The Therapeutic Conversation

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Table of Contents

Editorial

Welcome / Kia Ora to the 5th issue of The Therapeutic Conversation.

I'd like to begin with my thanks to Margie Darcy for all her hard work in stewarding the journal through the first four editions - thank you Margie!

TTC has continued to evolve in line with the Statement of Ambition which was published in TTC1, and in keeping with the wish expressed by Russell Meares in his welcome from that first edition:

"It is to be hoped that it can be a means towards unifying the efforts of those working in different countries, all striving to understand and transform the same complexities of existence besetting our patients, all working towards the same end".

It is fitting, therefore, that this edition includes papers by authors from ANZAP, Westmead and PIT-UK (formerly PITSIG), and it's been my pleasure to help bring these papers to publication.

In the first paper Anthony Korner and Steven Yeates discuss the importance of recognising "the significance of minds and the participation of individuals in their own recovery, as distinct from disease interventions which are often characterized by a more prescriptive approach".

Next, Frank Margison offers us a reflection on Lewis Aron's paper "Ethical considerations in psychoanalytic writing revisited", which focusses on the complex issues relating to confidentiality when including case material in papers for publication.

Robyn Chase then brings us an exploration of how CM concepts can be applied in a primary care setting in order to understand "the dynamics of a difficult primary care therapeutic relationship that has remained stuck in disconnection over many consultations".

We then move to David Atkinson's work with a patient with Anorexia Nervosa. David offers a comparison of resistance as it is conceptualised and managed from the psychodynamic and CBT perspectives, along with a proposal "that the understanding of the phenomenon of resistance from the perspective of psychodynamic theory and the CM might lead to better understanding and clinical outcomes".

MJ Basilio provides us with an account of her CM work with three neurodiverse clients, as part of her inspiring aim "to promote acceptance of differences in order to contribute to the co-creation of an inclusive and equitable society".

The film and book review for TTC5 is brought to us by Helen Frances. I suspect you'll feel motivated to read / watch The Power of the Dog after reading Helen's review.

In keeping with tradition, this edition of TTC finishes with updates from ANZAP and PIT-UK, with the addition of a 'new regular' update from Westmead.

Thanks, as always, to Leo LaDell for his expert work on the layout / formatting of the journal.

Happy reading!

Chris Garvie

Part I: Papers

What ails thee? A normative understanding of Mental Disorder

(Mental Health Dreaming)

Anthony Korner and Steven Yeates

Abstract

There has been a trend in psychiatric classification over recent decades towards understanding mental health presentations primarily in terms of a descriptive approach that de-emphasizes notions of mind and mental process. This led to the elision of the concept of functional psychiatric disorders with the advent of DSM IV in 1994 (i.e. abolishing the category of "disorders of the mind"). It is argued, in response to this development, that understanding of mental process at a normative level and the disruption of these processes in mental disorders is fundamental to clinical practice in the psychological professions. In so doing, we find that models of the development of mind and self are essential to the healing process and the development of effective therapeutic relationships. Recognition of subjectivity and respect for individual minds leads to appreciation of the healing potential of relational engagement, imagination and dreaming.

Introduction

The words psychiatry, psychotherapy and psychology all derive from *psyche*, defined as "the mind, or the deepest thoughts, feelings, or beliefs of a person or group" (Cambridge Dictionary, 2022). When one asks the question, "what ails thee?", of any person, one often meets with uncertainty, private concerns or unvoiced emotional pain that doesn't necessarily correspond to any specific medical or psychiatric diagnosis. The definition of psyche encompasses such concerns, the 'deepest thoughts, feelings or beliefs' of people who seek help. When someone goes to the doctor, it is common for the doctor to reach a conclusion that the problem at hand isn't going to be readily defined in terms of a disease for which there is a cure or clear treatment path. This is quite often the case for both somatic presentations and those presenting with emotional distress or mental disorder. In these instances, a general (medical) practitioner may turn to a specialist who has clinical experience and expertise in working with the mind. Indeed, when practitioners themselves have existential afflictions for which they can't find solution, they too will look to such a clinician, practised in the field of *psyche*. The answer to the question "what ails thee?", is not necessarily evident from an analysis of the presenting symptomatology and behaviour.

Consider the following clinical vignette:

A young woman, Helena, is admitted to hospital after a suicide attempt. She is highly emotional and distressed and, despite a number of attempts to discharge her to community care, she continues to self-harm and attempt suicide. She spends the better part of a year in hospital over multiple admissions. A number of pharmacological measures are tried and attempts are made at psychological work. The level of perceived risk results in her being confined to a locked area for long periods of time. She attracts various diagnoses including Depression and Borderline Personality Disorder. After many months she confides a background of sexual abuse at the hands of a relative. She has never disclosed this within the family. She is now prepared to do so and a meeting with her mother is arranged at which she finds the mother unexpectedly receptive and supportive. Within a week or so Helena is successfully discharged from hospital with arrangements for further counselling.

(Korner, 2021, p.61)

This is by no means an unusual situation. It took quite a long time for the patient to feel sufficiently safe within the therapeutic milieu to confide and disclose what really concerned her. It might be noted that what concerned her was a matter involving traumatic experience. The disclosure allowed appropriate action and a genuine resolution of her problems. A year later she was seen by her clinician shortly after having given birth. She was well and had come off medication.

Psychiatrists and therapists are not mind-readers. Sometimes even diligent attempts at history-taking will not meet with full and open responses from the patient. The skill of the therapist lies in creating a psychologically safe space which facilitates expression of the patient's underlying concerns, conflicts and traumas (Graham & Van Biene, 2007). This is to say, a space where the individual mind comes to be known and personal forms of feeling become evident in interaction. Where we come to know the individual directly, rather than simply knowing about him or her. Personal

forms of feeling and the sense of the inner life (that which is private to the individual) may come into existence in the space of an intimate, trusting therapeutic relationship.

In the medical lexicon, there is a distinction made between "disorder" and "disease". *Disorder* is the more general term, encompassing conditions where dysfunction is recognized but cause is unclear, as in, "A condition characterized by lack of normal functioning of physical or mental processes" (Medical Dictionary, 2022) whereas *disease* generally reflects a condition with known pathophysiology, as in, "A disorder of structure or function in a human, animal, or plant, especially one that has a known cause and a distinctive group of symptoms signs, or anatomical changes" (Oxford Dictionary, 2022). It is also reasonable to point out the distinction between "disorder" and "order" because the need for order is fundamental to individuals and, indeed, to all forms of life. We see in disorder the breakdown of a dynamic normative process rather than a static "thing".

Until the 1990s, the first distinction had been reasonably clear in systems of psychiatric classification. There were Functional Mental Disorders, for which there was no clear pathophysiological abnormality identified, and for which the adjective "mental" seemed appropriate (i.e. "of the mind"). There was an implication that function was disordered, involving alterations at the level of the CNS, the body and relational life, although not necessarily in a permanent or irreversible way. So understood, it should be noted that there is no denial of the physicality of such disorders, although there is an implication that often emotional and psychological factors are important. There was a more disease-like category of mental disorders in those days, termed Organic Mental Disorders. This included diseases with recognizable neurological alterations and lesions, like Alzheimer's Disease or Huntington's Disease. There was little argument that such disorders had a clearer disease status than the functional disorders.

All of this changed in 1994. DSM IV-TR abolished the distinction between functional mental disorder and organic disorders (diseases), saying, "Although this volume is titled the *Diagnostic and Statistical Manual of Mental Disorders*, the term *mental disorder* unfortunately implies a distinction between "mental" disorders and "physical disorders" that is a **reductionistic anachronism** of mind/body dualism." (American Psychiatric Association, 1994, our emphasis). Perhaps there was an intention of legitimizing mental disorders as *real*, with which we certainly would agree. However, the language is denigrating of the term *mental* and, by extension, the notion of *mind*. Furthermore, in practical terms, there continues to be a real distinction between functional disorders and organic diseases. Psychiatrists are found to be negligent if they miss an important organic diagnosis such as a brain malignancy.

Mental life, the inner life of a person, cannot be observed directly. It needs to be expressed. The need to do this is arguably as fundamental as the need to breathe. We take in information from our environment and we need to use it, organize ourselves and respond expressively in order to be heard and to take our place within a community. As psychiatrists, or psychotherapists, we need to be able to engage with those who seek our help at this level and be able to facilitate a therapeutic conversation. The personal world of the subject offers many therapeutic possibilities. It is not to be dismissed as "mere subjectivity". Emotional and relational dysfunctions become evident in what Winnicott termed the intermediate zone of experience, neither completely subjective, nor completely objective (Winnicott, 1971).

In this paper, we present a case for continuing the study of the mind and for engagement with individual minds in clinical practice. To this end the term *mental disorder* is an appropriate one, precisely because it avoids the reduction inherent in favouring a purely objective-descriptive account of psychopathology that eschews understandings of psychological causality, in favour of reliability of description. In so doing, it disavows the human level of understanding. Mental life is always evolving, with the stream of consciousness occurring in interaction with others and the world in a way where it is continually shaped and re-shaped. This speaks to the therapeutic shaping of experience as a creative possibility for many patients who present clinically. As in the example given earlier, it should be noted that effective engagement with the mind of another depends on the creation of a sense of psychological safety which, in turn, demands respect for the privacy of the individual and his or her mind. A safe and sensitive engagement may be necessary for the individual to develop a sense of an inner world that can be owned (a secure form of privacy).

Western culture prioritizes scientific objectivity, possibly to the extent of endangering psychological work in psychiatry through training which may engender the condition of "mindlessness" in psychiatrists (Eisenberg, 1986). Other cultures have placed more value on connection and respect for inner worlds that come into social being through being shared. One such culture is the *Dreaming*, the foundational culture of Australian Indigenous communities. An elder of the Kukatja people (Western Australia) says, "This is good country.

We are good dreamers" (Poirier, 2003, p. 113). What is implied here is the sense of belonging that comes from sharing inner worlds and the connection of personal experience to the environment. We use the phrase *Mental Health Dreaming* to emphasize the potential benefit of learning from other cultures as we strive to find better ways of meeting the challenges of helping people who present with mental disorder and distress.

Inner worlds & outer lives

In health, we integrate our experience as it unfolds (Siegel, 2015). Failures of integration are associated with disturbances in mental equilibrium. The maintenance of psychological equilibrium is the psychological concomitant of homeostasis. The mind is thought to operate through a process of prediction involving the matching of past experience to the present situation in order to manage information flow (Siegel, 2015; Solms, 2021). Where there is dissonance between the inner (mental) experience and the outer life of physical behaviour and interaction, there will be a sense of personal distress. In situations that surprise us, prior expectations don't match current experience, yielding an excess of information that may be overwhelming (Solms, 2021). This situation may involve disruption of homeostasis and an increase in internal disorder (chaos). This has been described as the "Free Energy Principle"[1] (Friston, 2014), which states that increased disorder is associated with increased information (increased entropy). It is argued that there are mental concomitants (loss of emotional balance when we feel overwhelmed) to the FEP (Holmes, 2022). Loss of mental balance is felt: "At this point the role of affect becomes important. Free energy is aversive and can be thought of as representing mental pain." (Holmes, 2022). In the case of psychiatric illness, various phenomena disrupt the ability to find peace in one's inner life. Thoughts and feelings are perplexing and intrusive as in obsessional phenomena; moods are unpredictable or agonisingly unrelenting as found in depressive states of mind; and inner phenomena are found in the external environment as in hallucinations. Such phenomena may be thought of, in part, as reflecting prediction errors, or failures in the predictive process, according to the *free energy principle* (Friston, 2010).

From early in foundational training students of health are counselled to take note of a patient's symptoms and to take an adequate clinical history. Symptomatic descriptions often go beyond the objective and may include some effort at expression of inner feeling. This element of medical evaluation moves toward more and more abstracted forms of observation that can't be understood simply as objective data. The physical examination looks for signs of pathology which may then be confirmed or measured by instrumentation such as MRI scans or blood sampling. Thoughtful clinicians look for correlation in symptoms and signs, which often go beyond the question of diagnosis, to strengthen conviction in formulating, and empathizing with, a patient's suffering. To achieve this, the qualia[2] of symptoms, inherently personal and private until shared, needs to be taken into account. Consider this vignette:

Joanne presented for help in her 30s with treatment resistant depression. After she rattled off a long list of symptoms and previous treatments in a manner which seemed to betray a sense of despair, her clinician asked:

"What does depression feel like to you?"

To which Joanne replied with clear affect:

"Like all of the oxygen has gone from the room and there is a gigantic weight on my chest."

Later on, in the interaction Joanne remarked on several occasions that, "no one had ever asked me that question before." She appeared somewhat relieved. It became clear that the question had set in train a process of meaning making which over time brought substantial relief.

Such an experience is common in psychotherapeutic practice. Drawing attention to the element which was therapeutic involved an expression of *inner* life, the communication of emotional reality. This formulation doesn't detract from the external markers of depression such as sleep disturbance or weight loss, but rather views the same phenomenon from the viewpoint of personal experience. Fascinatingly, it was the expression of the *personal* meaning of her depression which provided some relief to Joanne.

Keeping this vignette in mind, it is argued that mental health professionals should approach not only observation of the patient, but also be willing to engage with his or her personal experience in order to do justice to the specialties of psychiatry, psychology and psychotherapy. It is necessary for these disciplines to engage the individual self rather than simply address the diagnosis. In this

1 The Free Energy Principle (FEP) is based upon the 2nd law of thermodynamics: that heat transfer is irreversible and associated with some dissipation of energy (increased disorder i.e. less organization, more information).

2 Qualia is a term used in philosophical discourse. It refers to phenomena that have a discernible **quality** but that are not readily accessible to measurement. In psychological discourse an example would be feeling.

sense they are somewhat distinct from other areas of medical practice and specialization. They require the integration of social and natural science. The requirement is for the clinician to become both observer and participant in the therapeutic relationship. Put another way, psychiatry and psychology can never be like renal medicine, for example, since the kidney doesn't create conscious experience.

How do we become communicative beings?

If one considers this question from the point of view of studying individuals as isolates, one might be puzzled at the complexity of acquiring the skills to express what is going on in the individual mind. How can the complexity of inner experience be delivered to the world outside, to our fellow beings? In considering the human situation, it may be relevant to ask, "What constitutes life at its most basic level?" The definition adopted for the purposes of this paper is borrowed from Schrodinger, that of "negative entropy", or *negentropy*[3] (Schrödinger, 1944). That is, life is a series of physical, chemical and biological processes by which there is ordering of matter and energy that runs counter to the inexorable trend of entropy (i.e. the tendency towards chaos and disorder) (Holmes, 2022). Language is an important part of this ordering process: "whether spoken sung or gestured (language) is structured, ordered, negentropic (ibid). Mind, in turn, requires language for its full development.

Given that life has the property of order, it must also contain information. Life is delineated from what is not alive by its tendency to maintain homeostasis within a given boundary (Friston, 2010). The maintenance of homeostasis within the organism in toto is the net result of movements of energy across the semi-permeable membrane between the *inner* surface of the body and the *outer* as delineated by the existence of a boundary. The skin is an example of the boundary at a macroscopic level, although boundaries also exist at the scales of organ systems, organs and individual cells. By way of example, blood glucose levels are maintained in human serum within a range to approximately 5mmol/L. Disruptions beyond the bounds of this range by addition of external glucose (food), or waning supplies of serum levels of glucose result in activation of a feedback loop to re-establish homeostasis. This predominantly takes place via activation of the two hormones insulin and glucagon. What we see here corresponds to the most fundamental level of homeostasis, one that occurs outside of consciousness and therefore might be considered 'non-mental', even though it is a necessary support for mental life. For Stephen Porges' *Polyvagal Theory*, this corresponds to Level 1 (non-conscious) homeostasis[4] (Porges, 2011).

However, for many species there is an indirectly related affect to the (unfelt, non-mental) phenomenon of glucose level: the homeostatic affect of hunger. The information communicated to the organism through this affect has a *qualia* (Solms, 2021). That is, hunger *feels* like something. This relates to Porges Level 2 homeostasis where the organism experiences feeling states in consciousness that provide information which motivates the organism to act. Feeling states are a minimal requirement for the organism to become a communicative being. For complex organisms like mammals, they are associated with needs for emotional expression and communicative interaction within the species.

Prototypically in development, infant experience is communicated to caregivers via emotional communication. The forms of communication are multiple and include the musculature of the face, the occurrence or quality of the cry or physical posturing. The infant is equipped to engage in reciprocal, affectively-based communication with caregivers from the beginning: the infant is a *communicant* (Brazelton, 1979). Mind initially develops in relationship, in the process of reciprocally conveying information between infant to carer. Although the infant doesn't understand symbols and is not conscious of using them, he or she is, nevertheless, a relational participant in human communication which has a symbolic dimension absent in other creatures. As such the infant's expressions and movements express something in symbolic terms, albeit unconsciously from the infant's viewpoint (Korner, 2021).

Psychoanalytic theory attempts to describe the phenomenon of emotional communication by postulating the existence of an as-yet-undescribed function of mind called a-function (Ferro, 2011; Vermote, 2018). The purpose of this is to trans-

3 Negentropy refers to the tendency of all life to organize matter (the reverse of entropy) – for humans this includes the symbolic level (i.e. language) as an organizing principle.

4 Homeostasis according to the Polyagal Theory: Level 1 homeostasis is non-conscious but important to bodily regulation (e.g. bodily systems supporting renal function); Level 2 is at least to an extent felt and so has some potential accessibility to consciousness); Level 3 is that which can be observed and, often, measured – the objective view; Level 4 depends upon communication and social engagement incorporating shared attention and understanding, enhanced by language.

form and make meaning of emotional experience. In its most basic form, discomfort and other disturbances in homeostasis might be conveyed in tears and posturing which then activates the carer whose state of homeostasis may also be disrupted by the emotional pathways in the brain. Optimally this engenders a state of mind of interest and curiosity about the source of homeostatic disruption – "is it hunger or tummy pain?"; "maybe the need for sleep?". In this exchange, what is required of the caregiver is to make observations whilst also participating in the relationship. Observation and curious inquiry help to make sense of the information. We might think of such infant-caregiver communicative exchange as emotional "ground zero."

