a healthy distraction, pressing a pause button and creating a space to reflect. The client may also want to face some difficulties (i.e. standing up for themselves, saying they need some time for themselves in a relationship). It is helpful if the participant thinks of small achievable goals that they can attempt, and report back upon, in each of the interim sessions. The therapist should also begin to encourage the client to think about how this process can continue after the therapy has ended. It can be helpful if the client records and listens to the sessions.

Practical Issues

Many people who present with self-harm have considerable social difficulties and problems. Therapists are encouraged to respond in a practical, helpful way if a client makes a reasonable request for help with a particular problem (e.g. they request a letter about their mental health to help with a housing application).
Barriers to change
Enhancing change is more than just trying to motivate people; many people are motivated but are faced with barriers that make change difficult. Discussing such barriers (physical, financial, social, time, psychological) is central to enhancing change. Approximately half of people who are assessed by psychological services in the UK either decline treatment or drop out of treatment before it is completed (Health and Social Care Information Centre, 2014). Reasons for dropping out of therapy vary but nearly half of patients who drop out of therapy do so because of low motivation and/or dissatisfaction with the treatment or the therapist. In other words, factors related to either the therapeutic bond or the expectations of the client. This is one of the reasons why PIT-SAFE puts so much emphasis on building the relationship with the client and developing a therapy rationale that meets the expectations of the client.

Commonly cited problem scenarios of therapists who have attended PIT training include:

- Clients are very uncertain psychological treatment will be helpful
- Client's missing sessions

- Clients talk so much or so little it is difficult to do anything constructive in therapy sessions
- Clients present with too many problems it feels overwhelming
- Clients who are edgy or 'prickly' or angry
- Clients who report they have had a substantial amount of therapy previously and it's not helped
- Clients who have difficulties with ending
- Clients who present safeguarding issues that require a breach of confidentiality
- Clients who become very distressed in the sessions
- Clients who are very cheerful and minimise problem areas
- Clients drop out of treatment without warning

The manual and training for the PIT-nurse therapists specifically address some of these common scenarios (Guthrie E, McMillan D, Graham C, House A, 2020-available from the University of Leeds). One example is given below of client who is very talkative and circumstantial, so it is difficult to focus on feelings (Box 5).

Box 5

Example of a PIT intervention in a client who is very talkative and circumstantial.
CLIENT: I've been depressed for years, as long as I can remember, I can remember being upset at primary school, then when I was 13 I started cutting and it's just not stopped since then, it's not that I want to, it's just I can't stop, it's just part of me now almost, and a lot of my friends used to do it, I can't concentrate on anything and then I can't settle to anything, I was in town last week doing nothing, nothing at all and then boom, it just came over me, just like a cloud, just hit me, like I'd been fine before that, I'd just been to the dry cleaners and dropped off a couple of jackets, then I'd picked up a couple of things for my mam, just small bits and bobs, she wanted some deodorant and she'd run out of shampoo, and I was just coming out of boots, and thinking to myself about what I was going to have for lunch when, everything changed, just like for no reason, I can't work it out, it's like I'm a different person, nothing feels real, one minute I am up there and the next I've hit the bottom, and I have to like runaway from where I am, and it's like nothing's happened, nothing's happened, and I don't know what you think but it's been going on for years now, since I was little, since I was 13, before I was 13, I just flip, flip right down and when that happens, there's nowt I can do, no way I can get out of it, (conversation continues for several more minutes in a similar fashion)
THERAPIST (struggling to get a word in): I wonder if we could pause there….it felt like you were saying a lot of things there that were very important….I didn't catch it all….but like you feel ok and then something comes over you suddenly, left field and you feel very low, not the same person……(picks up verbal cue) and nothing feels real (understanding hypothesis, statement)
CLIENT (slowing): Yeah…I'm alright, bubbly really and then bam…..

THERAPIST: Bam……a sudden change, out of blue, you have no idea why or control or warning….. (picks up verbal cue, statement)
CLIENT: No……. (client makes eye contact, looks distressed)
THERAPIST: Well, I wonder if we could get in touch a bit …with this feeling…..that hits you out of the blue ……(focus on feeling, statement)…I'm not sure..but there's a bit of it now…….

In this scenario, the client gives the therapist a lot of information, but it is like a monologue and it is difficult for the therapist to interject. Amidst all the information, the therapist listens for cues as to how the client is feeling. When the therapist eventually interjects, she starts by recognising that the client is trying to tell them something that is very important, about being overwhelmed by feelings that seem to start suddenly with no warning.

When the therapist picks up these cues, the client's speech slows and she is able to get in touch with how she is feeling inside. The conversation deepens, and the client's 'problem' becomes apparent. Further conversation will lead to an agreed therapy rationale.

Whilst role playing this kind of scenario on the training, we often find that therapists either try to intervene by asking a lot more questions, or do not intervene at all, letting the client continue to talk for several minutes at a time. Asking questions in such a scenario typically encourages the client to talk more and go off on other tangents, making it very difficult to identify any kind of focus. Not intervening at all can mean that the session drifts without any real purpose, again making it difficult to identify a focus for intervention.

Goodbye letter

A goodbye letter was first used for PIT for self-harm in the late 1990s. They are extremely helpful and valued by clients. The letter can either be read aloud or given to the participant to read. An example of a goodbye letter is given below. The letter should be written in suitable language that the client will understand and should be an accurate reflection of the therapy. It should be positive and not in any way critical of the participant's behaviour. Strengths should be acknowledged, and there should be a clear plan for the future.

The goodbye letter aims to tell the story of the therapy and is something for the participant to keep when therapy has ended. It serves to draw on the work of the therapy, act as a reminder, and help them to carry forward the work they began in therapy. Below are the basic ingredients of a goodbye letter (Box 6) followed by an example of a goodbye letter (Box7). Not all letters will necessarily include all of the ingredients.

`Box 6

Ingredients of a goodbye letter:.

- Give a summary of reason for coming to therapy (self-harm)
- Formulate the self-harm in terms of inter and intra-personal relationships and how feelings are managed
- Incorporate key elements of history/past experiences
- Write what needs to be said and be concise
- Warm, engaging and empathic
- Written in your voice, personal use of self
- Use of 'I' and 'We'
- Use language that was shared: patient's words and metaphors
- Written in mind of what the patient can tolerate (not overwhelming)
  Refer to function(s) of self-harm
- Refer to therapeutic relationship and how this developed, including threats and ruptures
- Acknowledge endings and possibly feelings associated with this
- Review progress, what's changed, what's developed and been achieved

- Reminder of strategies that have been used effectively, keeping them in mind
- Acknowledge 'work in progress', what happens next and challenges ahead, the pull of old patterns or possible stuckness
- What's not been achieved in therapy and possible disappointments
- Express realistic hope and encouragement
- Thank patient for effort, commitment and openness

Box 7

Example of a Goodbye Letter

Dear Jane,.

As our sessions come to an end, I would like to put into writing a brief summary of our discussions together. This letter is from me to you. .

We first met 4 months ago after you had taken an overdose of your sleeping medication. You had been feeling low and stressed for several months and over that time had taken 5 previous overdoses. We spent quite a lot of time discussing the last time you had self-harmed. It was a Saturday night, and the other people whom you house-share with, had all gone to the pub. You were alone. You had not wanted to go with them. You had a couple of vodkas and went to your room. You felt all alone. As you sat on your bed you began to feel very empty inside and were able to share this feeling with me. As we stayed with this feeling, it brought back a memory from your childhood of being alone in your bedroom. You were about 12 years old at the time. Your

mum had died when you were 10 years old and your dad had just remarried. You felt your step-mother did not like you and favoured her own children from a previous marriage. Your dad did what your step-mum said and he had gone from spending a lot of time with you, after your mum died, to hardly seeing you at all by yourself. We talked about how you felt very let down and angry with him. You were able to share some of the pain you felt about your mum's death and her loss that still felt very raw although you covered it up. That Saturday, you had sent your dad a text in the morning just asking how he was. You had seen that he had read the text but had not replied to you. It gnawed away at you all day and after drinking the vodka you became more down, frustrated and angry with your dad. .

As we talked further, you spoke about the break up of your relationship with Josh and how painful that had been for you. You had been married for only three years and found out for the whole of that time he had been cheating on you and having causal liaisons with women. You had felt you had got over him and moved on but you had buried how bad you felt. Your friends all thought that you were fine and you laughed and joked with them about him. But you had also lost the house you had bought with him and had gone back to house-sharing, whilst you tried to save enough money for a deposit for a new home.

It's often the case that one kind of loss is connected to another. You had lost your mum and then your dad really (because he had emotionally moved away from you) and then Josh. You had buried the pain about as you felt humiliated and didn't want people to see that you cared about Josh even though he had treated you so badly. Your saw a connection with your mum. Your step-mum didn't allow her to be talked about in the house. You were forced to bury your feelings. .

You moved away emotionally from your friends, as you didn't want them to see that you were upset. You began to drink a lot more than usual and had become almost 'obsessed' (your word not mine) with contacting your father, even though he nearly always let you down. .

Many of the feelings you shared with me in the sessions were about loss. But you also experienced anger and frustration, not only with your father and Josh but also your mum, for dying (not her fault). As we were able to share these painful feelings over and over again you found you became less 'obsessed' with contacting your father and repeating over and over again a cycle of hurt. .

You have stopped drinking vodka and only now drink if you are out with friends. You have started to open up a bit more to two good old friends and they have listened to you and been sympathetic. .

You have not needed to self-harm and are beginning to feel you can enjoy life a bit more. It's been important for you to visit your mum's grave and 'talk to her' about how you feel. There are still times when you get down but you now have a variety of things in place to prevent hopefully you needing to self-harm. .

It will be important over the next few months to build on the changes you have made in the last few weeks. Continue to avoid drinking when alone, avoid contacting your father, continue to see your close friends and re-establish contact with your other friends, and continue 'talking' with your mum.

We have discussed the gap in your life you may feel when our sessions come to an end. The letter is a way of trying to help bridge that gap. We find some people like to keep it and read it over, if they are having a bit of a tough time. .

It has been a great pleasure and privilege to work with you. I hope that you will continue to put in place the things we have discussed and also that the understanding you have of things now is helpful. Good luck and best wishes.

Summary

The trials described in this paper will provide clear evidence of the cost-effectiveness of psychological treatments for multiple self-harm and the

cost-effectiveness of PIT for acute self-harm. If the results are positive, they will provide a compelling evidence base for the widespread implementation of psychological treatment for people who present to hospital with an episode of self-harm. The trials are due to start in approximately 12 months' time and will take several years to complete. Both studies include qualitative evaluations to assess the acceptability of the interventions for participants and therapists delivering the treatment. The studies also provide a template for the delivery of therapy using mental health nurses with expertise in the management of self-harm and upskilling them to provide treatment. .

References

1. Clements, C., et al., Rates of self-harm presenting to general hospitals: a comparison of data from the Multicentre Study of Self-Harm in England and Hospital Episode Statistics. BMJ Open, 2016. 6(2): p. e009749.

