The Therapeutic Conversation

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Editorial

Welcome/ Kia Ora

What a wonderful array of experiences, thoughts and creatively juxtaposed ideas are contained within. I hope you enjoy reading these contributions as much as I have.

Papers range from a moving and thoughtful story of the growth of a psychotherapist to an account of CM approaches to teaching and supervision which enabled the joyful co-creation of a collaborative mental health care team. Conrad's Heart of Darkness and the Arthurian legend of the Holy Grail become metaphors for exploring the subject matter of suicide and the impact of suicide on therapists.

The significance of privacy for psychotherapeutic work is examined, culminating in a proposition regarding creating a world which fosters kindness and care.

Film and book reviews incorporate TS Eliot, Homer, King Lear and the Great Mother as they inspire us to watch and read. These reviews speak to different ways of exploring how humans make meaning, and of how we deepen our relationships with ourselves, with others and with the world.

I thank the authors of the writing included within for their time, and for the intellectual and emotional effort required to produce such work. I also thank Leo LaDell for formatting this journal.

We'd be very glad to receive your feedback about this journal as it continues to evolve. Please don't hesitate to contact a member of PITSIG, the ANZAP Management Committee or myself to let us know your response to the journal.

Warm regards, Margie Darcy
Editor

Part I: Papers

Moving Beyond a Medical Model

Clare Green

'It's the stories that matter – and how they are told' (Hobson pg xi)

This is a personal story of my development as a psychotherapist. I have journeyed through 3 different employment roles in one hospital over a period of 30 years. Beginning as a medical secretary, then to intensive care nurse, and on to psychodynamic interpersonal therapy (PIT) therapist in a medically unexplained symptoms clinic (MUS). I would like to share some of my experiences in each of these areas, informed by my knowledge of the PIT model.
I hope that this might be interesting as I describe aspects of my experience that are fresh and different.

I should add that if I had not worked in the roles above, I would like to have worked as a poet or a painter, or a detective. What I love about PIT is that it encompasses all of these drives – imagination, fascination in words, creativity, pictures, aliveness and looking for clues.

My working life began as a medical secretary in a large hospital. I worked for an ear nose and throat (ENT) surgeon who was also a head and neck oncologist. I was fascinated to sit in on clinics where throughput of patients was very fast and there was little conversational exchange. There might be about 25 patients to see in an afternoon for 2 or 3 doctors. "Any heart trouble, chest trouble, diabetes, epilepsy, asthma, eczema, hayfever?" was rattled off and repeated for each patient. It was the territory of the predetermined criteria for diagnoses. I typed up letters, maintained a waiting list and selected patients for surgeries. Speed was of the essence and a patient who spoke a little too much became unpopular in interactions because it held us up.

Lump in throat, ringing in ears, hearing loss to high frequency sounds were all common symptoms. Symptoms were 'standard', generic, inert, or dead. I think Hobson and Meares might refer to these as scripts or chronicles (Hobson 1985). If ever a patient used a unique word to describe a symptom, it was corrected to make it fit the medical model. For example, "my throat feels hot and burning" would be corrected to "reflux". The summary was a necessary language tool – a form of closing down, just to main points. Emphasis was of course on speedy diagnosis and the context of symptoms beginning was not relevant.

One day I looked at a patient's CT scan report and noticed the tumour was reported as in the opposite ear to the patient's symptoms of hearing loss. A phone call to the radiologist clarified his mistake of putting 'right' when he meant 'left'. That very day I decided I wanted more involvement in patient care. I wanted to spot things and try to make a difference to patient care if I could. I picked up the telephone to my nearest university and set the process in motion to enrol on the BSc Nursing Degree course.

One of my early attachments in nursing training was in Accident and Emergency. A lifeless baby was brought in by its frantic mother. My mentor took the baby into a treatment cubicle and I followed along with a doctor. We all contributed in administering cardiopulmonary resuscitation (CPR) with two fingers on the baby's delicate body. Tragically the baby's heart did not restart. Later that day, still working on my shift, I developed severe abdominal pains, palpitations and tachycardia. I had an electrocardiogram (ECG) and a junior doctor checked with a consultant for his opinion. I was diagnosed with acute pancreatitis. I left the hospital and drove to my parent's house to share my shock at the day's events, and my diagnosis. "Acute pancreatitis?" my mother exclaimed, "No, it's because you are upset about the baby!". My symptoms settled within hours and my mother, without an ounce of medical training, correctly turned aside the medical diagnosis and correctly labelled emotional upset. It was a lesson for me in being understood, acknowledging the context when symptoms began, and an example of not so much what is wrong with a person, as what has happened to them! Bob Hobson would probably say it is also about knowing the patient, not a lot of facts about them. I soon had to choose whether my nursing training would follow a general medical route, or a mental health route.

Clearly there was a divide. I chose the medical.

My first taste of nursing was unsatisfactory as I singlehandedly had responsibility for up to 20 ward surgical patients. I again discovered it was not practically possible to converse with patients, as I did not have time to listen to their answer. I applied to work in intensive care, for there I would work with one patient on a one to one basis, and I hoped I could do a thorough and excellent job.

On the intensive care unit, equipment dominated the person. Tubes coming from all directions had to be mastered and bleeps and monitors thoughtfully attended to. On one occasion I stood at the bedside with 5 doctors positioning wires in order to measure the patient's central venous pressure. We checked the equipment was at the correct anatomical space, we checked the waveform on the monitor over and over. Suddenly the consultant marched up to the bed and said to the patient "are you thirsty?". The patient nodded. "Give him some fluid" the consultant barked. We all looked at each other in amazement. We could actually ask the patient for the information we needed! Such was the reliance on medical equipment.

ITU was the setting where buttons could be pushed to relieve pain. Suffering could be ended in that respect. It was hugely relieving and something I would miss very much when a therapist. Quite unconsciously, I had sought out this nirvana.

It often occurred on ITU that an emergency such as cardiac arrest would be occurring in the bedspace next to you and all that separated you was a flimsy curtain. What occurred then was what could be called a purposeful holding of your position. Instead of running to help, for there were already ample personnel in attendance, what was needed was a staying with your patient. A holding of my position was therefore learned that would later translate to a 'staying with' feelings when a PIT therapist….with all the effort to focus and selective neglect that involved. It still feels to me an action of the whole fibre of my physical and emotional being – to stay with a feeling, waiting for something to emerge.

One day my ITU patient bled to death in front of me. She had oesophageal varices due to liver disease. The varices bulged as their flow to the hardened liver had become impeded. It was a fast and gruesome death. As a person I was deeply affected by that but in my nursing capacity I helped clean the deceased patient and clean the bed ready for the next admission, which arrived into my care within an hour. Next morning I saw the blood of the previous patient on the bed wheels. A psychodynamic understanding was born in my mind…. the presenting past! (Jacobs 2012). I felt, in that moment, as though I was the only person in the world who could see the distress of yesterday in the same glance as the patient of today. It felt as though my eyes had been opened, and it felt overwhelming.

I began to think more about myself soaking up the trauma of the ITU, like blotting paper, aware I was becoming close to saturation.

One quiet Sunday afternoon shift, I took over the end of life care of a young man of 28 years of age with alcoholic liver disease. He was not conscious. He needed pain relief and attention to dignity. I noticed there was no next of kin in his notes. He had been in hospital for 30 days and had not been visited once. The buzzer to the unit went and I was asked to meet a man who wanted to visit the patient. He wore a long grey mac coat and, to my surprise, announced himself as the young man's father. I explained that sadly his son was expected to die that very day, but that because we believed a patient could hear until the very end of life, I encouraged the father to speak with his son. The father stood at the bedside and declined my invitation to sit. Evidently, he would not be there for long. I turned to record the patient's vital signs. As I did so, the father turned and went quickly out of the unit, his grey coat billowing behind him. I was cut up with what I perceived as the father's grief, and bitter regret. What had happened in both these men's past lives that was now too late to repair? Even at the very end, reconciliation had not occurred and I had not been able to facilitate it. The blotting paper could soak up no more. I finished nursing and took some time out.

It was to that patient, whose blood was on the wheels, and the man in the grey coat, and his son, that I dedicated by Masters in psychodynamic psychotherapy that came next. The distress that they had provoked in me had moved me into a new area of thinking. It would become a new area of working and caring for patients.

After finished my three year course at Leicester University I spotted a job as a PIT therapist in an MUS pilot project, again at the same hospital that I knew well.

After ITU and all the equipment there, I felt very empty handed as a therapist. No button to press to end pain. More an openness to feel with the patient, more a 'staying with' pain. More the use of my person and what I am. I found it excruciating. Hardly a day passed when I did not search in my mind for kit, equipment, medicines, tablets, pain relief.

I found a huge advantage that I was accustomed to hospital life and familiar with medical language, jargon and abbreviations. I found medical jargon very containing of anxiety in my new role. When a cardiology patient said "do you know what ejection fraction is"? I did….we were both on the same page. It seemed as though patients trusted me because I knew the words. I felt able to collaborate with the medical teams and their patients, dovetailing two services, aiding referral to MUS services and avoiding "I don't know why I have been referred here".

With PIT training in the MUS setting I now discovered symptoms had a unique and personal flavour to them that was vital to uncover or it held something of the unique inner experience. Rather than inert lists of symptoms, the PIT model urged a fascination for the way patients' used words and urged time to be given to do it. I was amazed that the PIT manual I was given described a 3-4 hour first assessment. I negotiated up to 2 hours for my first assessments and found the pace this afforded hugely rapport building and a crucial starting place in which to collect valuable morsels of information. I remembered that Hobson emphasised the importance of the first 5 minutes (Hobson 1985).

Often a word would occur in the first assessment and would occur also in later sessions bringing unique descriptions that began to stand out and meanings form. I was listening out for language curiosities, dual meanings, minute particulars, the significance of metaphor and "language-games" (Hobson 1985 pg 164). One woman presented with temporomandibular joint dysfunction with reduced jaw opening. When asked about her life day to day she said "my mother is so critical of me, I am afraid to open my mouth". Hobson describes this type of being as "different ways of thinking with different languages" (Hobson 1985 pg 169).

I was discovering that when people describe how they feel physically, usually they describe how they feel physically and emotionally. This is the 'forms of feeling' that Hobson (1985) writes about. The more patients told me about their symptoms, the more they communicated about their person and their story.

This is an example of my meeting with a 32-year-old woman whose description of having a 'bump' took me by surprise. I had never heard that description before. She had been investigated in the ENT clinic and had been reassured that her anatomical structures were NAD (nothing abnormal detected).

It's not a lump but a bump

T " So I wonder if you could tell me about your symptoms, what does it feel like?"
C I can't swallow
T I wonder what it feels like in your throat
C There is a bump
T A bump (I am surprised, we usually say lump) ….that might be quite different to a lump then?
C Yes, not a lump….a bump
T This bump seems to feel large, I wonder….
C Yes, and heavy….it moves up and down but never goes..
T No, It feels as though it is always there, a heavy bump and moving
C Yes, and it worries me because there must be something wrong
T I wonder if it feels like the bump is blocking the way? For food maybe?
C No, I feel it, it is heavy and it sticks into me, I keep swallowing to move it, and it makes my arm and neck hurt too.

This female patient was pregnant at the time of this interview though I did not know that at the time and she told me of this at the next appointment. The description of 'bump' then began to have dual meaning, regarding her feeling in the throat and also her pregnancy. The heavy bump helped us have a shared

understanding of the heavy emotional weight this women felt about carrying and protecting her children. She attended 12 sessions of PIT therapy, which included safeguarding, and symptoms were less at the end of our sessions.

Another example of a unique and personal description of symptoms was a 19 year old man who described his gastro oesophageal reflux pain as a "rough wall" within his throat. When I asked him about his day to day life, he told me about his demanding father who pressurised him to do onerous jobs in the house including sanding down a wall and painting it many times until his father was happy with it. Increasing anger in the patient was also understood in the terms that he had 'hit a wall' in terms of tolerance for his father. We used this description metaphorically in understanding his inner and outer worlds. This young man attended most of the 12 sessions offered but did not attend the final session.

I experienced the PIT model as encouraging me to look for something even in the ordinary (see Wordsworth quoted by Hobson xi 1985). I was searching for relational issues amongst the symptoms and very much enjoying the exploration. But I also had awareness of the persecutory therapist and wanting to avoid persecutory searching. I discovered that where the medical model had put full stops (in terms of questioning the patient – and I acknowledge this is due to time pressure), the PIT model encouraged a comma and invited more. This dialogue is taken from a first session with a 68-year-old female with right arm tremor. The neurology department had fully investigated this and given a functional diagnosis. She was relieved no pathology had been found. She had begun the session by saying her arm just shook and I could not elicit any other words to describe it. She smiled, though looked concerned, and welcomed my curiosity:

Above and Beyond the Medical Model – my finest 5 minutes!

T "You have been referred due to right arm tremor, when did your symptoms begin?
C "6 months ago".

T "So that is roughly January?
C Yes
T I wonder if anything was happening at that time particularly?
C No
T So that is just about Christmas time (awareness that Christmastime could be an interesting time in terms of relationships)
C Yes
T I wonder what was Christmas like for you?
C Yes, fine
T So I wonder if you were at home?
C No
T You stayed somewhere else perhaps?
C Yes, with my sister
T You were at your sister's house?
C Well, no, she took me back to my childhood haunt
T Oh
C Yes, and I felt upset, because my mother was never well when I was a child, and I came back feeling like…….I was reaching out"

I should add that in this exchange I teetered on the brink of being the persecutory therapist. But, because the patient did not appear to be experiencing it as one oppressed by it or probed as if a criminal in court (see Nin A 1966 quoted in The Persecutory Therapist 1977) I proceeded to go where curiosity guided and it was experienced by me as a creative exchange. The patient smiled and reacted with curiosity, which I interpreted as she being pleased that someone was asking.

"I was reaching out" – What Shall we Do with that?

Over my years in the hospital I witnessed many diagnoses, or the delivery of bad news, given to the patient. Sometimes the patient would respond with interest, sometimes relief. Some times the news was heard with shock and devastation. I remember seeing an elderly surgical patient recovering on the ward from abdominal surgery and the surgeon stood next to her and said "I couldn't get

it out". She said "You couldn't?" and dropped her head into her hands. Her abdominal malignancy was inoperable. This is particularly memorable because the patient was physically weak, alone on the ward in her nightclothes and the news came like a sledgehammer to a fragile soul. With this in my background, I appreciated great care at such times. But there was also an opposing pull, to leap with professional joy that a core nugget of truth had been found.

The patient's words "I was reaching out" felt like a diagnosis to me. We had struck gold! I wanted to spring out of my chair and say "here you have it – your arm is shaking because somewhere deep within you, you wanted to reach out to your mother. You wanted to connect with her. As you held your arms aloft you wanted her to come towards you". Of course, I did not do this. However, within the PIT model, I am guided to hold the pieces very carefully, very tentatively, like "jigsaw" pieces, holding them up for the client and guiding the client to "make connections" with the full awareness that this could be very painful. We needed to gain the shared feeling between patient and therapist, and not treat this important moment as an intellectual process. Together we would "get in touch with these difficult feelings" so that they were no longer warded off (Barkham, Guthrie, Hardy and Margison 2017 pg 104). At first I found the holding a great strain. Like when someone asks you to hold their keys. You must not lose them or forget where you put them. You want to give them back to their rightful owner as soon as you can. The responsibility can be overwhelming. And so it was with this understanding, it felt too much for me to hold. With good supervision, I did, and did not forget where we had put it. I particularly remember this client could not fill in questionnaires at the beginning of her therapy because she was shaking too much. She could not hold a pen and looked embarrassed and distressed. After 12 sessions of therapy she could fill them in and she reported that symptoms were much improved. In addition to difficult feelings for her mother, she talked about having to do many jobs as a child, such as being made to stack shelves over and over, even when they did not need to be done. We listened to her body communications – those hands shaking with tiredness, anger and reaching out for real connection. Her body held so much of her story.

Conclusions (So Far)

My journey through 3 roles highlights the use of patients' symptoms and what descriptions may hold if we have time to attend to it. As I found out, symptoms very often begin in a context. Beginnings are therefore so important. If we can 'stay with' we can focus ourselves on important feelings and therefore find a place of eventual resolution. The illustration of the man with the grey coat probably shows what not staying with difficult feelings looks like, with the agony of unresolved pain.

As I look over the journey so far I am aware of so many contradictions: I have found people to be so fragile, and yet so resilient. I have found the medical world fascinating, intricate and complex, but simple too. If you have ABC (airway, breathing, circulation) on the ITU we are doing well. Likewise, the psyche is awash with complexity but the essence of therapy is the 1:1 relating ; I and Thou, the relationship. I have moved in my journey from behind desks and administration to the full use of who I am as a person, close up and staying with pain, and at the coalface with emotion. A different hard place to be but what a privilege.

I feel in myself a lack of willingness to make too much of a conclusion here because the work goes on and is active and I resist closing it down in any way.

I end this piece with two sentences. Hobson (1985 pg xii) writes to anyone who hopes to respond to anyone " The 'heart beat' of therapy is a process of learning how to go on becoming a person together with others. That learning never ends".

And to the man in the grey coat, and for all our patients, hope never ends that peace can be found.