Perhaps one of the difficulties for psychoanalytic theorists has been the need to try and explain what is happening within the individual mind. Taken from an intersubjective perspective and also considering the evolutionary need for social engagement (Porges, 2011), it might be seen that the capacity for feeling-based communicative interaction and attunement reflects the social organization of the brain towards reciprocal relatedness (Siegel, 2015; Malloch & Trevarthen, 2009). Furthermore, the putative a-function may reflect the kind of state where relatedness and social engagement are nurtured, subsequently leading to the development of self and the emergence of the individual capable of reflection, with a mind of his or her own.

Returning to the child who cries in hunger, the experience of hunger, which can be considered innate, has additional significance in being a motive for relatedness, in that the infant isn't capable of feeding itself. Mental growth, however, only takes place if there is a prototypical experience of an auxiliary mind. Another way to say this would be to speak of mutuality.

Bion's conceptualization of the parental contribution to growth in the mother-infant dyad depends upon a mental receptivity that he saw as a form of reverie (Bion, 2018). This state of reverie is a mental posture of inquiry, affective resonance and intuition which begins to model the prototype of "thinking" to the infant. Of course, what we are calling "thinking" here is characterized initially by a felt exchange. A more fluid idea, consistent with the thesis of this paper might be to speak of "dreaming" in the sense that is fundamental to the Australian Indigenous ideas about "being-in-the-world".

As development progresses, language begins to appear contemporaneously with a broader capacity for symbolization. Psychoanalytic theory postulates that thinking is acquired by the internalisation of a-function from caregivers where thought is stimulated by imaginative processes occurring in the "gaps" between inner perceptual experience and outer reality. Bion would describe this as a process by which "frustration" (read homeostatic disruption) is mated with a pre-conception (Bion, 2018). For the Conversational Model, this development would occur through forms of feeling (Hobson, 1985) generated in the protoconversation, reflected in feeling patterns and images before coming to incorporate symbolic verbal language. Interactions grow in complexity and the child begins to engage in symbolic play (Piaget, 1954), usually in the third year of life. This is a precursor to the sense of having an inner relationship (an "I" and a "me") and an inner world (Vygotsky, 1934; Meares, 2005).

Subsequent conceptual developments that have elaborated the link between reverie, thinking and waking imagination, suggest that the semi-permeable "membrane" of the mind is the dream function itself (Ferro, 2002, 2006; Ogden, 2006). When we speak of "semi-permeability", we take note of the inherent uncertainties in individual lives and the fact that the boundary with the environment finds representation in consciousness through feeling: a flexible adjustment with the environment is made possible (Solms, 2021). One begins to see a theme here. Both mind and body exist in a state oriented towards maintenance of homeostasis, mediated by exchange with the external environment across some sort of semi-permeable boundary.

In its simplest form, energy is exchanged across this boundary because of a basic need for order which is true at the unconscious as well as conscious levels. The body needs to maintain equilibrium and the mind has to modulate feeling states. It may be the dream function that mediates not only that which is inner and outer but also what can be imagined and what can be done with others. Its existence may be fundamental to human life.

Mental Disorder as part of the *becoming* of mental health: a paradigm of trauma and recovery

"If we keep ever-present in our minds the idea of a veritable human order, if we think of it as something to which a total sacrifice is due should the need arise, we shall be in a similar position to that of a man travelling, without a guide., through the night, but continually thinking of the direction he wishes to follow. Such a traveller's way is lit by hope." *Simone Weil, 1943*

If we consider that the primary evolutionary advantage for *homo sapiens* is a capacity for social en-

gagement, the *sapiens* component might be thought of as a kind of "knowing in relationship" in the first place, evident from the beginning of life, that confers opportunities for the development of individual minds through engagement in mutual, intimate relatedness that nurtures imagination and creative thought. When we understand that homeostasis involves not only an internal relationship but also social relationships which serve functions not only in relation to mental life but also in relation to bodily physiological regulation, we see that mind and body are mutually entwined and interdependent. Higher levels of homeostasis correspond to Levels 3 and 4 in the Polyvagal Theory (Porges, 2011). Level 3 involves what can be observed through the senses (the objective behavioural view). The highest and most complex form of regulation, Level 4, involves engagement with other minds, initially through the affectively-based exchanges of the proto-conversation (Trevarthen, 1975), and subsequently through verbal exchanges. Critically, Level 4 involves connection with other minds at the subjective level (Porges, 2011). The "Psyche" sciences need to recognize this level of experience if they are to capture the complexity of mental functioning and its disruption.

If mental responses become too fixed in an effort to maintain homeostasis, the personality may become rigid, constituting a form of mental disorder. On the other hand, a lack of boundedness may lead to a different kind of breakdown, sometimes to the point of psychosis. What is being described are disruptions of mental process, rather than an unchangeable object or disease. For a social species, growth depends on social engagement. A healthy homeostatic spiral of exchange with others leads to growth and greater adaptability. In this form, homeostasis becomes *allostasis*[5] (Atzil et al, 2018). In humans, where communication is symbolic (through language) as well as affective, we have a condition of allostasis that supports the development of minds capable of transcending time and place, conferring significant evolutionary advantages. The allostatic path incorporates novelty that enlarges the mind, often taking the form of something *new* relative to the individual, introduced in a conversation.

The pathway to the development of a bounded mind, unique to the individual, is through the kind of relationship of intimacy and mutuality that is first found in the protoconversation (Meares, 2000; Trevarthen, 1975). It "*generates a particular kind of pleasure that neither could gain alone*" (Meares, 2016). Recovery from mental disorder (the disruption of mental process) often depends upon some level of engagement in a dyadic relationship where the sense of safety and pleasure gives rise to the growth of self. This kind of exchange involves a to-and-fro conversation in which both parties participate, although it still needs to operate within bounds. Even in the situation of the parent-infant protoconversation, there will be times when excitement leads to fatigue, when rest is required. The conversation needs to respect the limits of the infant's (person's) capacity. Without this kind of relationship of interplay and intimacy, individuals are left in states of alienation. There will still be a repertoire of coping modes but the person is left without the benefit of mutual pleasure in relationship and mutual assistance in dealing with the world, described by Holmes as "twogetherness" (Holmes, 2022). This kind of mutual aid is crucial at the beginning of life and important throughout life.

Reconsidering the concept of *mental disorder*, we maintain that it remains relevant to the mental health disciplines. However, that is not to say that it is easy to define. There has long been difficulty in "arriving at a naturalistic definition of disorder", let alone mental disorder (Rashed, 2021). In relation to mental disorder, it has been proposed that *social recognition* may be essential to understanding mental processes (Rashed, 2021). This makes sense if one understands that the development of self involves processes of recognition, whereby what is meaningful for the infant early in life is his or her recognition by the mother (other) e.g. being "the apple of mother's eye". Language itself depends on a network of shared understanding in relationships. Meaning and significance don't exist apart from relationships. Therefore, a science of meaning can't be understood by examining individuals (or brains) in isolation. Rashed argues that a normative view of individuality is that "the subject's relationship with itself must be mediated through a relationship with another", such that "the subject can only become free once it engages with other subjects in uncoerced relations of mutual recognition through which it finds confirmation of its self-conception as an autonomous subject." (Rashed, 2021).

If *mental health* involves relationship and social recognition, then the healing process for those afflicted from *mental disorder* will require a therapeutic relationship that provides connection and a sense of recognition and significance. What is implied is an empathic relationship with the individual that engages at the level of human understanding (*verstehen*) (Jaspers, 1913). One thing requiring recognition is the suffering commonly related to traumatic experience. Another is the basic value of each individual and the complex adaptations to

5 Allostasis refers to the processes of growth that occur in species that depend upon social relationships for their development. Human beings are such a species, with the added dimension of growing in a "languaged" world.

life they have made. Health policy in Australia has changed over the last two decades, from an emphasis on the patient with "severe mental illness" to a paradigm of "trauma and recovery". This has been influenced by people with lived experience of mental disorder (NSW Mental Health Commission, 2014; Kezelman & Stavropoulos, 2019). Lived experience involves a direct form of knowing mental disorder, not captured by objective description. Beyond the particular therapeutic engagement, a broader conversation is being conducted to improve recognition of the suffering and trauma of mental disorder. This also covers the many strange mental phenomena that may occur as a result of breakdowns in the homeostatic / allostatic process, often characterized by experiences of fragmentation and dissociation (Meares, 2020). The recovery process potentially transforms traumatic consciousness towards a form where the person feels both comfortable with themselves and with others, the state of "alone-togetherness" (Meares, 2020; Hobson, 1985).

At a recent seminar (Campbell et al, 2022), three people with lived experience of mental disorder shared their experience of recovery. What was held in common across experiences that involved severe depression, emotional dysregulation, hospitalization and even psychotic phenomena, was that the recovery work was arduous for each person and was also something that required ongoing effort in order to maintain an adjustment to life. It was an ongoing process rather than a disease that got cured. One person said that she felt her life had changed forever when she first became unwell, something quite often reported with serious mental disorder (Rashed, 2022). In some cases, "the central project we all have of constructing and maintaining our identity is profoundly undermined" (Kennett, 2009). Yet, for all three people there was meaningful recovery and in some respects an enrichment of life. The restorations of order had involved therapeutic and other relationships, periods in hospital, drug and alcohol intervention, drug treatments, social and occupational changes – all in varying degrees. In each of these journeys there were examples of turning points laden with meaning and hope. By recognizing the significance of *mental disorder*, we recognize the significance of minds and the participation of individuals in their own recovery, as distinct from disease interventions which are often characterized by a more prescriptive approach.

Conclusions

Terms like mind, mentality, mental disorder, mental distress are not "reductionistic anachronisms" because they refer to a level of experience understood not only within a professional community but by the community at large. Respect for individual minds and a capacity to engage with individual patients must be considered a cornerstone of effective interventions in all of the clinical disciplines that pertain to the psyche. Language provides us with a common sense and a common conceptual network of relationships. It is likely that the "brain shares the same causal structure as the world" (Friston, 2022), explaining why we are also able to begin to understand how neural networks support conscious experience. The brain and central nervous systems, parts of the body as a whole, are to be understood as facilitating human experience which always arises in interactions with others and the world. Minds and mentality should never be dispensed with in clinical practice.

We argue for retaining the notion of mental disorder within the clinical mental health disciplines. The mind develops in an interface with personal reality, as experienced by each individual. Its growth is a function of communicative exchange with other minds. To neglect mind, and mental disorder by extension, is to equate object and subject, obliterating the *personal* in the process. The personal, private and meaningful aspects of subjective experience are both intuitive and intrinsic to a humanised study of psychiatry and psychology. It is not simply a better psychiatry that comes from the retention of the notion of mind and mental disorder. It is one more congruent with advances in neuroscience and the knowledge-base of psychodynamic psychotherapy. Mind is the basis for the human sciences and disciplines concerned with meaning.

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The dilemma of sharing clinical case material: Reflections on a paper by Lewis Aron

Frank Margison

Abstract

Relational forms of therapy such as the Conversational Model rely on sharing stories to help us understand the complex interplay between therapist and client. We do this to help us make sense of the many pathways through which problems can be explored. The benefits include being able to follow the footsteps (including mistakes) of those who have gone before; deepening our range of empathic understanding; and modelling a culture of mutuality and respect.

Inevitably some of these stories mean sharing our experience as therapists, whether in books, journal articles, or other media.

Such sharing leads to inevitable conflicts within our ethical system about the right to confidentiality of clients and indeed to differing notions of what confidentiality and informed consent might mean in this context, and indeed ambiguity about who owns the material. Until recently, the client's voice has not been prominent in making these decisions and this paper explores some of the difficulties that can ensue even when we are careful about maintaining principles of confidentiality in an intersubjective endeavour.

This paper reflects on the contribution of the Relational psychoanalyst, Lewis Aron, in his paper "Ethical considerations in psychoanalytic writing revisited" (Aron, 2016, republished in Atlas, 2019 with introduction by Jay Greenberg):

"Few problems are as challenging to our efforts to develop psychoanalysis as an intellectual discipline as the problem of patient confidentiality. On the one hand, it is hard to imagine inviting patients to share what they hate or fear most about themselves without promising that we will do everything we can to preserve their privacy. On the other hand, for psychoanalysis to work either as a method for exploring human experience or as a therapy, we must be able to fully communicate to our colleagues about what happens—what really happens—in our consulting rooms".

This paper develops Aron's discussion of what it means for a patient or client to give "informed consent" and some of the institutional responses to the dilemma of confidentiality.

Introduction

Aron comments that in 1995 the International Committee of Medical Journal Editors [ICMJE] established a new international standard of editorial policy (ICMJE, 1995). This requires written informed consent by the subject for every case report published in a medical journal. This policy has had a direct effect on psychiatry and, therefore, on many psychoanalysts and psychotherapists.

In response, psychoanalytic institutions argued that they were a special case. For example, David Tuckett (2000), in his role as editor of the International Journal of Psychoanalysis, expressed the view that the 1995 requirements for all disclosed clinical records to be undisguised, but anonymous, and for the informed consent of the patient to be obtained prior to inclusion in any study, are in conflict with the very nature of psychoanalytic work.

One approach in the past relied on the idea that clients would be extremely unlikely to come across writings about them, as the literature was generally obscure and read solely by professionals, and if clients did it could be assumed they were pathological in some way.

This comforting illusion is no longer valid as Aron comments:

"Twenty years ago, it would have been unlikely that patients, not themselves professionals, would

come across their analysts' writings. Now one can simply Google one's therapist and potentially recognize oneself in the text of any publication" (Aron, op. cit. p.287, citing Kolod, 2010).

Alfonso (2002) described several methods through which we might write case studies ethically. He suggested several options, including:

- Informed consent
- Avoiding identifying details
- Disguising without 'distorting the essence of what was being reported'
- Creating case composites combining several stories into a prototypical case
- Using excerpts of the verbatim process
- Using any or all of the above freely and creatively

Each of these has its own problems that are worth exploring more fully:

Informed consent

Informed consent is a tricky concept at the best of times because of the intrinsic power asymmetry between therapist and client.

During the course of a therapy the therapist is constantly working with re-enactments of early patterns in the person's life. It seems fanciful that this can be put on one side temporarily while the therapist asks a favour of the client. Greenberg (2019), in the introduction to Aron's paper, comments as follows:

"In fact, [Aron] raises the question of whether even asking for permission is ethical. This strikes me as a very interesting although rarely addressed aspect of the problem. Most of us would agree that asking a patient for anything—from something relatively benign like a restaurant recommendation to something much more volatile like a stock tip—is questionable technique. And although we don't talk about it much, technical lapses can blend, sometimes imperceptibly, with ethical lapses…" (Greenberg, 2019, p.287).

He cites Aron, later in the paper:

"It is probably wise to think that all presentations and publications of clinical material represent some form of enactment …" (op. cit. p.289).

This comment is true at a profound level, but is often ignored by therapists of all levels of seniority and suggests that precautions are put in place to at least bring the issue into a reflective environment. Greenberg reminds us that Aron:

"advises seeking consultation whenever we are considering writing or presenting our work with a particular patient" for this reason (op. cit. p.286).

Aron (op. cit. p.287) gives an example that brings home the need for consultation even when the enactment may appear to be beneficial in unlocking the therapy as in the following case:

"A few years ago, the NYU Postdoctoral Program sponsored a conference featuring a clinical case discussion. Before the presentation was composed, I encouraged the speaker to ask the patient for consent. The analyst received the following letter from her patient, and the case was later published (Oram, 2013). In this case, asking for permission seemed to be a turning point in unblocking a certain treatment stalemate. The patient went from feeling that she could only take from the therapist to feeling that she could also contribute. The therapist had not been aware of this dynamic until after she obtained the patient's permission to present the case report.

"Dear Kate,

Would I mind if you referred to our work together at a Postdoctoral Program presentation at the Institute of NYU? Of course I wouldn't!! For someone like me who never met a boundary in a relationship that she didn't try to cross, this is a dream come true!!! I don't even have to do anything; you are doing all the work. You don't have to worry about disguising my identity … I'm sitting here imagining Margot [her friend who had helped her find her the therapist who had been so helpful and who had died a number of years ago] in the discussion group … howling out loud, "I know her"! Oh, that she was here; she would love this. Please know that I don't want to know any of the details unless I ask about it in a session with you. If it gets me little nuts, I want to be in a position to deal with it with you in the confines of your office. Besides, one of us has to keep up some semblance of a normal doctor-patient relationship here. [She puts in a smiley face at this point.] … Finally, it is an understatement, but thank you for making and keeping me a part of your work. Have happy holidays.

Peace, Rosalie (Oram, 2013, pp. 596–597).

A long therapy would be needed to disentangle the multiple layers of meaning in that letter, even if a therapeutic impasse had been overcome. If nothing else, it reminds us of the complexity that may be involved in asking permission to publish material

from a therapy. In this case the therapy was ongoing and, at least in principle, can be managed like a breach in the therapeutic alliance: to recognise something has gone wrong; to apologise for causing a perturbation in the flow of therapy; to reflect together on what it means; and to link the event to broader themes already explored in the therapy.

Who thought it could be so complex to simply ask permission to share in a respectful adult-to-adult way! But this is benign complexity and not seeking consent in a timely way could have caused even more serious difficulties. Aron cites one of several cases where the enactment could not be worked through and an alliance breach ends in the termination of the therapy:

"Worst-case scenarios include the patient experiencing the therapist's writing as a malignant re-enactment or a betrayal that may even result in unfortunate termination of the treatment" (Bridges, 2007, cited in Aron 2019).

Bridges describes seeking consent from 16 patients to use clinical material for publication. She elucidates her process with patients and focuses on the positive and harmful aspects of seeking permission, particularly its effects on the therapeutic relationship:

"Seeking consent raised issues of confidentiality and stimulated wide-ranging, layered and linked emotions and meanings for patients, including feelings of closeness, envy, and shame, which in some cases may lead to treatment interruptions.

If the analyst actively employs this process as a therapeutic tool, across time, with openness to unexpected meanings, it may advance the therapeutic conversation and developmental possibilities. When there is a negative effect on the patient or the process, analysts' shame and guilt may be evoked and consultation is recommended" (Bridges, 2007, p.23).

All of the above examples are drawn from ongoing therapies, but the consequences may only appear many years later:

"A therapist was working with a young woman who consented to publication of an article that detailed aspects of her personal life—in particular, sexual fantasies about her female analyst. The analyst was careful about having her read it and work through its meanings before deciding to publish the article. Some years later, the patient, after having benefited from the analysis, decided to change careers and go back to graduate school to become a psychologist. Guess which article was one day assigned for her class to read? Yes, the former patient sat through an entire class discussing her own analyst's article about her. Although she was not recognizable in the article, this incident brought her to seek further treatment, as it stirred up powerful old feelings and conflicts about her analyst, as well as about her sexuality, all of which had fresh meaning to her in the context of her new professional context" (Aron, op. cit. p.294).