2. Tsiachristas, A., et al., Incidence and general hospital costs of self-harm across England: estimates based on the multicentre study of self-harm. Epidemiol Psychiatr Sci, 2020. 29: p. e108.

3. Tsiachristas, A., et al., General hospital costs in England of medical and psychiatric care for patients who self-harm: a retrospective analysis. Lancet Psychiatry, 2017. 4(10): p. 759-767.

4. Carter, G., Page A., Large., Hetrick, S., Milner, A.J, Bendit, N., Walton C., et al Royal Australian and New Zealand College of Psychiatrists clinical practice guideline for the management of deliberate self-harm. Australian and New Zealand Journal of Psychiatry, 2016. 50 (10): p. 939-1000.

5. Bergen, H., et al., Epidemiology and trends in non-fatal self-harm in three centres in England: 2000-2007. Br J Psychiatry, 2010. 197(6): p. 493-8.

6. Kinchin, I., et al., Understanding the true economic impact of self-harming behaviour. Lancet Psychiatry, 2017. 4(12): p. 900-901.

7. Kinchin, I. and C.M. Doran, The Economic Cost of Suicide and Non-Fatal Suicide Behavior in the Australian Workforce and the Potential Impact of a Workplace Suicide Prevention Strategy. Int J Environ Res Public Health, 2017. 14(4).

8. McManus, S., et al (2016) Chapter 12. Suicidal Thoughts Suicide Attempts and self-harm, in McManus S, Bebbington p, Jenkins R, Brugha T. (eds) Mental Health and Wellbeing in England: Adult Psych Morbid Survey 2014. Leeds: NHS Digital. p. 294-322.

9. Carroll, R., et al., Socioeconomic deprivation and the clinical management of self-harm: a small area analysis. Soc Psychiatry Psychiatr Epidemiol, 2017. 52(12): p. 1475-1481.

10. Hawton, K., et al., Psychiatric disorders in patients presenting to hospital following self-harm: a systematic review. J Affect Disord, 2013. 151(3): p. 821-30.

11. Sinclair, J.M., K. Hawton, and A. Gray, Six year follow-up of a clinical sample of self-harm patients. J Affect Disord, 2010. 121(3): p. 247-52.

12. Quinlivan, L., et al., Scales for predicting risk following self-harm: an observational study in 32 hospitals in England. BMJ Open, 2014. 4(5): p. e004732.

13. Mitchell, A.J.e., Is there a difference between hospital-verified and self-reported self-harm? Implications for repetition. General Hospital Psychiatry, 2016. 43: p. 12-15.

14. Hawton K, W.K., Taylor Salisbury TL, Arensman E, Gunnell D, Hazell P, Townsend E, van Heeringen K. , Psychosocial interventions for self□harm in adults. . Cochrane Database of Systematic Reviews, 2016(5).

15. NICE, Self-harm in iver 8s: long-term management. Clinical Guideline (CG 33). National Institute for Health and Care Excellence, 2011.

16. Hetrick, S.E., et al., Effective psychological and psychosocial approaches to reduce repetition of self-harm: a systematic review, meta-analysis and meta-regression. BMJ Open,

2016. 6(9): p. e011024.

17. Briggs, S., et al., The effectiveness of psychoanalytic/psychodynamic psychotherapy for reducing suicide attempts and self-harm: systematic review and meta-analysis. Br J Psychiatry, 2019. 214(6): p. 320-328.

18. Guthrie, E., et al., Randomised controlled trial of brief psychological intervention after deliberate self poisoning. BMJ, 2001. 323(7305): p. 135-8.

19. Steeg, S., et al., Routine hospital management of self-harm and risk of further self-harm: propensity score analysis using record-based cohort data. Psychol Med, 2018. 48(2): p. 315-326.

20. Townsend, E., et al., Self-harm and life problems: findings from the Multicentre Study of Self-harm in England. Soc Psychiatry Psychiatr Epidemiol, 2016. 51(2): p. 183-92.

21. Tham, S.G., et al., Examining the mechanisms by which adverse life events affect having a history of self-harm, and the protective effect of social support. J Affect Disord, 2020. 263: p. 621-628.

22. Walker, R.L., T.E. Joiner, Jr., and M.D. Rudd, The course of post-crisis suicidal symptoms: how and for whom is suicide "cathartic"? Suicide Life Threat Behav, 2001. 31(2): p. 144-52.

23. Joiner, T.E., et al, Nonsuicidal Self-Injury and Co-occurrence as Viewed Through the Lends of Interpersonal Theory of Suicide. Current Direct in Psychol Sci, 2012. 21: p. 342-347.

24. Dhingra, K., et al, Differentiating suicide attempters from suicide ideators using the Integrated Motivational-Volitional model of suicidal behaviour. Journal of Affective Disorder, 2015. 186: p. 211-218.

25. de Beurs, D., et al., The association between motives, perceived problems and current thoughts of self-harm following an episode of self-harm. A network analysis. J Affect Disord, 2018. 240: p. 262-270.

26. Evans, C., et al., Towards a standardised brief outcome measure: psychometric properties and utility of the CORE-OM. Br J Psychiatry, 2002. 180: p. 51-60.

27. Spitzer, R.L., et al., A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med, 2006. 166(10): p. 1092-7.

28. Beck, A.T., et al., The measurement of pessimism: the hopelessness scale. J Consult Clin Psychol, 1974. 42(6): p. 861-5.

29. Barkham, M., G.E. Hardy, and M. Startup, The IIP-32: a short version of the Inventory of Interpersonal Problems. Br J Clin Psychol, 1996. 35(1): p. 21-35.

30. Keetharuth, A.D., et al., Recovering Quality of Life (ReQoL): a new generic self-reported outcome measure for use with people experiencing mental health difficulties. Br J Psychiatry, 2018. 212(1): p. 42-49.

31. Barkham, M., Guthrie, E., Hardy, G., Margison, F., Psychodynamic-Interpersonal Therapy. 2017, London: Sage.

A Culture of Shame

Dissertation
Kirsten Andreae
October 2019

When growing up the relationship between a child and his or her parents/caregivers has a major impact on the development of the child and on whether the child
develops a secure attachment style or not. While the parents' behaviour towards
their child is determined by their own childhood experiences and the extent they
have processed them (Ainsworth, 1971; George, Kaplan & Main, 1985) parents and
child are also influenced by the culture they live in, and – in case it is not the same
– the culture the parents grew up in.

In this dissertation I am going to look at the impact of culture on a small child, and
at one aspect of it in particular – how culture can

create the feeling of shame and the impact this can have on the development of the self.

I will start by defining shame, describe what shame looks like, its origin and its functions. I will then present defenses that are used to protect against shame.

Following that I will look at culture and explore the relationship between culture and shame. I will provide two examples: a clinical example from my work and my own experience of growing up in Germany.

Finally I will look at the impact of shame on the development of the self in my training client and on the development of my own self as a psychotherapist.

Definition of shame

Tomkins described shame as 'the affect of indignity, of defeat, of transgression and of alienation […] that strikes deepest into the heart of man'. He wrote that 'shame is felt as an inner torment, a sickness of the soul (Tomkins, 1963).

In 1987 the psychoanalyst Helen Block Lewis conceptualised shame as an acutely painful and disorganizing emotion. She contended that shame is one's own vicarious experience of the other's scorn. The self-in-the eyes-of-the-other is the focus of awareness, impelling us to hide, escape, or strike out at the person in the eyes of whom we feel ashamed and leaving us in an intensely self-conscious state (Lewis, 1987).

In 1993 Kaufmann wrote: 'Shame feels like a wound made from the inside. Shame is dishonor, fallen pride, a broken spirit. [...] To live with shame is to feel alienated and defeated, never quite good enough to belong. And secretly the self feels to blame.[...] Shame is without parallel a sickness of the soul' (Kaufmann, 1993, p. 24- 25).

Later a relational viewpoint of shame became more widespread. In 1997 Judith Jordan defined shame as 'a felt sense of unworthiness to be in connection, a deep sense of unlovability, with the ongoing awareness of how much one wants to connect with others ... there is a loss of the sense of empathic possibility, others are not experienced as empathic, and the capacity for self empathy is lost' (Jordan, 1997, p. 147, italics in original).

Brown provided another definition: 'Shame is the intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging' (Brown, 2008, p. 5).

DeYoung described shame as 'the experience of one's felt sense of self disintegrating in relation to a dysregulating other' (De Young, 2015, p. 18). Haliburn wrote that 'shame may reflect a sense of self as unworthy, flawed, or defective, a response to experiencing self as needy or failing' (Haliburn, 2006, p.

104). According to Meares 'in extreme circumstances, shame is devastation, associated with loss of a sense of personal worth (Meares, 2005, p. 83).

Shame can be seen as a normal experience from which recovery can be made relatively easily. However when one's core being is infused with the intractable belief one is defective and unlovable, a profound sensitivity to shame exists.

Dearing and Tangney distinguished between 'in-the-moment shame and shame proneness, with the latter being a dispositional tendency to experience shame across situations' (Dearing and Tangney, 2011, p. 5, italics in original). De Young (2015) referred to this population as being afflicted with 'chronic shame'.

Shame needs to be distinguished from guilt. The experience of shame is directly about the self, which is the focus of evaluation. In guilt, the self is not the central object of negative evaluation, but rather the thing done or undone is the focus (Lewis, 1971). We might feel guilty about something that we have done but we can make amends for it, we can apologize for what we have done. When we feel shame the whole self is experienced as bad, we feel we need to apologize for who we are and we cannot make amends.

There is a strong bodily reaction to shame: the physiological response is that of shutting down, similar to the response in life threatening sit-

uations. It is the body's attempt to disappear, sometimes expressed by covering the face with the hands. A person who is feeling ashamed will typically lower their head, lower their eyes, and roll their shoulders over (Tatkin, 2017).

Like fear, shame is a biologically stressful experience leading for example to elevated cortisol levels (Dickerson and Kemeny, 2004). Schore proposes that shame is mediated by the parasympathetic nervous system and serves as a sudden 'brake' on excited arousal states. Like fear it is a 'fast-track' physiologic response that in intense forms can overwhelm higher cortical functions (Schore, 2003, as cited in Herman, 2011). Shame is a relatively wordless state, in which speech and thought are inhibited.

Anne Adelman described the experience of shame: You feel shame in your bones, in the pit of your belly, where it burns, in your inflamed cheeks, in the tears that sting your eyes, in your racing, sinking heart, in the heat that courses through your body. Consumed with shame, we bow our heads and seek relief. When shame overtakes us, it is a moment of total exposure, raw and naked, whether it is on display for others to view or kept tightly under wraps, known only in the most private alleyways of our minds (Adelman, 2016, as cited in Hammond, 2016, p. 15).

Functions of shame From an evolutionary point of view, shame may serve an adaptive function as a primary mechanism for regulating the individual's relations both to primary attachment figures and to the social group (Izard, 1977; Gilbert and McGuire, 1998, as cited in Herman, 2007).