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References

Barkham M, Guthrie E, Hardy G E, Margison F (2017) Psychodynamic Interpersonal Therapy A Conversational Model Sage London
Jacobs M (1998) The Presenting Past: the core of psychodynamic counselling and therapy 2nd Edition Open University Press Maidenhead Philadelphia

Korner A (2021) Communicative Exchange, Psychotherapy and the Resonant Self. Roads to Realisation. Routledge Oxon New York

Hobson R F (1985) Forms of Feeling : The Heart of Psychotherapy Tavistock/Routlege London and New York

Meares R A, Hobson R F (1977) The Persecutory Therapist British Journal of Medical Psychology 50 (4) 349-359

'What ails thee?' Suicide and the therapist

Russell Davies

In the cycles of Arthurian legend Percival eventually finds the Holy Grail not by cunning, guile, conquest or heroism but by simply asking the right question. On his first visit to the wounded Fisher King, Percival is mindful of what he has been taught: do not ask unnecessary questions – as such an opportunity is lost. On his eventual return some five years on, he wisely poses a different question: Percival, in the Arthurian legend asks, "What ails thee?"

In this paper I consider the importance of the ineffable subject matter of suicide, as it affects us all, both as therapists and as ordinary imperfect humans. There are few events more catastrophic in the working life of a therapist than a patient's suicide (Hendin et al.. 200.0, 2004. Gabbard 2003). The impact and emotional maelstrom can be devastating, and for some can influence a change of career. Moreover, most of us at some point in our life, both therapists and non-therapists, will be touched by the spectre of suicide: a friend, a family member, a colleague, a member of our school or university, someone vaguely known from our local community or a celebrity. It makes intuitive sense that the degree of relational connectedness may influence the degree of emotional upheaval experienced, although this may not always be the lived experience. I hope to bring discussion around the intensity and range of these experiences as a conduit to understanding, working with and perhaps being creative in mitigating therapist distress and dysfunction.

Allegory with poetic, literary and artistic metaphor can offer an illuminating glimpse or an intimation towards this inscrutable event. Of particular salience is the work of Joseph Conrad and his novella Heart of Darkness. In an earlier paper (Davies 2020), I have expatiated on the term of Conradian Horror as being apposite in bringing illumination to the dark and dismal vista of suicide and loss. Percival, in the Arthurian legend asks, "What ails thee?" This represents a moment of humility and compassion. This can considered as a representation of supporting the therapist in the aftermath of a suicide. Thus the question "What ails thee?" is posed to the grieving therapist in a way that allows connection and empathic attunement. Emma Jung examined the question of "What ails thee?" as being central to the understanding of what ails western civilization (Jung, Von Franz, 1960). Percival, according to Jung, embodies the reconciliation of masculine and feminine: the logical and the intuitive. Percival's quest begins and ends not through a heroic or grand gesture but through humility, through asking a simple question.

Percival and the story of the Grail, 1330

I have often been asked what I believe about death, that unproblematical ending of individual existence. Death is known to us simply as the end. It is the period often placed before the close of the sentence and followed only by memories or after-effects in others.

> But when one is alone, and it is night and so dark and still that one hears nothing and sees nothing but the thoughts which add and subtract the years, and the long row of those disagreeable facts which remorselessly indicate how far the hand of the clock has moved forward, and the slow, irresistible approach of the wall of darkness which will eventually engulf everything I love, possess, wish for, hope for, and strive for, then all our profundities about life slink off to some undiscoverable hiding-place, and fear envelops the sleepless one like a smothering blanket.
>
> **C.G. Jung, The Soul and Death, CW 8 (par. 796)**

The impact of suicide and loss on the therapist

Mental health disorders are implicated in 90% of deaths by suicide. Research in a North American cohort (Chemtob et al. 1988) found that 53% of psychiatrists, 22% of psychologists and 23% of counsellors report this experience.
The emotional impact of this on the practitioner is considerable, coupled with stigmatisation, professional isolation and fear around medicolegal implications. There is the additional burden of being exposed at a time of traineeship, in itself a period of vulnerability. Anecdotally, I have seen this influence a precipitous change of career but, when handled well, it has been an opportunity for growth. Therapists from a medical background transition through acute hospital settings before embarking on higher specialist training in psychiatry. Thus they are exposed to death in a way that those from alternate backgrounds, such as social work or psychology, are not. This may in part inoculate against a more complicated or pathological grief response (Jacobs, Maltsberger 1992). However the personal immersion and attachment to the patient are far greater for the psychotherapist than an emergency department physician who fails to successfully resuscitate an acutely ill patient.

The responses have, arbitrarily but helpfully, been divided by the Seattle-based psychiatrist Dr Jeffrey Sung into three phases: Immediate, Middle and Final (Sung 2016). This is based upon a synthesis of the work of Bartles, Cotton and Little (Bartles 1987).

In 2001, Sung experienced the anguish of a patient's suicide when he was working as a resident in a psychiatry training program.

> I had just seen the person the previous day. My initial feeling was shock and disbelief, and then dread and confusion. The next day felt surreal. Should I keep seeing patients? Should I talk to the family? What would I say?

This experience prompted him to work with others on how to prepare and manage these difficult events.

According to Sung, the Immediate stage is characterised by shock and stunned disbelief. In the Middle stage there may be recoil, emergence of overwhelming feelings, emotional turmoil, intrusive reflections and anticipatory apprehension about enduring the inquisition, restoring personal integrity and obtaining emotional first aid. The Final stage includes recovery, new growth, moving on, dropping out, surviving or thriving.

Many therapists have provided written accounts of their experience of a patient's death by suicide (Gitlin 1999). It has been posited that familiarity with these accounts may decrease the sense of isolation. This has intuitive appeal.
Professional responses to a patient's suicide may include the following:

- Shame and guilt over failing to prevent the suicide
- Fear of condemnation or actual stigmatisation from colleagues
- Ruminations over missed clinical signs
- Questioning of professional roles
- Thoughts of leaving the profession
- Over-reactions to other suicidal patients (hypervigilance, avoidance of working with suicidal clients)

Tillman (2006) conducted a phenomenological research interview with twelve psychoanalytic clinicians who had been exposed to a patient's suicide. A thematic analysis of these interviews yielded eight themes grouped into three structures:

1: Traumatic responses
Initial reaction, dissociation, traumatic intrusion, avoidance, somatic symptoms.
2: Affective responses
Crying, sadness, anger, grief.
3: Treatment specific relationships
Review and reconstruction of work with the patient.
Contact with, or sense of responsibility to, the patient's family.

4: Relationships with colleagues
Personal analyst, supervisor, peers.
5: Risk management Fear of lawsuit.
6: Grandiosity, shame, humiliation, guilt, judgement, blame.
7: Sense of crisis
Professional identity, loss of faith about psychodynamic/intensive treatment, concerns about competence.
8: Effect on work with other patients.

These features have much in common with the literature around grief and loss. In addition, Tillman's study showed the prevalence of narcissistic injury with persisting consequences for the clinician.

All but one of the clinicians in Tillman's study felt surprised by the timing of their patients' suicide despite a rational appreciation that many clients were "high risk". A range of implications arising from her study is worthy of consideration. Suicide is rare, despite the ubiquitous presence of suicidal ideation. Clinicians are not always able to predict actual suicide in clients at risk. Clinicians may suffer anxious hypervigilance on one hand, or denial of risk on the other. Archinard's (2000) research shows that, while clinicians may not consciously know which patients are going to commit suicide, they often unconsciously register those patients who are at higher risk with greater specificity. Using Facial Action Coding Systems (Ekman, Friesen 1978), researchers were able to predict from analysing the clinician's facial expressions which patients were likely to attempt suicide with an accuracy of 82%.

Although a somewhat taboo subject, a theme worth considering is that of suicidal ideation and responses in the surviving therapist. Maltsberger (1992) describes melancholic reactions in the therapist which, on rare occasions, may be severe and associated with suicide attempts. He describes two incidents where, in the aftermath of treating patients who suicided, the psychiatrists themselves made suicide attempts, one of which was successful. Rotnoz (1970) also describes how a psychologist suicided after working closely with two patients who committed suicide. Over-identification with the lost patient may evoke suicidal daydreaming in the therapist. This and other more subtle attacks upon the self or self-recrimination are areas that have received scant attention.

Institutional responses vary in their nature and utility. Most, thankfully, have moved to a more enlightened stance beyond a culture of blame; however, this can still occur, covertly and overtly. All too often responses focus on the mitigation of potential legal redress. As practitioners, it is essential to have legal representation in court and in scenarios of coronial enquiry. One should not count on the institution to support our best interest as financial pragmatism will often usurp good pastoral care as the modus operandi. Thomas Gutheil, in Suicide and Clinical Practice, has devoted a chapter to the legalistic aspect suicide at its interface with psychiatrists in the United States. Clinicians may be drawn into a medicolegal defence when a patient dies by suicide or is injured by a suicide attempt. Few of us will have more than a passing lay knowledge of the legal system, with little or no formal training in managing these adversarial and inquisitorial examinations: these arenas are bewildering and anxiety provoking. Legal representation and the support of an indemnity provider are invaluable in supporting the clinician in guiding and making sense of this unfamiliar world. In addition, the backing of a senior colleague or mentor to discuss and vent has been of considerable utility to me.

Gutheil states: "Malpractice litigation results from the malignant synergy of a bad outcome (in this case, serious injury or death through suicide) and what we refer to as bad feelings." The "bad feelings" are understandable with such a catastrophic event: survivor guilt in the relatives and loved ones, anger, denial and bargaining representing aspects of the grief reaction. The "bad feelings" as enunciated elsewhere in these passages are ubiquitous in the surviving practitioners: sadness, guilt, shame, fear, anxiety of peer recriminations, professional and financial loss. Guilt in the clinician may be particularly poignant if the patient's suicide occurs soon after discharge from hospital or after a clinic appointment.

"Bad feelings" can be incubated and amplified in the presence of complex grief, with ambivalent or intense feelings in the survivors of cases such as suicide following separation, divorce or estrangement. The commonly encountered psychological defence mechanisms of projection and displacement may be evident here. It is the writer's experience that many family members pursue external means of investigating a death by suicide with the

intention of "finding out what happened" and a desire to "get to the bottom of it". This may evoke a somewhat paranoid and defensive stance in the clinician who distances him or herself from the family. This further fuels the anguish of grieving survivors who may feel they are not being handled with deserving sensitivity and candour: "What are they hiding?" This poses a bind for the clinician who may have received well intentioned advice from a solicitor, administrator or medicolegal advisor recommending no contact. This response lacks humility and compassion, and in all probability further cultivates "bad feelings" and the potential for an adversarial outcome. The worlds of jurisprudence and medical care are not easy bedfellows.

I believe particular mention should be made to suicides and suicide attempts that occur in the hospital setting or shortly after discharge from a hospital. So far we have focused mostly on patients in the community, namely those attending clinics, practices or outpatient departments. A question that is commonly posed is: "Should the patient be in hospital?" From a temporal perspective, this is asked within the constellation of good clinical care and risk management prior to a suicide or suicide attempt, but asked also from a defensive perspective when considered after the suicide. Further questions occur with regard to what additional safeguards should be in place to support the individual outside of hospital. A patient may be offered an admission or extra care (such as more frequent appointments) but they may decline. The question naturally arises of their capacity to make such a choice, and whether or not they should be detained pursuant with whatever mental health legislation is available to the practitioner in their jurisdiction. Non-medical practitioners may be disadvantaged here, and need to refer patients on to their local hospital emergency department or seek a conversation with their patients' family doctor. This is enormously difficult and fraught with considerable subjectivity and lack of precision.
When a patient is in admitted to a mental health ward, there is an understandable expectation from the patient and their loved ones that appropriate safeguards will be implemented to maximise safety, whilst ideally preserving some autonomy and dignity. All psychiatric hospitals have protocols and procedures around risk management and, by and large, are risk averse settings where the leaning tends towards benevolent paternalism and restricted liberty rather than too much liberty. The ethics of care in such settings are beyond the scope of this paper, but exist within a broader historical backdrop of asylums and institutional care. The patients are subject to repetitive processes of risk assessment and observation, with ultimate responsibility usually sitting with the senior doctor assigned to the patients' care. Paradoxically, it is not uncommon for this clinician to have had the least direct contact and knowledge of the patient. Fortunately suicides within inpatient settings are uncommon events, and often constellate around multiple systemic errors rather than a singular egregious mistake or error of judgement. Understandably such catastrophic events are the subject of a rigorous post hoc review, both internally within the hospital and also externally through forums such as a coroner's court. In the vignettes section I discuss examples of such suicides, namely Richard, James and April. Each appropriately led to significant cultural and procedural changes within their respective hospitals. However, I believe it is unlikely that any clinical setting can ever completely mitigate the risk of suicide or suicide attempts given the impulsivity, unpredictability and – at times – frankly creative means of self-destruction that do occur. Settings of mental health care are populated by committed, humane and professional teams of health providers who do their utmost best to maintain safety and a high standard of care. Departures from this do occur and it makes sense that such incidents, when associated with adverse outcomes, should be the subject of diligent enquiry. Obviously, such a post hoc analysis is the subject of considerable bias as the enquirer is already aware of the adverse outcome and is tracking back in a neat linear retrospective fashion. He or she may make connections and bold assumptions of causality, which may not have been evident during the real time non-linear, unpredictable course of a patient's admission in its many facets and idiosyncrasies. Such post-suicide enquiries risk becoming the proverbial witch hunt.

Suicide: a personal perspective

> "Happy families are all alike; every unhappy family is unhappy in its own way."
>
> **Tolstoy, 1875-1877/2001 (page 1)**

I believe this often quoted opening line from Tolstoy's Anna Karenina is apposite here. Every suicide is different, and imbued with its individual

nuances and idiosyncrasies. There are, of course, commonalities and repeating themes but they are, in way, each fundamentally unique. To amplify this there is, in my view, value in considering a range of vignettes.

Below I provide some accounts of suicide as experienced by me. This material is emotion provoking and may be distressing for readers. I also attempt to shine light on the phenomena of secondary trauma: how dealing with victims of trauma can vicariously traumatise us as therapists (Cieslak 2017). The identifying characteristics of individuals including names have been changed.

Rebecca

I still recall the day I came home from playing with friends in a park. This was South Wales in the 1970s, and I was barely seven years old. I could hear hushed adult speech, and my mother was upset. I didn't specifically enquire as this was adult business. However someone must have decided that the young child should know. Rebecca, a neighbour, had died. A pleasant, kind-faced and quietly-spoken lady, Rebecca was a similar age to my mother and had a son younger than me. For reasons I don't recall, I quizzically pumped for more detail, and was informed that Rebecca had drowned herself in the river. I was confused and could not comprehend. Why? Where? I returned to my friends in the park and that was that.

John

John had been admitted to a locked psychiatric unit as an involuntary patient under the mental health act. A lithe and fit young man, he was also floridly psychotic with paranoid delusions and hallucinations, perplexed and distressed. During a first episode of schizophrenia, he climbed over a twelve-foot wire fence and absconded. Protocol was followed, family and police were called and the day staff headed home for the day.

Arriving at the train station I was informed by a railway official that there had been an "incident" and all trains had been cancelled. I called the hospital but didn't need to. I knew instinctively that this was John. There was nothing half-hearted or ambivalent in his suicide. A perverse twisted fact was later relayed to me that he had removed his shoes and socks, and neatly placed them on the track before the "incident". What possesses someone to perform such a careful purposeful act as they approach the black abyss?

I felt sympathy for my consultant colleague who would sit with the grieving family, write reports for hospital administrators and attend the coroner's court. He did so with diligence, kindness and selfless compassion. I learnt much that would serve me well in my future career.

Since then I have worked with many first responders who were directly traumatised by attending scenes of suicide like John's. These are the other victims. Hearing their accounts and graphic description of scenes is simultaneously abhorrent and fascinating. Like Prometheus, the hero of Greek mythology, chained to the Caucasus Mountains, these first responders are traumatised each day. It is curious that Prometheus is eventually relieved of his burden and freed by Chiron, the wounded healer. Vicariously we, the therapists, are also traumatised and wounded. We bear witness to their horror. We, as therapists, attempt through a conversation, through a relationship and through moments of meeting (Sander 1962) to unshackle them from their state frozen in perpetuity.

David

David was one of these first responders. He had attended many scenes of suicide. I was asked to see him by his family doctor. David was a big muscular man with big hands that swallowed mine in his handshake. He was quietly spoken and kind. He was clearly passionate and committed to his craft, but he was done. He couldn't do it anymore. He'd seen so much trauma in his work. He relived it daily in his sleeping and waking states. He could no longer function in his job, and as a husband and a father. Like many in the caring profession, he had experienced his own darkness which preceded his career (Money-Kyrle 1956). David was a victim of developmental trauma, which had fractured his sense of self. Consequently, he was more vulnerable to the traumatic vicissitudes of his job. We worked together for three years, in and out of hospital settings. There were times of optimism and future focus, but the final year for David was a mess, with lengthy periods of hospital admission, alcohol and sedative abuse, protracted isolation from the world, and near complete non-functioning in his domestic life. As is often the way with post traumatic stress disorder (PTSD), the relationship with his wife fell into terminal decline. Inexorably David was heading towards the abyss. Many times he would say, "Russel, I'm a shot duck." I never fully comprehended this phrase despite often asking for his amplification and its

meaning. With hindsight I don't believe that I truly wanted to understand because to do so would be to confront the reality that I had failed David and, maybe shamefully, that I was a failure. David knew that he had failed. He had nothing left in the tank. All who worked with him felt his hopelessness. The treatments became more desperate: electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), complex multiple medication regimes, and lengthy hospital stays. We were unaware that David had in all probability been planning his suicide in meticulous detail for some time. Its finality and timing surprised me. I understood that he was "a shot duck" and finally had fallen from the sky. I was sad. I had failed David, his wife and his children. He had spoken and had stepped into the abyss. There was nothing more to say, no more conversation. Like Marlow in Heart of Darkness, I felt humiliated by having nothing to say. I felt a deep sense of inadequacy in my professional competence. I steered away where possible from some of the more risky suicidal patients by filtering referrals and being frankly avoidant. I feared that my colleagues considered me to be a charlatan and lacking professional acumen to do the job. This was a penetrating narcissistic assault that stayed with me for many months. In my fantasy I would walk through the hospital corridors and catch glances of staff, patients and family members looking at me pityingly. I suspect this was entirely within my imagination, but the stain of shame was palpable. Catastrophic, spiralling ruminations of professional deregistration and poverty would haunt me during hours of darkness.