Other examples show an extraordinary level of complexity, and the difficulties of having adequate foresight. For example, Aron cites an example of re-enactment where neither therapist nor client were at all consciously aware in advance, and the symmetry and accuracy of the re-enactment made it impossible to work through in the end:

"One therapist spent several years preparing and revising a detailed case history about a woman patient. After the therapist submitted the draft to a publisher, the journal's editorial board insisted that the author obtain written consent from the disguised patient... Feeling under pressure with the journal ready to publish her work, the therapist asked the patient for permission, only to have the patient react with great upset and conflict. The patient remarked, "But I want to tell my own story." The patient had, in fact, been writing her own short story about her life and therapy (of which the therapist was aware) and the week before the therapist had brought up the question of consent, the patient's own article had been accepted by a magazine for publication (she had not yet told her therapist)".

This resonance would have been complex enough, but there was a further level to be worked through:

"One aspect of the patient's childhood narrative was that her mother had been very competitive with her. The patient had a specific childhood memory of writing a story, showing it to her mother, and the mother writing her own stories in response. In this case, the patient did not want to read what her therapist had written and deliberated about whether she would be willing to consent to her therapist's publication in a journal. The therapist wisely, although with great disappointment, decided not to publish the article. Nonetheless, the patient was so angry that she opted to discontinue the treatment" (op. cit. p.293).

Aron cites Saketopolou (2015) to draw attention to the potential for therapist naivety in this matter in pretending it is a straightforward transaction:

"It is ironic that psychoanalysts who think clinically of patients having "multiple self states" and being "divided selves" will assume that patients give consent as if they are unified coherent agents, transparent to themselves" (op. cit. p.290).

Another example he helped to disentangle involved a client who had given consent verbally but had not signed a written "release". It emerged that she read an account of a therapy (albeit effectively disguised) but she realised it was a detailed account of her own therapy. She readily acknowledged giving consent but thought the consent was to be one of several subjects in a study of treatment of anxiety:

"But when the patient looked up the published article years later, she was astounded at what she found. The article included verbatim accounts of her dreams with deeply personal imagery. Now, she readily acknowledged that no one would recognize this personal material other than herself. However, the patient was shocked and appalled that her personal material was laid out for all the world to see, even if they did not know it was hers" (Aron, op. cit. p.291).

How have other therapists managed these difficulties? Alternative approaches

In order to have informed consent we would need to be able to provide at least some information about harms as well as benefits.

Bridges (2007) describes some of the dilemmas she faced in discussing publication with 16 clients:

"Analyst-authors who ask patients for permission to use clinical material and then share the results with these patients must confront and reconcile the inherent conflict between their role as therapists, the needs of their patients, and their professional ambitions. There is great potential for analysts to feel ambivalent about moving away from patients' needs or guilty, particularly if patients react negatively to the request. Requesting consent and sharing written material with patients stimulates disparate feelings and meanings for both patient and analyst. One never knows whether this intrusion into the analytic space will yield unexpected therapeutic benefit or cause harm".

The literature contains many moving and resonant accounts of therapy. Adshead and Horne (2021) wrote poignant accounts of Adshead's work in forensic settings. Her accounts sound remarkably nuanced and present a coherent account of an individual in each chapter, with detailed accounts of imagery and context, but Adshead wrote the pieces with a co-author, Eileen Horne, a dramatist and writer, and says they are composites of several cases, but states "the cases represented here" suggesting that the chapters are focused on particular accounts.

There are many books of illustrative case formulations, for example by Tracy Eells (Eells, 1997). These provide a very effective way of looking in depth at an approach, its conceptualisation, and an account of a particular case with transcripts of examples from several sessions as themes develop. It is unclear how identifiable these case formulations might be as Eells states:

"Authors were encouraged to present actual materials used in case formulation, for example, interview transcripts, questionnaires, or diagrams (All names used are pseudonyms)." (Eells, 1997, p.xii).

A similar approach was taken by Jacobs (1995), who wrote a series of books each based on several therapist authors representing different approaches who were asked to write about their model in relation to a person they had not met. Each book focused on a volunteer who gave consent to some information being collated from interviews and agreed and then circulated. The authors could seek additional information from the client in writing. The experience was like meeting a client remotely, but looked at from different perspectives (Margison, 1995).

Susi Orbach (2018) wrote a carefully detailed account of several therapies that similarly convey both the detail and the atmosphere. They have also been dramatized for BBC Radio 4 which adds to the realism that these are true therapies. Orbach comments that the process involved script development with a team of co-writers so this adds further distance from any actual therapy.

It is worth mentioning that therapies may be entirely works of imagination by writers of fiction rather than psychotherapists. For example, Geller & Spector (1987) have edited a compilation of nineteen fictional accounts of therapy, and some portray dilemmas faced by therapists in an illuminating way.

Experience in the Conversational Model

Within the Conversational Model we have several case stories that form the bedrock on which we can build our own development as therapists. Some are composites (Barkham et al, 2017) based on fragments of real therapy sessions, others are fictional, and some are from transcripts of sessions where permission has been given for use in research and teaching.

Russell Meares also draws out extensive personal narratives of the patients he includes in his various books such as "Intimacy and Alienation" (Meares, 2000).

Robert Hobson has some memorable, anonymised, accounts of therapies in "Forms of Feeling" (1985). All were based on real events but several had been edited to make particular points and all had been anonymised, even with explicit consent. However, he was subject to criticism in another published work which happened to be about the father of one of Hobson's patients (Callil, 2006, pp. 439-441) for putting in details of a daughter who had ended her life. This was many years after the patient's death and was several years after Hobson's death, so he had no opportunity of commenting, but the possibility of criticism of a published account many years after it was written and in an unrelated context has made me concerned to ensure that there is discussion of these issues.

Avoiding identifying details

Falsifying, or at least avoiding, contextual details has been a common strategy for managing anonymity. Simply altering the demographic details, such as occupation, age, location etc., is a very weak form of disguise, however. When the same case is discussed in several places it is particularly risky as it is simple to use internet resources to piece together fragments to identify the person as we know from experience with identity theft as part of internet fraud.

In any case, the core of the narrative does not depend on demographic data as discussed in the next section.

Disguising without 'distorting the essence of what was being reported'

Sometimes authors set the higher standard that the clients would not recognise themselves if they found the case discussion, whether by accident or design. With care, this could probably be achieved by disguising facts about the client systematically, but it is difficult to know which nuanced detail would trigger recognition. But, more importantly, the essence of a psychotherapy case should include the metaphors, images, and verbatim comments that guide the therapy, and translating these to a nondescript language would lose their fundamental meaning. So, what is gained in confidentiality is lost in the essence of the narrative.

This view is most clearly stated by Blechner (2012, cited Aron, op. cit. p.305) who took the view that the story is the property of the patient:

"The bottom line is this: If you want to disguise a patient, do so by eliminating identifying information, but not by putting in false details. Even if you think these false details do not change the basic thrust of the case, you cannot know that" (p. 17).

Aron comments that Blechner has the view that "disguising clinical material is equivalent to a scientific researcher publishing false data" (op. cit. p.305).

Creating case composites combining several stories into a prototypical case

This is an appealing strategy and is now widely used as a way of avoiding the complexity of seeking informed consent. As a way of generalising themes such as working with suicidal thoughts this approach is a good way of bringing a complex theme to life. Nevertheless, it is not the same as a unified account of a therapy unfolding. This approach is commonly found when therapists draw on their experience in role plays, often to the extent that the protagonist would have difficulty identifying which strands come from which particular client.

Aron also discusses the possibility of "clinically inspired fiction" where a case is made up:

"[The writer] may take as inspiration something that happened with a patient, or with several patients, and write a fictional case that they believe is "true" to the spirit of their clinical experience. The line between writing a "composite" and writing "fiction" can be a thin one".

Using excerpts of the verbatim process

Of all of the suggestions made by Alfonso (2002) this is the least easy to manage. Of course, it is simple to extract a simple phrase and not attribute it on the assumption that the client would not

know anyway, but a moment's thought draws attention to the difficulty here as well: If a section of text is worth citing it is likely to be more memorable than the average, and a client is likely to be left with confusion if they see a piece of speech they feel they recognise: is this a disembodied part of me on the page, or are my phrases so commonplace that they are no better than cliches?

There are exceptional cases where a client has given prior permission for anonymised content to be used in video teaching, as above, or where material is already in the public domain, but this does not alter the underlying need for reflection about the interpersonal meaning of using material from a client when permission is sought to use non-identifiable material at the beginning of a therapy.

The pros and cons of using client material

There are several examples in the literature where clients have responded with gratitude for their words being taken so seriously and reverently.

Pizer (2000, cited by Aron 2019), for example, reported his reactions to one patient upon her learning that he had written about her:

"To my surprise, she responded with enthusiasm. She told me that it felt easy for her to give her consent because she felt reassured by my writing, presenting, and publishing. She said that, in the face of the personal risks she experienced in her analysis, she felt that much safer knowing that our work was linked to a professional community and to my own serious commitment to contributing to my field. For her, the writing added to a sane context for her terrifying analytic journey" (op. cit. p.258).

Aron quotes Gerson (2000) along similar lines:

"I believe that the wish to discuss one's work, in publication or verbally, is essential to one's function as a therapist … First, there is the need to hold the patient's experience in one's own mind in a manner whereby it can be an object of reflection for both patient and analyst. Second, and a requisite for the accomplishment of the first need, is the need to have a relationship to an "other" that extends beyond the intimacy of the immediate experience with the patient. These two needs of the analyst are not in opposition to the patient's needs" (op. cit. p.263).

Aron makes a good point when he responds that "nothing in the previous two opinions suggests that the therapist should write without the patient's informed consent", but, also, both can be read as "special pleading". Seeing the written account of therapy as contributing an analytic "third" position to benefit therapy seems to be sophistry as supervision can hold this function with no need to publish the details of the therapy for the wider community. Seeing the writing as a "sane context in a terrifying analytic journey" could also be seen as evidence that the therapeutic frame was insufficiently resilient to contain the client's anxiety. It may feel safer to know your analyst is overseen by a whole community of therapists but that is not a justification to publish an account of therapy in order to make the client feels safer.

Against the possible benefit of the client offering something valuable as a gift (Spandler et al, 2000), by agreeing to publication, there is always the danger of a silenced client being unable to voice their objections. These dynamics can affect the therapist too, for example feeling the client has been "ungrateful" if they do not agree to the therapist sharing material. Equally, the client may feel they are letting down the therapist if they object, and these feelings then driving an unhelpful and unspoken re-enactment cycle involving both parties.

Co-creation and the therapeutic conversation

Aron discusses the complexity of "informed consent" and the importance of co-creation of understanding within a therapy. He speaks from a relational position within psychoanalytic thinking:

"We refer to the relational tradition, rather than to a relational school, to highlight that we are identifying a trend, a tendency within contemporary psychoanalysis, not a more formally organized or coherent school or system of beliefs. Our use of the term relational signifies a dimension of theory and practice that has become salient across the wide spectrum of contemporary psychoanalysis" (op. cit. p.iv).

Aron is drawing on a theme of intersubjectivity:

"The first is the evolution of psychoanalytic theory from a one-person to a two-person model. That is, psychoanalytic process and content are increasingly viewed as co-created by analyst and patient. It is therefore less reasonable for the analyst to make unilateral decisions regarding the use of clinical material" (op. cit. p.287).

This applies a fortiori when we consider the Conversational Model of psychotherapy. Central to this way of working is that meaning is co-constructed by client and therapist, so ownership of that co-creation is intrinsically ambiguous. In contrast, from the very early days of this model there is an assumption of an equal but asymmetric relationship, which Hobson called "mutual asymmetry" (Hobson, 1985, p.184), so we could argue that managing the "business" of the relationship (boundaries, fees where relevant, and relations with the external world) is somehow "delegated" to the therapist. But, even if this questionable assumption were true, the therapist would be working within a frame of reference set by law and professional regulation on the one hand and by peer discussion on the other.

Legal issues

The legal basis for making these decisions is unclear as it would depend on case law in particular jurisdictions. Aron writes advice from the perspective of lawyers he has consulted in New York City and his advice may not hold in other countries or even other US states. Nevertheless, I think his advice is helpful in confirming that this is not primarily a legal matter, but insofar as he draws any conclusions he summarises:

"…it should be stated that the legal experts with whom I have consulted advised me to not involve the patient in my professional life, to not get involved in a complicated dual relationship, but rather to disguise the material carefully and keep the patient at a distance from my professional use of the clinical material. I have to admit that although my own leanings are somewhat to the more radical side of these debates (that is, I lean toward always obtaining informed consent), hearing these cautions from my lawyers has kept me more restrained and conservative than I would otherwise be" (op. cit. p.313).

Each health system develops its own guidance, and these do not always refer specifically to the issues covered in this paper, as discussed below, but it is worth being familiar with the underlying concepts of

- being able to justify the purpose
- using confidential material only when it is necessary
- using the minimum necessary confidential information
- information being on a "need-to-know" basis
- being aware of our responsibilities
- complying with the law and using confidential information for lawful purposes
- sharing in the best interests of the patient
- informing patients how their confidential information is being used

(National Data Guardian, 2020)

These are known as the Eight Caldicott Principles drawn from the report by Dame Fiona Caldicott, herself a medical psychotherapist in the National Health Service [NHS] before taking on public service roles.

On the face of it, these principles (and equivalents in other jurisdictions) would affect the publication of identifiable material from a therapy. The report especially deals with "patient-identifiable information". This deals with information from which an individual patient can be identified (possibly in combination with other data), but the term reminds us that information that could be identified by the patient is also important to recognise.

This seems to lead to the position that information that cannot be used to identify the patient and could not be identified by the individual would not be covered by this guidance, but as discussed throughout this paper there are circumstances we cannot always identify in advance that mean that a person can become identifiable. For example, if the client decides to write their own account of their therapy as described earlier, or as in the example affecting Hobson, when an author identifies the patient in a completely different context subsequently.

Levin (2003, cited by Aron, op. cit. p.308) goes even further and states:

"Levin viewed the underlying issue of patient confidentiality in terms of the analyst having a separate life and existence apart from the patient. He concluded that anonymous disclosures of clinical material in supervision, teaching, or scientific presentations are not breaches of confidentiality at all".

Practical issues

It is clear that a presentation is always within a specific context. To some extent we can rely on

colleagues following conventions (stated at the outset of a presentation) that "the following material should be treated with professional confidentiality". But, even that is not a wholly satisfactory way of resolving the dilemma as we cannot know when members of the audience may in good faith quote examples we have given in their own presentations.

Aron, as always, provides thoughtful advice:

"It appears reasonable to weigh into one's decision-making the purposes of the presentation or publication. The use of patient material in a magazine article written for the public for the purposes of education may be different from the criteria used when the purpose is for entertainment. Discussing a patient's progress for the purposes of supervision or consultation may push for a different guideline of stringency than sharing a case presentation with a class for educational purposes, and that may yet be different than using the material to illustrate a particular methodology to a large audience. There are no clear criteria or guidelines available for these situations, but these factors should be weighed in making a decision" (op. cit. p.311).

In an educational context he suggests that open discussion as part of training is needed:

"Clinical instructors and institutes should be discussing questions of ethics, and clinical concerns related to the use of clinical material, when students present cases from the start in classes, at colloquia, clinical seminars, and so forth. Discussion among colleagues and with students will immediately bring to light the wide swath of variations and relevant considerations. What is the nature of the media—oral or written? To whom is it being presented? A public or professional audience? How large a group? For what purpose? Is it a comprehensive and detailed case history or a brief vignette? That we do not have consistent answers does not justify the neglect of addressing the dilemma." (op. cit. p.312).

As a contribution to the peer discussion, I offer the following thoughts:

At what point do I seek permission to share material?

There is a strong argument suggesting that the possibility should be raised at the outset so that the issues become an inherent part of the therapeutic frame. This is sometimes feasible within a teaching or research framework where we can discuss how and what information might be shared in advance. But the salutary tale of the woman in the anxiety study described earlier should make us careful that we are clear for what we are seeking consent. There is also a risk of tantalising the client by saying I "may" publish some of our discussion, but then not doing so.

How do I seek permission?

This is a surprisingly difficult question to answer. This paper shows just how complex an issue it is to seek permission from a client in the first place: we may have general consent at the outset of a therapy, but this means little if there is no mechanism to withdraw that consent later.

One way of seeking consent is to consider the client essentially as a co-author from whom we seek comment and agreement before publication, but then the client – if truly a co-author- should be cited by name as someone making an explicit contribution to a publication. However, then the whole process of confidentiality of the material is rendered pointless anyway as the client is named as an author. Perhaps a workable compromise would be formally to acknowledge the client's contribution, not just for the therapy but for any comments they may have made. This deals with the issue of attribution to some extent, but does not deal with the disruption to the frame of therapy incurred when permission is sought. It is inevitable that bringing in the therapist's agenda and needs would cause disruption of some form.

Whose account is it?

In the introduction by Jay Greenberg, he draws attention to the special difficulties arising from discussion of countertransference responses to the client.

"….'disguise'—however we understand or implement it—must not only prevent the patients' acquaintances from figuring out who they are, it must also keep the patients from finding themselves in our reports. This makes crafting our case reports more difficult, and it also raises the stakes. Contemporary clinical vignettes include a great deal of discussion of the analyst's inner experience, including countertransference experience that we may believe is best kept from our patients. Patients

who are still in treatment, and even those who no longer are, can easily be injured by what they learn, even if the analyst correctly believes that his or her awareness of the countertransference was a crucial aspect of the eventual success of the treatment" (op. cit. p.285).

To be fully open to discussion of every countertransference theme experienced in a therapy starts to edge towards "mutual analysis". This idea was originally developed by Ferenczi (1988) and deliberately blurs the boundary between the analyst and patient and Gabbard (1995) has commented that mutual analysis set the stage for unfortunate boundary violations.

Hence, truly open sharing with a client where the content deals with personal material arising in the countertransference must set a limit on what is ethical to share and discuss with the client and still maintain necessary boundaries.

At a practical level, the issue of "signing off" the draft before submitting it (and presumably this would apply to any subsequent amendments too) may be correct in principle, but will impact on the nature of the relationship and the discussion may potentially become the "cuckoo in the nest" pushing out all other aspects of the therapy.