Shame generalizes to become an emotion that serves to regulate peer relationships, social hierarchy, and all the basic forms of social life. Mild experiences of shame are a part of ordinary social life. The everyday family of shame emotions includes shyness, self-consciousness, embarrassment, and feeling foolish or ridiculous. Through ordinary experiences of shame, individuals learn the boundaries of socially acceptable behavior. In more extreme forms, shame is the reaction to being treated in a degrading manner. The extreme family of shame emotions includes humiliation, self-loathing, and feelings of disgrace, or dishonor (Herman, 2011).

Defenses against shame Constructive shame management occurs when individuals allow themselves to feel shame, acknowledge it, and directly address the source (Nathanson, 1992), a pattern of emotional regulation that is more likely to be associated with a secure attachment style (Cassidy, 1994, as cited in Atkins, 2016).

Several defenses are being used to protect against shame. These have been described in different ways, i.e. with the concept of the 'Compass of shame' (Nathanson, 1992). This compass consists of four systems of defense each representing a set of strategies by which an individual has learned to handle shame affect: withdrawal, avoidance, attack other and attack self. All of us use the techniques and strategies of all four systems but we tend to favour one or another of these systems of defense.

Origin of shame Tomkins argued that shame is one of nine specific innate affects that are hardwired into the brain. Shame is seen as a sudden drop from a positive high arousal state to a negative low arousal state (Tomkins, 1962, as cited in Nathanson, 1992).

Nathanson continued to view shame as connected to the self and as such not essentially relational. In the social sense he considered shame to be an interruption to the more pleasurable influences of engagement (Nathanson, 1992).

In his stages of social development Erikson formulates the central conflict of the second developmental stage as 'Autonomy vs. Shame and Doubt'. This takes place between the age of 18 months and three years. Erikson states that it is critical that parents allow their children to explore the limits of their abilities within an encouraging environment which is tolerant of failure. If children are criticized, overly controlled, or not given the opportunity to assert themselves, they begin to feel inadequate and feel a sense of shame or doubt in their abilities (Erikson, 1950).

More recently the origin of shame has been traced back to the primary attachment relationship. Schore suggests that shame makes its initial appearance at 14 to 16 months (Schore, 1998). Separations, which evoke fear and protest in normal toddlers, do not evoke shame; rather, shame can be seen in reunion interactions, when the toddler's excitement is met with indifference or disapproval.

To a certain extent, such experiences are inevitable and normal, since no caregiver can be empathically attuned to the child at all times, and sometimes the caretaker must criticize the child. However, under normal circumstances, the child's shame reaction evokes a sympathetic response which in turn dispels the feeling of shame. The breach in attachment is repaired. The child learns that shame states do not signify a complete disruption of the attachment bond and that they can be regulated.

Through repetition of this sequence the securely attached toddler learns the limits of the caregiver's tolerance and also learns to self-soothe and regulate shame states (Schore, 2003).

When expected sympathetic responses are not provided by the parent shame results. The ongoing misattunement of the primary caregiver towards the child leaves the child with shame intertwined in her identity. Shaming scenes are internalised and interpreted, influencing self-image and future interpretations of relationships. They leave the child with the belief that she is worthless and inadequate and that relationships are not safe havens (Hammond, 2016).

De Young shares the view that shame originates in relationships. She says that shame is activated because our need for connection and emotional joining has not been met (DeYoung, 2015).

Meares writes about 'attacks upon value' (Meares, 2005, p.83). When we expose those experiences, ideas […] and feelings that are peculiarly personal and intimate, highly valued, and sensed as part of our core, there is a chance that the responses of others may invalidate, damage or devalue this central aspect of self. Exposure risks the experience of shame. Only responses from others which resonate with our immediate states of feeling evoke an emotional positive tone that can lead to a relatively enduring feeling about oneself, out of which arises a judgement of value (Meares, 2005). When one is seen by the other as being of value, one sees one self as being of value to the other. When there is a lack of value the self can not develop and the internalization of shame begins. Multiple traumata superimposed on this early deprivation of a sense of value […] create a complex state of mind, in which self in relation to other, and self in relation to self is shamed (Haliburn, 2006).

The relationship with our culture These ideas regarding the origin of shame indicate that shame is something that originates in a relationship, something that arises when we feel invalidated, unaccepted and when there is an ongoing misattunement between our personal states of feeling and the responses we get from others.

If the experience a child has in the primary attachment relationship is one of ongoing misattunement this is very detrimental for the child's development and can lead to the feeling of shame. While this relationship is influenced by the parents own childhood experiences and the extent they have processed them another factor that has an impact on the way the parents behave towards their child is the parents' and child's culture. Culture not just influences the parents' behaviour, every child is also directly exposed to the culture he or she grows up in and the child develops a relationship with it.

'Culture' can be defined as 'the total inherited ideas, beliefs, values, and knowledge, which constitute as shared bases of social action' or as 'the total range of activities and ideas of a group of people with shared traditions, which are transmitted and reinforced by members of the group' (Collins English Dictionary, 2011, p. 413).

These definitions show that culture is something that has to do with beliefs and values that are shared by members of a group. Being in a relationship with our culture means we are part of a group. There is a feeling of belonging and being understood as all members of the group share similar beliefs, values and ideas.

Like the primary attachment relationship the relationship with our culture can be a relationship where we feel accepted and valued. It can be a relationship that provides a 'cultural secure base' (Mercado, 2018). On the other hand it also has the potential to be a relationship where we feel invalidated and unaccepted leading to negative feelings like shame. While guilt threatens punishment - perhaps even death - shame threatens an end to a relationship, an exclusion from the community (Jones, 1995).

I am now going to describe the impact it can have

- when our own personal ideas and values do not align with those of our culture

- when some of the inherited cultural beliefs are unhelpful or negative beliefs
- and when other members of our cultural group experience us as different and do not accept us.

I am going to do this by looking at two examples - my own example of growing up in Germany, and my training client who grew up in New Zealand.

German Culture

I grew up in a small town in northern Germany in the 1970s and 1980s. I experienced German culture as very rigid, and often cultural beliefs and ideas differed from my personal ideas. There were a lot of regulations. Things were being done in a certain way, i.e. there are things you do only once in your life like choosing a career, buying a house or joining the health insurance. A lot of people seemed to find this clear structure helpful, I experienced it as restrictive. While it was not impossible to do something a bit differently it sometimes could be a real challenge.

One example of this is my professional career. Initially I trained as an occupational therapist. Towards the end of my studies, when my fellow students started applying for jobs, I decided to spend half a year travelling through southern Africa before trying to find employment. Booking flights was easy, dealing with the German health insurance was not. I knew that they would not be able to cover me while I was in Africa and planned to terminate my membership and then to rejoin once I got back.

My insurance provider was puzzled by my request. I was told that the whole system is set up in a way that does not allow you to leave it, if I terminated my membership now I would not be able to get insurance cover on my return to Germany. Luckily eventually a solution was found - in order to be eligible to rejoin the scheme I had to pay reduced contributions every month despite not being covered while I was away.

While this was not ideal it made it possible for me to leave. This was in the 1990s, this rule might have changed by now as it has become much more common to spend time abroad.

I managed to do what I wanted to do but the feedback I got was very clear - that it was a very unusual thing to do and that I was lucky that I was allowed to rejoin.

Later, after spending a few years working as an occupational therapist, I decided to change career and to train in antique furniture conservation and restoration, following my passion for art and woodwork. Again, this was something highly uncommon in Germany - normally people choose one career and follow this path until they retire. I was even interviewed by a journalist who was writing an article about people who do such an unusual thing like changing their career! A prerequisite for the training was some work experience so I spent time doing unpaid internships in several furniture conservation workshops. Financially it was not easy but I learnt a lot. As I was not in paid employment and not yet studying I had to register with the 'Arbeitsamt' (the German equivalent to Centrelink in Australia or Work and Income in New Zealand) and report to them regularly despite not being entitled to any kind of benefit. The staff there made it very clear that they had little understanding for why I had given up a paid job. I also once again ran into difficulties with the health insurance provider. In order to be covered by them I had to be either in paid employment or on a benefit, and I did not meet any of these criteria. Fortunately the conservator I was doing the internship with at the time was very supportive of my plans and agreed to set up an employment contract that stated that I was getting paid by her. This was not the case but at least it enabled me to pay contributions to the health insurance. Later, in a similar situation, my selfemployed partner set up a contract pretending to employ me – once again its sole purpose was to enable me to have health insurance.

I was able to change my career but the messages I got while doing this were challenging : 'There might not be a place for you here if you behave like this', 'This is not an acceptable behaviour' or 'There is something wrong with you if you behave like this'. At times my own personal ideas seemed incompatible with what was considered acceptable in Germany.

Rigid ideas and beliefs can send shaming messages to those who do not agree with these beliefs, and

in Germany there seems to be a lot of rigidity. But this is not the only way German culture can create the feeling of shame. Shame is also being passed on from previous generations, there is 'borrowed' or 'inherited shame' (Broucek, 1991; Rothe, 2012). Frie suggests 'that a legacy of shame and responsibility links generations of postwar Germans, and forms part of the collective and ongoing memory of Germany's perpetration of the Holocaust' (Frie, 2012).

By acknowledging their membership in a group, people may experience shame as a consequence of the past and present deeds of that group, even if they are not personally responsible. There is a collective shame (Dresler-Hawke & Liu, 2006).

Goldberg states that shame 'is frequently the result of having been in some way associated or identified with someone who has committed a guilt-involving act' (Goldberg, 1991, p. 56).

I was born about three decades after the end of World War II. I grew up in a country where it was not acceptable to be proud of your country. National pride, especially when it came to publicly displaying a love, or even a mild affinity, for Germany was a taboo. When Horst Köhler became Germany's president in 2004, he said in his speech: 'Ich liebe unser Land' (english: I love our country). ("Ansprache von Horst Köhler", 2004). At the time it was reported in the news that the sentence 'sent a hush through the packed Reichstag (parliament) building.' ("Germany's Patriotism Problem", 2006). Usually if someone said that he loves Germany or was proud of being German people would assume that he was a Nazi, or at least that he supported very right-wing ideas. This was similar when it came to the German flag.

The flag was flown outside the parliament building but you would hardly find it anywhere else. If someone had the German flag on his house or in his garden this would lead most people to believe that this person had very conservative and possibly extremist views. Over the last 15 years it appears to have become more common to fly the German flag but some of the unease about it still persists. Even though I knew that personally I had done nothing wrong I often felt an unease about being German. This was especially the case when I was abroad and when the topic of Word War II came up.

After finishing high school I spent a year in Ireland. During this time I realised for the first time how different the experience of being German was. I noticed that the Irish were very proud of their country and did not shy away from showing this. Irish music was hugely popular - in contrast German music occupied a very small niche in Germany and people were often embarrassed to admit that they enjoyed listening to it. Irish flags could be found everywhere, i.e. in private homes, shops or on large public buildings. Unlike German culture Irish culture was not associated with shame or rigidity, there was no discomfort around it just pride, joy and - especially during sporting events or of course on St Patrick's Day - excitement. I realised that this was clearly a culture people were proud of and that they enjoyed being part of it.