Richard

I was asked by a senior colleague to take over the care of Richard, an inpatient in a psychiatric facility. This would prove to be a poisoned chalice. A traumatised young man, Richard was challenged by addiction, depression and chronic pain. I met with him many times. He was likeable, humorous and clever. There were moments of meeting, togetherness and fellow feeling (Meares 2004).
On a bright Thursday I was phoned by the hospital, and informed that Richard was missing from the ward. I told the nursing staff to contact the family and police. A short time later, the phone rang again. A wave of intuitive anxious doom churned in my stomach. Once again I knew. Richard had been found dead in the hospital grounds by his father. I drove to the hospital to meet with the parents. Richard's father was distraught, stunned and speechless. I put a hand on his shoulder, and we stood looking at the ground. I then sat with Richard's mother. There really weren't words, just sickening grief and silent shock.
The shock gave way to sadness and shame, a sense of profound failure. Two colleagues enquired how I was. I provided largely unconvincing banal, empty responses that I was fine: "A hazard of the territory", and so on, and so forth. I was however pleased that they had acknowledged my troubled mind. Others avoided me. Looks of pity evoked feelings of contempt. I felt marked, stained, no good and really not up to the job. Therein followed a period of marked anxiety and risk averseness in work, signs all too familiar to those who have experienced an adverse incident. I would like to say that I reacted wisely on this tragic loss and took some time off to reflect and care for myself. However the reality was quite different: I buried myself in work, ploughed on and desperately tried to maintain an internal and external perception of industriousness, professionalism and stiff upper lip. A shamefully unenlightened position but an understandably human one where the defence mechanism of denial was employed. This manic defence drove me to take on unnecessary new projects and roles.

Richard's case eventually went before the coroner. This was a deeply unpleasant experience. I was told that such hearings are inquisitorial rather than adversarial although it did not feel that way. I believe it helped the family, and for this reason it was clearly worthwhile. I kept in touch with them until one day I called and they didn't know who I was. I knew then it was time to stop contact as it was evident they didn't need me anymore. I was maintaining contact to appease my own grief and guilt, and that wasn't right. I needed to let them move on to another chapter as did I. These atonement reactions (Jacobs, Maltsberger 1992) can be considered as representations of displaced anger or reaction formation. At a conscious level, it would have been unacceptable for me to hate Richard for abandoning me so it is likely that I engaged in guilt driven behaviours to undo these injuries.

Herman

Herman was a chap in his sixties. He'd had a successful career in elite sports coaching in his younger years, although that was firmly in his past well before we met. He was blunt, very matter of fact and didn't suffer fools gladly. He suffered

debilitating episodes of depression that were becoming more intractable as he grew older. He managed a tight routine that helped him function. This even included daily ocean swims throughout the year and somewhat masochistically especially in the winter months. He claimed the colder water was more effective at clearing the mental fog that would otherwise envelope him, and espoused its virtues to me as something that I should consider. I did not. He periodically spoke of suicide as a point of exit from his anguish, should the suffering become intolerable. He was reluctant to disclose if or what his method of suicide would be. He did however share that no one would know it was suicide and "there would be no mess for others to clear up". On one occasion, I put it to him that one day he might go out for his morning swim and head for the horizon deliberately, leaving no resources for a return journey. He neither confirmed nor refuted my hypothesis, but his wry smile suggested I was in the territory of correctly guessing his private fantasy. Several months later, when he uncharacteristically failed to attend his appointment, I instinctively sensed something was seriously amiss. My phone calls went straight to his voicemail. I searched the local online newspapers for his name. I searched for news of local drownings. The next day I received a message that his body had been founded washed up on a beach. I spoke with the forensic examiner, who had concluded that it was a straightforward case of drowning, "death by misadventure", as there was no evidence of suicidal intent or suspicious circumstances. Herman had been true to his word; there was no mess and nobody, including his family, believed that his death was by his own design. However I knew the truth and Herman knew that I knew. I felt a confusing morass of thoughts and feelings in the time that followed. I felt a sense of anger with being rudely abandoned by Herman and left holding this private knowledge. Should I call his family and let them know the truth? I did not. What good would come from this? Do the ethics of confidentiality persist beyond the life of the patient? I believe so. Perhaps I was complicit, to a point, in holding this knowledge and not doing more to help. Ah! A familiar position of self-reproach! In tension to this, there also exists a quiet admiration for Herman: he had been true to his word and consistent with his values to the very end. He had brought a peaceful conclusion to his suffering.

> "It was written that I should be loyal to the nightmare of my choice."
>
> **Joseph Conrad, Heart of Darkness**

Malcolm

In stark contrast to Herman's clean and calculated death, Malcolm's suicide was an exceptional mess. He was a well-liked local businessman and associate of mine: not a patient. His suicide was reactive to a sudden and very public shaming for financial impropriety and associated criminal charges. There was nothing ambiguous about the cause of death or his intentions as he shot himself with a borrowed gun. His tragic death left a grieving wife and two young children. Given that Malcolm could no longer be actively pursued by the governing bureaucracies of his profession, the sententious officials shifted their attention to those around him. The poor unfortunate but well-meaning soul from whom Malcolm had borrowed the gun, under the auspices of euthanizing an injured horse, was served with criminal charges by the police. The ramifications were enormous, with Malcolm's death leaving in its wake a muddy battlefield of bloodied and traumatised to lick their wounds, lament and perhaps project blame.

> "The spearhead sliced right through to the flesh, And when Diomedes pulled it out, Ares yelled so loudly you would have thought ten thousand warriors had shouted at once, And the sound reverberated in the guts of Greeks and Trojans, As if Diomedes had struck not a god in armour but a bronze gong nine miles high."
>
> **Homer, The Iliad**

This suicide left a community reeling in sadness and shock, but simultaneously in a position of widespread anger and vocal condemnation. From a personal perspective, I was saddened deeply by his untimely passing. Through my association with Malcolm, I was questioned by what felt like a scary and omnipotent authority. This was unpleasant and unwelcome, but ultimately harmless and paled to insignificance when considered next to the grief of his family.

April

April was a lady in her mid-20s. She was a university student and one week into a phase of inpatient care in a private psychiatric clinic as a voluntary patient. She had been assigned a diagnoses of major depressive disorder and borderline personality

disorder. There was a past history of impulsive suicide attempts, usually in the form of medication overdoses, which were reactionary to interpersonal discord and brief periods of emotional dysregulation. April had undergone previous uncomplicated admissions to hospital, and was supported at home by a caring partner. They had been together for a year. April had the demeanour of someone younger than her years. Her hair was dyed a shocking shade of bright purple in a curious juxtaposition to an otherwise introverted "don't look at me" persona. In hospital, she had been to many the model patient: she attended groups, she was polite and accommodating. April did nothing to engender a sense of wariness from her caregivers around posing a risk to herself or others. April approached the writer and asked to be discharged for a few days to attend a family gathering in a neighbouring town, and then to return to hospital to continue treatment and the remainder of her hospital stay. She reported that this was an important event that she didn't wish to miss. She provided assurances to me around her safety, and arranged for a family member to collect her and her belongings from hospital. I had no real grounds not to acquiesce to her request. She was given a supply of medication to take home. A few days later I was informed that April was not returning to hospital as she had taken an overdose and had been admitted to a nearby general hospital. In the following days further information filtered through that she had become gravely ill and, shortly afterwards, the sad news of her death was made known. April's death was referred to the state coroner, and an internal enquiry (termed a "root cause analysis") was conducted.
I spoke with her partner by phone and in face to face meetings on a number of occasions after her suicide. He was distressed, but by the same token also pragmatic and curious to understand what had happened. Apparently she had consumed alcohol at the planned gathering and argued with a friend. She consumed the box of medication that had been given to her on the day of discharge. In hospital, she expressed regret around the overdose and did not wish to die. She became tearful as she began to understand that the effects of the overdose were not as easily reversible as had been the case in similar past events. As organ failure ensued, she slipped into a coma and subsequently died. It would be hard to imagine how harrowing this would have been for her partner and family as she pleaded with them to live. Therein followed understandable sadness, anger and blame.
April's case emblazons a number of themes constellating around the associated risks of attempted and completed suicide.

- A patient's risk profile can change rapidly and unpredictably with catastrophic outcomes.
- Even though April was settled and emotionally regulated whilst in hospital, she was leaving to enter a social setting that historically had been challenging for her in the past. Hence, there was a degree of predictability that she was entering a time of higher risk.
- The disinhibiting effects of alcohol became salient outside of hospital whereas this was absent in hospital.
- Being an inpatient on a mental health ward brings with it a state of emotional and behavioural regression. There is a tacit expectation from the patient and their loved one that they will be cared for and kept safe. Discharge represents a venture into a liminal space of taking back control and responsibility and, with it, a time of heightened risk.
- April did not wish to die but did so nonetheless. A double tragedy.

April's case will go before the coroner where the hospital and individual care providers, the writer included, may be the recipient of adverse comment. All parties will require legal representation. Given that this may take years to occur, there is a need to implement changes in advance of its published findings where shortfalls in care are evident. This isn't the same as admitting fault but means developing practice in a way that promotes self-reflection, open disclosure and quality improvement. The coroner's court will offer a valuable forum for the family to be heard and their questions to be answered. I believe that meeting with the family along this journey has already gone some way in achieving this goal. Although not explicitly intended, it may also diminish the "bad feelings" as enunciated by Gutheil.
From the ashes of April's suicide, an unexpected phoenix was born with her family electing to donate her life insurance payout to a mental health charity. For a family to be so magnanimous in their grief is truly humbling.

These personal accounts of suicides are not exhaustive but provide a framework for understanding. Themes repeat including sadness, shame,

subsequent hypervigilance around risk, and a deep but fortunately temporary sense or erosion around one's professional competence.

> I have wrestled with death. It is the most unexciting contest you can imagine. It takes place in an impalpable greyness, with nothing underfoot, with nothing around, without spectators, without clamour, without glory, without the great desire of victory, without the great fear of defeat, in a sickly atmosphere of tepid scepticism, without much belief in your own right, and still less in that of your adversary.
>
> **Heart of Darkness (page 87)**

This extract speaks of the despairing, hopeless loneliness in death and loss. The abject undiluted misery for me is quite palpable.

My work with patients has on innumerable occasions brought me to another facet of suicide: that of the surviving family and loved ones. The pain leading to suicide does not end or die with the individual's suicide, but persists and remains alive within a broader family system, sometimes following an intergenerational trajectory (Pitman et al. 2014). The developmental trauma of maternal or paternal suicide can leave an indelible wound that can be associated with guilt, shame, depression and rage. It is well documented in most formulaic, so-called "suicide risk assessment tools" that a family history of suicide can predict an elevated risk of suicide in the individual (Hawton 1987).

Supporting the therapist

What might help the therapist in such situations? Supervision with a sensitive, non-judgemental colleague enables working through questions of why, guilt, shame and stigma. For the writer, group supervision felt too exposing in the initial stages of a patient's suicide. After time, however, group supervision did bring benefits. Where a colleague shares their own experience of suicide with empathic validation, there is the opportunity for mutual growth and understanding.

Personal psychotherapy is also helpful in managing the intense emotions arising after a patient's suicide. This relationship is containing, confidential and ideally non-judgemental.

Group meetings after the event, particularly if the patient was managed in a team setting, can be of great support. It is preferable that a facilitator is found who is external to the group. The meeting should ideally be in the immediate days after the suicide, and then repeated serially thereafter. The needs in the initial aftermath of a tragic event will be different from those in the weeks and months that follow.

The seven days following a patient's discharge from hospital represent a time of heightened risk of suicide (Appleby 2020). In an ideal world, discharge planning will be well thought out: encompassing a multidisciplinary appraisal of the patients' current clinical state and clearly identified avenues of follow up and community support. This will typically involve dialogue with carers and family members with a considered joint consensus around a plan of care. This utopia of "best practice" can easily derail when presented with the complexity of imperfect systems and the unpredictability of real life. However, when done well, there is some sense that the burden of concern and risk is a shared endeavour. Solo practitioners are not always privy to this luxury.

For a clinician, the importance of accurate note-keeping is never more evident than after a patient's suicide or looming medicolegal challenge. To be presented with one's own notes sometimes years after they were written and in an adversarial setting is sobering, to say the least. To be exposed as having unintelligible handwriting that neither the reader nor the original writer can decipher is confronting. Notes may be subpoenaed, and usually we are forced to oblige or risk being accused of obfuscating the legal process and being held in contempt. Medically trained practitioners are often as equally adept at keeping records from a position of defensiveness as they are from a position of good care. Defensiveness and good care are by no means mutually exclusive, but neither are they synonymous. I believe many health practitioners would like to deny this unfortunate truth. Non-medical therapists may have other more meaningful means of record-keeping, and some psychoanalysts may keep little or no written notes.

The decision to attend a patient's funeral is a personal one. Evidence suggests that the involvement of a clinician can have a positive effect for both the clinician and the family, if done sensitively and in respectful collaboration, with consent sought. It is the writer's experience that families are usually welcoming of clinicians' attendance. Grieving with the patient's family and friends provides a broader perspective on the patient and their life. It can also partially mitigate a sense of loneliness and isolation

in the surviving clinician. The presence of clinicians at a patient's funeral can potentially have a de-adversarial effect on the tension dynamic that may exist across family and clinicians.

Another important factor is the assumption that we 'cure' patients, whether as psychiatrists or psychotherapists, that psychotherapy leads to them getting better: therefore suicide is a penetrating challenge to the fundamental principle of our work that therapy will lead them to be able to 'work and love' in Freud's sense … the goals of therapy are to have a healthy functioning sense of self and self-worth.

Conclusions

Marie-Louis Von Franz said that the wounded healer is the archetype of the self (our wholeness, the god within) and is at the bottom of all genuine healing procedures. "Through the spontaneous compassion of a loving heart both the wound and the land can be restored and healed" (Jung, Von Franz 1960). Thus, the therapist who is wounded by a patient's suicide needs another to bear witness and ask the simple question: "What ails thee?" There is, I hypothesise, a complex co-mingling of wounded parts where both therapists are changed. Ultimately it is my hope that this often neglected subject is afforded greater salience in training programs, where the tenets of therapist welfare can be effectively inculcated in a way that encourages healthy dialogue rather than shame, blame and isolation.

References

Archinard, P. (2000) Doctors and patients' facial expression and suicide reattempt risk assessment. Journal of Psychiatric Research 34: 261-2

Appleby, L. (2016) National Confidential Enquiry into suicide and homicide by people with mental illness. The University of Manchester.

Bartles, S.J. (1987) The aftermath of suicide on the psychiatric inpatient unit. In General Hospital Psychiatry. Elsevier. 9(3): 189-97.

Bonanno, G. (2004) Loss, trauma and human resilience. In American Psychologist. 59 (1) 20-8.

Bowlby, J. (1969) Attachment. London: Hogarth.

Brown, H. (1987) The impact of suicide on the therapist in training. In Comprehensive Psychiatry. Vol.28, No.2 (March/April).

Chemtob et al. (1988) Patient's suicide, frequency and impact on psychiatrists. In American Journal of Psychiatry. February 145:2.

Cieslak, R et al. (2014) A meta-analysis of the relationship between job burnout and secondary traumatic stress among workers with indirect exposure to trauma. Psychological Services. Volume 11(1): 75-86

Conrad, J. (2007) Heart of Darkness. Penguin Books.

Coppola, F.F. (1979) Apocalypse Now. Omni Zoetrope.

Davies, R. (2020) Suicide, loss and the heart of Darkness. British Journal of Psychotherapy, 1-23.

Dupont, J. (1988) The clinical diary of Sandor Ferenczi. Harvard University Press

Ekman, P. (1978) Facial action coding system: A technique for the measurement of facial movement. Palo Alto. Psychologists Press

Fawcett, J. (2001) Treating impulsivity and anxiety in the suicidal patient. Annals of the New York Academy of Science. 932:94-105

Gabbard, G. (2003) Miscarriages of psychoanalytic treatment with suicidal patients. The International Journal of Psychoanalysis. 84 (part2):249-261

Gitlin, M. (1999) A psychiatrist's reaction to a patient's suicide. In American Journal of Psychiatry. October 156:10.

Goldney, R. (2009) The benefit of forgetting suicidal ideation. Suicide and Life-Threatening Behaviour. 39:33-37

Gutheil, T, G. (1992) Suicide and suit: Liability after self-destruction.
Suicide and clinical practice. Chapter 9. 147-167. American Psychiatric Press.

Hawton, K. (1987) Assessment of suicide risk. In The British Journal of
Psychiatry. Vol.150, Issue 2, pp. 145-53.

Hendin et al. (2000) Therapists' reaction to a patient's suicide. In American
Journal of Psychiatry. 157: 2022-7.

Hendin et al. (2004) Factors contributing to therapists' distress after the suicide
of a patient. American Journal of Psychiatry. 161: 1442-1446

Hillman, J. (1998) Suicide and the Soul (Second edition). Spring Publications.

Hobson, R. (1985) Forms of Feeling: The Heart of Psychotherapy. Routledge, pp. 26-7.