There may be some circumstances where it is helpful to consider publishing the client's take on the therapy within the paper itself, possibly as an appendix, but it is hard to avoid some degree of asymmetry with the therapist writing for a particular audience and this in turn shaping the paper.

Sometimes consent may be sought after a therapy is complete, but Aron gives examples where this has required additional sessions to process the perturbation caused by the request.

Discussing with a client is not a simple matter too when you are drawing up a composite from several clients. Even if you could identify clearly what came from a particular encounter, it would be difficult to seek meaningful consent.

The conclusion from Aron's paper summarises these issues cogently:

"I have raised questions that cross over among ethical, legal, clinical, professional, and educational concerns. It is readily apparent that at this stage of our profession's history we do not have a single unified position or anything like a consensus, and expert opinions range from ultraconservative to radical. Furthermore, each situation, and each patient-therapist dyad, is unique, requiring the application of general principles to distinctive situations….

It is probably wise to think that all presentations and publications of clinical material represent some form of enactment of unconscious dynamics; enactments, after all, are often played out through our technical interventions and through management of the therapeutic frame, and therefore it is advisable to give careful thought and to seek consultation on all cases one considers presenting, both at early and later stages of the writing and publications process" (op. cit. p.314).

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Transference and the Expectational Field in Primary Care Relationships

Robyn Chase

Abstract

There is increasing awareness amongst primary care practitioners that experiences of trauma are life experiences that are very common in the general population. The sequelae of trauma may underlie a diverse range of health issues and, with this recognition, there is momentum amongst primary care practitioners to question reductionist approaches to health care and move towards a paradigm of whole person care, Generalism, where the relationship between patient and practitioner is a key component. Yet, despite the intent of the generalist practitioner to create a safe therapeutic relationship, some primary care relationships remain enduringly "difficult". This essay explores how the Conversational Model's trauma-based conception of transference, countertransference and the phenomenon of the expectational field may assist in understanding the dynamics of a difficult primary care therapeutic relationship that has remained stuck in disconnection over many consultations, and how these concepts may assist in moving the relationship towards connection and safety.

Introduction

"She is young to have so many layers to her suffering. I know about the fragile life she leads on the edge of homelessness. I can….feel the wariness she has acquired through her short life of abandonment. Together, we leave our usual talk of sex and substances behind while she struggles to articulate what the memories do in the night-time……The stories curdle in the room and leave a taint of cruelty and loss. I listen……her words come in ragged clusters with long silences, and I wait for them to settle in the space between us. Her narrative drifts in clumps around us, and in the silences, I gently try to bring a little coherence so she can feel understood…. Somewhere, another part of my mind rummages through my ragbag of frameworks and metaphors…. Somehow, she finds a little comfort, a little lightening. ….."I hear you" I say "I believe you. We will face this horror together". And she gathers her defences around her and stumbles out into the night."

Dr Louise Stone, Un(en)titled, 2021

This excerpt from Dr Stone's evocative opinion piece reflects the knowledge that experiences of trauma are very common in the general population (Felitti, 2002) and are increasingly being recognised in primary care as life experiences that may affect all people and underlie diverse health issues (Lynch & Kirkengen, 2019) though this may not be obvious or even recognised by the patient or practitioner (Kezelman & Stavropoulos, 2018). Many primary care practitioners are questioning the assumption that reductionist, psychiatric criteria-based diagnostic frameworks and paradigms of care are applicable to primary care (Lynch et al, 2012) and are looking toward a new paradigm of whole person care, the "Craft of Generalism" (Lynch et al, 2020; Lynch et al, 2021; Lynch, 2021), where the practitioner seeks to know and understand the interplay between each life story, social context and physical and emotional health (Sadler & Hulgus, as cited in Lynch et al, 2012). The "Relational Process" between patient and GP is a key component of Generalism (Lynch et al, 2020, Lynch et al 2021, Lynch, 2021).

In Dr Stone's writing, the relationship between doctor and patient is suffused with a feeling of gentle care, connection and safety, enabling the young woman to feel some comfort despite the adversity she faces. This, perhaps, reflects a careful relational process over many previous encounters as trauma causes a multiplicity of effects (Farina et al, 2019) which disrupts the ability of a person to form relationships in any setting. Therapeutic relationships with such patients tend to feel "difficult". Several authors have written from a primary care perspective about what may help difficult relationships (Scott et al, 2008; Stone, 2014; RACGP, 2021). These approaches are helpful in many circumstances yet despite the best efforts of the practitioner, some therapeutic relationships remain mired in difficulty and disconnection.

Here, the Conversational Model (CM) offers much which complements primary care approaches to difficult therapeutic relationships and which may assist with understanding and change. In this essay, I will focus on three key concepts of the CM: transference, countertransference and the expectational field which, I feel, are part of the puzzle of relationships that feel enduringly difficult.

The Conversational Model – A Brief Summary

The Conversational Model is a form of psychodynamic psychotherapy which takes a trauma-informed, intersubjective and relational approach. The CM draws on several areas including attachment theory, linguistics, developmental psychology and evolving knowledge of human memory. The CM has two main therapeutic foci: 1. To potentiate the emergence of self and 2. To identify and integrate unconscious traumatic memory systems into the form of consciousness characteristic of self (Meares et al, 2012). Meares (2005) uses the analogy of play of a young child and interactions with their caregivers (the proto-conversation and symbolic play) to describe how self develops. The CM aims to recreate a type of mental activity that is analogous to that which occurs when a child plays and interacts with an attuned caregiver (Meares, 2005), thus facilitating the emergence of self. The relational process between therapist and patient is at the heart of therapy as this creates the form of relatedness in which self may develop and later, traumatic memory systems may be integrated. Yet, many impediments to this may be encountered (Meares et al, 2012). Amongst these are the phenomena of transference, countertransference and the expectational field. These are powerful influencers of the dynamics of every human encounter, clinical or social, yet largely remain outside of conscious awareness. If unrecognised in a therapeutic relationship, they have the potential to cause great harm yet if recognised, can be a useful source of information about the nature of original trauma.

Transference and the Expectational Field in Primary Care – An example

Consider the following clinical example of a first meeting with a patient in primary care*.

I am the designated "acute" doctor for the morning, seeing patients who nominally have single, urgent problems which are to be dealt with in short appointments. I have not previously seen the next patient, Tanya (pseudonym), a 45-year-old woman. On opening her file, I see that she has seen multiple doctors and has had exhaustive investigations performed over the last 6 months for facial pain. I also see that Tanya has had several recent stressful life events. Past notes record that her older brother committed suicide when she was a young child and that her father was an alcoholic. Previous entries from colleagues and letters from specialists reflect a general feeling of frustration and irritation about the intractability and inordinately distressing nature of the facial pain. There has been conflict with the last GP she saw who noted that Tanya had been very critical of the care provided by her and other doctors.

The consultation starts calmly. Tanya's acute problem today is severe lower back pain which started the previous day after lifting some heavy boxes. Despite the short duration, she would like a referral letter to a neurosurgeon with whom she has already booked an appointment. I feel immediately irritated by the request but attempt to hide this and start asking questions to gather history about her back pain. Tanya rapidly becomes distressed. Through tears, she jumps from her current back pain to her facial pain, to her worry that she has multiple sclerosis (despite negative tests), to workplace conflict, to her recent separation from her husband and her subsequent estrangement from her son. I attempt to give some acknowledgement of all these difficulties but the consultation is suddenly feeling out of control. I am worried about time constraints so, in an attempt to bring order, I focus on her presenting issue of back pain. She responds with complaints about the other doctors she has seen then bursts out "What do I have to do to get someone to care for me in this town?". I suggest that perhaps we could book a longer appointment to look at her other difficulties. This has the effect of amplifying her distress that I do not care. I write a request for a CT lumbar spine which, in reality, was an inadequate attempt at placation and a prescription for analgesia. Tanya leaves. Phrases float through my head: "She was too much", "She needs to be rational", "What an over-reaction", whilst, at the same time, I feel annoyed at myself for these judgmental thoughts. I am left feeling off balance, irritated and confused about what was really going on in that consultation.

I think an explanation can be found in the CM understanding of transference, countertransference and the expectational field.

Transference, Countertransference and the Expectational Field – A Conversational Model Perspective

Historically, Freud was the first to use the term "transference" in 1895. In his view, transference

originated intrinsically and represented a reflection of the repressed drives of sexuality and aggression which gave rise to unacceptable thoughts, feelings, and behaviours that were displaced onto the person of the therapist in the current encounter (Meares, 2005). Freud thought of transference as a sign of resistance that needed to be overcome through interpretation and confrontation.

This was the dominant view until the beginning of the 1970's when there was a move towards a psychology of self which considered relational and developmental influences (Meares, 1992). A different approach to transference emerged as something that is extrinsic, originating in past events but transferred unconsciously to events in the present and that can be worked with (rather than interpreted or confronted) as a powerful form of communication from the patient (Meares, 2005).

Within the CM, transference is used in a restricted, rather than totalistic, sense. As Meares (2005, pg 98) explains, he feels that to use the term to describe "the totality of the patient's feelings towards, perceptions of and responses to the figure of the therapist", renders the conception useless. Instead, he uses the term transference to mean "a revival of experiences from the past of which the patient is totally unaware" and that it refers "specifically to the manifestation of the activation of unconscious traumatic memory". When triggered, a "whole scene" or a "traumatic script", including a form of relatedness involving a particular mood, body feelings, postures and facial expressions from the past, is transferred unconsciously to the present relationship (Meares et al, 2012).

Countertransference is defined in a similarly restricted way as being activation of the therapist's past traumatic memory by some aspect of the interaction (Meares et al, 2012).

The unconscious traumatic memory system creates powerful subliminal signals which underlie the concept of the expectational field (Meares et al, 2012). When in an expectational field, the therapist may feel subtle pressure or coercion to behave or respond in a certain way. Projective identification, named by Melanie Klein in 1946, also describes this same phenomenon of subtle pressure though the explanation of the effect differs. Projective identification, an object relations concept, is conceived as a defence mechanism in which some element of memory which is unacceptable to the patient is split off and projected into the psychic system of the other, which it comes to influence (Meares, 2005). Meares (2020) disagrees with this metaphysical notion "of evacuating a part of oneself into another person" (Ogden, as cited in Meares, 2020). Rather, in the CM, the phenomenon is thought to be due to subliminal signals within speech, facial expression and body language, which are detected below the level of consciousness by the therapist and cause the therapist to feel pressure to behave in a certain manner. This formulation is supported by data from studies performed by Lea Williams (Williams, as cited in Meares, 2005 and Meares, 2020). The unconscious nature of the process is important. When a face showing fear was flashed on a screen for a period too brief to be consciously perceived, skin changes consistent with sympathetic arousal and amygdala activation were provoked – i.e. a fear response. These changes did not occur when the fearful face was shown for long enough for it to be perceived consciously. Meares (2000) expands upon this with the concept of "priming" which depends upon an unconscious form of memory, operative from birth, called the perceptual representation system (PRS). It is a system of rapid recognition of sensory information without connection or meaning (Meares, 2019). The PRS recognises minute sensory aspects of human interactions such as the presence or absence of wrinkle lines around the eyes with a smile, body language, voice tone.

In a therapeutic interaction, both patient and therapist unconsciously "read" signals from the other, registered via their PSR, and Meares (2020) suggests that these signals are stronger when unconscious traumatic memory systems are activated. When transference is triggered, the behaviour and physiology of the patient changes to those that occurred in the form of relatedness present when the original trauma occurred, leading to subtle changes in voice, body language and facial expression (Meares, 2005). These are registered, below the level of awareness, in the PSR of the therapist and activates a response which, if not detected and modified, may cause the therapist to behave in a similar manner to the original traumatiser (Meares, 2000).

How may a clinician recognise and work with the expectational field? Meares (2000) describes a "doubleness" which involves being taken into the patient's personal system, while at the same time monitoring the experience of this for the therapist. This requires awareness and monitoring of patient and therapist responses and behaviours as well as knowing how one's own personal traumatic mem-

ory system manifests when triggered (Meares, 2000). A shift towards a more associative, right brain mode, may be helpful to catch the subliminal signals emanating from the patient (Meares, 2000). What words or images come to mind? Who I am to the patient in this relationship? Meares makes the point that priming is bidirectional, so that both therapist and patient co-create each other and the form of the relatedness.

Primary Care Example from a Conversational Model Perspective

Returning to the clinical encounter, how might these phenomena have been at play? When called in from the waiting room, Tanya was already feeling anxious due to her past encounters with doctors and earlier developmental experiences. An unconscious traumatic memory system is already subtly activated in Tanya, producing subliminal changes in her behaviour that are registered unconsciously by my PSR and which subtly influence my behaviour. I begin to feel slightly impatient. To ensure Tanya receives what she perceives as "care" she has organised what she thinks she needs – a neurosurgical appointment. Her request for a referral triggers significant countertransference in me, a mixture of feeling devalued and invisible, which I respond to by becoming authoritarian. I attempt to hide this behind questions about her back pain but the tone of my voice and body language conveys my stance. My authoritarian response triggers a disjunction with intrusion of an unconscious traumatic memory system for Tanya. There is a marked change in her demeanour. She starts crying. Her voice adopts a demanding, accusatory tone, and her speech becomes disjointed and pressured. The interaction develops a chaotic feeling. As my own unconscious traumatic memory system is further activated, I respond with rigidity and attempts to regain control with a superficial attempt to acknowledge her emotional distress before focussing once again on her back pain. By this stage though, the factual matters of the presenting symptom were peripheral. Tanya was needing to feel care and understanding and, I think, feeling ashamed of this need. I was completely unable to provide this, experiencing her as irrational, a burden and "too much".

Surprisingly, after this rocky start, Tanya has continued to see me. There have been several further stressful life events and other medically unexplained symptoms have developed and persisted. As I reflect on the consultations, I see that the form of our relatedness has changed little from this initial meeting, though the subject matter differs. Tanya usually has a request for a new specialist referral, a different psychologist, an investigation or a treatment which she is sure, this time, will provide "the answer". I find these requests difficult to negotiate as I usually feel they will not be helpful yet they have the dual effect of triggering feelings that Tanya is devaluing my abilities to assist her as well as throwing our previously agreed plan for management into disarray. Despite my intentions to remain empathic and calm, countertransference inevitably intrudes as I attempt to manage my feelings of being devalued and regain stability in what feels like a barrage of symptoms and requests. My manner adopts an authoritarian tone, Tanya feels dismissed, judged and fearful, triggering intrusion of an unconscious memory system. There is escalation in her distress and attempts to seek care through referrals. And so, the relationship remained stuck in disconnection.

In recent times, however, there has been some change, as I have gained understanding of how these phenomena may be influencing the dynamics of our interactions. If, as Meares suggested, I let myself shift into a more associative state and wonder who I am in these encounters with Tanya, an image comes to mind of a woman, perhaps her mother, who is harsh, invalidating, and rejecting. Under the influence of the expectational field, I suspect I repeat this behaviour. Remembering that the expectational field is co-created, an image of a baby bird, constantly demanding attention from its harried parents, also comes to mind. I think this gives form to my countertransference. Tanya's needs feel overwhelming and I feel I will never meet her expectations - quite a trigger for my countertransference! These images give form to previously unconscious feelings and, by bringing them into conscious awareness, I have more choice about how I respond rather than having my behaviour directed by previously unconscious countertransference and the subliminal signals of the co-created expectational field. I have felt more able to tolerate and provide some containment of the chaos of the consultations with connection and staying with feelings, rather than by authoritarianism and control.

As an example of this, in a recent consultation whilst trying to negotiate a pathway through Tanya's request for referral to a third neurologist,

I ventured, "I wonder if it feels as if I don't care?" Tanya responded in a surprised tone, "Well yes, it does feel like that!". I responded, "I'm sorry, that must be difficult. There seems to be so much suffering here." Tanya responded that she felt that no one cared for her and went on to talk about how she always had to be "stoic" as a child and the judgment and shame she felt at not being able to "cope" now.

It is still early in this new phase of our therapeutic relationship but this exchange moved us out of a traumatic way of relating and created a sense of connection, for a brief period. This opened the door to an easing in the tension of the relationship. With this growing sense of trust and understanding, unconscious traumatic memory systems are now triggered less frequently and, though this still occurs, I am able to notice earlier and offer repair. On a practical level, we have been able to negotiate and stay with a plan of approach to Tanya's medically unexplained symptoms, which includes staying with the same therapist for long term therapy. Her desire to see new specialists, and have further testing, has lessened. I hope to build on this through an ongoing process of reflection and learning as I seek to understand and work with these phenomena in this, and other therapeutic relationships.

Conclusion

This essay acknowledges the increasing awareness in primary care that trauma may be a part of the life story for every person, prompting a growing movement towards alternative paradigms of care, such as Generalism, which values caring for the whole person. The relational process is central to healing in Generalism yet the effects of trauma disrupt the ability of a person to form relationships. The CM is a relational model of psychotherapy which takes a trauma-based conception to transference and countertransference and describes how the phenomenon of the expectational field powerfully influences therapeutic relationships. An understanding of these concepts and how to recognise and work with them complements and adds additional guidance to the relational process in primary care relationships, particularly in "difficult" therapeutic relationships.

*This essay reflects on the dynamics of a non-fictional therapeutic relationship however the specific details of the case material have been altered for publication. The presented case material is a composite and does not represent any single patient.

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Anorexia Nervosa and an exploration of resistance through the lens of Psychodynamic Theory and The Conversational Model with comparisons to CBT-E.

David Atkinson

Abstract

In this paper I will describe Anorexia Nervosa (AN) and the phenomenon of what has been termed resistance. I will discuss how resistance, a prominent feature of AN and a core determinant of prognosis, is understood and addressed within psychodynamic theory and The Conversational Model (CM). I will differentiate this approach with Cognitive Behaviour Therapy Enhanced (CBT-E) and consider resistance through the lens of each model. I propose that the understanding of the phenomenon of resistance from the perspective of psychodynamic theory and the CM might lead to better understanding and clinical outcomes. I will support this position by applying a case study of Sarah (pseudonym) a 21-year-old female with AN whom I have treated in psychotherapy using the CM.