Results of a data survey illuminated the dilemma that the Nazi past holds for the German people, even those who were two generations from being born during the Third Reich. High identification with the national unit was correlated with low shame, low willingness to confront the past, and lack of responsibility for the Nazi past. Young Germans find themselves in the unenviable position of either feeling shame for the past and making amends, and having low identification to the national unit, or feeling a strong sense of national identity, avoiding shame, and denying responsibility for the past (Dresler-Hawke & Liu, 2006).

As mentioned earlier not having a secure attachment style does make it more difficult to process shame. In a study carried out in Bielefeld in northern Germany over 22 years from 1976 onwards Grossmann et al. replicated the Ainsworth Strange Situation (Ainsworth, 1967, 1971, 1978). They found two thirds of the children of their sample to be insecurely attached, most of them having an avoidant attachment style. This was different to Ainsworth's results where the majority of children was found to be securely attached. The avoidant nature of the children was attributed in part to the fact that independence was highly valued by northern German parents and early self-reliance was encouraged before their first birthday (Grossmann, Huber, & Wartner, 1981; Grossmann, Spangler, Suess, & Unzner, 1985). I wonder if in addition to this the potential of the German culture to not be a cultural secure base and to create shame has played a role as well.

Caught between Pākehā and Māori culture

One of my training clients, Lucy (not her real name), is another example of how our culture can create the feeling of shame.

Lucy is a woman in her thirties who grew up in New Zealand. Her parents are both Pākehā, New Zealanders of European descent. Nevertheless she was exposed to both Pākehā and Māori culture and she identifies with and values both cultures.

The town she grew up in was predominantly Māori. Several members of her extended family were Māori. At her primary school she was one of very few Pākehā children who attended the school. Despite being familiar with Māori customs and even having some knowledge of the language she never felt accepted by the other children. She described incidents where she was told that she was 'not brown enough' to be one of them. A few years later Lucy moved to a much wealthier, predominantly Pākehā neighbourhood. At her intermediate school there were hardly any Māori children. The other children at the school knew where she used to live and which school she used to attend and as a result of that told her that she was 'too brown' to fit in! Both ethnic groups experienced her as different and because of that were not willing to accept her. There were a lot of ruptures but there was no repair. Her need for connection and validation was not met. Her experience with both Māori and Pākehā culture replicated the relational experience she had when growing up in a highly dysfunctional family – it was a relationship where she felt invalidated and unaccepted.

In addition to this I am aware that Lucy might also be experiencing some inherited shame even though I am unsure to which extent this applies to her. Crawford writes: 'When first confronted by the impact that white settlers had on Aotearoa New Zealand [...] my first emotions and thoughts were of guilt and shame (Crawford, 2016). Literature shows that these feelings can be prevalent for Pākehā and other colonisers (Addy, 2008; Bell, 1999; Bennett, 2015; Lang & Katene, 2007; Webber, McKinley, & Hattie, 2013, as cited in Crawford, 2016).

The impact of shame on the development of the self We are not born with a 'self'. It is a potentiality, to be realised in the context of a particular form of relationship with others (Meares, 2000). The self is not an isolated system. Rather, it is 'part of a larger organism which includes the social environment. The psyche and the world are interrelated, constantly nourishing and recreating each other' (Meares, 1977, as cited in Meares, 2012, p. 13). The psychic state of self arises through a form of relatedness that involves the feeling of a 'fit' between psyche and the world (Meares, 2012). Out of the feeling of resonance between my inner, essential and highly valued experience and the responses of the other, there emerges the sense of myself. A state of fellow feeling is created which gives pleasure to each but which neither could have generated alone (Meares, 2000). Hobson wrote about 'alone-togetherness' (Hobson, 1971, 1985, as cited in Meares, 2012, p. 14), Meares used the term 'intimacy' to describe the form of relatedness that is needed for the development of the self (Meares, 2012).

Knowing that shame is a feeling that has its origin in a relationship and that threatens an end to a relationship it becomes clear that shame has a negative impact on the development of the self. A child that grows up in an environment where shame is being triggered repetitively does not experience a 'state of fellow feeling', there is no feeling of a 'fit'. Instead there is a disconnection between self and other, between inner and outer, and this leads to a psychic state in which self is lost, intimacy is not achieved.

The child then starts to use modes of defense like pathological accommodation or avoidance. According to Meares pathological accommodation is one of the satellite systems of trauma, designed to prevent reexperiencing the trauma (Meares, 2004).

It leads to what Winnicott called a 'false self" (Winnicott, 1960).

As described shame can not just get triggered in the relationship we have with our primary caregiver(s) but also in other relationships, i.e. the one we have with our culture. A secure attachment relationship with at least one caregiver might help us handle the culturally transmitted shame. If we neither have a cultural secure base nor a secure attachment relationship this will have an impact

on the development of the self. The cultural experience then reinforces the message we already got in our family environment – that we are flawed, or defective and unworthy of acceptance and belonging. This increases the feeling of disconnection and is an obstacle to the development of the self.

Development of the Self – Lucy's case

The case of Lucy is an example of how shame that has its origin in early relational experiences within a family and within a culture has a severe impact on the development of the self. When Lucy started seeing me she was suffering from severe depression. There had been a recent episode of self-harm and she was having suicidal thoughts. She had been unable to complete the first year of her studies in architecture and was struggling in her role as a wife and a mother of young children. Quite frequently she was finding it hard to get out of bed and leave the house. During the first few months of therapy Lucy regularly missed our session as she did not have the energy to get up and get dressed. There was very little sense of self. The main characteristics of the Jamesian Self, including duality (reflective awareness), movement, sense of vitality, positive feeling, coherence or agency (Meares, 2012) were mostly missing. Her life appeared to be determined by what others required her to do, i.e. childcare and housework. She was in a state of stimulus entrapment, her conversation had the form of a chronicle (Meares, 1997, 1998, 2005). There were few moments where I could detect glimmers of positivity in her demeanor. After a while I noticed that something seemed to happen when Lucy was talking about her plan of becoming an architect - suddenly she appeared more alive, there was even some passion in her voice. Meares emphasizes the importance, not only developmentally but also therapeutically, of the response of the other to moments of aliveness, however muted, and to the emergence of positive feeling which, in the characteristic subject affected with a disorder of self, has been crushed (Meares, 2005). I joined Lucy in her excitement, amplified those positive glimmers in order to give them reality and to enhance them (Meares, 2005, 2012). Soon she started giving me detailed descriptions of the kind of house she would like to design as an architect and from time to time showed me some of her drawings she had done for her coursework. About four months after starting therapy Lucy found a way to return to her studies and to continue with the course.

In the literature a house is often described as a symbol of the self. When thinking about the meaning of one of his dreams Jung realised 'that the house represented a kind of image of the psyche – that is to say of my then state of consciousness, with hitherto unconscious additions' (Jung, 1989, p. 160). Jung built his own house, the Bollingen Tower, over a period of 30 years. He wrote about the building process: It gave me a feeling as if I were being reborn in stone. It is thus a concretization of the individuation process, a memorial aere perennius. […] I built the house in sections, always following the concrete needs of the moment. […] Only afterward did I see how all the parts fitted together and that a meaningful form had resulted: a symbol of psychic wholeness. At Bollingen I am in the midst of my true life, I am most deeply myself (Jung, 1989, p. 225, italics in original).

Jung described the last addition to his house, an upper storey, as a representation of himself, 'it signified an extension of consciousness achieved in old age' (Jung, 1989, p. 225).

In her paper 'The House as Symbol of the Self' Cooper writes that the house therefore nicely reflects how man sees himself, with both an intimate interior, or self as viewed from within and revealed only to those intimates who are invited inside, and a public exterior […] or the self that we choose to display to others (Cooper, 1974, p. 131).

It is interesting that out of all the different courses that are available Lucy has chosen architecture. When I hear her talking about her studies and the kind of houses she would like to design it often seems to me as if she is talking about the development of her own self, about the kind of person she is, the one she would like to be and about the one she sometimes fears she might become.

Lucy experienced severe physical and emotional abuse and neglect as a child. She never felt safe in the family she grew up in. When talking about one of her house designs Lucy emphasized that the house needs to be a safe place, warm and comfortable. She told me that the house needed plenty of windows, all positioned in a way that the sun could come in to make sure that the house was full of light and warm.

In Lucy's family of origin she did not experience a state of fellow feeling. There was no feeling of resonance between her inner, highly valued experience and the responses of her parents. During one of our sessions Lucy described to me her ideal house. It sounded to me as if she was talking about her experience of not being seen, of not daring to show her feelings and of her longing for this to be different. She explained that her ideal house is not perfectly white but has a rugged look, a bit messy and full of marks. She said she wants it to be the opposite of a G.J. Gardner house (G.J. Gardner is a large New Zealand home building company that has franchises all over the country. Their houses are modern yet their designs lack distinct features, they all look rather similar and sterile). Lucy told me that the fact that the house was messy was a sign that there were people living in it, and that they were experiencing happy and unhappy moments. Unavoidably they left some marks which was not just normal and acceptable, it also made the house more interesting. If a house was absolutely pristine this would mean that the people in it were not alive or not daring to move around freely.

According to Lucy every house needs a fireplace. She described the fireplace as the heart of the house, a place where people meet and connect, where they can go when they feel cold and tired and need to rest. For Lucy it is difficult to look after herself. She is very busy studying full-time while looking after her family, and she always puts other people's needs first. Regularly she ends up feeling overwhelmed and exhausted by all the demands. This leads to her emotionally and physically collapsing, she does not have an 'internal fireplace' yet, a place where she can go to recharge her own batteries.

About a year into her therapy Lucy talked about the porch being the most distinct feature of a New Zealand house. For her the porch is the transitional space between inside and outside, between spirituality and reality. She described the porch as the thin veil between the worlds, a place where you can sit before you feel ready to go into the house. This happened at a time when Lucy had slowed down a bit, she was not talking in the form of a chronicle all the time anymore, and sometimes she was able to access and express some of her feelings. When thinking about the session afterwards I wondered if the two of us were currently sitting on the porch, with the front door being open. From our position we could get a glimpse of life inside the house but it was still a bit too scary to get up and go inside.

A few months later Lucy showed me one of her designs – a house that included one room that she called a 'deprivation chamber' (Figure 1). She explained to me that this is a room where you focus on your feelings, there is no distraction from the outside world. She was adamant that it is a very important part of the house.

Figure 1: Lucy's design of a retreat on a rock Deprivation chamber While Lucy usually sounds excited and positive when talking about her designs this is different when she is feeling very depressed. During these times she doubts herself and everything she does. She does not mention any house designs she is excited about but expresses fear that she might end up building houses for rich people that cost millions of dollars and that destroy the local environment so that the children that live in the area have nowhere to play.

As described Lucy's sense of self was not just affected by her experience in her family of origin but also by her experience of the culture she grew up in. Being exposed to both Pākehā and Māori culture when growing up she identifies with aspects of both cultures but her cultural experience was not just a positive one. It was also one that replicated her family experience of not being valued and not being accepted which had an impact on the development of her self. Lucy still values both cultures. Despite her negative experiences she wants both Pākehā and Māori culture to be part of her life and longs to be accepted by both of them. Her architectural designs reflect not just her personal but also her cultural experience.