James, W. (1892) Psychology: Briefer
Course. Macmillan. pp. 151-175

Jacobs, D. (1992) Suicide and Clinical Practice. American Psychiatric Press.
Chapter 10. The implications of patient suicide for the surviving psychotherapist. pp. 169-182

Jung, E, Von Franz, M-L. (1960) The Grail Legend. Princeton University Press.

Kübler-Ross, E. (1997) On Death and Dying. Simon and Schuster.

Maltsberger, J. (2010) Suicide fantasy as a life-sustaining recourse. The
Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry.
38(4): 611-623

Maltsberger, J. (2004) The descent into suicide. The International Journal of
Psychoanalysis. 85(3):653-667

Meares, R. (2004) The conversational model: an outline. In American Journal of
Psychotherapy. Vol.58, No.1, pp. 51-66.

Meares, R. (2005) The Metaphor of Play (Third edition). Routledge, pp. 176-7,
pp. 114-5.

Meares, R. (2002) Intimacy and Alienation. Routledge.

Meares, R. (2012) Borderline Personality Disorder and the Conversational
Model: a Clinician's Manual. New York: WW Norton.

Meares, R. (2012) A Dissociation Model of Borderline Personality Disorder. New York: WW Norton, pp. 9-11.

Meares, R. & Hobson, R. (1977) The persecutory therapist. In The British
Medical Journal. 50(4), pp. 349-59.

Money-Kyrle, R.E. (1956) Normal countertransference and some of its
deviations. International Journal of Psychoanalysis. 37: 360-366

Parkes, C.M. (1989) Coping with loss. In British Medical Journal Books.

Pitman, A. et al. (2014) Effects of suicide bereavement on mental health and
suicide risk. In Lancet Psychiatry. 1:86-94.

Rotov, M. (1970) Death by suicide in hospital. American Journal of Psychotherapy. 24: 216-227

Sander, L. (1962) Issues in early mother child interaction. In Journal of the
American Academy of Child Psychiatry. January 1(1): 141-66.
Stephens, A. (2018) Anthony Bourdain a biography. Combray Media

Sung, J. (2016) Suicide and the psychiatrist.
In Agency Practices for Responding
to Client Suicide.

Tillman, J. (2006). When a patient commits suicide: An empirical study of psychoanalytic clinicians. International Journal of Psychoanalysis. 87: 159-177

Winnicott, D. (1971) Moments of Meeting.

The Privacy of the mind: a limit of mental violability

Anthony Korner

Abstract

Privacy is a concept that is defining of what we mean by personal experience and mental life. Psychotherapy can be understood as a relationship that creates conditions whereby this personal experience can be safely shared. In the current era there are many threats to personal privacy, with much being written about the impacts of social media and measures that have the purpose of tracking individual behaviour. The very concept of mind and mental life is challenged by prominent views in the sphere of neuroscience. In this paper, the significance of privacy for psychotherapeutic work and the need to respect the privacy of the individual is considered, together with implications for the communities in which we live. The principle of equal grievability (Butler) may be key to creating a world in which there is genuine recognition of human beings as persons.

Introduction

This paper has been inspired by several matters that have been subjects of my reflection in recent times. One is the issue of privacy, specifically privacy within the psychotherapeutic relationship. Elsewhere our group has discussed ways in which this may be under threat in relation to whether recordings of sessions, used for teaching and supervision, should be treated medicolegally as part of the medical record (Korner et al, 2018). In a broad sense, one of the primary reasons why patients voluntarily seek help for mental distress, is that they trust that mental health professionals will respect their privacy. Confidentiality is one of the ethical pillars of psychotherapeutic practice. Psychotherapy, nevertheless, is a practice that has to be learnt, preferably with access in supervision to the actual exchanges that are occurring between therapist and patient.

The Conversational Model (CM) refers to an understanding of self as the stream of consciousness (James, 1890). Within that flow of experience, "a certain portion of the stream abstracted from the rest is so identified in an altogether peculiar degree, and is felt by all mean as a sort of innermost centre within the circle, of sanctuary within the citadel, constituted by the subjective life as a whole" (ibid, p. 297: italics = James' emphasis; bold = my emphasis). This forms part of a discussion of what James refers to as the spiritual self. He asks, "Now, what is this self of all other selves?" (ibid). An attempt will be made to engage with this question.

A second concern behind this paper relates to the modern tendency, evident now for some decades to equate mind and body (e.g. Detre, 1987). This amounts, in my view, to a negation of the mental life that is uniquely experienced by each individual. In reality "there is no such thing as an isolated brain" (Korner et al, 2008). In fact, the brain is an organ within a body. It does not constitute, by itself, a mind. A view of the mind-body relationship will be put forward that doesn't rely upon Cartesian dualism or a denial of the importance of the brain to mental function. It will highlight the importance of other minds, in relational engagement, involving exchanges that foster growth of self and the development of individual minds. This includes consideration of the significance of the privacy of the mind.

A third prompt for this paper was a recent invitation to give a talk on the theme of dealing with humanitarian crises. This forms the last section of the paper, entitled, In Times of Crisis, Choose Humanity. This addresses the need to understand the notion of "mental violation" if we are to better equip ourselves to form more civil societies and address the needs of people in times of crisis.

The development of self and a sense of interiority: the mind as sanctuary

We aren't born with a sense of self. Self develops in relationship with others. The reality of engagement with other people (other minds) is necessary to its development. A critical point in the development of self occurs around the age of 4 when the

child makes the momentous realization that secrets can be kept internally, separate from the awareness of others (Meares & Orlay, 1988). This marks the birth of a sense of interiority and the capacity for reflection.

The achievement of this sense of mental separateness is an outcome of good enough circumstances in relational experience, including at least a measure of security in attachment and the stimulation of interaction within an attuned interplay with carers, the protoconversation (Trevarthen, 1975; Bateson, 1975). In the protoconversation, the infant feels recognized and that his or her communications matter. Qualities of care and tenderness within a field of play are important to such interactions. It engenders a sense of value that will enable the child to form a bounded mind, capable of thinking and reflecting on personal experience. These interactions can be seen to have evolutionary value in a social species that learns in interaction with others and maintains a sense of emotional stability through social engagement. Species that require social interaction for survival and learning engage in allostasis (Atzil et al, 2018), which not only serves homeostatic functions but additionally a spiral of growth and maturation. In humans this form of spiralling growth of self occurs at both the level of physical contingencies and at a symbolic level (Korner, 2021).

The attainment of an area of privacy of thought, free from external impingement, allows children's development to proceed in the situation of being alone as well as in interaction with others. While on their own, there is often greater opportunity for reflection and the play of imagination. An internal conversation is set up with potential for reasoning and independent realization. While with others, continuing interactions provide opportunities for new experience, also crucial to the growth of the mind. Opportunities begin to emerge for the sharing of experience and for mutuality, reciprocity and intimacy. For the CM, we speak of the state of alone-togetherness which implies some degree of security in both of these mental spaces (Hobson, 1985). Being able to have periods of solace and solitude, free from the impingement of relational interaction, is probably critical to the maintenance of mental equilibrium. Equally, being able to be oneself when with others is critical to the maintenance of a sense of personal integrity.

Brain and Mind are not one

In saying brain and mind are not one, I do not mean to imply that they are unrelated. Indeed, it would be impossible to imagine a human mind without a brain. Specifically, a human brain. However, it would also be impossible to speak of a mind which had no content. The contents of the mind arise in relation to interaction with the environment. This includes relational and emotional experience. It is also impossible to imagine anything resembling a mature human mind that doesn't involve language, the vehicle for what most people mean by thought. So, mind is mutually interdependent on the brain-body and on language. The "space" for mental experience is dynamic, which is to say it is not a physical space but rather occurs in the dimension of time.

Higher forms of consciousness, reflecting the realization of mental capacity, are not the property of a single brain but rather brains in communication: "we emphatically do not identify consciousness in its full range as arising solely in the brain, since we believe that higher brain functions require interactions both with the world and with other persons" (Edelman & Tononi, 2000, p. xii).

From a logical perspective it makes sense to say, of relationships between mind, brain and environment that:

Mind and brain cannot be separated.

Mind cannot be separated from the objects of perception.

The embodied human brain is a necessary but not sufficient condition for human minds.

The (peopled) environment is a necessary but not sufficient condition for human minds.

(Korner, 2008)

Logic is not an aspect of mind clearly present in early development. Nor should it be considered the only measure of the validity of concepts. One needs to consider their social and personal value. Some systems of belief may not be logical but may be socially cohesive, for instance. Individual minds which become more distinct and differentiated over time have great potential for contributing creatively not only in the sense of communal knowledge but also in terms of relationships and participation in life. A central value for the individual mind is that of privacy, which allows people to use judgment in personal relations and to explore new areas of understanding in their own time.

In the next section I consider how the principle of

privacy might contribute to the conditions for a more civil and less traumatized society.

In Times of Crisis, Choose Humanity

When originally asked to speak on this subject, the pressing crisis was the 2019-20 bushfires, Australia's worst fire season ever. In 2020 the focus had shifted, and remains, linked to the Global Pandemic. In the last month or two, we have seen the fall of Kabul in the context of American withdrawal, roughly coinciding with the 20th Anniversary of 9/11. Perhaps one could be forgiven for saying that the state of crisis seems never-ending with, in the digital era, the sense of proximity to crisis being accentuated by the 24-hour news cycle and communication technologies that bring catastrophe into every living room.

We navigate a path of relatedness against this disturbing background. With the relational turn in psychoanalysis, the orientation to social connection is now seen as primary to the development of mental life from the beginning. We have evolved towards social engagement, needing relationships to help regulate our emotional lives throughout life (Porges, 2011). Yet each mind develops as a singularity. Self has a dual aspect reflecting the privacy of the individual flow of experience ("the privacy of the mind") and the public manifestation of identity (Meares, 2005). As therapists we need to try and see the private dimension of experience for each patient.

This sense of privacy and of being possessed of a bounded mind is an outcome of the interplay between child and carer(s) in development. An achievement that reflects a measure of security and the sense of personal value. Its maintenance requires continuing exchanges with others and the environment and is often disrupted by exposure to trauma.

How can this be reconciled with crises that push people into survival mode, often shutting down the sense of self and destroying relationships and lives? While we may often witness heroism and teamwork in these circumstances, we also see barbarity, displacement and relational disruption leaving individuals feeling alone and exposed. The cumulative trauma of the world is overwhelming. Most of the time we numb ourselves from it, at least to an extent.

In the face of trauma and stress we automatically and understandably shift into defensive modes of functioning. People will vary considerably in the capacity to remain present to the environment. As we move beyond the immediate stress, we realize the extent of losses, injuries, dislocation and isolation. We find ways of dealing with situations we could never have prepared for.

One kind of response may be to toughen up, distance oneself from feeling and prepare to meet for future aggression or disaster. Some cultures and regimes will facilitate this kind of militant preparation, although it involves some degree of dehumanization, both of self and other, particularly when applied to the interpersonal sphere.

The situations of grief confronted as the consequences of trauma unfold are associated with a sense of personal vulnerability. Grief and personal vulnerability, experienced at a private level, are, paradoxically, what is most universal within our emotional lives, reflecting the tender heart of humanity from cradle to grave. The risk of turning to others for help and sharing the sense of vulnerability may seem considerable to some. Yet, this is the path forward in social terms, the path of humanity which offers opportunities for recovery and sometimes the possibility of growth.

The risk of sharing personal vulnerability may feel greater to many in the 21st Century as we experience the power of social media and satellite tracking technology, manifest as intrusions into our associations and movement. Many may feel there is no safe relational space and that any expression of convictions or emotional response may be dangerous. In some cases, technologies may be brought to bear on the individual by regimes bent on control rather than human rights.

Some now even claim that technology can be brought to bear that allows us to 'see' what is occurring in the privacy of the individual mind, on the basis of fMRI recordings, even to the extent of specific moving dream images (Solms, 2020, p. 278, citing Nishimoto et al, 2011). This doesn't, in my view, fit with the clinical reality in which we aren't able to read minds nor predict the future for individuals. It is a disturbing claim, however, one which has led Solms to embark on a program of developing an "artificial consciousness", based upon feeling rather than cognition (artificial sentience rather than artificial intelligence). Some-

times it seems that science may still take us down dehumanizing paths.

Minds actually develop in communication with the environment and particularly the interpersonal environment. We come to know ourselves through knowing others. We come to have "minds of our own" through exchange with others. This framework of mutual interdependence and reciprocity is the basis of Judith Butler's radical critique of political and interpersonal violence. The argument is made that if we truly understand the nature of the social bond, we would understand our dependence on social life and the institutional structures that support it. We also are challenged to see all people as being "equally grievable", a condition which doesn't seem to be achieved in a world full of inequality and strife. The argument, perhaps a 'utopian' one, is that the sense of equal grievability leads to an understanding of what is described paradoxically as "the force of non-violence" (Butler, 2020). In grief we may find a principle that helps us find the path "beyond doer and done to" (Benjamin, 2004).

For psychotherapy, much of the process of working through is to be understood in terms of loss and trauma (i.e. grief). Each life is the product of a long conversation each person has with their significant others and with the larger culture and community (Korner, 2021). The exchanges of this lifelong conversation are the vehicles for individual growth and the sense of belonging. Growth occurs when the privacy of the individual mind is respected. Trauma occurs when the individual mind is violated. The privacy of the mind isn't absolute – each person can decide whether to share his or her experience. For a civil world, the right of each person to make that decision would need to be considered inviolate. When people experience a sense of personal safety in therapy, the opportunity for growth is achieved.

Butler's critique of violence, with its notion of equal grievability, might be considered part of a long conversation at the level of the larger (world) community. To me, it seems to bridge the levels of the personal and the political. In Western culture, the writing of St Augustine, specifically his Confessions, is considered one of the earliest examples of a writer sharing the interiority of his mind. As such it is a forerunner of modern literature, including works of non-fiction (e.g. psychodynamic literature) and fiction (e.g. novels). This kind of sharing of what is felt in the heart has, I believe, a humanizing effect at a cultural level. These communicative exchanges contribute to interpersonal and intercultural understanding and reductions in violence. Despite everyday evidence to the contrary, those who look at "big data" tell us that the world is actually a less violent place than it once was (Fernando-Armesto, 2019).
When St Augustine says, "we learn kindness from our very weakness", he refers to a universal truth emphasizing the vulnerable state in which all human life starts and to which we always remain subject. He is not, as many do, using weakness in a pejorative sense. Rather he sees it as having a central value, fostering kindness and care in human societies. (St Augustine, 2006).

References

Atzil, S., Gao, W., Fradkin, I. & Barrett, L.F., Growing a Social Brain. Nature Human Behaviour, 2018. https://doi.org/10.1038/s41562-018-0384-6

Bateson, Mary Catherine (1975) 'Mother-Infant Exchanges: The Epigenesis of Conversational Interaction' In D. Aaronson and R. Rieber (eds.) Developmental Psvcholinguistics and Communication Disorders. Annals of the New York Academy of Sciences 263: 101–113.

Benjamin, J., Beyond Doer and Done to: An Intersubjective View of Thirdness. The Psychoanalytic Quarterly, 2004; 78:5–46.

Butler, J., The Force of Non-Violence. London & New York, Verso, 2020.

Detre, T., The Future of Psychiatry. American Journal of Psychiatry, 1987; 144:621–625.

Edelman, G.M. & Tononi, G., Consciousness: How Matter Becomes Imagination. London, Penguin, 2000.

Fernando-Armesto, F., Out of Our Minds. London, Oneworld, 2019.

Hobson, R., Forms of Feeling. London, Tavistock, 1985.

Korner, A., Living the World Knot: Towards a

Reconciliation of the Brain, Mind and the Living Environment. International Journal of Psychotherapy, 2008; 12:26–38.

Korner, A.J., Gerull, F., Meares, R. & Stevenson, J., The Nothing That Is Something: Core Dysphoria as the Central Feature of Borderline Personality Disorder: Implications for Treatment. American Journal of Psychotherapy, 2008; 62:377–394.

Korner, A., McLean, L.,Bains, J., Crisante, L., Graham, P., Haliburn, J., Halovic, S., Lianos, G., L., Philips, T., Stevenson, J., Touma, K. & Williamson, M., (2018) Holding the Space, Protecting the Personal. Australasian Journal of Psychotherapy. 2018, 36(1):8-21.

Korner, A., Communicative Exchange, Psychotherapy and the Resonant Self. London, Routledge, 2021.

Meares R. & Orlay, W., On self boundary: a study of the development of the concept of secrecy, British Journal of Medical Psychology, 1988, 1: 305-16.

Meares, R. The Metaphor of Play, 3rd Edition. Hove, Routledge, 2005.

Nishimoto, S., Vu, A., Naselaris, T. et al, Reconstructing visual experiences from brain activity evoked by natural movies. Current Biology, 2011; 21: 1641-6.

Porges, S.W., The Polyvagal Theory. New York, W.W. Norton, 2011.

Solms, M., The Hidden Spring. London, Profile Books, 2021.

St Augustine, Confessions, trans. Wills, G. London, Penguin, 2006.

Trevarthen, C., Early Attempts at Speech. In, Child Alive: New Insights into the Development of Young Children. London, Temple Smith, 1975.