Anorexia Nervosa

AN is a serious and complex mental illness often characterised by a chronic and disabling course. It is a predominantly female disorder, typically occurring in previously healthy individuals and often arising during adolescence and early adulthood (Swift & Stern, 1982). The frequency of the illness, severity of symptoms, risk of chronicity, seriousness of physical complications and related social costs emphasise the clinical importance of this disorder (Gutierrez & Birmingham, 2020). AN can present on a spectrum of symptom severity and can become a life-threatening illness associated with numerous psychological and medical comorbidities including death (Fairburn et al., 2013). The aetiology of AN remains unclear, although evidence suggests a multifactorial and complex intertwining of genetic and biopsychosocial pathogenic factors. It is understood that discrete events can promote the onset of the disorder or that it can emerge without a consciously identifiable trigger. Of relevance is the individual's susceptibility and vulnerability to the factors that interact to predispose, precipitate and perpetuate the disorder (Gregertsen, Mandy & Serpell, 2017). Perhaps of all the mental illnesses, it is the most misunderstood, generally inappropriately treated and stigmatised (Bang, Treasure, Rø & Joos, 2017). There is divergence in how different psychotherapeutic modalities understand and approach the treatment of AN. Two approaches that differ are Psychodynamic Theory and CBT, with CBT-E being specifically discussed in this paper.

Four important theoretical approaches have contributed to our understanding of the psychodynamics of AN.

An understanding of AN from a psychodynamic perspective draws on the concepts contained within Attachment Theory, Object Relations Theory, Developmental Theory, and trauma as it is conceptualised within the CM.

Attachment Theory

Bowlby (1958) stated that human beings are born with a biological need for a secure base (i.e. a secure attachment with caregiver/s) in order to make safe connections with others and to maintain affirming affiliations (Stevenson-Hinde, 2007). These early bonds with the caregiver help establish a secure attachment and a 'secure base' from which to investigate the world. In order for individuals to grow and face the world they have to establish a sense of object-constancy or an 'internal working model' based on the availability of responsive caretakers (Thompson-Brenner, 2014). However, traumatic events and adverse circumstances can interfere and disrupt the attachment process. Emotional growth and development can be restricted if a secure base is not formed at the beginning of life, or if the attachment system fails to bring safety and comfort when it is needed most (Milić, 2020). An insecurely attached infant - or one who has suffered adversity or who has lacked appropriate stimulation - may not have the resources that Bowlby & Ainsworth (2013) viewed as essential to be able to process feelings of anger, fear and abandonment. Research has found that

approximately 70-100% of those with anorexia nervosa have an insecure attachment style (Tasca & Balfour, 2021), with more disorganized mental states compared to controls.

Object Relations Theory

Psychodynamic perspectives by Klein, Fairbairn and Winnicott envisioned the internal world of the patient with AN as having a failed attachment and of embracing self-destructive behaviours. The individual has an unconscious need to be punished based on a past rejecting or abusive internal object (Friederich et al., 2017). These patients have significant difficulty attaining self-esteem and maintaining bodily self-regulation because they cannot evoke in themselves 'good enough' others to help them in times of duress. Paradoxically, AN can become a rigid source of comfort and solace despite its propensity to cause significant harm (Serpell, Treasure, Teasdale & Sullivan, 1999). Having the body express what cannot be expressed in words derives from deficits in the external environment such as the shortcomings of a caregiver who is unavailable, inconsistent or punitive, and incapable of meeting the needs of the child.

Developmental Theory – Self.

A pioneer in the study of AN (Bruch, 1978) attributed its roots to an insufficiently developed sense of Self - due at least in part to an insecure early attachment to caregivers. The therapeutic relationship with a 'safe other', as in the therapist, can help the individual explore these issues and ultimately establish a stronger sense of Self. However, brain structures negatively impacted by early attachment deficits can impede the creation of future effective relationships and the development of Self. It is therefore the therapeutic interpersonal relationship that represents the beginning of the reconstruction of Self through the mechanism of neurobiological change. The interactions between client and therapist have been shown to modulate the structure and the tropisms of brain neurocircuitry related to attachment, and so can stabilize and strengthen the sense of the Self (Amianto, 2015). Additionally, individuals with AN unconsciously and paradoxically value and feel empowered by their disorder. Without this comprehension the therapist may fail to understand why AN patients continue to resist recovery at their great personal cost.

Trauma

According to Korner & McLean (2017), psychotherapy such as the CM is directly orientated towards an understanding of trauma and its integration into a narrative of self. Therefore, the CM recognises and understands the need for the growth of self "and helps to provide a 'normalizing' response to recovery from illness and/or trauma."

CBT-E theory of AN

Cognitive behavioural therapy (CBT) for AN was developed in the early 1980s. In recent years, improved knowledge of the mechanisms underpinning eating disorder psychopathology has led to the development of a specific form of CBT, termed CBT-E (E = enhanced); (Dalle Grave, Calugi, Doll & Fairburn, 2013). The CBT-E model assumes that typical cognitions akin to AN, such as over-evaluation of body shape and weight, underlie all eating disorders (Signorini, Sheffield, Rhodes, Fleming & Ward, 2017). The cognitive- behavioural viewpoint holds that eating disorder symptoms are principally maintained by a characteristic set of overvalued ideas about the personal implications of body shape and weight. This over-valuation originates in the interaction and compounding of individual traits, characteristics and sociocultural values like perfectionism and sociocultural ideals of appearance (Atwood & Friedman, 2019). Once formed, these beliefs prompt the individual to process information in accordance with specific cognitive biases and to adopt distinctive eating behaviours. Such disordered beliefs and behaviours are eventually sustained by the sequelae of starvation (Fairburn et al., 2013). CBT-E theory focuses on addressing, disrupting and modifying the factors that maintain the eating disorder (Dalle Grave, El Ghoch, Sartirana & Calugi, 2015). This treatment is explicitly focused on the achievement and maintenance of a healthy weight. It is a time limited, goal-orientated and structured treatment that utilises psychoeducation, problem solving skills and cognitive and behavioural strategies in its application (Frostad et al., 2018).

Contrasting the CBT-E and psychodynamic psychotherapy theories of AN

CBT-E practitioners place greater emphasis on biological and cognitive aspects of the aetiology of AN while ostensibly disregarding the role of early developmental relationships and other social influences. CBT-E therapy often attempts to supresses internal conflict by targeting behavioural change - relying on ideas of operant conditioning with the use of negative and positive reinforcers like reward and punishment. In contrast, psychodynamic theories of AN such as The Conversational Model, Object Relations Theory, Ego Psychology and Attachment Theory utilize basic psychodynamic concepts with both an intrapsychic and interpersonal focus to treat the client relationally. Psychodynamic psychotherapy is a unique and useful modality in the treatment of patients with AN because it emphasises personal narrative and subjective experience allowing for exploration of past relationships and events. A complex multi-faceted clinical disorder, AN necessitates a psychotherapeutic approach that goes beyond behavioural and cognitive change. Psychodynamic therapy explores the root causes of symptoms rather than simply the symptoms themselves and aims to rectify interpersonal and intrapsychic issues with the objective of attenuation of the client's self-destructive symptom patterns (Milić, 2020). It can also help understand the feeling and experience of the symptoms as they are explored.

Psychodynamic theory of resistance in AN

In almost all therapies, mental health practitioners will encounter some form of patient resistance during therapeutic engagement. Resistance has been described as a fear of reliving traumatic experiences which have been warded off from consciousness. Resistance, whether conscious or non-conscious can be understood as a form of defence, or a way of coping to ward off thoughts or feelings that may be anticipated as difficult, unbearable or damaging to the client (Barabasz, Barabasz & Christensen, 2016).

Psychodynamic concepts addressing the various component aspects of resistance in AN

Conscious and non-conscious resistance

Broadly speaking, resistance can be broken down into conscious and non-conscious components. Conscious resistance is interpersonal and situational. It includes the notion of fear of the arousal of guilt or shame through the therapeutic process, or a fear of being misunderstood, or simply an unwillingness or opposition to participate in therapy. Non-conscious resistance, on the other hand, occurs below the level of personal awareness and is closely aligned to the unconscious traumatic memory system. Russell Meares (Meares, 2004) describes the unconscious traumatic memory system and the complex out of personal awareness processes which are 'designed to prevent the re-experiencing of trauma'. For example, an individual's accommodation of a caregiver 'controlled by the effects of anxiety', helps to maintain the belief 'that they can maintain an attachment to the caregiver'. Meares believes that 'such processes might determine the shaping of an entire life'. In this instance, the client is unaware of their motivations and opposition to engage fully with the therapist. However, the patient engages unconscious mechanisms to unwittingly obstruct or sabotage the course of therapy. This can be understood as a non-conscious response to external threat or unwanted thoughts and feelings. Resistance in therapy can either temporarily or continuously distract or detract from the process of therapeutic change, with clients often moving between conscious and non-conscious resistance.

Alexithymia

Clients with AN often experience alexithymia, a construct which is categorised as an inability to feel and express emotions. Such clients can have difficulty discharging emotions both physiologically and psychologically (Krystal, 1979). Those with alexithymia lack a lived understanding of what they experience emotionally, a scenario that could erroneously be perceived as resistance. It is commonly observed when working with clients with AN that they struggle to put into words what they are experiencing emotionally.

Complexity

AN is a complex disorder that manifests differently depending on diagnostic severity, patient age, and duration of the disorder (MacDonald, 2002). These factors can help inform the therapist of the types of resistance they are likely to encounter and on potential options in addressing these barriers

(Beutler, Moleiro & Talebi, 2002). It is important to understand how each client individually views their symptoms and the perceived functions they serve in the context of their lives.

Ego-syntonicity

Patients suffering from AN do not typically welcome intervention, often perceiving intervention as a personal attack. The notion of ill health is therefore vigorously disputed by patients who dismiss or contest the appeal of others to recognise their predicament (Gregertsen, Mandy & Serpell, 2017). What is seen as a lack of motivation to recover from AN is likely due to its ego-syntonic nature - where individuals value their disorder and so typically resist and deny the need to change (Zeeck et al., 2018). Ego-syntonic refers to behaviours, personal values and feelings that are in harmony with or acceptable to the needs and goals of the ego. A sufferer of AN therefore perceives their condition as consistent with their ideal self-image. There is a subjective link between a patient's positive experiences of their illness and their reluctance toward recovery - thus supporting the notion that the positive value of AN symptoms comprise a significant contribution to maintaining AN (Vitousek et al., 1998). The debilitating consequence of these seemingly volitional acts can confuse and frustrate the participants involved in the client's care. Remarkably, many patients remain otherwise capable of reasoned and rational thought with a general sense of reality remaining intact (Sommers-Flanagan et al., 2010).

Impasse

The therapist's task is to understand the client's attitude towards their illness and examine the idiosyncratic meaning AN holds specifically to them (Serpell, Treasure, Teasdale & Sullivan, 1999). This understanding will help the therapist conceptualise why and how resistance is enacted. Recognition of resistance, whilst highlighting problem areas for therapeutic focus, can provide key information about the client's ambivalence to change (Arkowitz, 2002). However, failure to recognise and understand resistance can result in a therapeutic impasse.

Resistance as communication and coping

Therapist interventions can be threatening to the client and the notion of change can range from uncomfortable through to traumatic. The therapist's style of engagement is therefore crucial. Engle & Arkowitz (2007) found that a non-directive, reflective and less interpretive approach seemed to minimise therapeutic resistance. Additionally, helping the client become curious about their own self-experience fosters validation which in turn can lessen resistance (Thompson-Brenner, 2014).

Resistance and CBT-E

In CBT-E, resistance in therapy is typically seen as client opposition and as an obstruction to goal achievement (Frostad et al., 2018; Atwood & Friedman, 2019; Signorini, Sheffield, Rhodes, Fleming & Ward, 2017). Furthermore, CBT-E practitioners do not particularly value consideration of the role played by the unconscious mind. From their perspective, resistance should be challenged rather than understood. According to their cognitive model, resistance is merely a manifestation of unrealistic expectations and irrational beliefs (Beutler, Moleiro & Talebi, 2002). According to this viewpoint, resistance, like other irrational thought, requires head-on confrontation and for the client to surrender this irrationality (Leahy, 2003).

Exemplifying a behavioural perspective, de Jong et al., (2016) suggested that effective treatment requires two levels of intervention—microanalytic procedures to modify the contingencies that exist within the therapy session, and macroanalytic strategies that focus on increasing compliance during the time between sessions. It is assumed that resistance can be avoided or overcome through the identification and alteration of reinforcement contingencies at these two levels. From this perspective, resistance is defined in terms of the degree that it interferes with the patient's willingness to consider information that does not conform to the individual's existing views of the world (Abbate-Daga et al., 2014). In treatment, resistant behaviours are acknowledged as technical problems, countertherapeutic beliefs, avoidance behaviours, and passivity (Newman, 2002).

Whilst the theoretical literature conflicts in many areas, research by Shedler (2010), Banon et al., (2013), Kellett, Clarke & Matthews (2007) offer

a comparison between psychoanalytic and cognitive theoretical understanding of resistance. They speak to differences in conceptualisation between the two modalities and conclude that both theories recognise the existence of resistance and acknowledge similar meanings in its manifestation. Nonetheless, both theories differ widely in the assumed causes of resistance and the methods of dealing with resistant clients (Stefini et al., 2017).

The Conversational Model, resistance and AN

The CM was developed by Robert Hobson and Russell Meares who linked the ideas of the development of Self with that of trauma theory, linguistics and brain dynamics (Haliburn, Stevenson & Halovic, 2018). A principal aim of the CM is to foster a kind of relatedness through conversation and to help develop an expanded dualistic consciousness and a 'reflective awareness of inner events' based upon the ideas of William James (Meares, 2004). These notions are interwoven with the classical psychoanalytic theories of Jung and Freud.

Freud suggested that resistance results from the patient's confrontation with unresolvable conflicts. Accordingly, the ego has several specific defences or ways of coping. As a result, clients may be unaware of their actual problems because their defences – exhibited as resistance - protect them from the truth (Leahy, 2003).

Meares (2012) saw this quite differently. Using his understanding of developmental and relational dynamics and the effects of early trauma, he alluded to resistance when he stated – 'systems of avoidance are built around this zone to protect the person from the extreme anxiety and distress associated with remembering traumatic experience' (Meares, 2012). More recently, resistance has been defined in terms of a fear of being re-traumatised through collusion with the therapist - a fear of re-exposure to the original trauma, re-experiencing painful memories and notions of shame (Haliburn, 2019). The term 'resistance' encapsulates a wide range of psychological dynamics - all our defences and coping mechanisms as well as all our unresolved conflicts.

This understanding helps the CM therapist conceptualise patient resistance from the perspective of early traumatic experience and its impediment to recovery. In my opinion the CM comprehensively addresses the complexity of resistance, with CBT-E being less effective in comparison. The effective use of the CM is illustrated in the following case description.

The Client and The Conversational Model

Sarah is a 21-year-old woman who I have been working with using the Conversational Model.

Sarah was diagnosed with AN aged 14, and Oppositional Defiant Disorder (ODD) aged 16. She witnessed continuous verbal altercations between her parents from when she was around five years of age, and remembers her fear that her parents would separate and divorce. She had been Dux of her school, having also excelled as a gymnast and dancer. She recounted developing significant weight loss when she was around fifteen years of age. She dropped out of school and ceased to engage in her usual recreational and sporting activities, withdrew from her friends, and was hospitalised soon after.

A significant aspect of Sarah's presentation is her seeming inability to eat in the absence of her mother, and her requirement that her mother eat the same food, and quantity, as her. After six years her mother eventually indicated her refusal to continue with this arrangement.

Sarah ostensibly presented for therapy under the duress of an ultimatum from her mother that, if she did not seek help, her mother would withdraw her support. Sarah experiences this as an abandonment and now lives with her father - her mother having recently moved out due to the stress around Sarah's eating requirements. In addition, Sarah's mother has previously taken out several Apprehended Violence Orders (AVO's) due to Sarah's aggressive and assaultive behaviours.

Sarah has been treated unsuccessfully with the Maudsley program, with Cognitive Behavioural Therapy (CBT) and Dialectal Behavioural Therapy (DBT) on two separate occasions in the past.

Traumatic Attachment

To help explain Sarah's difficulties, we must explore her traumatic attachment to her mother.

Attachment styles can influence how young people deal with the demands of adolescence. A secure attachment can act as a buffer to psychological risks,

providing availability and support during times of physical change (Allen, 2008).

Sarah has a disorganised attachment style as seen in the sense of hatred and terror in the transcript excerpt to follow later in this paper. Sarah had endured a traumatic childhood; her trauma was cumulative and occurred in an environment akin to a form of dependent captivity at the hands of her mother. It was from this dependent captivity that Sarah's symptoms would eventually manifest. Sarah's over stimulated attachment system ensured her survival but has remained chronically hyper-activated. This has fostered a state of pathological accommodation and a traumatic attachment to her mother. A strong activation of the attachment system, whilst not necessarily comprising mal-treatment, can induce a failure in the integrative functions of consciousness at the beginning of life (Schore, 2001). Dissociation often accompanies traumatic attachments such as the disorganized type.

I have come to understand that Sarah's capacity to revaluate her relationship with her mother during the normal process of separation/individuation has likely proved overwhelming for her. Several studies (Bruch, 1982; Steinhausen, Rauss-Mason & Seidel, 1991; Eckert, Halmi, Marchi, Grove & Crosby, 1995), have shown that failure to find independence from the caregiver can act as a pre-cursor for the development of an eating disorder. Bruch has described AN as a disorder of the process of separation/individuation from the primary caregiver, even from one who has not provided a secure base.

This conflict between dependence and independence has resulted in the development of Sarah's symptoms - her way of coping and maintaining some form of control. Her disordered eating initially served to elicit care from her mother, allowing her to experience the concern, attentiveness and kindness which she craved. However, her mother has since become openly rejecting of Sarah.

Within our work together I have reflected on my impression that, beyond Sarah's conscious thoughts and emotions, her anxious attachment style coerces her to go on yearning for the love of her mother. Sarah tries to stay close to her mother with proximity-maintaining attachment behaviours developed and enacted out of her awareness. She idealises her mother in the hope that her love will be reciprocated and, by seeking constant contact, that she might experience the declarations of affection and praise that she craves. As a child she had believed her mother would be her solid foundation and continual source of validation, and now Sarah longs to recapture the past - before the present day fear and pain linked to her mother leaving the family home. Sarah lives with a constant fear that she might be further abandoned by her mother.

Sarah is bright. She has learned how to keep health practitioners like me at bay. She consciously wards off any attempts of separation from her mother with a façade of apparently agreeable behaviours, often giving the impression that she is trying to comply. Part of Sarah knows that she should get help, while another part of her resists help if it necessitates separation from her lifeline, her beloved mother.