Lucy explained to me that she thinks that many New Zealand architects are scared to use aspects of their culture in their designs as they are worried about offending someone. She talked about a longing to embrace both cultures in her designs, and said to me (in a loud and determined voice): 'This is what I want to do!'. Lucy showed me some of the assignments she had to do for her course including an essay where she writes about how important it is that New Zealand architecture students learn about Māori culture and that it should

always be part of the curriculum. Recently we have started using the house as a metaphor during our sessions. For example Lucy told me about her plan to remove some of the internal walls on one of her designs. She then went on to talk about having taken down some of the walls she had put up between herself and her husband and how much the relationship has improved since then.

The shame Lucy is feeling makes the development of self very difficult for her. It does make it hard for her to build her own house. While Lucy has been able to return to her studies and is getting positive feedback from her lecturers she is finding the coursework challenging. Often she doubts her ability to finish her studies and to successfully work as an architect. She struggles to connect with the other students, experiences herself as very different to them and feels not accepted by some of them.

Shame is also having an impact on how Lucy experiences therapy. It was her own decision to come to therapy, and she says that she is finding therapy helpful but that she does find it hard to talk about herself. While our relationship has developed really well Lucy is still hardly able to look at me, I can sense the shame she is feeling during our sessions. But I can also see changes in her. Bit by bit she is letting me see more of herself and of the shame she is carrying. This year Lucy has been able to complete more of her coursework, and while she is still a long way away from finishing the course (and therapy) she certainly has made considerable progress building her own house..

Development of my own Self as a psychotherapist
Like in Lucy's case my own early relational experiences left me with the feeling of shame. When growing up I experienced emotional and physical neglect which prevented me from developing a secure attachment to my parents. In addition to this there were difficult relational experiences with teachers at school. The German culture did not provide me with a secure base either. All of this left me with a significant amount of shame. I felt inadequate and unworthy of belonging which was an obstacle to the development of my self. It led to the development of a part of me that strongly doubts myself and my own abilities. This clearly had an impact on how I experienced the training in the Conversational Model.

I had done a lot of work to improve my sense of self prior to the training, unlike Lucy I had already built a large part of my house. By the time I started the training I had been in individual therapy for over six years, in couple therapy for two and a half years. This had helped me build a good foundation with a house on it. What I was doing now by training as a psychotherapist felt as if I was adding another part - a significant part - to my house. I knew the house rather well. My house seemed reasonably stable but its foundation was not as solid as the foundation of the house of someone who had grown up with a secure attachment to his caregiver(s). From time to time this insecure part of me with the feeling of shame and its message of being inadequate and unworthy of belonging becomes quite dominant, making the foundation rather wobbly, and making a training as a psychotherapist more challenging.

When I started the course I felt excited and determined but also scared. Despite faculty members and the other students being very friendly and welcoming I felt intimidated and wondered if I would be able to do the training - was I fit to belong? I was the only student in our year who came to this training with limited clinical experience. It had been more than a decade since I stopped working as an occupational therapist. I had spent the year before I started the course volunteering for a helpline as a phone counsellor. While this had been a helpful and enjoyable experience it did not provide me with an opportunity to see clients face to face. I could feel my self-doubt coming up and had to work hard to push it aside.

Supervision was daunting. I learnt a lot from listening to the recordings of the therapy sessions. But playing my recordings in supervision was not easy, especially not in group supervision during the intensives. I felt exposed, could feel my fear of being inadequate coming up. Most of the time once I started presenting my patient I realised that I can do this and I calmed down. Despite this my anxiety always came back the next time around. I tried to convince myself that it will eventually get easier, that if I persist then one day I will be able to send this anxious part away or it might not even show up.

The seminars were not always easy either. I enjoyed reading the papers and learning new things but sometimes the seminars took me right back

to being at school. I then felt like the shy little girl who was too scared to say anything, waiting for the teacher to criticise her and to tell her how inadequate she was.

There was a lot that helped me deal with these challenges. I felt supported by my supervisors, faculty members, colleagues, and by my fellow students, especially my training buddy. Feeling valued and accepted by them and the positive feedback I kept on getting helped me immensely during those times when I was doubting myself. Writing was helpful too. While I sometimes had to push myself to write into my learning journal once I had started writing I found it a useful way to reduce my anxiety. I really enjoyed the clinical work a lot and my number of patients kept on increasing. I was very motivated to complete the training. There was also pressure to finish the course in order to be able to register with the Psychotherapists Board of Aotearoa New Zealand (PBANZ).

Despite feeling well supported and becoming more experienced it took until the third year of the training before I noticed a shift in myself. I started to feel more relaxed during the seminars and during supervision, and to feel more confident in my abilities as a psychotherapist. The part of me that is full of shame and tells me that I am unworthy, flawed, or defective is still there. I have not been able to chase it away, I have failed to fight it. The only thing that has changed is that I feel more accepting of it now. Instead of seeing it as something that I need to fight and get rid of I accept that I will probably never be totally comfortable in certain situations. I can see that there is a reason why this part exists. Paradoxically not fighting it seems to reduce the intensity of the discomfort it causes. It makes the message of shame less intense and it enables me to have more compassion for myself and to soothe myself. I feel reminded of what is called 'The Paradoxical Theory of Change' in the Gestalt Therapy literature. Beisser writes that change 'does take place if one takes the time and effort to be what he is - to be fully invested in his current positions. […] Change can occur when the patient abandons, at least for the moment, what he would like to become and attempts to be what he is.' (Beisser, 1970). Accepting that there will always be times where the foundation of my house might feel a bit unstable seems to have helped to strengthen this foundation. It is never going to be perfectly solid which can be challenging. But sometimes it also feels useful to have this kind of foundation, it might make it easier to relate to and empathise with my patients. My foundation is certainly more than stable enough to carry my house, including the additional room I am about to complete. It is a beautiful room and I feel excited about using it! Summary and conclusion In summary shame is an intensely painful emotion that all of us experience at some stage. While it is possible to recover from it reasonably quickly this is different for people who are being afflicted with chronic shame. Shame has its origin in a relationship. If the primary attachment relationship is one where the child experiences ongoing relational misattunements shame results. Another relationship with the potential to be one that can lead to shame is the relationship we have with our culture. Shame results for example if our personal ideas or beliefs are considered unacceptable by our culture or when there is inherited shame.

Someone who neither has a secure attachment style nor a cultural secure base might experience a significant amount of shame and not have the tools to process it.

It seems crucial that we consider in psychotherapy not only the primary attachment relationship(s) of our patients but also the relationship they have with their culture.

This might be a more obvious thing to do if the patient comes from a culture the therapist is not familiar with. But even if the therapist has good knowledge of the patient's culture it is still important to explore the impact of the culture as the patient's experience of it might not be the same. An awareness that a culture has the potential to trigger feelings like shame can help therapists to understand their clients better and to get a more accurate idea of the amount of shame someone is experiencing. Therapists also need to be aware of their own shame that they are carrying and the impact it has on them. As shame is not just an unpleasant feeling but also an obstacle to the development of the self it is important for psychotherapists to provide a space where patients get a chance to slowly process some of their shame by having a different relational experience, one where they feel valued, accepted and experience a 'state of fellow feeling'.

In a larger context the potential for a culture to trigger shame highlights the importance of being inclusive and accepting as a culture and as a society. Ideally all members of a culture should feel valued and respected. If this is not the case the impact of this is profound and longlasting as it is felt by future generations a well.

References

– Adelman, Anne (2016). The analyst's sense of shame. In S. Akhtar (Ed.),
Shame: Developmental, cultural, and clinical realms (pp.185-203). London,
UK: Karnac.

– Ainsworth, M.D.S. (1967). Infancy in Uganda: Infant care and the growth of
love. Baltimore: Johns Hopkins University Press.

– Ainsworth, M. D. S., Bell, S. M., & Stayton, D. J. (1971). Individual differences
in strange- situation behavior of one-year-olds. In H. R. Schaffer (Ed.) The
origins of human social relations. London and New York: Academic Press, p.

17-58.

– Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). Patterns of
attachment: A psychological study of the strange situation. Hillsdale, NJ:
Erlbaum.

– Atkins, Sarah A.H. (2016). The Relationship between Shame and Attachment
Styles. Retrieved from https://digital.library.unt.edu/ark:/67531/
metadc862746/m2/1/high_res_d/ATKINS-DISSERTATION-2016.pdf

– Beisser, A. (1970). The Paradoxical Theory of Change. In: Fagan, J. and
Shepherd, I.L., Eds., Gestalt Therapy Now. New York: Harper & Row, p. 77-
80.

– Bowlby, John. (1969). Attachment. Attachment and loss: Vol. 1. Loss. New
York: Basic Books.

– Bowlby, J. (1973). Attachment and loss. Vol. 2: Separation: anxiety and
anger. New York: Basic Books.

– Bowlby, John (1978). Attachment Theory and its therapeutic implications. Ch
1 in Adolescent Psychiatry – Developmental and Clinical Studies (in Annals of
the American Society for Adolescent Psychiatry), Vol VI: Feinstein, S. C. and
Giovacchini, P. L. (Eds.): 5-33. Chicago: University of Chicago Press.

– Brisch, K.H. (2002). Treating Attachment Disorders. New York: Guilford
Press.

– Broucek, F. J. (1991). Shame and the self. New York, London: The Guilford
Press.

– Brown, B. (2008). I thought it was just me: (but it isn't): Making the journey
from "What will people think?" to "I am enough". New York: Gotham Books.

– Collins English Dictionary - New Zealand Edition (2011). Glasgow:
HarperCollins Publishers.

– Cooper, Clare. (1974). The House as Symbol of the Self. In: Land, J., Ed.,
Designing for Human Behavior. Dowden, Hutchinson and Ross, Stroudsburg,
130-146.

– Crawford, H.S. (2016). A Pākehā journey towards bicultural practice through
guilt, shame, identity and hope. Aotearoa New Zealand Social Work 28(4),
80–88. Retrieved from https://anzswjournal.nz/anzsw/article/viewFile/300/360

– Dearing, R. L. & Tangney, J. P. (Eds.). (2011). Shame in the therapy hour.

Washington, DC: American Psychological Association.

– De Young, P. A. (2015). Understanding and treating chronic shame: A
relational/neurobiological approach. New York, NY: Routledge.

– Dickerson, S.S. & Kemeny. M.E. (2004). Acute

stressors and cortisol responses: A theoretical integration and synthesis of laboratory research.

Psychological Bulletin 130:355-391.

– Dresler-Hawke, E. & Liu, J.H. (2006). Collective shame and the positioning of
national German identity. Psicología Política, N° 32, 2006, 131-153
– Erikson, Erik (1950). Childhood and Society,. New York: Norton
– Frie, R. (2012). Memory and responsibility: Navigating identity and shame in
the German-Jewish experience. Psychoanalytic Psychology, 29(2), 206-225.

– George, C., Kaplan, N., Main, M. (1985). The Attachment Interview for
Adults. Unpublished manuscript, University of California, Berkeley.

– Gilbert, P. & McGuire, M.T. (1998). Shame, status and social roles:
Psychobiology and evolution. In P. Gilbert & B. Andrews (Eds.): Shame:
Interpersonal Behavior, Psychopathology and Culture. NY Oxford University
Press, 99-125.