Implementing a Trauma-Informed Model of Care in an Acute Mental Health Team

Setting: A Conversational Model Teaching and Supervisory Approach

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Abstract

This paper will describe and discuss the teaching and supervisory approach with an adult acute mental health team (AAMHT) in a local project aimed at adopting the Conversational Model (CM) as the team's model for Trauma-Informed Care (TIC). The CM approach to contemporary psychodynamic

and trauma-informed psychotherapy (TIP) is to co-create collaborative conversations that foster the development of self and the integration of trauma. The approach aims to be modelled in individual and small group teaching and supervision and within the larger group process of normal training. Team implementation of the model needed to consider how to apply this approach to a particular acute team setting: how to "walk the talk". Coming from a background in Consultation-Liaison Psychiatry and Psychotherapy, the lead supervisor (LM) along with the psychologist project leader (IC) and psychiatrist psychotherapist Program Director (AK) considered ways to offer supervision to the team project that would allow the co-creation of a space fostering positive relationality and cohesion amidst an agenda of change. This occurred in the context of the ongoing challenges of the turbulent clinical environment of acute community psychiatric care. In this case this was realized as initial fortnightly conversations with the project leader, supporting team education, training and enculturation, that then segued into fortnightly video-conferenced supervisory sessions with the multidisciplinary team. This has been a deeply satisfying experience of an innovative model of TIC and psychodynamically-informed collaborative care that, as the CM suggests, aimed to "use what is given", "find and affirm that which is positive", and work with "what happens next" (Meares et al, 2012, pp. 162 -165). The importance of deep listening for the creation of a relational space for "a deliberate chat" and "yarning" is noted: layers of parallel process support TIC and reflective practice (Ungunmerr Baumann; Atkinson, 2012; McLean, 2015a).[1]

"Conversation, creativity and communal experience are central to human life and form a key part of the Conversational Model perspective" (McLean, 2015b).

The Conversational Model (CM)

The CM approach to contemporary psychodynamic and trauma-informed psychotherapy has grown from the foundational conversations between Robert Hobson and Russell Meares that synthesized knowledge across a number of domains: psychodynamic practice, neuroscience, developmental psychology, philosophy and linguistics (Meares et al, 2012). It has continued to be developed in both the UK and Australia and has generated research into the short and long-term treatments of mental health presentations and disorders and now offers manualized approaches (Stevenson & Meares, 1992; Barkham et al, 2017; Haliburn, 2017; Meares et al, 2012; Korner & McLean, 2017).

The individual and small group supervisory approach to teaching the CM has been from its inception to "model the model" and "walk the talk", both by collaboratively working with the supervisees to use the model and from a position that the supervisor aims to foster a collaborative and positive connection in the supervisory relationship, and between the parts of the group to promote the growth of relational and team cohesion. Although much individual and small group supervision has been done during the training of clinicians in on-the-job training or through short courses or longer certificate, diploma or Masters level courses, the demands of public mental health services has meant that the adoption of the CM as a "whole of team approach" has been less often formally attempted.

The other aims of supervision include the empowerment of clinicians to take up the enriched roles of the scientist-practitioner model including as peer educators, trainers, peer mentors, and as evaluators and researchers.

This paper will describe and discuss the process of approaching teaching and supervision to an acute mental health team where the aim was for the team to adopt the CM as its "whole of team" model for TIC. The clinical approach on the ground has been described elsewhere and comprises risk interventions, brief counselling, collaborative formulation and pharmacological treatment and on-referral as needed (Moloney et al, 2018).

We are growingly aware how many mental health presentations are triggered or underpinned by vulnerabilities secondary to relational trauma, often

1 Dr Miriam-Rose Ungunmerr Baumann was Senior Australian of the Year, 2021 and speaks to Dadirri, deep listening, a concept for which she is the local custodian in her people. A video can be viewed at https://www.youtube.com/watch?v=vtD_cvTZO3Y. Judy Atkinson writes about the importance of this in healing for ATSI people. We believe it is an essential approach in CM psychotherapy for all.

early childhood attachment disturbances and the sequelae of unresolved loss and trauma (Carr et al, 2013). While more straight forward education can teach clinicians "about" traumatic experiences, and their theoretical importance, a procedural approach that addresses aspects of how to be with a patient and create a therapeutic conversation has been harder to embed across mental health settings (Kezelman & Stavropoulos, 2012; Balu & McLean, 2019).

While the importance of empathy has been known as a key factor for some time and the importance to all therapeutic encounters of the therapeutic relationship, it has taken deeper integrative thinking to arrive at ways of connecting that to harness what we know of states of mind and how to shift them (Elliott et al, 2018a). We now know that people simply can't "think" in the same way when they are in states of traumatic disruption (Hesse, 2008; Meares et al, 2012, pp. 36-39). This is where the Conversational Model enters the stage usefully, as an approach that suggests we aim to match the language in the moment of the therapeutic encounter to the state of consciousness of the patient. It suggests that therapeutic language prioritise affect and then, in traumatic states of mind, simple speech (Meares et al, 2012, pp. 36-44). The clinicians attune to the patient's state and are ready to respond sensitively to connect positively to foster association amidst dissociation.

For many practitioners in Mental Health a "questioning" approach to eliciting a history has been learned in normal training. The Conversational Model suggests there may be a better way to gather information in the context of creating a therapeutic alliance, serving several aims in the context of what is now termed trauma-informed care (Kezelman & Stavropoulos, 2012). In research that has applied the approach through very short-term psychotherapy including crisis presentations, through to medium term and longer-term approaches, the model has been shown to offer effective treatments across a number of disorders, levels of severity and treatment settings (Korner & McLean, 2017).

The Feeling Safer Project

When one of the centres teaching the CM in Australia via a University program opened its doors again to local clinicians in a non-degree program, the opportunity for up-skilling of coalface staff and a shift in local knowledge and culture became possible. After the first year of the new program's approach a local psychologist (IC), training with the program, approached the program staff and his management with the idea that the CM might provide a "whole of team" approach for the busy acute team in which he was working, alongside another couple of clinicians training in the program. The context of this opportunity was created by the area health service which was conducting an area wide clinical improvement process. The area had engaged an external consultant and one of his recommendations had been to provide training in counselling and the opportunity for counselling supervision to the community acute teams. IC had previously worked in a local psychotherapy team within community mental health for 17 years and had felt the need for a change within the team and within his work. As with the other teams within the area the psychotherapy team had been anxious about impending change and had struggled to evolve and engage with the opportunity. IC was aware that being part of the psychotherapy team and the team's dynamics was preventing change. After discussing different opportunities within the area with the Service's clinical director an offer was made for IC to move from the psychotherapy team which provided longer term psychotherapy to severely traumatised individuals, to the acute care team with the broad aim of providing training and supervision.

With a collaboration argued for and agreed to, IC obtained a half-time release and the Feeling Safer Project was born. For much of the first year he and the lead supervisor for the project (LM) met fortnightly, developing local teaching and relational and systemic approaches, that aimed to "hold the team in mind" and nurture the process of culture change. We were not sure it could be managed but we wanted that, a little like the caravanserai, no one to be left behind. This was actively aided by the other clinicians familiar with the model who served as "Change Champions" for the approach (BM, AB). The team was closely thought about and ideas considered about professional support and teaching as well as personal conversations and a cultural tone of sharing, camaraderie, (termed "fellowship" in CM language). We were only too aware of the vicissitudes of close daily contact with trauma and the pressures of a public mental health service. Mental health is a difficult place to work and those of us who

deal with patients and mental health services are ourselves prone to vicarious trauma and burnout. Furthermore, change itself is simply hard, including learning new ways and new knowledge.

The Context of the Project

As with many of the stores we hear in therapy, change, opportunity and development are frequently happened upon and so often don't have a road map. To add context to the development of the program, as IC initiated the Feeling Safer Project he was just moving into his second year of the three-year training in the CM and, in the context of feeling stuck and frustrated in his clinical work with his former team, he had also considered leaving the CM training. In first year he had argued with his seminar leader at times, perceiving that the CM was being presented in idealistic terms and that any criticisms of the model and the metaphors used, were met with what seemed like defensiveness. Additionally, his therapy was not progressing with his training client. He was struggling to engage with the client he had been allocated, an angry isolated man, who alternated between chronicling about his life or bellowing so loudly that IC would be unable to think, becoming mindless. In supervision he perceived the feedback to be that he was too distant and sloppy in applying the CM processes, or that the client was unsuitable and should not have been included in the program. It became apparent that just as the client acted out with IC and only saw fault in him, so too IC, in turn, mirrored this with the program, and the supervision was also at times rendered mindless.

Needless to say, when IC started the project with the acute team, he could not initially reflect that his ambivalence about his skills, and his doubts about the effectiveness of the CM were actually necessary experiences of growth and change. On being seconded to the team he had an open agenda and was welcomed by the team manager. She was keen to have a more uniform counselling skill level within the team and was active in planning processes and content. However, within a month of the start of this manager left the team and the project entered a phase of acting managers from within the team who were viewed by the team as only having a caretaker mode and not having a legitimate authority to drive change.

At this point IC sought the support of AK and LM. LM agreed to provide regular supervision to develop the model within the team. The team began to express their tensions and difficulties. There were private frustrations with the functioning of the team and a concurrent defensiveness to change when the team met as a whole. Within the team there were different skill sets and opinions as to the team's role. While there were team members who were agreed that the acute team was a skilled team, already using psychotherapy skills and processes, no members saw that the team's therapeutic success was attributable to their own individual counselling or psychotherapy skills. Furthermore, there were other team members, who quite bluntly stated that it was a nursing team that provided care and containment predominantly by ensuring that clients took their medications.

How change began to happen: "Same Same", using seminars, individual cases, individual supervision

In introducing the model to the team IC and LM chose the conventional change process of recruiting people who were either trained, skilled or curious about psychotherapy. As with the CM training process IC conducted seminars for those who had volunteered. He gave an overview of the methods of the CM, and in particular focussed on the elements of the proto-conversation, attunement, amplification and representation (Meares, 2005, pp. 171-179). In addition, we discussed Meares' concepts of trauma and dissociation and looked for examples of the phenomena in the teams' clinical work. In terms of skills training, we started by reading and critiquing transcripts. Rather than starting with the ideal, IC experimented with the idea of utilizing transcripts from moments in therapy when an intervention had not gone well. He presented transcripts from his own Phd research of times when themes had been missed or attainment had not been optimal (Cameron, 2008) The hope was to engage with the innate empathy of the clinicians. Through their rather gentle play of criticising, suggesting and 'doing better' they inadvertently had to acknowledge their own skills. These participants were then encouraged to select one of the acute current clients and practice their skills.

We initially utilised as a process base the model originally developed by Else Guthrie and others from the CM, termed Psychodynamic Interpersonal Therapy (PIT), and applied to many disorders and settings, including in acute presentations of

deliberate self-harm (Guthrie, et al, 1991; Guthrie et al, 2001). Clinicians offered clients a four-session counselling intervention. These sessions were taped for individual supervision with IC. IC received individual supervision from LM with a focus on IC reflecting on process and the moments of emergence of the trainees' sense of a therapist self. At the end of the selected clients' third session, a farewell formulation letter was written and read to the client in the last session. The feedback was positive and the clinicians reported enjoying the opportunity. The project leader (IC) was supported by the lead supervisor (LM), who was supported by the Program director (AK). Encircled in these layers of support and holding, ideas and process slowly shifted. While ideas were coalescing, so too was the group process developing. However, as with the project leader's training experiences, new ideas need to be played with, and ideally when we are playing a game, everybody is learning through the play.

Which game are we playing?

As the seminar series and counselling practice was completed, IC then held discussions with the acting team leader and the team's consultant psychiatrist as to roll out the model to more team members and to bring some of the processes into general team practices. These discussions were the moment of reckoning for the project and more so for the project lead. IC had come from a quiet psychotherapy team where conflict was rarely expressed, and by tradition, rarely resolved. In this psychotherapy team, play was thought of in hallowed terms of Winnicott's squiggle game with children, a nuanced and curious endeavour (Winnicott, 1989). In the CM as a whole it was often thought about in terms of the protoconversation (Meares, 2005, pp 171-179). The acute team played rather, by analogy, on the footy field. The initial response to the idea that the team as a whole would join the project, and furthermore, would then take extra time to write a 'farewell letter' was not well received. There were quite strong objections from the teams' consultant psychiatrist to the use of farewell letters. While the consultant could not see the value in spending precious clinical time in writing a therapy formulation for the clients, his strongest objection was his perception that a farewell letter would create a medico-legal vulnerability should there be an adverse outcome down the track. While we may disagree with this particular idea, this discussion gave rise to an important and pivotal observation from the then acting Team Manager (and CM trainee), Michael Gillen. Following the meeting he observed that using the Guthrie model for selected clients had created the perception within the team that the project was "cherry picking easy clients". He argued that the CM approach would not have any relevance unless the project be turned on its head and be applied with the most clinically challenging and complex patients, with whom the Team struggled the most.

In retrospect, the blunt honesty of those who thought the project's processes were ill timed, ridiculous, or risky, was the moment that play had started. The project lead didn't hear the whistle and was not ready for such hard tackling. But play they did, and each objector to the project strongly argued their positions, ideas and fears. LM celebrated these developments and encouraged IC that the project was being taken seriously as the robust criticism demonstrated that they had been listening and had held the project in their mind. In supervision IC and LM came to realise that as the team began to argue from a client- centred approach they had come onto the field and were using relational language despite themselves. Without regular supervision these moments, developments and accomplishments would not have been recognized as the constructive emergence of the play.

LM encouraged IC to stay on the field and get into the game, to model the CM skills of listening intently and re-presenting the team's ideas, feelings and behaviours. It was recognized that footy is not just about defending. LM could also give a rousing coaches' talk about the importance of running with the ball, to express ideas and innovate in the moment. These ideas are central to the CM: it is only through engaging in the play that change will occur. These moments of hard play and of encouragement were opportunities of growth for IC which were invaluable in resolving his ambivalence towards his own training, as he came to value and assert what he knew, and to sharpen ideas. As the next process of the project emerged, IC joined the team as a clinician to bring the CM into the teams' game and LM would change from supervising IC to offering supervision to the team.

Playing together, demonstrating, learning, naming and valuing

IC began to work shifts with the team as a clinician to facilitate demonstrating skills with clinicians who were hesitant about the model. This was an important process. It was a method to demystify the process, and also engaged with the dominant nursing teaching model in which skills are practically demonstrated and discussed. It also facilitated IC developing his understanding of the team's skills, resources and processes from within. IC still struggled with the pace of the acute team's footy game. The acuity of the population meant the team "ran" for most of the game, whereas IC had a different match fitness and pace. He was an endurance specialist, where long term work had a very different sense of time, the opportunity for iterative processes, where ideas could be mutually discovered and developed over time. In the acute setting time is always limited: they would get the measure of the client on the run.

By working with the team IC was able to join the already established processes introduced by BM, AB and others who had joined the CM training. Clinical care at home was delivered by two clinicians which gave the opportunity for IC and BM to demonstrate CM processes and then use trauma-informed formulations and language during the twice daily handovers. IC also came to realise that almost universally the clinicians used rich metaphors in their work and were so much more relational and empathic than they would ever acknowledge. Unsurprisingly, when IC was being coach for some team members, as LM had been for him, amplifying the clinicians' warmth and empathy, he noticed there was a cultural negation of these skills and processes. These processes belonged to the trained teams who had time. The acute team delivered care and containment. Furthermore, when meeting as a group, initially there was a strong prohibition to the acknowledgement of these attributes.

However, these barriers began to dissolve as some of the team culture carriers expressed their anxiety about the CM. There were reflections that many of the team were schooled in the dominate narrative of the 'old school schedule 5 training', referring to the way older versions of mental health practice, before recovery models, had relied upon more restrictive care. The trainees had previously learned the maxim that there are "staff" and then there are "patients", as in "us and them". Throughout that older training, relational language was taboo as it was seen as an unsafe process. Relational language was, in that older thinking, a possible precursor to boundary violations. One clinician voiced that they had revisited this core belief and that s/he could also see that empathy and thoughtful use of self, were key therapeutic processes (Graham & van Biene, 2007) rather than shameful or illegitimate transgressions.

The time then came for the next stage of change and the lead supervisor offered a couple of "workshops" on attachment, trauma and the CM to the team, face to face at their worksite. At the second of these the moment of truth came when a team member, pre-electronic record days, appeared with the "10 phone book case" – i.e. was carrying the extensive medical records of a "difficult" patient, currently on the team's mind. We set to work thinking together about this person and the story of the unrelenting nature of their early and later trauma appeared. It seemed likely that the "bizarre" presentations that had troubled the service had the marks of a triggered traumatic memory system. The perspective shifted to consider that the patient was not "manipulative" but dissociative and disorganized in the face of that triggered trauma. Fostering "association" through relational connection in any therapeutic encounter with the acute team then became a doable treatment goal.

A similar process from the clinician and team's view has been described in the companion paper to this (Moloney et al, 2018). However, the process at the heart in each clinical scenario was offering connection and containment together to shift the team's understanding, our collective state of mind, termed bodymind, allowing the team to go back and reconnect and offer care in a way that applied that a fresh sense of the humanity and need for "association" in the patient.
Fortnightly supervision then became a feature of our work. Apart from the initial and occasional face-to-face on-site sessions these were video-conferenced. Initially some reflection and writing up and circulation of annotations happened. These initial "yarns" offered containment, small doses of didactic learning on the CM, amplification of the positive and much reflective space. This then consolidated fairly quickly into an ongoing supervisory and reflective practice process for the team and supervisor. This has been a deeply satisfying experience of an innovative model of collaborative

care that, as the CM suggests, aims to "use what is given", "find and affirm that which is positive", and work with "what happens next" (Meares et al, 2012, pp. 162 -165).