I have found myself wondering, who is feeding who? Has Sarah taken on the role of a compulsive caregiver, a symptom of an anxious attachment style - by demanding her mother attend her and eat with her? Conceivably, if Sarah feeds mum so that mum survives, perhaps in turn mum will feed Sarah, so that Sarah survives.

The Psychodynamics of resistance in Summary

Unknown to Sarah, her AN has likely evolved as a protective factor to thwart separation from her mother and acts as a means of mis-perceived self-control. These mechanisms, manifesting from unconscious intrapsychic resistance, maintain her tenuous psychological homeostasis. In this instance, her AN is a response to fear of separation and maturation and evolves in the context of developmental trauma and low self-esteem. It is a survival instinct, a contrariant mechanism to protect the already traumatized Self from capitulation. It is therefore paradoxical that any challenge to the AN could leave her denied of this means of survival. If her resistance were breached, she would have to come to terms with separation and individuation from her mother. For Sarah - if recovery necessitates separation she would cease to exist – she must resist change - she must resist recovery – she must remain mother's little girl.

Vignette

Sarah - well she's the dictator now

Therapist - oh

Sarah - get therapy or she goes and I die

Therapist - mum dictates

Sarah - she hates me

Therapist - oh, it sounds so harsh, confusing

Sarah - no, she really hates me, she's always telling me

Therapist - that must feel...

Sarah - I've ruined her life

Therapist - hmm, feeling responsible

Sarah - nothing helps

Therapist - nothings worked before

Sarah - she hates coming round

Therapist - it's come to this

Sarah - hates being forced to eat with me

Therapist - too much pain, so much effort just so you can eat

Sarah - well it's the eating disorder, apparently

Therapist – who's in control?

Sarah - hmm

Therapist - perhaps, you need control

Sarah - I can't

Therapist - seize control

Sarah - how

Therapist - break free

Sarah - is this about seeing less of mum

Therapist – if she's in control, maybe a little freedom

Sarah - I already have all the freedom

Therapist - freedom to feel in control

Sarah - I don't need separated from her why can't you just see that?

Illustration (1)

In this transcript (Illustration 1) from an early session with Sarah, she is conflicted between her dependence on her mother and her mother's apparent hatred towards her. She has internalised the devaluing characteristics that she is unlovable and projects them in these responses. Any attempts at linking her emotional statements result in Sarah further verbalising strong cognitions of her mother's hate - a form of rationalisation. Meares (2012) suggests that linking can help widen the patient's consciousness to incorporate several other possibilities. Additionally, the attempts at representation have no effect at this stage in therapy as Sarah remains fixed on her narrative. This scenario is played out on a background of her unconscious traumatic memory system and the expectational field that it has elicited (Meares, 2004). This expectational field centres around previous devaluing or traumatic interactions where Sarah has an expectation of previous disturbing experiences being played out again. According to Meares (2005), in this scenario the therapist can also be experienced as the original abuser. We then witness a shift in tone and a disconnection followed by a disjunction - her exasperation is evidenced when she suggests that I am inferring that she should see less of her mother. In the transference she begins to experience me as 'the other' trying to influence her to change. Her fears of annihilation seem real. Her annihilation anxiety centres around the fear of losing her mother and therefore not eating - ultimately dying. Themes of projective identification also emerge in response to my choice of language such as the word 'control'. This experience has helped in understanding Sarah's traumatic relatedness and what it feels like to perceive hatred from her mother - and why she resists my endeavours.

Discussion

It has been discussed throughout this paper that resistance in AN can range through notions of conscious, unconscious and ego-syntonic resistance. Notions of alexithymia and dissociation are also useful considerations as impediments to communicative engagement in therapy and clinical improvements. It is apparent that the term 'resistance' is outmoded and remains aligned more with Classical Psychoanalysis. A reconsideration of these notions is needed to enhance and augment our understanding of resistance in therapy.

In my view the following conceptualisation may be a more useful way of understanding resistance:

'Forms of defence, or ways of coping to ward off thoughts or feelings that may be anticipated as difficult, unbearable or damaging. A wide range of psychological dynamics - all of our defenses, as well as our unresolved conflicts – act as forms of resistance.

As the vignette has shown, Sarah is struggling

to move beyond her familiar, gratifying role as a good girl, betrayed and abandoned by her mother amidst her debilitating eating disorder. She is unaware of the cost of rigidly maintaining this role - in that it inhibits her freedom to survive and function independently. The Conversational Model recognises these dilemmas and understands and validates Sarah's fear of change. Through facilitation of a good therapeutic relationship within a safe environment, resistance can be appreciated and worked through. Recognising and understanding Sarah's resistance will eventually help reduce the rigidity with which she holds onto her eating disorder. Korner & McLean (2017) explain that the CM 'is not restricted to a 'stand-alone' treatment' and that the use of adjunctive interventions can play an important role in particular circumstances.

There is limited consensus in the literature between CBT-E and Psychodynamic Theory in the therapy of AN and the concept of resistance. Although both modalities advocate the establishment of a sense of safety in the therapeutic relationship, there is a preferential emphasis on these components within the CM. While it could be argued that a positive, trusting and transformative co-created therapeutic relationship is something established with CBT-E therapists, these components are at the very core of the CM's therapeutic approach, and are vital to addressing resistance. The CM also explores issues occurring below the level of personal awareness within the unconscious traumatic memory system. In CBT-E, by comparison, there is scarce consideration of the psyche, with CBT-E proponents principally viewing resistance in terms of irrationality. However, it should be acknowledged that CBT-E can provide useful therapeutic gains and that some patients may be suited to this type of therapeutic modality.

Medication, hospitalisation, and various cognitive behavioural therapies have not helped in improving Sarah's disorder. My own clinical experience in a specialised eating disorder ward has shown that many patients with AN may not significantly improve with CBT-E interventions. By remaining engaged in psychodynamic therapy and overcoming the threat of uncertainty, Sarah can be hopeful of therapeutic change. Finally, although Sarah's resistance has provided me with some useful insights into understanding her subjectivity, our work together is at an early stage and her resistance currently remains a hindrance to maximal change.

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Two meetings[6]: Neurodivergence and the Conversational Model of Therapy

MJ Basilio

Abstract

Growth and learning is boundless and endless. I have dipped and dived into so many different types of therapeutic model, but the one that feels like home to me is the Conversational Model (CMT) of therapy. I'm drawn to the model because it humanises the treatment of mental health conditions (Benjamin, et al., 2019) and because it is a process of "learning, and learning how to learn, within a personal conversation…the mutual creation or discovery of a feeling-language – language of the heart" (Hobson, 1985 p.15).

This paper will explore my clinical experience as a trainee CMT psychotherapist and how I evolved and transformed as a therapist and as a person. It will explore a two-person experience: the client, the therapist, and the relationship. In this space both participants in a conversation grow and find themselves exploring a co-created world, a mutual exploration into the unknown "alone and yet together" (Meares, 2005). I will discuss clinical applications of the CMT and how it may also benefit neurodivergent individuals, mainly those diagnosed with Autism and Attention Deficit Hyperactivity Disorder (ADHD).

This paper will first begin with a summary of the CMT and neurodivergence, before discussing how CMT may be a useful model in helping neurodivergent individuals find and discover a stable sense of self. The paper will then explore case examples and how my learning in the CMT has expanded my therapeutic skills and enhanced the experience of co-creating a world between therapist and client[7].

It is also an aim of this paper to promote acceptance of differences in order to contribute to the co-creation of an inclusive and equitable society. When people feel accepted, supported and understood they can "emerge from loneliness" (Hobson, 1985) and feel more empowered in their healing and growth journey.

The Conversational Model and Neurodiversity

> To discover truth about the patient is always discovering it with him
>
> and for him as well as for ourselves and about ourselves. And it is
>
> discovering truth between each other, as the truth of human beings is
>
> revealed in their interrelatedness
>
> Hans Loewald, 1980

Neurodiversity

Neurodiversity is a term used in the context of people who have been diagnosed with neurodevelopmental conditions such as Autism, ADHD, Dyslexia, Tourette's Syndrome, and Dyscalculia. This paper will mainly explore neurodiversity in

6 Hobson, 1985

7 Please note that in order to maintain confidentiality, client personal details including client names have been de-identified and other identifying information has been altered. Consent was kindly given by 'Seth,' 'Angela' and 'Charlotte' in order to promote a neurodiversity affirming approach to therapy.

relation to ADHD and Autism as the symptoms tend to co-occur (Lau-Zhu, Fritz, & McLoughlin, 2019).

Neurodiversity is a term that proposes that people experience and interact with the world in a multitude of ways and there is no "right" or "normal" way of thinking, feeling, learning, or behaving (Baumer & Frueh, 2021). It is a strength-based approach that emerged during the 1990's and was first coined by Australian sociologist Judy Singer. It embraces neurological differences with the aim of increasing awareness, acceptance, and inclusion for those who are neurodivergent (Silberman, 2015). Attitudes regarding autism are changing, and there are ongoing discussions within society as to whether it should be considered a disorder. A survey on autism in March 2022 conducted by Chris Bonello (an autistic teacher, author, and advocate) revealed that most of the autistic respondents in the survey see Autism as a "neurotype" rather than as a disorder, with 60% of autistic respondents indicating that they like being autistic. Additionally, identity-first language (autistic person, autistic, autists) is preferred over person-first language (person with autism).

Dr Edward Hallowell, a Psychiatrist with ADHD and Dyslexia, has been a strong proponent of strength-based approaches to treatment. He argues that for centuries most psychiatric conditions "were relegated to the dungeon of 'moral' diagnosis and treatment, where weak character was assumed to be the cause of the problem, and shame, pain and humiliation were the standard 'treatments.'" (Hallowell, 1998, p.344). Ratey et al. (1997) suggest that discovery of one's own sense of self can occur when neurodivergent individuals feel understood, accepted, and are helped to recognise that their functional and interpersonal limitations are due to their underlying biology rather than defects in their character, morality, or abilities.

Currently the most supported treatment for Autism and ADHD are cognitive and/or behavioural approaches for children and young people (Hume et al., 2021) however there is limited research into autistic adults. Price (2022) has found that finding a therapist who understands neurodiversity and is able to work with autistic adults is very difficult. Additionally, Associate Professor Dr Vanessa Bal, a researcher in understanding adult autism, indicates that "there is a shortage of mental health clinicians adequately trained to provide supports for autistic adults" (Choi, 2022).

Applied Behaviour Analysis (ABA) is the most commonly used early intervention treatment for autistic children. Research has shown that ABA can have positive effects on an autistic child's intellectual functioning, language skills, daily living skills and behaviour (Makrygianni et al., 2018; Medavarapu et al., 2019). This however has been contentious, and some autistic advocates do not recommend ABA as a treatment for children (Bonello, 2022). What is advocated for instead is the concept of 'neurodiversity' whereby people

should be accepted as naturally different rather than trying to 'fix' or make them 'normal' (Devita-Raeburn, 2016).

Milton (2012) highlights the 'double empathy' problem which means that autistic people and non-autistic people have a difficult time understanding each other. It is a "double problem" because the disconnection in interrelatedness is experienced by both autistic and non-autistic people due to the lack of insight into each other's minds and culture. The idea that autistic people have a 'social deficit' or 'lack a theory of mind' does not consider that perspective taking, theory of mind and empathy are two-way processes (Milton, 2019). This is very closely related to Jessica Benjamin's concept of intersubjectivity whereby relationships involve mutual recognition of each other, in which a person experiences the other as a "like subject" yet "has distinct, separate centre of feeling and perception" (Benjamin, 2004, p.5). The 'double empathy problem' might, then, be analogous to 'the doer/done to' dynamics where one person feels 'done to' and "not like an agent helping to shape a co-created reality" (Ibid, p.9). It then follows that society and relationships are co-created and neurodivergent people should be understood rather than pathologised for their unique way of thinking and feeling (Milton, 2019; Grace, 2021).

The Conversational Model

The CMT is a contemporary form of psychodynamic psychotherapy that was developed by Robert Hobson and Russell Meares. It is an approach that was initially developed to treat 'unanalysable' patients; mainly those with 'disorders of the self' also known as Borderline Personality Disorder (BPD) (Korner & McLean, 2017).

The CMT has been found to be effective for the treatment of Depression, Personality Disorders, Irritable Bowel Syndrome and Self-Harm. Moreover, "CMT, and indeed other psychodynamic psychotherapies, are not 'stand-alone' treatments. CMT aims to develop a

creative therapeutic relationship. The use of adjunctive interventions (writing; painting; music) may have an important role in some cases. More broadly, many interventions

(e.g. eye movement desensitization and reprocessing; yoga; meditation; judicious use of medication) may play a critical role for some patients and can be used in conjunction with psychodynamic treatments" (Korner & McLean, 2017, pp. 220-221).

The CMT approach focuses on empathic attunement, empathic responsiveness, interpersonal 'connectedness' and a feeling of cohesion. The therapeutic conversation highlights 'moments of aliveness' and gives emphasis to 'fellow feeling' which is generated in the therapeutic relationship. The therapist gives value to the patient by responding to 'what is given' focusing on the 'minute particulars' and attuning to what is most 'alive' in the patient. (Hobson, 1985; Meares, 2005).

The Principles of the CMT and clinical indications for neurodiverse clients

Neurodivergents often have difficulties in relationships and with constructing their own sense of self (Brezis et al., 2016; Mate, 2019). The research on autism indicates that women and gender minorities tend to 'mask' or compensate for their autistic behaviours in an attempt to 'blend in' and fit in with society (Price, 2022). Autists who 'mask' tend to develop an unstable and insecure sense of self, suffer from low self-esteem, and have poorer mental health outcomes (Cage, Troxell & Whitman, 2019; Hull & Mandy, 2020).

Autists are more susceptible to bullying, interpersonal conflicts and sexual and physical violence (Grace, 2021). Moreover, children and adults with ADHD "crave highly charged and highly stimulating activities and situations" which predisposes them to conflict and trauma (Ratey et al., 1997). These situations cause those with ADHD to feel overwhelmed and also serves as a "pivotal force to quell feelings of boredom" where individuals are drawn to live from one crisis to another (Ratey et al., 1997).

There is a high comorbidity rate between ADHD and Personality Disorders, with ADHD being a developmental risk factor for Borderline Personality Disorder (Weiner et al., 2019). A recent study conducted by Jadav & Bal (2022) showed that adults diagnosed with autism after the age of 21 years old were more likely to report co-occurring psychiatric conditions such as anxiety, eating, and personality disorders. Moreover, some studies have found that autistic adults are likely to be misdiagnosed with personality disorders (Au-Yeung, Bradley, & Shaw et al., 2019; Kentrou & Oostervink et al. 2020; Iversen & Kildhal, 2022).

Whilst diagnoses are important in the medical model, the central focus of the CMT is the development of the self through empathic resonance in the therapeutic conversation. The theoretical framework is based on the development of self in relationships, the processing of unconscious traumatic memories and the integration of self (Meares, 2005). The development of self during the therapeutic process is seen in language where there is a shift from literal, linear, and concrete to something more poetic, metaphorical, spontaneous, and imaginative demonstrated in the play space and inner speech (Meares, 1992; Meares, 2005). The attuned therapist makes space for play, creativity, and love which supports the development of the client's own capacity for play, love, creativity, and intimacy in other relationships.

The therapeutic encounter can help shift inner affective and somatic states from deadness to aliveness, from alienation to integration, from rigidity to fluidity, and from struggle to play. It is in this sense that the CMT can greatly assist neurodivergents to develop a stable sense of self, find joy and fulfilment in their life, and heal from trauma.

The road of discovery with Seth

Seth is 15 years old and has a diagnosis of Autism, ADHD, Oppositional Defiant Disorder, and Anxiety. I first met Seth when he was about 5 years old when I was his Applied Behaviour Analysis (ABA) therapist. I was his therapist for about 12 months and we worked together with his parents and a team of ABA therapists to help improve his communication, play, and social emotional skills. Like most neurodivergent children he had a 'spikey' cognitive profile and, whilst he struggled in some areas, he was very good in other things such as Maths, Computers and Music. He loved his cat, playing outside, playing on his iPad and jumping on the trampoline. Seth's parents were evidently loving and nurturing. They were dedicated to his growth and happiness.

Nine years later his parents contacted me to ask whether I could work with Seth again as his therapist. Having very fond memories of working with Seth and his family I immediately agreed.

Working with Seth as a teenager has been very different to working with him when he was 5 years old. Seth remembered me as his former therapist, but he did not talk much at the start and there was limited reciprocity in our interaction. He was very quiet and withdrawn, often responding with "I don't know." His parents reported aggressive behaviours at home including physical fights with his dad. He seemed to have lost the aliveness and exuberance that had been so prominent when he was a child. Recalling his five-year-old smile and his excitement when it was time to play outside on the trampoline, I wondered what had caused Seth to move away from his vibrant self.

Due to COVID restrictions our sessions were online, which made it very difficult to engage.

Despite this, we both persisted in our work together. Similar to other autistic teenagers, Seth opposed cognitive behaviour therapy strategies, and refused to engage in certain activities. Rather than resisting and attempting to teach Seth skills that he didn't want to learn, I decided to listen, observe, find moments of 'aliveness' and 'windows' of engagement.

One day Seth spontaneously created an 'infinity of windows' on his computer which was comprised of our images multiplied on the screen (see image 1).

I said, "Wow there is an infinity of us."

He giggled and laughed. He continued doing this on his computer.

He asked, "How many is there of us now?"

I said, "Still infinity."

He giggled again, then combining both our images he created a different image which looked like a road in a tunnel.

I said, "Oh I can see you are making a road." He smiled and he kept going.

I said, "I wonder where this road is going?" No

response from Seth.

I said, "I'm curious about who is driving? Is it you and me?"

He said nothing then he said "Meow meow".

I said, "Oh I can hear a cat. Maybe the cat is driving."

Again, with a cheeky smile, he said "Meow meow".

I said: Oh, maybe its Ari[8] (Seth's cat)."

He laughed, I laughed, and Seth continued to create the road which was a combination of our images. This spontaneous interaction created a positive shift in our relationship.

Image 1: The road of discovery which Seth created on his computer using infinity windows which includes a combination of our images together.