– Grossmann, K.E., Grossmann, K., Huber, F. & Wartner, U. (1981). German
children's behavior towards their mothers at 12 months and their fathers at
18 months in Ainsworth's Strange Situation. International Journal of
Behavioral Development, 4, 157- 181.

– Grossmann, K., Grossmann, K.E., Spangler, G., Suess, G. & Unzner, L.

(1985). Maternal sensitivity and newborns' orientation responses as related
to quality of attachment in northern Germany. In I. Bretherton & E. Waters
(Eds.), Growing points in attachment theory and research. Monographs of the
Society for Research in Child Development, 50, 233-256.

– Haliburn, Joan (2006). Reversing the Developmental Sequence – from devaluation to identity. In: The Self in Conversation; Vol. V:104-117. Sydney:
ANZAP Books.

– Hammond, Marian D. (2016). Therapists' Experience of Shame – An
Heuristic Study. Thesis submitted to Auckland University of Technology in
Partial Fulfilment of the Requirements of the Degree of Master of Health
Science, Faculty of Health and Environmental Sciences
– Herman, Judith L. (2007). Shattered Shame States and their Repair. The
John Bowlby Memorial Lecture.

– Herman, Judith L. (2011). Post Traumatic Stress Disorder as a Shame
Disorder. Ch.11 in Dearing, R. L., & Tangney, J. P. (Eds.). Shame in the
therapy hour. Washington, DC: American Psychological Association.

– Izard, C.E. (1977). Human Emotions. New York: Plenum.

– Jones, Joseph M., (1995). Affects as Process. London: The Analytic Press.

– Jordan, J. (1997). Relational development: Therapeutic implications of
empathy and shame. In: Women's Growth in Diversity: More Writings from
the Stone Center. New York, NY: Guilford.

– Jung, Carl Gustav (1989). Memories, Dreams, Reflections. New York:
Vintage Books. (Original work published 1963)
– Kaufman, G. (1993). The psychology of shame: Theory and treatment of
shame-based syndromes. London, UK: Routledge. (Original work published
1989)
– Köhler, Horst (2004). Ansprache von Horst Köhler vor der
Bundesversammlung nach seiner Wahl zum Bundespräsidenten. Retrieved from http://www.bundespraesident.de/ SharedDocs/Reden/DE/Horst-
Koehler/Reden/2004/05/20040523_Rede.html
– Lewis, H. B. (1971). Shame and guilt in neurosis. New York, NY: International
Universities Press.

– Lewis, H. B. (1987). The role of shame in symp-

tom formation. Hillsdale, NJ:
Lawrence Erlbaum Associates.

– Meares, Russell (1997). Stimulus entrapment. Psychoanalytic Inquiry,
17:223-234.

– Meares, Russel (1998). The self in conversation: On narratives, chronicles
and scripts. Psychoanalytic Dialogues, 8:885-891
– Meares, Russell (2000). Intimacy and Alienation. Memory, Trauma and
Personal Being. London: Routledge.

– Meares, Russell (2004). The Conversational Model: An Outline. American
Journal of Psychotherapy; 2004; 58, 1; Health Module: 51-66.

– Meares, Russell (2005). The Metaphor of Play: Origin and Breakdown of
Personal Being. Revised edition, London: Routledge. (Original work
published 1992)
– Meares, Russell (2012). Borderline Personality Disorder and the
Conversational Model – A Clinician's Manual. New York: Norton.

– Mercado, Gabriela (2018). Qué ves cuándo me ves? What do you see when
you see me? Entering my own otherness. The Newsletter, December 2018,
p.41-43, New Zealand Association of Psychotherapists.

– Nathanson, D. L. (1992). Shame and pride: Affect, sex, and the birth of the self. London, UK: W. W. Norton & Company.

– Rothe, K. (2012). Anti-semitism in Germany today and the intergenerational
transmission of guilt and shame. Psychoanal Cult Soc (2012) 17: 16.

https://doi.org/10.1057/pcs.2011.6
– Schore, A. N. (1998). Early shame experiences and infant brain development.

In P. Gilbert & B. Andrews (Eds.), Shame: Interpersonal behaviour,
psychopathology and culture (pp. 57-77). New York, NY: Oxford University
Press.

– Schore, A. N. (2003). Affect regulation and the repair of the self. London, UK:
W. W. Norton & Company.

– Spiegel Online (21.04.2006). Germany's Patriotism Problem - Just Don't Fly
the Flag. Retrieved from https://www.spiegel.de/international/germany-spatriotism-
problem-just-don-t-fly-theflag-a-411948.html

– Tatkin, Stan (2017). The Neurobiology of Shame, Part 2: How the Psycho-
Biology of Shame Can Help Your Work. Webinar, video 3, part 2. National
Institute for the Clinical Application of Behavioral Medicine (NICABM). Retrieved from https://s3.amazonaws.com/nicabm-Shame17/confirmed/
Shame-Video3.2.pdf

– Tomkins, Silvan S. (1963). Affect Imagery Consciousness: Volume II, The
Negative Affects. New York: Springer.

– Winnicott, D.W. (1960). Ego Distinction in terms of true and false self. In: The
Maturational Processes and the Facilitating Environment (1965). New York:
International Universities Press.

FILM REVIEW

Les sauvages /Plus ça change, plus c'est la même chose.

(SBS Demand)
Brendan McPhillips.

Currently streaming on SBS for the next 2 years, Les sauvages is a French mini-series, based on the quartet of novels by the young Parisian writer, Sabri Louatah, and directed by New York based Rebecca Zlotowski, that takes us deep into French history that much of France would like to forget. It's certainly got history, but it's also a political thriller, and I can't do justice to it without revealing what happens, so … SPOILER ALERT!
First, some background context. On Sunday 29th

April 1827 the Dey of Algiers, angered that the French were still refusing to repay a loan from 1790, hit the consul, Pierre Deval, on the cheek with a fly whisk. As a consequence, things did not go well for the Algerians. The facially-sensitive French tried blockading the port. When that didn't work they invaded, and 4 years later formally annexed Algeria as a colony. The 'civilised' Europeans were not benign. In Blood and Soil, a history of genocides, Ben Kiernan writes:

By 1875, the French conquest was complete. The war had killed approximately 825,000 indigenous Algerians since 1830. A long shadow of genocidal hatred persisted, provoking a French author to protest in 1882 that in Algeria, "we hear it repeated every day that we must expel the native and if necessary destroy him." As a French statistical journal urged five years later, "the system of extermination must give way to a policy of penetration."

A military officer in Algeria, Lieutenant-colonel Lucien de Montagnac wrote to a friend on 15 March 1843:

All populations who do not accept our conditions must be despoiled. Everything must be seized, devastated, without age or sex distinction: grass must not grow any more where the French army has set foot. Who wants the end wants the means, whatever may say our philanthropists. I personally warn all good soldiers whom I have the honour to lead that if they happen to bring me a living Arab, they will receive a beating with the flat of the saber.... This is how, my dear friend, we must make war against Arabs: kill all men over the age of fifteen, take all their women and children, load them onto naval vessels, send them to the Marquesas Islands or elsewhere. In one word, annihilate all who will not crawl beneath our feet like dogs.

It has been estimated that by independence in 1962 ten million Algerians had been killed by the French, and, in addition, 2 million were sent to internment – i.e. concentration – camps and tortured. In 1951, before the War of Independence, which spanned 1954 to 1962, an outraged French journalist, Claude Bourdet, in L'Observateur, was comparing the actions of the authorities in Algeria to the Gestapo. It took until 2018 for the government – i.e. Macron – to admit that the use of torture had been official policy.

In the opening scene it is 2012. A Friday. We are in a car in Saint-Étienne, 500 kms to the south of Paris. Inside are the Nerrouches, French Algerians, and there is to be a wedding. Driving is Dounia (Farida Rahouadj), mother of Slim, the groom (Shaïn Boumedine), who sits glum in the back seat. Next to her is Rabia (Carima Amarouche), her sister. Next to Slim sits Krim (Ilies Kadri), Rabia's son, wearing headphones and playing an air piano on his knees. Next to him is his sister, Louna (Lyna Khoudri). They joke that Krim is 'working'.

His 'work' begins to play. It is the *Danse des Sauvages* from *Les Indes galantes* by the 18th century French Baroque composer, Jean-Philippe Rameau. It is background to a scene of many people moving fast, preparing for an important event. We are in Paris. A young woman is giving directions. A young man grabs her and kisses her full and deep. She likes it. Responds herself full and deep. The many people are preparing for the final TV debate in the French Presidential election due in two days, always on a Sunday (Americans take note – Tuesday is a work-day!). The contenders are Idder Chaouch (Roschdy Zem),a French Algerian and former professor of economics at Harvard, and M.Noyer (Laurent Claret), French Ancien Régieme and non-former hater of all things non-white-French. Noyer argues that terrorism is alive and well and perpetrated by all those who cannot trace the purity of their blood back to Charlemagne (who, by the way, was German). Asked to respond, Chaouch, much to the consternation of his team, which includes our young lovers, is silent. When he does speak it is deliberate and fierce. He says that the law of the Republic is the same law for all French people whatever their origin, and he, as their 'chaouch' which means 'servant', will govern as the candidate for life, not the candidate for revenge. It's a hands-down knock out. Idder Chaouch will be the next Monsieur le Président. The lovers celebrate on the roof-top. She is Jasmine Chaouch (Souheila Yacoub), Idder's daughter and campaign manager. He is Fouad Nerrouche (Dali Benssalah), son of Dounia, escapee from Saint-Étienne, now the famous Dr Frank on a much-loved soapie. But the champagne is laced with gall. The Nerrouches and Chaouchs, despite a common Algerian background, lie far apart culturally. Jasmine is keen to come, but Fouad is reluctant to take her to his brother's wedding. She mentions Nazir: his brother, at present in gaol for hate-speech (no prizes for guessing toward whom the hate is directed, and her mother is Jewish). He flares. She flares back. Did he not think, being in a relationship with a

presidential candidate's daughter, that the security services had not checked him out? They settle. Touching her on her lips, breast and genitals, he asks if the security services know that he has kissed her here, here, and here. She laughs *they do now*!

France has a complex history of engagement with 'savages'. On the 25th of November 1725, Chief Agapit Chicagou of the Mitchigamea and five other chiefs from Illinois were presented to Louis XV in Paris. They swore allegiance and performed dances. Witnessed by Rameau, he wrote what ended up after many revisions as *Les Indes galantes* (The 'Indians' in love). In quotes, as the four Acts are amorous dalliances between, in order, Turks, Peruvians, Arabs, and finally American Indians, the one entitled *Les sauvages*. The plot, if it can be called that, involves Adario, an Indian, pining for Zima, the daughter of a local chief. But she is also pined for by a Spaniard, Don Alvar, and a Frenchman, Damon. She spurns Alvar for his jealously, and Damon for his fickleness, choosing the open-hearted Adario. In the end the Europeans bury the hatchet, so to speak, and join the lovers at their wedding.