Time and time again the adage that trauma unravels consciousness and needs to be repaired in positively connected conversation is demonstrated. The team's consciousness rises and falls then rises again. The way that group dynamics allow some to "carry" the trauma and others to "carry" the hope are demonstrated repeatedly, as well as the way the group then meets to integrate the perspectives. We have noted that those members well-rested after days off or after holidays were the wellspring of freshness and more rounded perspectives. Trauma disorganizes and restricts, and so those more restored members offered more integrated or creative views of a patient's presentations, problems and predicaments and the team's challenges in the relationship. Within a supervision session we could see the repeated pattern of chaos, frustration or restriction moving to something possible – the remembering of a forgotten loss or trauma mentioned by the patient, remembering something positive and particular about them, like that they knitted baby clothes, the guitar in the corner of the room on a home visit, or the loving connection with dog or nieces and nephews, a photo, a painting, a turn of phrase...

We had some hopes of documenting the application more formally but found this hard in the context of the busy mental health team and the need to protect everyone's privacy. A compromise was managed in terms of supporting the group, with writing lead by the CNC, BM, to document the clinician's experience and publish (Moloney et al, 2018). Presentations at local and national conferences have helped us describe and speak to the process. We still hope to do some qualitative documenting of the process but wrestle with the approach and the time demanded.

In terms of further parallel process, the co-facilitating support in some of the supervisory sessions of a participant observer in the form of a then senior trainee in psychiatry and psychotherapy (CC) provided an initial invaluable second set of ears and eyes and documenting hands for some sessions. In later years senior psychiatry trainees have been able to participate in the supervisory session and so learn something of this approach.

The background support of the Program Director (AK) has been ongoingly essential so that the supervisor and process were supported and backed up when necessary. This was particularly important at times of more dramatic loss in the team. The team occasionally loses a patient to sudden death by suicide or ill health and needs to meet and grieve. Even more painfully the team has occasionally lost a member to death and so this process has needed a face-to-face meeting. At times when losses and trauma happen while the lead supervisor is away then there is back up by the Program Director, so that the team are supported, where possible, till regular supervision can resume.

The CM often speaks of holding in term of Winnicott and Bowlby (Winnicott, 1960 and 1971; Bowlby, 1971). Bowlby has powerfully described the role of "mutual delight" in the secure attachment relationship of care-giver to child and the mirrored capacity for the relationship to manage together sadness, loss, trauma and other difficult feelings (Bowlby, 1971, p201). However the holding of the acute team appears to have another layer, very different to the parent-infant relationship. In particular the holding was very focussed on sustaining and promoting a responsive consciousness in the face of high dynamic risks, where the implicit and explicit agreement was that the team all held the clinical and emotional risks. This mutual responsibility to each other also meant consideration of group behaviours: the team will at times be hard on the clinician thought to be "slacking", freezing or not responding intelligently to the risk. As humans we have survived and thrived in the face of risk when we have acted in groups and teams, not as individuals. As in football, skilled responding to risk requires the clinician to play hard with and for the team, which means thinking with the team and sticking to the rules and sometimes keeping going in the face of adversity.

In Consultation-Liaison psychiatry we term our longer relationships with a team to be "attachments" and here, with the AAMHT, the attachment has been characterized by a joy and, in general, a shared capacity to meet, name and respond to what is troubling. We have noted a high level of team cohesion and, although people do move on, it is more often in the direction of a career or life advancement rather than a "flight". Members are missed and new clinicians come to be mentored

into the team approach. The project leader himself has moved on to further the model's use in other ways, but enough holders of the cultural and skill capital have remained to keep the model in mind and at play. Team members are encouraged to come and do the one-year clinician's "scholarship" training with the program to learn about principles of the CM and its application in Short Term Dynamic Interpersonal Psychotherapy [STDIP] (Haliburn, 2017; Stevenson et al, 2019).

We are currently struggling somewhat with the COVID challenges of social distancing. Instead of gathering around one round table and a video screen, several computer screens serve as the portal for the supervision, but so far, we are proceeding.

This has been for the supervisory group a deeply joyful experience of an innovative model of collaborative care applying the CM as a team model for TIC. We can, we believe, only manage these traumatic spaces together. Hobson states: "I can only find myself in and between me and my fellows in a human conversation" (1985, p. 135). The layers of relationship and conversations that promote reflection and integration have been crucial in applying the CM to work with an acute team. We hope to research and apply the model in other settings and hope that others will speak and write about their similar paths.

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References

Atkinson, J. Trauma Trails, Recreating Song Lines. North Geelong, Victoria: Spinifex Press, Kindle Edition, 2002.

Balu, D., McLean, L. (2019) Conversations of Care: A Narrative Review of Collaborative Care Systems for Foster and Kinship Care Australian and New Zealand Journal of Family Therapy, 40(2), 228-241. https://doi.org/10.1002/anzf.1362

Barkham, M., Guthrie, E., Hardy, G.E., Margison, F., Psychodynamic Interpersonal Therapy: A Conversational Model. Sage, London, 2017.

Bowlby, J. Attachment and Loss. Vol 1: Attachment. Pelican Books, 1971.

Cameron, I. (2008) Surviving Severe Interpersonal Trauma: An Examination of Hope. Dissertation, University of Western Sydney.

Carr, C.P., Martins, C.M., Stingel, A.M., Lemgruber, V.B., Juruena, M.F. (2013) The role of early life stress in adult psychiatric disorders: a systematic review according to childhood trauma subtypes. Journal Nervous Mental Disorders, 201(12), 1007-1020. doi:10.1097/NMD.0000000000000049

Cleary, M., West, S., McLean, L., Kezelman, C., Karacsony, S. & Kornhaber, R. (2018) Connecting past and present: Nurses' role in identifying signs of child sexual abuse in adults and supporting survivors. International Journal of Mental Health Nursing, 27(6), 1587-1591.

Elliott, R., Bohart, A.C, Watson, J.C. & Murphy, D. (2018) Therapist empathy and client outcome: An updated meta-analysis. Psychotherapy (Chic), 55(4), 399-410.

Graham, P. & van Biene, L. Hierarchy of Engagement. Self in Conversation VI, (eds) Russell Meares & Pauline Nolan, 177-196. Sydney: ANZAP Books, 2007.

Guthrie Elspeth, Creed Francis, Dawson David,

Tomenson Barbara. (1991) A controlled trial of psychological treatment for the irritable bowel syndrome. Gastroenterology, 100(2), 450-457.

Guthrie, E., Kapur, N., Mackway-Jones, K., Chew-Graham, C., Moorey, J., Mendel, E., Marino-Francis, F., Sanderson, S., Turpin, C., Boddy, G. & Tomenson, B. (2001) Randomised Controlled Trial of Brief Psychological Intervention After Deliberate Self-Poisoning. British Medical Journal, 323, 135-138.

Hesse, E. (2008) The Adult Attachment Interview: Protocol, Method of Analysis and Empirical Studies'. Chapter 25, in Handbook of Attachment: Theory, Research and Clinical Applications, 2nd ed, (eds) Jude Cassidy & Phillip Shaver, 552-598. New York: The Guildford Press, 2008.

Hobson, R. Forms of Feeling. Routledge, London, 1985.

Kezelman, C., & Stavropoulos, P. (2012) Practice guidelines for treatment of complex trauma and trauma informed care and service delivery. Retrieved from https://m.recoveryonpurpose.com/upload/ASCA_ Practice%20Guidelines%20for%20the%20Treatment%20of%20Complex-%20Trauma.pdf

Korner, A. & McLean, L. (2017) Conversational model psychotherapy. Australasian Psychiatry 25(3): 219-221.

McLean, L. (2015a) Leaving the Old House in Story and Song: An Attachment and Relational Perspective on Personal and Communal Crises and Post-Traumatic Growth. In At the Crossroads of Crisis and Opportunity: Interdisciplinary Conversations (eds) Peter Bray & Loyola McLean. Oxford, UK: Inter-Disciplinary Press, 2015.

McLean, L. (2015b) The Conversational Model Theme Song: In Pursuit of Playful Reflexivity and Call and Response. Conference Abstract. Australian and New Zealand Journal of Psychiatry, 49(S1): 37.

Meares, R. The Metaphor of Play: Origin and Breakdown of Personal Being, 3rd Edition. New York: Routledge, 2005.

Meares, R., Bendit, N., Haliburn, J., Korner, A., Mears, D., & Butt, D. Borderline personality disorder and the Conversational Model: A Clinician's Manual. New York, Norton, 2012.

Moloney, B., Cameron, I., Baker, A., Feeney, J., Korner, A., Kornhaber R., Cleary., M. & McLean, L. (2018). Implementing a Trauma-Informed Model of Care in a Community Acute Mental Health Team. Issues in Mental Health Nursing, 39(7), 547-553.

Stevenson, J., Haliburn, J., Halovic, S., Korner, A. & McLean, L. (2019). Mobilizing self through short-term dynamic interpersonal psychotherapy: a preliminary report. Psychoanalytic Psychotherapy, 32(4), 351-367.

Ungunmerr Baumann, M-R. https://www.youtube.com/watch?v=vtD_cvTZO3Y.

Winnicott, D. Playing and Reality. London, Tavistock, 1971.

Winnicott, D.W. Psycho-Analytic Explorations, (eds)Clare Winnicott, Ray Shepherd and Madeleine Davis. Harvard University Press, 1989.

Winnicott, D.W. (1960) 'The Theory of the Parent-Infant Relationship', International Journal of Psycho-Analysis, 41, 585-595.

FILM REVIEW

The White Lotus

Brendan McPhillips

In the afternoon they came unto a land
In which it seemed always afternoon.
All round the coast the languid air did swoon,
Breathing like one that hath a weary dream.

Freud, aficionado of Austrian Spas, may well have been a fan of that literalized return to the uterus – or attempt thereof – the Resort, but a fatal stabbing, defecation in a guest's suitcase, multi-flavoured sex, and a cast of appalling human beings, some of whom may or may not find redemption, make this particular Resort more suited to a Kleinian sun-lounger with a long knife and a taste for revenge

.
Nice and tight, The White Lotus is a television series with only six episodes. Like Eliot, at the end of our exploring we do indeed arrive where we started, but unlike TS, the start and finish of this journey has a body bag, a seriously bewildered American, and a gaggle of characters who, in the main, probably wished they never got on the boat in the first place.
In both the first episode and the last, Shane (Jake Lacy) is sitting in an airport lounge. A middle-aged couple opposite him ask if he's been on holiday. He says he has. And where did he stay. At the White Lotus Resort. Oh, they say, wasn't someone killed there. With respect, he says, will you fucking leave me alone. They do, not particularly looking as if they feel respected. Shane gets up and moves to the window. He watches as a crate is wheeled to the cargo bay of a plane. It is labelled: Human Remains. It does not appear as if a week in Hawaii has been quite the holiday Shane envisaged.

In episode one, after meeting Shane, we are taken back seven days. A boat is speeding over the wine-dark sea towards an island. On board are our characters: a young couple, Shane and Rachel (Alexandra Daddario); Nicole (Connie Britton) and Mark (Steve Zahn), middle-aged parents to late teen Olivia (Sydney Sweeney) and her mid-teen brother Quinn (Fred Hechinger). Olivia is with a friend Paula (Brittany O'Grady). Sitting alone is Tanya (Jennifer Coolidge), a somewhat overflowing woman past her prime.

On the island – Maui – Armond (Murray Bartlett), the manager of the White Lotus resort, is instructing Lani (Jolene Purdy), a local woman on her first day, on how to deal with the guests. The bottom line is that they, the staff, should be faceless entities anticipating and fulfilling whatever need or want might arise. As Armond and Lani process the new arrivals we learn that Shane and Rachel are honeymooners, Nicole and Mark et al are here to relax from their busy American mainland life, and Tanya, her mother's ashes in her arms, is in urgent need of a massage. A problem: the appointment book is full, but, no want being too much, Belinda (Natasha Rothwell), the spa manager, also seemingly a local, gives Tanya a personal treatment ending with a ceremonial chant which brings a delighted Tanya back into an unfragmented state.

Another problem. About to consummate the marriage, Shane, on top of Rachel, suddenly realises that, far from being in the promised and supposedly booked Honeymoon Pineapple Suite with its own plunge pool, they have been given an inferior non-tropical-fruit room. As you can imagine, much to Rachel's chagrin, the moment of magic is no more.
But wait: it's only the first afternoon and it would seem that the patina of this island of endless pleasure has more cracks on offer. Mark has a presumptive diagnosis of cancer, and distressingly can't get through to his doctor, irritating Nicole who wants him to man-up. Rachel, thinking she will soothe her unconsummated state with a lounge by the pool, starts a conversation with fellow sunloungers, Olivia and Paula, who are reading Nietzsche and Freud respectively. Exuding a cool that would freeze out a polar bear, they parry Rachel's overtures with such devastating sang-froid that she, beautiful aspiring writer and wife of a rich man, is left with as much self-esteem as would fit on the head of a pin. And speaking of heads of pins, it should not go unnoticed that Olivia and Paula are directly channelling those dark angels, Anna and Dasha of the Red Scare Girls. Anna Khachiyan and Dasha Nekrasova, Russian-American women in their thirties, have, for the past three years, hosted a pod-cast, which, if it doesn't enrage you at some point, then you are no longer breathing. The essence of political incorrectness, they savage anything that comes within their purview. Very, very funny, unless of course you are the Rachel in their sights. Sydney Sweeney who plays Olivia, and newly come from being an executed adulterous wife on The Handmaid's Tale, said that she would listen to a Red Scare episode before every scene.

And yet this languid air carries more (literally) humid disruption for our unsuspecting friends innocently embarking on a week that will bring them all, to varying degrees, undone. Unbeknown to Armond, Lani is pregnant. Just how pregnant becomes clear when her waters break mid-foyer and labor ensues. Having to suddenly deal with dinner service, a seriously-angry, room-deprived Shane, and Lani's fully-dilated cervix, our manager (an Aussie, no less) is not managing.

Homer doesn't give much space to the Lotus Eaters. Odysseus' first port of call after sacking

Troy was the island of Ismarus. Perhaps unable to break bad habits:

There I sacked the city, killed the men, but as for the wives and plunder, that rich haul we dragged away from the place – we shared it round so no one, not on my account, would go deprived of his fair share of spoils.

But lingering a little too long after their rape and pillage, the islanders were able to regroup and gave it back to the Greeks. Barely escaping, and having got seriously on the wrong side of Zeus:
Nine whole days I was borne along by rough, deadly winds on the fish-infested sea. Then on the tenth our squadron reached the land of the Lotus-eaters, people who eat the lotus, mellow fruit and flower.

Far from itching for battle, the inhabitants were all smiles, merely wishing to share their fruit:
Any crewmen who ate the lotus, the honey-sweet fruit, lost all desire to send a message back, much less return, their only wish to linger there with the Lotus-eaters, grazing on lotus, all memory of the journey home dissolved for ever.

Odysseus, seeing the danger, imprisoned the mesmerized sailors under the rowing benches and skedaddled. All Over Red Rover in twenty-four lines.

Day Two, and apart from Tanya who is so impressed by the massage and chant administered to her by Belinda, that she suggests to the Spa Manager she could fund her setting up her own clinic, no one else appears to be getting the Lotus-vibe. Shane, even more unhappy that the Pineapple-breast is still out of reach, calls his mother – who else! – to get her to complain to the travel agent: the Honeymoon Suite was her gift to the newlyweds. Rachel, again at the pool – when will she learn?! – approaches Nicole, a big name in online things, to curry favour for her work. But Nicole, learning that Rachel had published a trashy article about her, feeds her into the shredder. Her pin-head self-esteem now reduced to the size of an atom, things don't get any better when her husband tells her to drop any thoughts of a career – he's rich, and she can spend the next sixty years in lounge-mode being a pretty handbag for him.

Mark seems to get good news – he has not got cancer like his Dad did – but in ringing an uncle to let him know, he is informed that his tough, possibly abusive but much-admired Dad, did not die of cancer; he died of AIDS after a lifetime of covert homosexual liaisons. This is very, very funny … for us. More so as 'I've got lots of gay friends' Mark finds this just a little too close to the bone, so to speak, and proceeds to unravel in front of his family – he tells Quinn about an affair he had early on in the marriage – in front of the other guests – intoxicated, he informs Rachel he was affected by priapism when he and Nicole first had sex – and in front of Armond, who, being gay, he propositions. Meanwhile, Olivia and Paula are on the beach, high on substances Paula has secreted in her bag. Cornered by 'I'm an out-of-control alcoholic' Tanya, and unable to focus on her ramblings, they escape … but, of course, forget the bag. Tanya helpfully hands it in to Armond, who, five years sober, but getting more and more irritated by the incessant demands from Shane to be relocated into the Pineapple room, indulges.

While Homer, perhaps himself a tad worried about substances that remove motivation – he'd just clocked twelve thousand lines in The Iliad, and still had the better part of ten thousand to go in The Odyssey – gives the Lotus short shrift, Tennyson had no such compunction to be brief. Coming in at 173 lines, in The Lotos Eaters we find out exactly what it is like to taste of this fruit. The sailors are approached by the locals:

Branches they bore of that enchanted stem,
Laden with flower and fruit, whereof they gave
To each, but whoso did receive of them,
And taste, to him the gushing of the wave
Far far away did seem to mourn and rave
On alien shores; and if his fellow spake,
His voice was thin, as voices from the grave;
And deep-asleep he seem'd, yet all awake,
And music in his ears his beating heart did make.
They sat them down upon the yellow sand,
Between the sun and moon upon the shore;
And sweet it was to dream of Fatherland,
Of child, and wife, and slave; but evermore
Most weary seem'd the sea, weary the oar,
Weary the wandering fields of barren foam.
Then some one said, "We will return no more";
And all at once they sang, "Our island home
Is far beyond the wave; we will no longer roam."