Seth's astonishing ability with computers and his creation of 'the road' is mesmerising. At the start of our therapy, I was anxious about not teaching Seth social skills and cognitive behaviour strategies. I sensed, however, that he didn't want to learn 'skills' - he wanted me to be a participant in his world. In supervision, my supervisor helped me notice that what was happening in the virtual room is similar to Winnicott's (1989) 'squiggle game[9]' – albeit a more modern version on the computer.

Analogous to Hobson's (1985) story with 'Sam,' Seth helped me to learn about psychotherapy and deepen my understanding of the 'two meetings' that Hobson beautifully described in his book Forms of Feelings. I came to realise that I was also making 'metaphorical statements,' conveying to Seth that I wished to understand him and sought a togetherness and a "feeling with".

Over time, the depth of our conversation and reciprocity in our interactions developed even more. Seth no longer says "I don't know", but plays pranks and jokes on me. He is now able to talk about his fears of hurting others (particularly his dad), his frustration with things that are 'incorrect,' his difficulties with school, and his feelings of worthlessness in subjects he doesn't understand, like English. He also shares things that he enjoys such as mathematical equations, video games, and YouTube videos. He shares YouTube videos that he has created, his hopes to get more followers, and songs that he is learning on his guitar. Seth also reminisces about our time together when he was 5, recalling when we would play on the trampoline, kick a soccer ball in his backyard, or play on the slide.

In a session which was immediately prior to the Christmas break he said, "I'm going to miss you"

8 De-identified name

9 The squiggle game is a pencil-and-paper technique for eliciting children's thoughts and feelings in an unstructured format.

and wrote in the chat box "Never gonna say good-bye."

I smiled and I wrote back "Never gonna give you up."

Seth then played the Rick Astley song 'Never Gonna Give You Up' and we laughed as we listened to the song together.

Seth seems to be emerging from isolated loneliness (Hobson, 1985) through the sharing of positive affect and experiences. We are mutually seeking and discovering his uniqueness, co-creating a new world we can both take part in. I continue to grow from these experiences with Seth. Seth has helped me fully understand what it means to be "alone together" (image 2). A new and different kind of experience is co-created within the "many universes of discourse" and many forms of relating (Hobson, 1985). 'The road' continues to evolve, and what was once an image of a black and white road, has transformed to a road with blue water and an orange ledge (image 3).

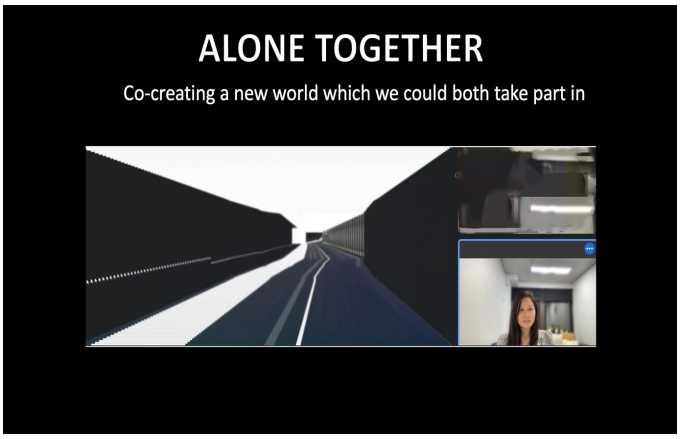

Image 2: "Alone together"

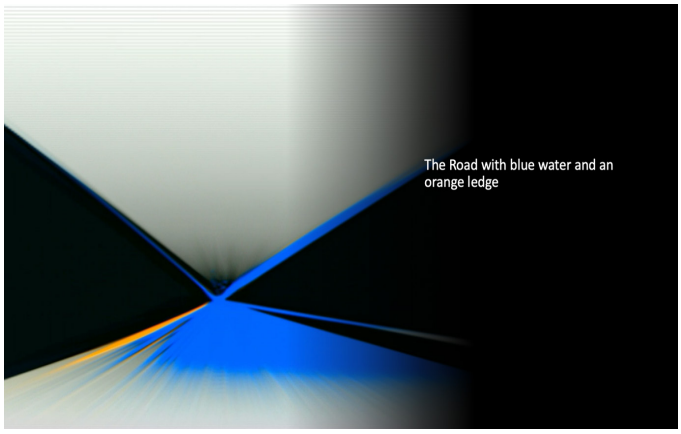

Image 3: A different kind of road has evolved

A plea to just "sit with it" - a story about Angela

A plea

Tired, angry sad

Pain, fear, loss.

Can you sit with it?

Not fix it,

Not react to it,

Not control it.

Tiredness, angriness, sadness

Grief-stricken, heart-broken,

Loss, loss, loss…

Can you sit with it?

Not schedule it,

Not medicate it,

Not make plans, or change thoughts,

Not brainstorm, examine, or question,

Not prescribe "breathe and relax."

Not judge.

Just sit.

Just feel.

Just flow.

Just be.

Can you listen?

Can you hear me?

With me in

This moment

Now.

Anonymous (as cited in Benjamin et al., 2021)

I met Angela[10] in 2019 when I was just a year into my training as a CMT psychotherapist. Angela works part-time, is in her fifties, and was referred by a social worker for the treatment of her depression and anxiety. As I got to know Angela, I discovered that she had multiple diagnoses which included Schizophrenia, Bipolar Affective Disorder, Borderline Personality Disorder (BPD), Schizoaffective Disorder, Anxiety, Major Depressive Disorder, and Post Traumatic Stress Disorder (PTSD). She was taking various medications, however she continued to suffer from chronic insomnia, depression, and anxiety. She heard voices telling her "you're hopeless, you're worthless, go kill yourself." Angela also suffered from diabetes, sciatica, and hypertension, and was on medication for treatment of these conditions. Angela had very vague recollections of her childhood but remembered that her father died when she was 7 years old and that she was left in the care of her grandmother. When Angela was in her mid 20s her grandmother became chronically ill. At this time Angela's mental health deteriorated and she was detained in a mental health hospital. There had been many admissions since that time, with Angela having had annual voluntary admissions in the last 10 years.

As we were working together I noticed that Angela also presented with autistic traits, and I wondered whether Autism might be a diagnosis that could help explain Angela's particular constellation of difficulties.

Angela prefers to be on her own, gets overwhelmed by social interactions, has restricted and repetitive patterns of behaviour, is hypersensitive to noise and finds it difficult to tolerate change. Angela requires a lot of notice in order to cope with any type of change. She prefers to be in the comfort of her own home, has a strict routine (getting visibly upset when this routine is disturbed), and has an unusual preoccupation with horror movies and crime fiction. Angela also has a keen interest in Medical Forensics and had completed a course in this.

Angela frequently rubs her thumb on her index finger which appears to be a 'stim[11]' and this

10 De-identified name

11 A stim is short for stimming. These are repetitive behaviours, e.g. movements or noise, commonly displayed by autistic people to help them manage and regulate their emotions.

behaviour increases in frequency when she is highly stressed or anxious. She has never been in a romantic relationship but has one good friend, Sam[12], who has ADHD. She reports that she often finds Sam annoying because "they talk too much". She limits her interactions with Sam and will see them on special occasions or when they need each other's help. Angela will also help Sam with things related to technology and lets them come over when they need company. Whilst their friendship seems to involve limited social interactions, it is a friendship that works for them and enhances their lives.

Angela doesn't like inconsistencies and is upset when rules are not followed. This became evident during the COVID-19 restrictions. Despite her social anxiety she ensured that her neighbours followed COVID-19 social distancing rules. When I discussed the possibility that she may be autistic Angela agreed to do the Autism Quotient (AQ) and her high score was indicative of autism. Angela has indicated that she would like to identify as someone who is autistic and high functioning.

As a novice CMT psychotherapist, I initially did not feel adequate to be Angela's therapist. I wondered if she would be better cared for by someone with more experience.

Our CMT journey began in March 2020 and we moved from once a week to twice-weekly therapy. The shift was initially challenging and Angela conversed with a sense of 'deadness' talking about the same 'chronicle' of stressful things happening to her at work. I also became concerned about her suicidality, especially when she talked about her intent to overdose, which was coupled with voices telling her to "kill yourself". In supervision my supervisor listened and provided space and containment for my anxiety and negative feelings. My training as a psychologist had been about finding effective solutions and working towards a goal. Additionally, when a client discloses self-harm or suicidal thoughts, it has been embedded in my training to complete a formal suicide risk assessment. The CMT, however, is a different way of relating and being. Whilst it is important to keep safety in mind, and to liaise with the crisis team who can support Angela when this becomes necessary, it was more important to understand and connect with her feelings (Bendit, 2011). I learned through this experience that what is most useful is to provide a consistent, secure, predictable environment and a containing space for Angela's feelings, just like my supervisor provided for me.

As time progressed, we were able to play within the 'conversational play space' and what was 'dead' became 'alive' (Meares, 2005). Angela has a very good sense of humour and we laugh a lot during our sessions. I get the sense that Angela enjoys our sessions as much as I do, and I look

12 Sam's name has been de-identified and uses a non-gendered pronoun they/them

forward to our continued time together.

By 2021 a change had occurred. For the first time in 10 years Angela had not had an annual hospital admission. We reflected on this as a significant achievement. Her contact with the crisis mental health team had also become infrequent. Although Angela experiences ongoing work stress, she remains a conscientious worker. There continues to be a sharing of positive moments and our interpersonal dynamic is ever changing. Our therapy is ongoing and our experience together has been humbling. I have become comfortable with being present and can now "sit with it, just be, just flow".

A re-evaluation of devaluation – A story about Charlotte

Charlotte[13] has been my client for 12 months and we have been working together in CMT therapy twice a week in the last 6 months. Charlotte is in her 30s and is a design student who initially contacted me for the treatment of Anxiety, ADHD, and Complex Post-Traumatic Stress Disorder (cPTSD).

Charlotte reported difficulties with interpersonal relationships, reading social cues, severe anxiety, fear of abandonment and maintaining a job. She described herself as clumsy and very disorganised. She was often late to appointments and had low self-esteem. She also questioned her gender and wondered whether she was heterosexual, bisexual, or non-binary. Due to a fear of abandonment, she had a pattern of being very compliant with others and easily became distressed with any personal slights or perceived rejection.

Charlotte's developmental history had been characterised by neglect, instability, and devaluation from her father. She had witnessed domestic violence incidents between her parents and felt isolated in her childhood and teenager years. She described her mother as controlling and reported that her father was cold, uncaring, and manipulative. She felt like a burden to her parents but craved their love and affection. Due to Charlotte's learning difficulties, which included Dyslexia, she experienced a lot of bullying at school and felt disliked by her teachers. In order to conform and make friends, she would mimic other people's behaviours and overly comply, but she also felt resentful that she was unable to be herself. Charlotte is also a survivor of sexual abuse. Charlotte reported that, as an adult, she often talked about her trauma and difficulties with "everyone" she met, and I got the sense that her trauma had become interlinked with her identity.

Charlotte told me that she had wondered whether she had Borderline Personality Disorder (BPD) and/or Autism. After further exploration she told me that she resonates with being autistic telling me that she struggles with following 'social norms', relates better with neurodivergent friends, and that her own research on autism had helped her understand herself better. We are continuing to

13 De-identified name

discover different aspects of herself and are working towards a more coherent and integrated sense of self.

When I first met Charlotte, she told me that she had previously worked with other therapists but felt that I was a better fit for her. I noticed that there was some idealisation which made me feel cautious. Her speech was initially choppy, fast, and high pitched. It was sometimes difficult for me to get a word in, and her speech was 'curly', often bouncing between one topic to another and then, midway through, she would say "what was I talking about again?" She would often apologise for being "all over the place". Prior to agreeing to work together in CMT Charlotte would request to do a certain type of therapy like CBT or DBT[14]. When I agreed to do so, and we would begin working in that other therapy modality, she would ask if we could "just go back to talking again".

Despite setting the frame and the expectations of attending the scheduled sessions on time, Charlotte was often late and sometimes did not turn up to sessions. Just like her speech our relationship felt 'choppy', and I reflected on Charlotte's struggle to connect with me.

When Charlotte missed her appointments she often apologised, stating that she got her days "mixed up". She was distressed for being late and missing her appointments but continued to repeat the same pattern. I was pulled into the 'expectational field'[15] and there was a part of me that also did not want to turn up to appointments on time, or even not show up at all. I did not want to "commit a crime" and "submit" to her devaluation (Frederickson, 2017) but I also knew that in the CMT I needed to try and understand her experience. I pondered on how to approach this and brought it to supervision.

In supervision I was able to take notice of what was going on for her and came to understand that her behaviour was not just the ADHD, it was also because of her early life experiences. She had not had the experience of a caring other, and her experiences of rejection and neglect has resulted in an impairment to respond to other minds (Benjamin, 2018). I realised that the 'yoyo' and the mixed-up feelings inside of me may also be happening for her. I sensed she was strongly reliant on me, but that there was also a fear of dependence because those she had previously relied on had let her down. I was also conscious about the possibility of unconsciously repeating similar traumatic experiences. I was encouraged to let her know that when she missed her appointment she misses out on her own therapy and the opportunity to get better. For psychological healing to occur, it was important

14 Dialectal Behaviour Therapy is a type of psychotherapy which was initially developed by Marsha Linehan for the treatment of Borderline Personality Disorder and interpersonal conflicts. It is mainly a skills-based approach designed to teach emotional regulation, mindfulness, distress tolerance, interpersonal effectiveness, acceptance and tolerating change.

15 The expectational field is the notion of bi-directional experiences, and a mutual involvement of the client and therapist in past and present experiences. It is a relatedness that is constantly shifting and involves a "particular mood or feeling, body feelings, postures, and facial expression." (Meares, 2012 pg.9). An unconscious traumatic memory can pull the therapist into the client's trauma system where the therapist unconsciously (and without awareness) find themselves drawn and behave like the original traumatiser (Meares, 2000a, 2000b).

for me to facilitate a new relational experience of 'being with', one that involves empathic resonance, sharing of positive affect and a mutual recognition that her actions affect me and that she matters to me (Benjamin, 2018).

As I have understood Charlotte better, our ways of relating have changed. Charlotte is able to recognise that she had a hard time forming a relationship with me and was fearful of being manipulated, which was analogous to her early childhood experiences with her parents. As Charlotte gained more awareness of the childhood patterns she was repeating in our relationship, the voices of mistrust and the chaos in her mind softened. There is now more of an ease to our relating. She turns up to her appointments on time, is less accommodating, and is working on setting her own boundaries. She has identified that the most appropriate place to talk about her trauma is in therapy, and she is now able to enjoy different kinds of conversations with her friends. Charlotte has come to realise that gender is a spectrum and that she does not have to fit into definitive and 'neurotypical' stereotypes. She identifies as non-binary and uses the pronouns she/her or they/them. Charlotte stills struggles with emotional regulation, and there is still anticipatory anxiety in expressing her own needs and opinions, however she has come to notice that she can be herself and still be accepted.

Conclusion

I hope I have been able to convey how the CMT can assist those who are neurodivergent find connection and explore their own sense of self without having to 'mask' and conform to societal norms. The CMT approach acknowledges difficulties as well as strengths and works with the relationship to increase self-reflective capacity, self-compassion, and acceptance of self. This sense of acceptance will help neurodivergent individuals understand their difficulties and apply adaptive coping strategies that are positive. Most importantly, the mutuality and the relational approach creates a widening of one's 'window of tolerance'[16] (Siegel, 1999), an integrated sense of self, and an ability to connect with others.

It is also important to keep in mind that everyone has a role in co-creating an inclusive culture, and that this is an ongoing process of negotiation and accommodation of differences rooted in mutuality and compassion.

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16 The window of tolerance is the optimum zone of arousal (or comfort zone of tolerating stress and emotions). This is where a person is able to self soothe and self-regulate when dealing with daily events and stressors. When a person has had traumatic life circumstances, or has a dysregulated nervous system, their window of tolerance narrows and they are more prone to quickly move into a state of hyperarousal (anxious, angry, out of control, fight/flight) or hypoarousal (zone out, frozen, shut down, numb, depressed). A widening of one's window of tolerance allows an individual to be able to cope better with stress and daily challenges.

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Film Review: The Power of the Dog

Helen Frances

A review of the film and book.

In this review italics are used to denote quotes and plot references that do not appear in the film.

Film cast main characters:
Phil Burbank – Benedict Cumberbatch
George Burbank – Jesse Plemons
Rose Gordon – Kirsten Dunst
Peter Gordon – Kodi Smit-McPhee

Filmed in Central Otago, Aotearoa/New Zealand

"When my father passed, I wanted nothing more than my mother's happiness. For what kind of man would I be if I did not help my mother? If I did not save her?"

Jane Campion's 2022 film interpretation of Thomas Savage's novel of the same name opens thus enigmatically onto a dark screen with a young male voice over. Cut to a dusty herd of bellowing, head butting cattle and ranch hands twirling lasso ropes – raw, actively masculine images of something primal and herd-like. This image cluster is followed by a panning shot from within a dark house interior.

Through three consecutive windows framing a sunlit yard strides a man wearing chaps and a cowboy hat - dark, light, dark, light, dark light, dark. Roughly 12 minutes before the film ends the same panning view frames this man dressed in a dark suit and hat walking slowly, carrying a coil of handmade rope.

The film itself moves slowly, paradoxically at times in short, clipped shots, providing glimpses of character and story, snatches of dialogue, lingering in more sensually charged scenes, while leaving the viewer to ponder in the dark, "what is going on?" Jane Campion's style of direction is suggestive, pared back, perspicacious, visually and beautifully stark, with a predilection for the darker aspects of psyche.

"What is going on," is revealed more fully in Savage's novel, to which the film provided a tantalising stimulus. The story, published in 1967, evolves through the dynamics between the characters and their psychological states. Set within a post-colonial context it concerns the relationships between two brothers, Phil and George Burbank, Rose, George's new wife, and her son Peter Gordon.

Montana, 1925, brothers Phil and George co-run the wealthy Burbank ranch, left to them by their parents, the Old Lady and the Old Gent, who have moved to a hotel in the town of Herndon following a never divulged disagreement with Phil, their eldest son. They are both intellectuals who shifted out West from the city, have made a lot of money running cattle but never really fitted in with the ranch owning culture.

Phil is an intelligent multi-talented man, who once conformed to the urbane, intellectual mould of his father and studied at university. Turned Philistine, he has bucked against the cultured intellectualism of his parents, and instead sports a one-sided cowboy persona - not washing, wearing filthy chaps, and talking roughly – there is little evidence of his Greek and Latin scholarship. Phil is trying to maintain the connection with his lost love and hero, Bronco Henry, whom he also refers to as the wolf that raised Romulus and Remus (Phil and George). There is a suggestion of "in loco parentis" and boundary transgressions in the role/s Bronco played. Phil continually refers to the good old days before Bronco died, and before cars and suits invaded the West.