The French are not unique in attempting to engulf the other into their cultural norms so as to reduce fear and universalise their particular take on how humans work. Ronald Reagan infamously blamed the plight of the indigenous population on their not being more willing to abandon their 'savage' practices, and become more like white people. Our own Stolen Generation could add some words on this. But *La Patrie* puts American Exceptionalism into the shade. Even Jean-Jacques Rousseau's *bon sauvage* (noble savage) – although he apparently never used this phrase, it instead appearing in a 1672 play by the English playwright, John Dryden – has little to do with actual indigenes, and everything to do with a society that idealised something of itself that was missing. Rousseau, himself, idealiser and caresser of women's breasts; possessor of so little opinion of himself that he could say: *I believe no individual of our kind ever possessed less natural vanity than myself*; arch-enemy of Rameau who had, apparently, with co-conspirator, Voltaire, stolen his own idea for an opera which had, in fact, been based on *Les Indes galantes*, typifies the extreme insularity which has driven the French to sublime peaks of art and thought, and the utter barbarism of treating the other as commodity to be used and then discarded.

What is interesting about this series is that it not only exposes the brutal racism of the white attitude toward the Algerian, but also the deep split within the Algerian community itself as to how it should comport itself toward the oppressor. Saturday, and its time for Slim to get married. The reason for his glumness becomes apparent: Slim is doing his Muslim duty, but his heart is elsewhere – he has a secret lover, and this lover is male. The wedding duly takes place. Jasmine does come, but so does Nazir (Sofiane Zermani, also known as the rapper Fianso), the latter, allowed out from prison, borne on the shoulders of like-minded hate-speakers, surrounded by fireworks. He embraces Slim, who tells him *I can't do this*. Nazir tells him it will get better. We are left guessing how much Nazir knows. No bromance, however, between Nazir and Fouad, this latter clearly exhibiting signs of homicidal rage. What's the issue? The issue is that Nazir thinks the Chaouchs have sold out to the white French who only despise them: *no one wants swarthy, savage frogs*; Fouad and the Chaouchs see participation in French political life as the only way forward.

And moving forward, its Sunday, and time for the election. Idder wins hands down. Against the advice of the head of his security team, Marion (Marion Foïs), he mingles with the crowd. Fouad sees Krim, his cousin, in the melee, and invites him across the barrier. We already know that Krim has come to Paris from Saint-Étienne for a music audition. Fouad brings him to meet Idder. Krim pulls a gun from his coat and shoots the newly-minted M. le Président in the chest.

John Gray looks like a perfectly reasonable human being. He's 72 and, until 2008, was the Professor of European Thought at the London School of Economics. He dresses nicely and speaks with an educated English accent. Not the image one would have of a full-blooded apocalyptic nilihist wedded to a theory of virulent misanthropy. Such, however, is the opinion of Terry Eagleton writing a review of Gray's 2002 book *Straw Dogs*. An opinion repeated by Peter Conrad reviewing Gray's next book, *The Silence of Animals*, published some 11 years later where our mild-mannered misanthropist seems not to have changed his spots one bit. Conrad quotes Germaine de Staël, French-Swiss writer and political theorist, who,

having witnessed the *Liberté, Égalité, Fraternité* of the French Revolution, commented *The more I see of men, the more I like dogs*. Gray's mantra – *Barbarism is a disease of our civilization* – is hard to argue with. In a universe that exists for absolutely no reason whatsoever, and where morality is a deluded flight of fantasy, our technological advances are put to use to simply construct more efficient ways to massacre each other, particularly if that other has different coloured skin and speaks a different language. The French colony of Algeria seems a perfect case in point.

Idder is on life-support; Krim is in custody and has no words for the police, nor for his distraught mother, Rabia; Marion, having stuffed up majorly, is off the Chaouch security team; Fouad is questioned, released, but refused access to Jasmine; the Nerrouche household in Saint-Étienne is turned upside down by the riot squad and interrogated; Jasmine and her mother, Daria (Amira Casar), start tearing each other to pieces over who is to blame; meanwhile, Nazir sits quietly in his cell, claiming he had nothing to do with Krim's act. No one believes him.

But Idder is made of strong stuff. His ancestry is Algerian, but from the Kabylia region in the north, ranging across the Atlas mountains. Populated by the Berbers, it doggedly resisted the French colonisation in the 1850s and 60s, and also the autocratic behaviour of the FLN, the party that took power after independence in 1962. Its local tongue, Tamazight, is, in addition to Arabic, the other official language of Algeria.

Things are moving fast. There is a push in (white) government circles to declare the election invalid and hold another. Jasmine, desperate, lies to a friend who is close to said circles that her father has woken up. But, wake up he does thereby saving his daughter's bacon, though, being Muslim, she may not find this metaphor tasteful. His first act is to speak words from Kabylia and put his hand between his wife's legs. No one does subtle erotic like the French. His next act is to view a recording of Krim's audition. The young man sits at the piano, correcting the pronunciation of his name by the panel of judges. He plays *Danse des Sauvages* until … is it a mistake? … is it becoming fed up? … he slams his hands on the piano and flees. His third act is to meet Krim and ask him why. Krim gives no reason. Idder is deeply unsettled that people from his own community want him dead; did not he run in order to bring France – including its Algerians – together as one?

Meanwhile, back in Saint-Étienne, Fouad and Marion have teamed up to nail Nazir who, they are certain, masterminded the assassination attempt. They discover that Fouad's mother has a passport for his evil brother; discover that she has terminal lung cancer; discover that Krim's sister,

Louane, is having an affair with Kevin, a white supremacist, who was in possession of the gun used by Krim to shoot Idder; discover that Nazir is in cahoots with the white supremicists to do … what? There is to be a soccer match between Saint-Étienne and Paris and the authorities are worried about violence. That worry escalates to outright panic when Idder, still recovering and it still being uncertain whether he can become President, announces he will attend. That panic escalates to dissociated, chaotic mayhem when Nazir, with the help of Sylvain, his supremacist buddy, escapes from prison.

Idder's courage and intuition is perfect. With the stadium at bursting point and every television camera in France pointed at him, he stands on his seat and greets the crowd. Yes, he will be President of France. Fouad and Jasmine find each other. We know, but he doesn't, that she is pregnant. Fouad, however, has no time to waste as he spots Nazir and Sylvain and fears they are up to no good. He chases them, but they knock him out, bundling him into the back of their car. No, they are not going to kill Idder; they are going to blow up a mosque, by way of Fouad tied up in the basement with a suicide-vest. Their motive is to cause outrage and division; no coming-together of divergent cultures and races for them. John Gray could only nod sagely. Cutting to thriller-mode, Marion finds him; cuts the wires in the nick of time just as Nazir is about to push the button; police converge on the mosque; Nazir, foiled, runs off. Whew!

But this ain't America, the land of the happy ending, made more so by having the President of the happy ending. This is France, this is Europe, where things take on a darker nuance. Krim, on his way to another interview in the continuing fruitless process of trying to figure out why he did it and who was supporting him, takes advantage of the police being distracted to throw himself down a stairwell. We never find out why, nor whether Nazir had a hand.

The end approaches. Idder's swearing-in ceremony alternates with Krim's funeral. Idder tells the assembled dignitaries, which includes the rehabilitated Marion and Kabylia elders, that he comes from the 'other' side of the history of France; the side of violence and colonialism which forced his ancestors to become French whether they liked it or not. He tells them that a young man killed himself today because he had two voices in his head: the voice that said he could become anything he chose, and the voice that, carrying the burden of humiliation, said he had to revenge those of his tribe who were murdered. He tells them that all French are both proud and ashamed and that's what makes us free human beings; we carry both good and evil within us. We alternate between being civilized and utterly savage, but nothing is stopping us from breaking free and, despite having different skin, other language, loving those of the same sex, coming together.

One suspects John Gray would not, at this point, be nodding sagely. He would, though, be smiling sardonically at the events unfolding in Saint-Étienne. Nazir tries to attend the funeral of his cousin in disguise. Kevin, the white-supremicist boyfriend of Krim's sister, Louna, recognizes him, stabs him. In the confusion, Nazir, wounded, escapes in his car only to die, slumped over the wheel with his passport in his hand. Idder may have the last word, but the credits close with the band playing *Danse des Sauvages*.

Brendan McPhillips

Call for papers

The Therapeutic Conversation provides an ideal opportunity for trainees and members of ANZAP and PITSIG to publish work relevant to the process of psychotherapy. Papers may be relevant to work with individuals or to promoting broad social cohesion and prevention of trauma. Work may have an objective, scientific style although there is also room for personal contributions, reflecting the individual voice, the perspective of lived experience and work that may draw upon literature and the arts or involve poetic expression. Papers may be up to 5000 words in length and will be peer-reviewed. However, the peer review process in The Therapeutic Conversation will be designed to help the author develop the work further – there is a policy of constructive criticism. We also welcome members of both organizations who may be interested in becoming involved as a peer reviewer.

Please contact Margie Darcy on **Margie@MargieDarcy.com** in response to this call for papers and to express interest in becoming a peer reviewer.

Part 2: Information

ANZAP Matters

President's Report

You all know that it has been quite a year, and I wish to contribute to the end of the year with words of gratitude, and Ngä Mihi Maioha - appreciation.

I am grateful that ANZAP, and its members, were well equipped prior to the pandemic, to deliver therapy, supervision, and training via zoom, and Skype and phone. It means that, for most of us, we could get the hang of it pretty quickly.

All of our education seminars were successfully conducted completely via zoom. Our conference committee had to make the call to not go ahead with an in-person conference this year, so we convened a series of fabulous seminars with 3 international speakers: Donna Orange, Nancy McWilliams and Beatrice Beebe. Then to finish, we had an excellent seminar on dissociation presented by Tony Korner and Nick Bendit. What was hugely missed was the collegial, and friendship gatherings in the breaks of our usual conference. Hopefully we can have this next year.

We had a short AGM following the dissociation seminar. Tricky on zoom, but we got through with good humour. We now have a full contingent of directors on the MC, and we have some fresh faces in Leo LaDell (NZ/Aotearoa)), and Wendy Corliss (Sydney, and Westmead trained). I am very grateful to the whole MC team.
ANZAP made a healthy profit from the seminars (usually we only earn a small amount in the conference season) and so it has secured us very well financially.

As our editor, Margie, is indicating, this is an exciting edition as it is the beginning of our collegial and intellectual endeavours with the Manchester arm of the Conversational Model. As you will all know, Russell Meares joined forces with Bob Hobson in the early 70s, in Manchester, and together they conceived the conversational model. Russell came back to Australia and he took it in into his particular direction, and those trained by Bob took it in theirs.

ANZAP has kept close ties with Bob's trainees, Frank Margison and Else Guthrie. Both have been keynotes at previous conferences, and a number of our members have trained in their particular short form CM dynamic therapy (psychodynamic interpersonal therapy – PIT). Our Strategic Planning Committee has been generating further connections, and one of them is this Bulletin, now "The Therapeutic Conversation". It is the beginning of a joint Journal between ANZAP and PITSIG (Psychodynamic Interpersonal Therapy Interest Group).

Welcome to all those from PITSIG! It is the beginning of something very rich, and rewarding. Thank you, Else, for your paper you have contributed to in this edition - a great kick starter!