Olivia and Paula are very keen to sit back down upon the yellow sand and be once more laden with flower and fruit, but, although Armond has returned their bag, he has not returned their drugs. Given the fine legal issues in play, there's not much they can do but fume and give him evil, knowing looks. All, however, is not well between our friends. Paula – a black-skinned woman herself – has begun a sexual relationship with one of the hotel staff, Kai (Kekoa Scott Kekumano) and has been trying to keep it secret from Olivia, who, however, witnesses them in flagrante, though they don't see her. Paula is outraged that Kai must be a servant in his own land, and, feeling patronised by Olivia and her white family, concocts a plan to get him some money from their overflowing coffers. Back in the Non-Pineapple room, Rachel is now seriously worried that she is to be merely a trophy-wife, nice for sex and cocktail parties, but that's it. Confronting her still-obsessed husband he promises to give her a surprise that will show he does, in truth, love and value her, though, in truth, if there was a choice between Rachel and the longed-for suite upgrade, there ain't much doubt about which way he would jump. He approaches Armond who, in turn, has a surprise for him: someone has rented the luxury boat owned by the resort, and, this someone being but one person, Shane and Rachel can have the sunset dinner tour and should be undisturbed. But this is revenge: the 'someone' is Tanya who wants the boat to spread her mother's ashes, and being, as she puts it an 'out-of-control alcoholic' this may be a noisy and chaotic occasion. And so it proves to be. Armond one, Shane psychotically enraged.

Meanwhile, Quinn, the son, is booted out of the apartment each night by his sister, she objecting to having to share the lounge-room, doubling as a bedroom, with him. And besides 'he'll probably wank himself over Paula while she's asleep'. Nice. Sleeping on the beach, he is awakened each morning by a group of local men practising for a canoe race. Approaching them uncertainly, they welcome him aboard saying that a team-mate, who's a 'pisshead', has dropped out and they are looking for a replacement.

While Homer's heroes make it safely off the island, no such luck for Tennyson's. And it is hard to see why they would want out:

There is sweet music here that softer falls
Than petals from blown roses on the grass,
Or night-dews on still waters between walls
Of shadowy granite, in a gleaming pass;
Music that gentlier on the spirit lies,
Than tir'd eyelids upon tir'd eyes;
Music that brings sweet sleep down from the blissful skies.
Here are cool mosses deep,
And thro' the moss the ivies creep,
And in the stream the long-leaved flowers weep,
And from the craggy ledge the poppy hangs in sleep.

In this Trump/Bezos/Musk/Putin/Insert desired megalomaniac-infested world, some music that gentlier on the spirit lies sounds pretty damn good. And besides, the Lotus-loving sailors say, it's all going to end anyway, so why get your knickers in a twist in the meantime:

Hateful is the dark-blue sky,
Vaulted o'er the dark-blue sea.
Death is the end of life; ah, why
Should life all labour be?
Let us alone. Time driveth onward fast,
And in a little while our lips are dumb.
Let us alone. What is it that will last?
All things are taken from us, and become
Portions and parcels of the dreadful past.
Let us alone. What pleasure can we have
To war with evil? Is there any peace
In ever climbing up the climbing wave?
All things have rest, and ripen toward the grave
In silence; ripen, fall and cease:
Give us long rest or death, dark death, or dreamful ease.

Tennyson may not be one of the greatest poets, but I think that this is a great poem. Mostly told in the first-person of the intoxicated sailors, he deftly varies the rhythm to suit the sense of the words, conveying both the drugged state, and the longing for the violence and uncertainty of the world outside to go away. And woven through their words is the truth that this state is, in reality, the antechamber to death. Life has ceased. This was seen equally if not more clearly by one of the greatest, John Keats, especially in his Ode to a Nightingale, whose song, echoing Tennyson, takes him Through verdurous glooms and winding mossy ways. But, Keats says, there's a catch:

Darkling I listen; and, for many a time

I have been half in love with easeful Death,
Call'd him soft names in many a mused rhyme,
To take into the air my quiet breath;
Now more than ever seems it rich to die,
To cease upon the midnight with no pain,
While thou art pouring forth thy soul abroad
In such an ecstasy!
Still wouldst thou sing, and I have ears in vain-
To thy high requiem become a sod.

Nice while it lasts, but then what? Homer gives us an answer of sorts. In Book Eleven Odysseus goes to the Underworld to discover his future from the great seer Tiresias. While there he meets his comrade at Troy, Achilles, newly dead. Thinking that the warrior must enjoy being king of the castle down under, he's soon put straight about the pleasures of death:

No winning words about death to me, shining Odysseus!
By god, I'd rather slave on earth for another man –
some dirt-poor tenant farmer who scrapes to keep alive –
than rule down here over all the breathless dead.

It would seem that, for Homer, nothing beats being alive, no matter how rough the life. A couple of stops before Ithaca, Odysseus lands on Ogygia, the island of the goddess Calypso. Unutterably beautiful, she pleads with Odysseus to stay with her forever on this Greek version of the Pineapple Suite. But seven years is as much as he can take. Back onto the wine-dark, storm-darkened sea he goes, buffeted yet again before hauling up on Ithaca to finally reclaim his home and his wife. Calypso would seem to be a no-brainer, but few of our friends at the White Lotus spend any time at all of their seven-day holiday lounging peacefully poolside. All are driven by forces they themselves barely understand or control.

To say more about how events unfold in this Paradise-turned-Hell would be to seriously spoil, for those of you who haven't seen it, some seriously amazing moments in television. Suffice to say that Shane does get his Pineapple Suite but, to again reference Eliot, costing not less than everything, though possibly making him a nicer bloke; Armond continues to spiral, but does manage to go out in style; Olivia and Paula both hit a wall and, with remorse and tears, find their humanity; Mark and Nicole get physically manhandled but thereby rekindle their love; Rachel finds her soul, but will she keep it; Tanya gets a man who loves her but meanwhile dumps Belinda; and Quinn, the quietest and most lovable and most innocuous of all our misfits, leaves the island having become a man.

Mike White, who wrote and directed The White Lotus, has form regarding Hawaii. A previous series, Enlightened, chronicles the struggles of a woman who falls off the corporate ladder and goes to the island to 'find herself'. White himself has been a participant in a number of those reality shows, such as Survivor, where people are deposited in strange and unfamiliar places and must battle nature and each other. In this current series, though still mostly about the struggles of the white people, he also delves into the plight of the Hawaiians, servants in their own land; taken for granted by the rich tourists – Belinda is tossed aside by Tanya when someone else does a better job of feeding her narcissism; and having their culture exploited as nightly entertainment, trenchantly critiqued in the relationship between Paula and Kai. The story is bathed hotly and luxuriantly in the extraordinary music of Cristobel Tapia de Veer, a Canadian composer born in Chile. While all our friends, apart from Quinn who paradoxically does leave by staying, do 'leave' Hawaii in the end, White makes it clear that none actually escape the deeper intoxication of American consumerist culture.

So what is it to be? Alfred Lord's sailors sipping cocktails by the pool, deciding that:

Surely, surely, slumber is more sweet than toil, the shore
Than labour in the deep mid-ocean, wind and wave and oar;
O, rest ye, brother mariners, we will not wander more.

Or Odysseus, never ceasing from exploration:

The man of twists and turns
driven time and again off course, once he had plundered
The hallowed heights of Troy.
Many cities of men he saw and learned their minds,
many pains he suffered, heartsick on the open sea,
fighting to save his life and bring his comrades home.

The White Lotus would seem to say that we crave narcosis to escape who we are, but who we are, in equal part, compels us to strive to live our lives. Perhaps a battle fought until we do actually die. I don't think Freud or Klein, sometime Spa combatants, would disagree.

Book Review

Mythic Imagination Today The Interpenetration of Mythology and Science

Terry Marks-Tarlow

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Pages 1-141 pp (includes acknowledgements, references and author index).

Reviewed by: Elana Cohen

Mythic Imagination Today is a creative and thoughtful exploration of how we make meaning of the universe and the nature of reality and of how humans attempt to engage with the world around them. Marks-Tarlow tackles the commonalities of our evolutionary history across cultures and our "biologically based urge to communicate with others and make meaning out of personal and collective experiences", particularly in relation to our inner and outer worlds. We are taken through an engaging exploration of how mythic imagination involves the human drive to employ visual images, verbal symbols and narratives to create meaningful stories that guide us as individuals as well as preserve and evolve cultures more broadly.

Before I started this book I felt daunted by the prospect of the scientific concepts and technical language that I imagined would alienate me from the narrative. But it is not an overstatement to say that Mythic Imagination Today is a compelling story that I could not put down. I was captivated and intrigued by Marks-Tarlow's refreshing approach to timeless questions such as patterns that exist in the universe and patterns of engagement. In spite of the complex subject matter her discussion of the interpenetration of myth and science flowed smoothly. I was constantly in awe of her breadth and depth of understanding supported by references and resources that could keep a curious mind engaged for a lifetime. She offers a rich worldview that can broaden our understanding of psychotherapy's potential as well as deepen our relationship with ourselves, others and the world.

A central thesis of this book is that the brain's emotionally rich right hemisphere speaks the poetic and metaphorical language of mythology, while the rationally driven left hemisphere speaks the descriptive, analytic language of science. The book interprets mythology as a universal product of the human imagination in interaction with the surrounding physical and social world. It draws on myths of all cultures and eras to illustrate how the timeless wisdom of ancient stories live on today, arise the world over and establish greater certainty about our origins. Marks-Tarlow's insightful interpretation of the myth of Psyche and Eros – origins of the very concepts of 'psyche' and 'psychology' - explores our deep desire for connection and is presented from an interpersonal neurobiological perspective and includes inner (intrapsychic), relational (intersubjective) and outer (interobjective) elements. Marks-Tarlow suggests that "each person must juggle needs for connection with those of autonomy" and that "no matter how brave or accomplished we are as individuals, the capacity for connection and intimacy remains important for each one of us, both to perpetuate our lives as individuals as well as to perpetuate society at large".

Contemporary disciplines of nonlinear sciences with a strong emphasis on dynamical systems thinking, chaos theory, complexity theory, frac-

tal geometry and interpersonal neurobiology are drawn from to propose a complex, nuanced picture of how these disciplines correspond with ancient wisdom. Marks-Tarlow explores how early myths dovetail with truths of nonlinear science and she suggests that nonlinear science broadly and fractal geometry specifically provide a holistic flexible meta-framework for understanding even the most complex psychological, social, cultural and historical systems.

All levels of existence are explored with curiosity by Marks-Tarlow through an integration of mythology and science and she examines how combining these can transform both inner and outer worlds.

Throughout the book Marks-Tarlow energetically harnesses her creativity to weave together her multidimensional thoughts and concepts. She includes a collection of visuals (many of which she has drawn herself) to illustrate these concepts, further illuminating the depth of her creativity and brilliant mind. It is Marks-Tarlow's creativity rather than a desire to assert and prove a logical argument that contributes to her publication being such an engaging and interesting story.

We are living in a challenging time with a great deal of rapid change, both social and environmental. Many of us are deeply curious about the nature of the world around us and this book provides a rich and unique contribution to helping us all know ourselves and the world and times we live in.
Mythic Imagination Today, is a extraordinary work on the relationship between our interiority and externals worlds, a fascinating dissertation on the interplay between mythology and the sciences and an innovative exposition on the chemistry amongst all of these. As such, I believe that it offers a unique approach to anyone interested in the depths of psychological exploration, and a novel perspective for understanding the process of transformation.

Reflections on The Babadook and The Mirror Book

Helen Frances

Two seemingly unrelated works of art coincided with the second year of my training in the Conversational Model through ANZAP. The class was reading Nathanson on affect and Kim Hopkirk recommended watching the film The Babadook, 2014, by Janet Kent. Kim's article on the film appeared in the previous issue of the journal.

Other, more creative articles were also recommended. They fired up my appreciation of how art conveys the depth and immediacy of experience. At the same time I was reading The Mirror Book, a memoir by New Zealand author, Charlotte Grimshaw.

Works of art about the human condition "hold the mirror up to nature," and by implication, nurture. Larger than life, on the screen or within the pages of a book they can stir collective and individual emotional responses, memories, imaginings and associations thereby attracting a variety of connections and projections. A film or book review can also reveal something about the personality and inner world of the writer, about his/her preoccupations and challenges.

I felt a strong pull of interest towards both works, recognizing my own struggles as a young mother and issues arising from my own early experiences. The roles of masculine (agentive) and feminine (relational) in my psyche have played out in many different ways over the years as have mother and child, father and daughter relationships and their intra and inter psychic meanings– all elements in becoming a more authentic, "native" self.

I would like to share some thoughts about both works, which, while very different art forms, share the struggles of the protagonists as they navigate their way through personal change and relationship.

In a film the director is in charge of producing a finite, concentrated version of psychological experience. A memoir presents a selection of memories and reflections threaded with themes and the unique perspective of the author.

Samuel (Amelia's son in The Babadook) and Charlotte, in her memoir, both seem to be crying out for maternal relationship – to be seen, heard and responded to in ways that validate their being. Love without relationship, without adequate "mirroring" or reflection falls short of being "good enough". Then the Babadook rages, and the daughter writes a memoir, telling it how it really was for her.

At the same time in personal therapy, I was recycling some 69 year old themes, and working with training clients who bring their versions of absent mothers and emptiness, scary Medusa-like faces (a female Babadook) distressing experiences of shut out feelings, and expressive imagery. Empty rooms, grey nothingness, eating chips to fill a void that cannot be satisfied with junk food because this just repeats the unsatisfying "junk" served up by scary, scared, wounded parents.

But wait, there is Hope - in Pandora's box, in the film, in the book and in therapy rooms.

The Babadook directed by Jennifer Kent

Cockroaches scuttle out of a widening crack in Amelia's kitchen wall. The sensations and feelings (disgust, dissmell) are almost as horrifying as those engendered by the Babadook, a monstrous, shadowy scarecrow-like figure that haunts Amelia and Samuel night and day.

Symbolically the insects, psychotic images, break through Amelia's persona armour – a mask of pretence that everything is fine and she doesn't need help; the armour of a dissociative defence.

Repulsive are these cockroach creatures that live in the basement (the unconscious) among filth and garbage, consuming the things humans reject. They are creatures of the earth, devourers that eat, hidden from sight. Just so, Amelia is being eaten up, unawares, by her grief, rage, anger, despair, and the possible hatred and resentment she feels towards the son whose birth coincided with the death of his father in a car accident, the husband she loved and has missed for the past seven years.

But seven seems to be a propitious time, a highly symbolic number in many world religions. In Genesis the world was created in six days and God rested on the seventh, creating the basis of the seven-day-week. A prime number signifying completeness, in this case accomplishment of a life changing task for both Sam, the boy and Amelia his mother.

Carl Jung writes in The Development of Personality that, "in every adult there lurks a child – an eternal child, something that is always becoming … the part of the human personality which wants to develop and become whole."

Becoming whole rather than trying so hard to appear good is a hard task for Amelia. Her unprocessed feelings emerge in terrifyingly unpalatable forms – cockroaches and Babadook. She has to cope with the day-to-day tasks of being a working mother, conforming to a patriarchal society that does not support the time needed to process difficult affects. Expectations to cope are represented by school and social workers and by Amelia's conditioned/defended attitude towards her grief. So Amelia is absent and Sam, disturbed, tries every way he can imagine to make his Mum present.

But the life supporting, relational feminine attitude is not absent in The Babadook. She lives next door, embodied in Mrs Grace Roach – infirm with Parkinson's, accepting of both Sam and Amelia. Sam seeks her out and she offers to help, understanding of the single mother's situation and appreciative of Sam's unusual, and frank personality. But Amelia rejects Grace's offers of help.

Grace Roach is a potent name that would seem to combine opposites – earth and sky, matter and spirit. Roach is another word for cockroach and the origin of the word roach also relates to the Old French "roche" or rock. The elderly "wise old woman" with Parkinsons could represent the good face of the Mother archetype, grounded in feeling, feeling and relationship from which Amelia has dissociated. Amelia initially pushes this away as she has known up until now only the negative face of the Mother. She is shaky and unwell, her pent up feelings are attached, as she still is, to her dead husband, and they turn deadly.

Cockroaches are of the earth, creatures of the Great Mother. They transform the garbage; recycle it performing a similar transformative function to the earthworms that make an appearance

towards the end of the film.

Amelia kills their pet dog that knows instinctually something is wrong then she threatens Sam with a knife – a masculine emasculating weapon. But on the point of destroying her child and herself, Amelia wakes up.

Worms (more acceptable than cockroaches) feed on the dog's corpse in the garden where Amelia buries it. She then feeds the worms (rather than Sam whom the dead father claims) to the Babadook whom she keeps away from her son in the basement. The Babadook is finally back where it was hidden, however Amelia is now aware that it is hers – her shadowy feelings, and the negative energy associated with the masculine. Sam will eventually have his own version but the work his Mum is doing will lessen the impact of intergenerational trauma.

The name Grace associates with divine grace, with Mary mother of Christ and Sophia (feminine wisdom), the blessings of the Holy Spirit, bird of Aphrodite mother of Eros and the dove of peace that Sam conjures at the end of the film.

Such magic has been wrought through the conscious assumption of suffering and the power of relationship. Once Amelia has let in the Babadook, wrestled with "it" owned it, taken a strong, female position and dis-identified, the tied up energy comes free.

The "masculine" or "yang" in a woman's psyche can have this enabling, active quality. Images of males in my own dreams bear this out.

At the end of the film Amelia has assumed a more active role in relation to her own "stuff" and begins to bloom, becomes more grounded and assertive as a woman and as Sam's Mum. The relief is palpable and the acting superb.
Interestingly Jungian analyst Edward Edinger writes that the word individual is etymologically related to the word widow (Latin vidua) that derives from videre meaning to part. "Jung has demonstrated that the images of widow and orphan are part of the individuation process."(Edinger: 1972, p. 163)

I found the imagery and symbolism dreamlike and symbolic, emotionally charged in ways that resonated with my evolving understandings of archetypal processes. The film is rich in themes and associative possibilities – the absent, negated or unwell "feminine" (Eros or relatedness); a demonic, tyrannical masculine figure (Thanatos - death as opposed to life and relationship.) Once the energy is made available and Sam is reconnected with his father (birth and death occurring on the same day), Father Death becomes Father Life.

The viewer suffers along with Amelia and Sam as they endure (as clients and therapists do in therapy) a process of transformation. The final images of dove, mother and child are full of hope.

The Mirror Book A Memoir by Charlotte Grimshaw

Unhappy that I am, I cannot heave
My heart into my mouth. I love your majesty
According to my bond, no more nor less.

Cordelia, King Lear Act 1 Sc. 1
"We two alone will sing like birds i' the cage. /
When thou dost ask me blessing, I'll kneel down, /
And ask of thee forgiveness,"
King Lear Act 5 Sc. 3.

Charlotte Grimshaw is a well-known New Zealand author as is her father Karl Stead, a former Poet Laureate. The memoir, written by a member of New Zealand "literary royalty" (the author would no doubt cringe at the epithet) has had multiple reviews, and struck differingly loud collective chords among the reading public, from criticism about the possible gossip interest in public figures and the perceived temerity in airing "family linen" while parents are alive, to readers feeling helped, mirrored by the author's sharing of her reality.

The attention wrapped an aura of theatricality around the work. There are resonances of King Lear (Donald Trump also gets mention), Hamlet, Sylvia Plath's and Philip Larkin's poetry among others. A book too has its hour upon the stage when readers feel spoken to, emotionally involved. A book opens up a conversation.

Unlike Cordelia Charlotte does heave her heart into her mouth. She calls her memoir an enquiry, rather than a setting of the record straight, having grown up with what she calls the fiction of "a

happy childhood, house full of books," a perspective she says is still adhered to by her parents, both now in their 80s.

Following a separation from her husband, who admitted to having had an affair, Charlotte says she set out on "a quest to find out why my reaction to that particular crisis seemed to be more extreme and more troublesome than I thought it should have been."

She found herself alone with no women friends, and having no confidants for deeply personal matters, sought professional help. She consulted a forensic clinical psychologist and this "set me off on a whole lot of trails of enquiry about all sorts of mysteries about my life." But her questing after the truth about her childhood and family relationships has encountered resistance.
"Father had his own ideas about how to present the family," as he has done in a substantial, recent autobiography of his own.

I found the book engaging, much more alive than her fiction, which has been a covert vehicle for her own and family experiences, which family encouraged her to fictionalize. The story dips in and out of different time zones - memory, reflection, questioning, and occasional references to sessions with the psychologist.

There is at times a conversational tone struck with the reader. While Charlotte has read psychological texts the writing is in no way burdened with jargon. Her descriptions of the natural world in which she "roamed" and "ranged" as a largely unsupervised child and teenager, are crisp and sparingly evocative. Her relationship with the natural world, the world of the Elementary Feminine is alive with love, soul and spirit.

Charlotte, like Amelia has been through her own emotional hell - sexually assaulted at 13 years, as a teenager witness to the death of a dear friend, an abusive partner relationship and deeply but differently problematic relationships with her mother and father, to whom she says she is devoted.

Perhaps the truths she writes appear like Amelia's cockroaches – distasteful, hard to swallow or understand. And I wonder how the child in the parents, the dismissed, hurt, hidden, shamed, angry and possibly hating child may experience the publication of the book.

I have found it hard to keep in mind the undoubted sufferings her parents must have experienced growing up, reading about Charlotte's distress and shame, and efforts to attract her mother's favourable attentions. There seems to have been a real difficulty in relating between this mother and daughter and times when Charlotte was shut out or competed with for her father's attentions.

Charlotte writes, "when I turned 13 it seemed that, for Kay and Karl, I had become simply another woman in the house. He joked and flirted, annoying Kay, and behaved as if we were not a family but a group of individuals …"

In King Lear, which came to mind reading the memoir, the mother, a Queen, is missing along with feminine relatedness that can give and receive authentic feedback; "I love you as salt loves meat," says Cordelia in a folk tale version of the story.

The sisters Goneril and Reagan offer inflated, insincere flattery to bolster an insecure King's ego for their own ends, then they betray their father – the kind of role that Charlotte's family seem to have required.
"I had been loyal to my father all my life and had publicly praised and defended him when called upon," Charlotte writes.

A secure relationship is impossible with a mother who regularly delivers the silent treatment to a daughter out of her own wounding and who competes with her in a dynamic set up with the husband, who has also lacked secure parental relationships.

So when Charlotte's husband left the abyss opened – as we see in Amelia's dissociation and encounter with the Babadook and King Lear's descent into crazed nothingness on the heath.

"Abandoned by his mother-daughters, left alone on the heath to endure the night storm, he will be forced to suffer his inner emptiness, and through that ordeal experience himself as he is. Jung says, "… your own inner emptiness conceals just as great a fullness if only you will allow it to penetrate into you". (Macdonald: internet article)

And as Charlotte writes, "to feel that you are

reaching out into the void and catching hold of nothing is a terrifying, annihilating experience." "When I was a child my mother would shut her bedroom door, locking me out, and I would feel the same existential despair. I felt there was nothing holding me to the Earth, nothing between me and the cold universe."

Mother was missing and Charlotte's persona or coping self –construct crumbled. The more secure, albeit idealized and prescriptive relationship with father also fell short.

In her article Electra, The Dark Side of the Moon, Jungian analyst, Sheila Powell examines issues in female individuation within a patriarchal culture (Powell: 1993).
Experiencing herself as a separate individual, or as the author quotes, Winnicott, "unit status," becomes problematic when a positive, embodied identification with the mother has not been possible – the pattern over time (not necessarily linear) tends to go mother, father, mother – identification (with mother/feminine), separation, identification (with father/masculine), separation, re-identification (with mother/feminine self), separation from parents, integration of both masculine and feminine, and emergence of the third – the woman self. An idealized, psychologically incestuous bond with the father may replace the mother if she remains unavailable to her daughter, through intergenerational failure to achieve a separate, validated sense of a female self.

This process can happen through therapy as well as good enough parenting or other relational experiences. Without trying to analyse further what went on for Charlotte, I wonder whether through her marriage, therapy and evolving relationships she is achieving "unit status".

Her relationships with and separating from her parents has been documented in a very public way, and who would wish the intensity of King Lear's suffering on another? I am thankful both for her parents, who have remained silent after affirming their love for their daughter, and for Charlotte's work, which I find both moving and insightful.

The Babadook and The Mirror Book end with peaceful images of mother and son. Not the agony of pieta – Mary with the dead Christ - but rather with the hopeful image of new life for both, for the potential of growth and change.

References

Edinger, E Ego and Archetype: Individuation and the Religious Function, Boulder, Colorado Shambala Publications

Grimshaw, C (2021) The Mirror Book, A Memoir, NZ: Penguin Random House New Zealand

Jung CG. (1954), Development of Personality in Collected Works of C.G. Jung, Vol.17. Princeton NJ: Princeton University Press

Powell, S (1993) Electra, The Dark Side of the Moon The Journal of Analytical Psychology, 38(2), 155–173

Macdonald, R Alchemy, Prima Materia in Shakespeare's King Lear https://robertmacdonald.org/alchemy-2

Call for Papers for Issues 4 and 5

Margie Darcy

The Therapeutic Conversation (TTC) 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. The peer review is designed to help authors develop their work further – we have a policy of constructive criticism. Papers should include an abstract.
The 4th Issue of TTC will be published in April 2022. The 5th Issue will be published in November 2022.
The due date for submissions for TTC4 is 31 March 2022. The due date for submissions for TTC 5 is 31 October 2022.
Please contact Margie Darcy on Margie@MargieDarcy.com if you would like to submit a paper.

Part 2: Information

PITSIG

Chairperson's Report

Simon Heyland

Looking back over the last 12 months it is sobering to note how the pandemic continues to affect so many areas of our lives. We have adapted as best we can to the 'new normal' it has precipitated, but things often feels far from normal both at home and at work. The most obvious impact on PITSIG has been the delay to the start dates for our new face-to-face training courses, due to the University of Manchester being – understandably – preoccupied with adapting its existing courses for an online world. National restrictions have also forced us to continue to hold our regular CPD sessions via Zoom.

But there has been at least one silver lining. A highlight of late spring over here in the UK was hosting the first ever joint PITSIG-ANZAP educational event via Zoom on 7th May 2021. Wendy Macdonald led a discussion of chapter one (Cry & Response) from Tony Korner's new book Communicative Exchange, Psychotherapy and The Resonant Self: Roads to Realization. The first Friday in May is a traditional PITSIG CPD dates so I was sure there would be a good turnout from PITSIG - the unknown quantity for me was how many ANZAP cousins would be joining us. I didn't do a headcount on the day but the meeting was well-attended and it felt like a 50/50 mixture which was great to see. The next issue on my mind was how well would the two groups blend. Over here we talk about the UK and the USA being 'two nations divided by a common language'. Would PITSIG and ANZAP have the same problem, or would we find a shared (feeling) language I wondered? Happily it was the latter. In fact I was struck by how easily the conversation flowed in this newly constituted group, something which could not be assumed in advance. I would like to thank all the ANZAP folk who attended, and in particular Tony for his eloquent and emotional contributions to the discussion. There are firm plans to hold another joint meeting via Zoom in April/May 2022, so please look out for details.

Our September meeting was a discussion of Clare Green's inspiring and moving story of her journey from medical secretary to cardiac nurse and then PI therapist, from biomedical model to conversational model. Her paper in this edition of our journal is based on that talk, so it is great that the story is going to reach a wider audience. Hopefully Clare's example will encourage other new UK writers to submit papers for future issues of The Therapeutic Conversation.

The other major update from PITSIG is at the organisational level. The Psychodynamic-Interpersonal Therapy Special Interest Group (PITSIG) was established in 2009 by a handful of people from Macartney House and Gaskell House Psychotherapy Centres in Manchester, with the aim of promoting interest in PIT and creating a community of practitioners of the model. It has been a fascinating and rewarding journey for many of us so far! As the group has grown and developed over the last 12 years our activities have deepened and diversified to include promoting and providing CPD events, training, supervision, research, publications, new learning materials, and this enriching link to ANZAP.

Many people have contributed to those efforts, in particular our coordinating committee of Richard Brown, Else Guthrie, Rebecca Hughes, Kath Sykes, Mary Lewis, Wendy Macdonald, Frank Margison, and Laurence Regan. Behind the scenes Frank has been working tirelessly with technical colleagues to finalise our new teaching videos and a new website. He says he enjoys that side of things but we all know it is a lot of work nonetheless, so a special 'thank you' is due to him.

PITSIG has now reached a stage in its development where it both represents PIT at a national level and needs a more formal structure in order to continue to grow. We need to become an organisation with a formal constitution, elected officers, and a more sophisticated way of managing our finances. To support these processes, you will see in the coming months that PITSIG is going to change! The most visible sign of this is that we are changing our name, from PITSIG to PIT-UK. This new name better signifies the identity of the group as it becomes a formal organisation.

PIT-UK will offer more to members than was previously possible as PITSIG. As part of enabling us to offer a better experience to members, a new website is being designed for PIT-UK. Joining PIT-UK will provide members-only access to areas of the new website where you will find additional and new PIT resources (including access to The Therapeutic Conversation journal) as well as a simple way to book and pay for CPD events. Modern computers and laptops are unlikely to have DVD players so PIT-UK will be providing a high-quality streaming service to give members access to the new training films.
These are exciting developments which we hope will support and build on everything achieved in the last 12 years. We are very much looking forward to the launch of PIT-UK
Best wishes to everyone Down Under

ANZAP

President's Report

Kim Hopkirk

ANZAP has just had its AGM, and part of my report was to thank all the people who volunteer their time to keep ANZAP alive and well. We have 100 members, and nearly 30 of them offer us volunteer hours, with plenty of people having several hats. It takes a lot to run our training, to create the educational seminars, and see to the organisational functionality of ANZAP. It is truly fantastic what we are doing within ANZAP, and I feel deeply grateful to you all for giving us what you do.
Having said that, we are on the lookout for any member who would like to join us on the Management committee (MC), and take up the coordination of the PD seminars. We have lost Annie Stopford who did a fabulous job all the way over in the US, but it became too tricky with the immense time differences. I would love to hear from anyone who has some time and interest in participating in our vibrant team.
The MC had spent some time debating creating a new membership category, Research. We have always been a clinical organisation, and our membership categories reflect that. However, CM is now recognised as a viable treatment modality for BPD, trauma, and complex PTSD, and it has been through research that this has come about. ANZAP, and the Westmead master's program have become desirable training options in psychodynamic psychotherapy due to this important research.
The MC decided that we would like to encourage further development of research in psychotherapy. CM is an evolving model, and research is one of the important ways we can evolve. We want to encourage writers in the field, as well as those directly involved with research to join us. We still expect these prospective members to have a small clinical practice, but we respect that the main thrust of their work may be in the academic field.
The special resolution to create this category was passed by our members at the AGM, to my delight. I hope that perhaps even our UK compatriots may think it worthwhile to join ANZAP through this membership category?
The MC, through Tony Korner, has created links with the Westmead training program. Both ANZAP and the Master's program train clinicians in CM, and although there are some differences in the style of training, both trainings offer a 3 year post graduate training in CM, using supervision and seminars as the foundation of the training. Both trainings have Russell Meares and Bob Hobson at the heart of the work.
All Westmead trainees automatically become trainee members within ANZAP, and get membership privileges, while Westmead gives access to all ANZAP members in their Grand Rounds on Thursday mornings. They are a terrific adjunct to psychotherapy education, and I encourage everyone to attend. Anne Malecki sends out a zoom link each week they are on. Well worth it, I assure you!
A reminder to everyone to put into your calendars the twice postponed ANZAP conference, The Deep Roots of Trauma: Attachment and Adaptation through the Lifespan.
The new date is 25-27 March 2022. Go to the ANZAP website for the conference program, which will be available in the New Year.
As we come to the end of the year, I wish you all well, and I look forward to connecting with you in the New Year.

Faculty Report

Nick Bendit

We were very excited to have 24 trainees start year 1. One has dropped out, so we currently have 12 Australian trainees and 11 New Zealand trainees. Of the 9 trainees who completed year 1 in 2020, 5 continued into year 2 this year, and a trainee from several years ago who had dropped out midway through the three-year course re-joined year 2, so there are 6 trainees. There are also 6 trainees in year 3, although one is doing the practical component this year and the seminars next year.

For the first time ever we had to forego our face-to-face Sydney intensive weekend, which has been the start of teaching for each year, usually the last weekend in February or the first weekend in March. It was replaced by a Zoom intensive, which went surprisingly well. Having said that, the trainees and faculty have really missed the opportunity to meet face-to-face, both during the seminars and informally over a weekend in a live-in situation, which was the purpose of the Sydney-based intensive. For next year we have tried to organise to get all the New Zealand trainees to meet for the February intensive in Wellington and the Australian trainees in Sydney, but I'm pretty pessimistic that that will be manageable. So it is very likely that we will have another intensive entirely via Zoom, which is suboptimal.

Faculty has been further supplemented by having seven New Zealand supervisors and two new Australian supervisors, as well as much-needed help from previous faculty supervisors. Furthermore, it has been wonderful to have Michelle Rousseau rejoin faculty.

I would like to formally thank the hard work of faculty, the extra support of the non-faculty supervisors and teachers, as well as the support of the management committee behind-the-scenes.

Of course, Faculty could not exist without the hard work and corporate knowledge of our administration coordinator, Anne Malecki. Many times in the last year (and previous years) Anne has (gently) suggested and guided me away from mistakes and potential "cliff edges"!

Introducing We Can Recover

Lauren Durbridge

I am founder and Executive Director of the not-for-profit organisation. "We Can Recover." I was first diagnosed with complex PTSD 15 years ago. My symptoms where quite server and I lived in a lot of fear and bounced in and out of hospitals and treatments that worked to varying degrees. In more recent years I was lucky enough to stumble across a therapist who is trained in the conversational model of psychotherapy and who works within the Extended Medicare Safety Net, which means that I can afford to see them as often as I need. For the last two years I have had two to three weekly sessions and for the first time in my recovery journey I am seeing improvements in my life, in my relationships, in myself, and the relief is immense.

I have been inspired by my own journey towards recovery and wanted to be able to share it with others living with CPSTD. So I founded a charity called We Can Recover whose main aim is to financially subsidies specialist therapy for people living with CPTSD. We are in the early days and currently working on raising funds so that we can begin our initial phase of providing grants for therapy to those living with CPTSD. Www.wecanrecover.com.au

The charity is registered with the ACNC with deductible gift receipt status. We are currently in the start-up phase where we aim to raise an initial $7000 to support 5 people with CPTSD. We will work with the existing medicare subsidies to achieve 12 months of continued therapy for individuals living with CPTSD. The charity subsidises sessions with therapists who have undergone extra training in treating CPTSD, such as the conversational model of psychotherapy. The charity is run 100% by volunteers. We have a passionate and dedicated team that is excited to make a difference in the lives of those living with CPTSD.