Faculty has been in the forefront of increasing the presence of CM in New Zealand/Aotearoa. We now have 5 accredited CM supervisors, one in Wellington, one in Christchurch and 3 in Dunedin. We have 4 New Zealand/Aotearoa trainees currently, with 9 wishing to apply for our 2021 training. It is truly becoming in Australia and New Zealand Association of Psychotherapy.

The MC is now recognising that it's now time to start supporting satellite ANZAP Christmas/holiday parties. There is a very strong contingent of ANZAP members in Newcastle, Adelaide, Tasmania, and several centres in New Zealand/Aotearoa. Email Anne Malecki if you would like to be a part of one of these satellite gatherings.

Kim Hopkirk, President

Faculty Report
November 2020.

The faculty team (Andrew Leon, Cecile Barral, Kim Hopkirk, Geoffrey Borlase and Colette Rayment) have done a terrific job this year of providing quality training for nine trainees in year one and six trainees in year two. Although

there is a wide range of experience within our trainees in psychotherapy, they are all working to a high standard, and continue to impress me with their willingness to learn and their capacity to provide good quality psychotherapy. I'm particularly indebted to Geoffrey, who has moved quite a bit of the administrative detail onto an Internet-based learning management system run by Google ("LMS"), so that trainees can check the lecture program in real-time, as well as lodge essays and receive feedback through their LMS digital folder. As we all get better at this, it will mean less work for Anne Malecki. Of course, Anne continues to provide an enormous amount of help. She doesn't just administrate, but with her vast experience, provides a "quality control" function. I also rely a lot upon Cecile and Andrew for the corporate historical knowledge re training, as well as wisdom born from many years of experience.

A new development this year was introducing New Zealand based supervisors as part of our training. Particular thanks go to Annie Beentjes, Rashi Gadekar, Angelika Treschl and Dianne Hendey who have done a great job with their first trainees, despite the steep learning curve. I'm also grateful to Judith Pickering, who has continued to lecture and supervise for faculty to her usual high standard. It was very exciting to welcome back Rochelle Hersch to full faculty duties this year, and equally exciting to have Michele Rousseau return to faculty next year. Finally, we are hoping to induct more members to lecture and supervise next year, with a view to doing more of this, and hopefully joining faculty.

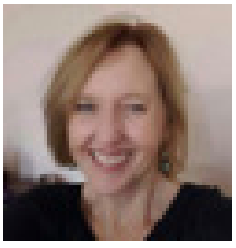
Next year we are planning to run all three years, with a good number of applicants for year one in 2021. Unusually, there are substantially more applicants from New Zealand than Australia! Because of the pandemic uncertainties and continuing need for quarantining for travellers between Australia and New Zealand, our weekend intensive in February to start the new year training will be done via Zoom, rather than face-to-face. Not ideal, but we seem to maintain a quality learning experience.

Next year we will be expanding the indigenous component of our training. This is increasingly being mandated by New Zealand authorities who are starting to regulate psychotherapy training programs, but is also in response to changing attitudes in Australia. Furthermore, we have floated the idea of getting some regular supervision for New Zealand trainees with Maori supervisors, depending on the trainees' clientele.

This year ANZAP has introduced a free peer supervision zoom meeting for any (paid!) clinical member of ANZAP on the last Wednesday of the month from 7 PM-8 PM. We have managed a minimum of 12 participants throughout the year, which has provided a wonderful diversity of ideas and experience. I would like to invite any of you who have not participated yet to come along. The format is that someone offers to present a clinical case, preferably one that brings up some difficult clinical issues and questions, and everybody is invited to offer questions, thoughts and reflections. I have been the convener of this, although thanks go to Leo van Biene for facilitating during the year when I was unable to attend.

Nick Bendit
Director of Training

ANZAP Education Committee report



Despite the challenges of the pandemic, all seven online seminars since March have gone fairly smoothly, due to presenters' expertise and flexibility, and to Angus's technological savvy and Anne's thorough advertising. All seminars have been well received. The last four seminars of the year were organized and conducted by the conference committee, replacing ANZAP's annual conference.

In terms of numbers, every seminar apart from Katina Ellis and Kerrie Kirkwoods' "Gender diversity in a contemporary Jungian context"

(37 attendees) has seen attendance numbers over 50, with the highest number (127) for Nancy McWilliams' presentation,"Rethinking madness". It should be noted that although the gender diversity seminar had modest attendance numbers, it received extremely positive feedback from participants.

We have started to track professional affiliations of seminar attendees (e.g., ANZAP, IARPP, Westmead trainees etc) , so future reports will provide information about the diversity (or otherwise) of participants, and whether there is progress in strengthening ties between ANZAP and Westmead.

For 2021 we have four seminars lined up thus far. Anthony Korner will present on "Communication exchange, psychotherapy and the resonant self" on February 20; Joan Haliburn will present "Short-term dynamic, interpersonal therapy" on April 17; Robert Bosnak and Cecile Barral will do a presentation related to embodied imagination and working with dreams (title and abstract TBA) on May 22, and Elizabeth de Preez (NZ) will present on "Relational and ethical considerations in online communication with clients" on July 31.
For future themes, we plan to follow up requests made by participants of previous seminars, such as: working with adolescents, death/dying/complex grief, working with psychotic illness, attachments and how polyamory and sexual drives (etc) may be affected by trauma. We also aim additional seminars on dissociation/DID, and relational therapy.

Annie Stopford, Education Committee Convenor

ANZAP membership report November 2020.

We have recently accepted 2 new clinical members:

- **Lisa Fleming** (Westmead + ANZAP training) who practices in Sydney
- **Narine Strachan** (Westmead training) who practices on the Central Coast
- Total number of members as of 1 Nov 2020 = 99 (20 more than a year ago).

This is a very satisfying increase.

We have reviewed

- The membership application form to allow for a greater openness to forms of self-development other than psychodynamic psychotherapy.
- The membership categories document to clarify the requirements for each category, especially clinical membership. The document is available on the website

We are discussing how to give more recognition to ANZAP graduates who have opted for research work over clinical practice.

Cecile Barral, Membership Convenor

ANZAP and PBANZ

Under the Health Practitioners Competence Assurance Act 2003 (HPCAA), the Psychotherapists Board of Aotearoa New Zealand (the Board) governs the practice of psychotherapists by setting and monitoring standards and competencies for registration.

The title psychotherapist is legally restricted in New Zealand. This means that anyone calling themselves a psychotherapist must be registered with the Psychotherapists Board of Aotearoa New Zealand (PBANZ.).

New Zealand clinicians are not permitted the use the term 'Psychotherapist' unless they have completed a qualification from an organisation whose training and qualification are recognised by PBANZ and are registered with PBANZ.

PBANZ has undertaken an extensive consultation process to establish standards to accredit organisations that provide Psychotherapy training and qualifications. ANZAP has been actively involved in this process.

Since the beginning ANZAP training has been recognised by PBANZ and since 2008 it has been recognised under its grandparenting policy.

ANZAP understands, under Grandparenting, until the PBANZ accreditation framework is in

place the ANZAP qualification is recognised and ANZAP graduates are eligible to apply to PBANZ for registration. We understand Grandparenting will continue until the PBANZ accreditation framework is in place, and will apply for example, to New Zealand trainees enrolling in 2021.

ANZAP has been proactive and has prepared much of the documentation for accreditation by the PBANZ.

PBANZ considers it is possible that the first accreditation (test case) will take place in 2021/22.

Dianne Hendey 14-11-20.

MEMBER PROFILE

Leo LaDell, ANZAP
Graduate Member

My early experience with post-secondary education included the study of classical philosophy and a Master's degree in Russian History. After two decades of working in various roles outside of academia - including much-loved work as a musician and music teacher - I pursued study in psychology, counselling, and the ANZAP psychotherapy training.

I currently maintain a private psychotherapy practice in Dunedin, New Zealand and work a day each week at Moana House, a therapeutic community for paroled clients dealing with alcohol and drug issues. I participate in the Conference and Management Committees with ANZAP and enjoy the regular interaction with these delightful groups. At home I maintain an uneasy truce between Freya (cat) and Paco (dog) and try to keep the latter from becoming intrusive in Zoom meetings. Music performance still features frequently in my life.

EVENTS DIARY
•ANZAP EVENTS•

NB: All 2021 ANZAP Seminars venue-arrangements are to be
advised (TBA) due to ongoing Covid-19 developments.

Bookings for ANZAP Events & Details TBA via: http://
www.anzap.com.au/index.php/events/upcoming-events

20 Feb 2021:
Dr Anthony Korner - Communicative Exchange, Psychotherapy
and the Resonant Self

17 April 2021:
Dr Joan Haliburn - Short -term Dynamic Interpersonal
Psychotherapy (STDIP) – to relieve distress, develop awareness
and improve functioning

22 May 2021:
Cecile Barral & Robert Bosnak - Further information TBA

31 July 2021:
Elizabeth de Preez (NZ) - Relational and ethical considerations in
online communication with clients

OTHER EVENTS
Please check with providers re availability / Covid-19 restrictions, etc

STARTTS:
https://www.startts.org.au/training/#1542774259624-a5584a0d-4c0f

IARPP:
http://iarpp.net/events-hub-page/event-calendar/?cid=mc-30c031f3e51e7c50e805261ec0b-01b82&month=9&yr=2019

ASPM:
https://www.aspm.org.au/other-training/diary-dates-australia.

David Harvey, ANZAP Member

PITSIG Matters

Comments from Chair

As PITSIG chair I would first like to say a very warm hello from all of us in PITSIG to everyone in ANZAP! Over here in the UK we have always had a sense of familial connection to you, like cousins separated by geography rather than anything else. In recent years that connection has grown noticeably amongst a small group from each country, and it was a great pleasure to finally meet Tony Korner and Loy McLean during their visit to the UK in July 2019. This first edition of The Therapeutic Conversation is a tangible sign of that strengthening link, and I would like to thank everyone who has worked to create it.

PITSIG has had a complicated year thanks to the pandemic. We are probably quite a long way behind our ANZAP cousins in experience with using online platforms for meetings, so have had a crash course in using Zoom during 2020 to hold our regular bimonthly CPD events and most recently our annual Advanced Training Day, bravely hosted by Kath Sykes. We would very much welcome ANZAP members to attend our meetings, though the 11-hour time difference doesn't help!

For 2021 PITSIG has several ambitions. We expect to relaunch the introductory PIT training course at the University of Manchester, and with a bit of luck also welcome a first cohort of therapists onto an exciting new PIT practitioner training. In the tradition of the conversational model we have created a new set of therapy roleplay films, and editing is now at an advanced stage under the watchful eye of Frank Margison. We hope the films will be a useful training aid, and when ready we plan to make them available via the PITSIG website. So lots to look forward to, at the end of a desperately hard year for everyone on the planet.

Simon Heyland, Chairperson

PITSIG EVENTS DIARY

Diary dates for 2021 PITSIG CPD meetings are:

Friday 5th March

Friday 7th May

Friday 2nd July

Friday 3rd September

Friday 12th November

Advanced Training Day, date tbc