In the town of Beech, a watering place for cattle drovers, Rose and Johnny Gordon live in an Inn, which Rose runs. Johnny (he prefers the longer, younger version of John) is the local doctor, a kind, sensitive man, who lacked confidence until he married Rose. Having failed to impress the hospital director he misses out on an internship, moving as a GP to the small town where he also does pro- bono work among the struggling dry-land farmers. The wealthy ranchers who own access to water prefer to see the doctor in the prosperous town of Herndon. Why stop in Beech, a place that "smells of despair and failure?"

Rose and Johnny have a son whom they, "erred in attaching … the faintly epicene name of Peter." The child is sickly, late walking and talking al-

though he can read by age four. Peter lisps and at school, taunted as a sissy, he experiences a "daily Gethsemane." At home he retreats to a shed where he reads his father's medical books, examines slides under a microscope, and kills, dissects, and stuffs animals.

Peter develops a "cold impersonal hatred" for "those normal, secure, rich, envied ones who might dare insult his private image of the Gordons." He cannily realizes he must deal with the bullies on his terms and continues this strategy further into the story. Dreaming beside the river in the moonlight "his face caught in the cool radiance," he builds a fantasy life of wealth and comfort for his family.

Peter makes his first friend at university, a fellow student with whom he plays chess and there is a sense of belonging or "twinning" in this horizontal peer relationship.

On their 25th cattle drive Phil and George arrive with their ranch hands at the Inn where Rose runs a dining room. Phil mocks Peter who has made delicately "feminine" rose coloured paper flowers, with which his mother has decorated the tables. Phil lights a cigar with a flower, harbinger of the psychological scorching to which he will subject Rose and Peter, and which, earlier, has precipitated Johnny's descent into depression, alcoholism and suicide. Phil, unnamed at that stage, is by implication the rancher who strips Johnny of his dignity intellectually, physically and emotionally in front of his peers in the bar, nailing him to an unbearable cross of shame and failure.

George is moved by Rose's distress at Phil's treatment of her and her son, which undoubtedly resonates with Phil's scornful treatment of the brother he calls "fatso". Unbeknown to Phil, George courts and marries Rose before bringing Rose and Peter to the ranch. He has quietly embarked on a separation from the enmeshed relationship with his persecutor. Phil embarks on a mission to destroy Rose and to appropriate her son. With his "day-blue" eyes and solar gaze, Phil ferrets out people's vulnerabilities and, unawares, reveals his own. He touches Peter's arm when they make a rawhide rope together and Peter uses his intuition to play to Phil's needs.

Despite sharing a bedroom all their lives and spending much of their waking moments together, neither brother has seen the other naked. There is a stilted character to their conversations, a lack of intimacy, almost as if they are a Janus type character, back to back, unconsciously connected, one looking back, the other ahead. The reader is told:

"They had always been close their lives had so complemented each other's one thin, one stocky, one clever, one plodding – they were like a single twin…" (Savage, p. 65)

Phil constantly puts down his brother who takes refuge in silence. George seems passive, wears a suit on horseback, owns a Reo car and is, unlike Phil, stolidly moving with the times.

Phil hunts and kills animals, castrates bulls with his bare hands, and people's personhood with his tongue. He has experienced physical closeness and psychological blending with Bronco Henry (suggested in the book and made more explicit in the film), keeping the cowboy's saddle as a shrine to his lost love. George, who also knew Bronco Henry, seems more like a symbiotically manipulated screen-object, across which Phil attempts to replay and come together with his lost love/hero.

Phil is creative – making miniature furniture, playing the banjo, reading widely - however he lacks a mirroring twin and seems to hunger after a primitive form of merger in relationship. Phil is alone.

"But Phil knew, god knows he knew what it was to be a pariah, and he had loathed the world, should it loath him first" (Savage, p. 251)

Bronco Henry, whose death Phil witnessed, remains a shadowy, idealised figure that epitomised the tough, rough, sensate male of the Wild West era. The loss of Bronco and disruption of a presumably merged closeness is devastating for Phil and he seeks a replacement to fill the emptiness.

"The boy wanted to become him, to merge with him as Phil had only once before wanted to become one with someone … " (Savage, p. 250)

But Peter has other ideas.

The shadow of a predatory dog hunting across the distant hills references Psalm 22, and is visible to just three characters – Phil, more of a visibly,

masculine solar dog; Peter, a more feminine lunar canine in his intuitive modus operandi; and the now dead Bronco Henry. The shadow (a malevolent third), reflected back from the screenplay of light and dark in nature, suggests a primitive, unconscious dynamic operating beneath the surface in these characters' savage struggle to be.

With a lone wolf instinct to survive, without a pack or tribe and fuelled by frustration, resentment, loss, grief, rage, envy, hatred and fear, Phil and Peter enact both opposite and similar extremes in a dog-eat-dog battle.

"In the outcropping of rocks on the hill that rose up before the ranch house, in the tangled growth of sagebrush that scarred the hill's face like acne he saw the astonishing figure of a running dog… the hot snout was lowered in pursuit of some frightened thing – some idea – that fled across the draws and ridges and shadows of the northern hills. But there was no doubt in Phil's mind of the end of [the] pursuit. The dog would have its prey. Phil had only to raise his eyes to the hill to smell the dog's breath." (Savage, pp. 62-63].

The dog in Biblical times as an enemy to humankind, a dangerous outcast, is also likely to carry the cruel scapegoating collective shadow. The title of the novel and film refers to part of Psalm 22 "Deliver my soul from the sword; my darling from the power of the dog."

Far from being "man's best friend" the dog, apart from the pig, is given a very low rank, lower even than carrion eaters," writes Daniel Berkovic in Beware of dogs! : the position and role of dogs in biblical discourse.

Peter, played by Kodi Smit-McPhee, twin-like in his superb embodiment of the character, idealises his mother, his "beloved", Rose, like a knight, the courtly lover enamoured of his medieval lady. The rose is associated with feminine symbolism such as the Grail, the Virgin Mary, and Aphrodite the goddess of love. Peter is like Rose's protective thorn, hidden, dissembling, quietly scheming.

Like the dog and the wolf gazing at the moon, and the pathway in the Tarot card "The Moon," Peter instinctively, animal-like, intuits a way towards obtaining his goals.

A parallel story concerns a Shoshone Indian seeking, with his son, to reconnect with his ancestral lands. The father is humiliated at Phil's hands when he and his son escape the reservation and travel 200 miles to reconnect with their mountain home. Phil turns them away at the fence, which bounds the Burbank property, underlining the Indian tribes' loss and powerlessness in reconnecting with their homelands. Rose later gives them hides, adding fuel to Phil's rage.

Enigmatic, tensely powerful, the film creates a pervasive atmosphere of unease and underlying menace. Dissonant music, cello, horn and other instruments play on the body/mind and emotions - at times thudding, like horse hoofs, or in slow, breath-holding rhythms that build towards a climax that never arrives; the sense of dread and distress evoked by the sound track also mirrors the dis-regulated self-states of the characters.

The film has been called Gothic or noir western. There is a strong flavour of the macabre in the design of the ranch house which sits, mirage-like, in the empty landscape, both blending in with its brown tonings and standing out in odd textures, in particular the roof. It is easy to imagine it sprouting chicken legs like the house of Baba Yaga, perhaps harbouring a witch in a grander version of the witch's house in Hansel and Gretel or, Transylvania style, concealing a cowboy Dracula.

The landscape dwarfs the characters in the film, magnificently conveyed by the New Zealand Central Otago scenery. It seems a very different terrain from Savage's poetically detailed, sensual descriptions - a sun-seared, "hostile" environment, studded with sagebrush.

"… the sun lingered over the mountains, reddish-hued through the smoke of distant forest fires; and then sank suddenly, trailing bloody streamers. Phil liked it that there always followed on the heels of the vanished sun a stunning silence, an unearthly hush, and how into it crept little sounds – as night-things creep into the dark – the whispers of willow leaves and branches kissing … (Savage, pp. 210-211)

The vegetation of the Central Otago landscape in the film, with its sea of russet tussock grass and enfolding hills, is quite different in colour and texture, more golden. Google images of Montana

sagebrush country revealed a much greyer, coarser, scrubby terrain that stretches even further than the Central Otago plains.

Despite some criticism aimed at Campion's choice of a non-USA Western context, both landscapes seem fit settings for the human themes of loneliness, aloneness, dispossession and disconnectedness that pervade the works. The characters of Phil and Peter, both outsiders, compensate for this by identifying differently and possibly omnipotently, with the outcast, dark side of God – the less than human, predatory dog they recognize in the mountains, the ancestral mountains to which the Shoshone Indian father and son are reaching out.

The interior of the house in the film is clatteringly empty, the sound of any movement amplified by the high stud and dark timber walls. There is no place to hide from predatory eyes as Rose, played by Kirsten Dunst, discovers. But Phil too demonstrates his own needs and self-discomfort, the vulnerability he sees in Rose and Peter.

Phil is hungry for touch and closeness. In Campion's version, watched unbeknown by Peter, Phil bathes in a secret pool. Taking from his trousers a scarf embroidered with the initials BH he trails the material across his naked body. To me the device of the scarf seemed contrived - an instance where Savage's words made the more subtly poignant suggestion that Phil's misery is connected to very early unmet (narcissistic) needs for adequate (self) reflection.

"After the first year George lost interest (he lost interest easily) and only Phil went there to swim, sometimes strangely moved by his own naked reflection." (Savage, p. 162)

Benedict Cumberbatch as Phil seemed ill at ease in his cowboy body, affecting a cowboy's awkward swagger. He seeks to belong as well as dominate but is perceived by a young hand as "a lonely cuss" who may have been unloved. His withering words and viciousness are terrifying. Occasionally, however, the mask cracks revealing Phil's deep seated insecurity, such as when he realizes that Rose and George have moved into the parents' bedroom leaving him alone with the sounds of their love-making next door.

Like the moon reflecting the sun's light, Rose mirrors positive aspects of George in contrast to the negativity heaped on him by his brother. Rose is kind and full of feeling, one-sidedly so, as she conforms to the expected role of the times. In the film she wears filmy, light floral prints which complement the fragile character Dunst portrays. The film focuses more on her vulnerability; her competence and agency running the Inn is lost when she comes to the ranch.

Rose takes to the bottle in an attempt to anaesthetize herself against Phil's attacks. Losing her sense of worth and moral compass, "Since she had married a Burbank she had become sly. She had become dishonest. … She couldn't be anything unless someone believed in her, nothing at all. She could be nothing but what someone believed she was." (Savage, pp. 238- 239)

Terror stalks the house and Rose is alert to every sound of Phil's presence. His persecution of her is mesmerizing.

"Doors, doors, doors, doors; five outside doors in the house, and she knew the sound of the opening and closing of each one. The back door Phil used let the prevailing wind billow the hall carpet so it writhed like a snake." One afternoon "he walked with a quick, light, high-arched step on his rather small feet …" and when she starts to practice for the soiree she hears Phil echoing on his banjo the tune she is struggling with on the piano – "now she knew a crawling sensation up the back of her neck; he was playing precisely what she was playing – and better." (Savage, p. 118)

The film distills the essence of Rose's fear and despair as she tries over and over, fingers, stumbling, to practice for the expected performance.

A torturous scene follows in the dark living room where Rose freezes in front of guests over the piano keys – a scene of excruciating shame and humiliation.

Next day Phil whistles the tune Rose had been unable to play, watching her gulp Bourbon behind a shed from the right side of a top floor window. An almost reverse image at the end of the film shows Peter looking down from the left (the sinister side) of his top floor room bedroom at Rose and George (Jesse Plemons) embracing in the moonlight. He turns away smiling.

Campion's horror of a physically and emotionally abusive nanny informed her understanding of both Rose and the atmosphere that Phil brings to the house. She tells Jordan Kisner in the New York Times:
"We [Campion and her sister] were really little, and it was a lot to carry when you're really little. But it did make me think, that's how I understand the terror of Phil. I would always know where she was in the house."
George, however, discovers more positive aspects of himself in relationship with Rose and Peter. The couple's tremulous beginnings of relationship are both warm and fragile.

"I just wanted to say how nice it is not to be alone," George tells her in a scene where she teaches him how to dance – two tiny figures connecting in a vast landscape which suddenly seems less overwhelming. The tender aspects of relationship are detailed more fully in the novel, as are the kinder, yet defended, attitudes of some urban folk (Johnny, Rose, George, the Old Lady and Old Gent) towards difference, perceived abnormality (Phil, Peter, "freaks" in a circus Rose refuses to visit), disability, and the plight of indigenous peoples.

The road, seen in aerial shots, makes a tenuous connection between town and country etching a thin line through the vast landscape. Along with the dark, empty interior of the correspondingly large house, these outer and inner perspectives brought to mind the atmosphere of unease explored by actor Sam Neill in his perspective on New Zealand cinema in The Cinema of Unease, 1995. Neill, a lone figure on another Central Otago road, includes Campion's films in his classification of dark, brooding films that reflect post-colonial struggles to form a sense of identity. Neill includes clips from Campion's films The Piano and Angel at my Table in his illustration of these themes.

"What we needed was a sense of ourselves, a culture of our own," Neill says. "Because our own culture was absent from the screen our own country was somehow not worthwhile." This statement also begs the question to what extent may a director's artistic creation represent a collective, cultural "third" - a screen, like the notion of a therapy screen, through which we may get to know ourselves better and grow, both as individuals and as a collective.

The Power of the Dog is a visually striking, coolly intuitive, thinking film that lacked much of the feeling fullness and complexity of the novel. While the characters seemed quite one dimensional on first viewing – with the subtlety of the acting sometimes lost while trying to piece together the story - a later viewing allowed me to immerse more in the acting.

Changes were, however, inevitable in bringing the story to screen; a great deal of backstory and character flesh had to be left out. Campion's minimalist "show don't tell" approach makes the viewer work, and the film benefited from another viewing and a reading of the novel.

Savage writes a powerfully evocative, richly layered novel, dubbed "a classic" and a "visceral" "slow-burn psychological novel." His show and tell style takes the reader inside the characters' minds without revealing all. There is a feeling of wholeness about his writing that brings together sensory detail, imagination, thinking and feeling, sun and moon, masculine and feminine, in a way that, gauging the response of readers discovering the book today, speaks to people 55 years after publication.

Themes dramatically enacted through the character dynamics stimulate reflection on the effects of various forms of colonisation - on indigenous peoples and on those who by their nature fall too far from the tree of collective norms. What can happen when early needs for merger, construction of authentic self, and later healthy twin-ship with 'alike enough' others is frustrated, is graphically illustrated - along with the effects of abandonment, loss, addiction, adoption of a "false self", shame, humiliation, rage and vengefulness among others. There is an undercurrent of same sex relationships in the novel, which is taken up more explicitly by the film, both by the director and certainly by some reviewers who express a sense of recognition and understanding.

The road to becoming human among humans in The Power of the Dog may be viewed as a journey of Biblical proportions.

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"The Power of the Dog" film can be viewed on Netflix:

Information about the film

https://www.nzfilm.co.nz/international/showcase/power-dog-0

New Zealand director Jane Campion

https://www.nzonscreen.com/profile/jane-campion/biography

Australian producer Emile Sherman

https://en.wikipedia.org/wiki/Emile_Sherman

Call for Papers for Issue 6

Chris Garvie

The Statement of Ambition in TTC1 noted that:

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

For those of you considering whether to submit a paper to TTC, I'd encourage you to go back and read the Statement of Ambition in TTC1. I hope you'll feel encouraged to get in touch.

TTC welcomes papers around 5000 words in length, and these will go through a peer review and editorial process.

Please contact me on drchrisgarvie@gmail.com if you'd like to submit a paper, or if you have any questions.

Part II: Information

Australia and New Zealand Updates

ANZAP President and Conference Committee Reports

Kim Hopkirk

Hello and Kia ora, to all our members spread far and wide.

When I wrote in April, I let you know of the addition 3 new members to ANZAP's management committee (MC) who bring fresh energy, experience and expertise in their particular fields. I wish to introduce them to you.

We have Kris Rao, who has taken over as chair for the professional development committee (PD). He has organised and run webinars for a number of years, and is getting us to think outside the box, like accessing social media to spread the good news of our very interesting seminars that Kris and his committee are busily creating.

We have Chris Garvie, from Aotearoa/New Zealand, as our new editor of TTC. He brings a bouncy, can-do enthusiasm along with his editorial savvy to the job. Chris is also helping us to figure out how to make our website a place that members, clients and the public wish to go to for information and help regarding CM and psychodynamic psychotherapy. Thank goodness! This area has been plaguing us for a long time, where we've done small fixes (for a lot of money) but we really want to give it a proper overhaul now.

We have Deb Moran, who is shadowing Dianne Hendey, as Treasurer, ready to take over when Dianne retires from the MC. Deb has been involved with the financial portfolio of the Greens party in Aotearoa/New Zealand. That is a big hefty piece of expertise that she brings to ANZAP, and I'm very grateful to have her.

This means that we have 4 out of the 10 people on the MC (this includes me) from Aotearoa/New Zealand. It is truly an ANZAP organisation. We continue to strengthen our bonds with PIT–UK. We had a combined seminar where experts by experience spoke movingly of what it means to be a sufferer of mental health. We continue to have regular meetings together, and Else Guthrie spoke from the UK via zoom at our conference in October.

We had a very successful seminar series from March into May of the conference that kept being cancelled; "The Deep Roots of Trauma: Attachment and Adaptation through the Lifespan". The various speakers complemented each other, and it was rich with information and clinical perspectives.

We continued the theme of attachment into our one-day conference "Attachment and Adaptation: in Practice" in October. This conference had a clinical focus, and some wonderful papers were presented. Jackie Amos, our keynote, developed her theme of attachment and adaptation from her keynote that she gave within the conference seminars. Jackie also ran a 3-hour preconference workshop on shame and its ramifications. Russell presented his paper "The Loom of Existence: Relational structures facilitating personal unity".

This is my last report as president for TTC. I am handing over the presidency to Tony Korner, where he will continue to take ANZAP into the direction of growth and deepening development that has been going on over the last number of years.

I came onto the MC in 2013 when ANZAP was mired in the mud of a stressful, and most difficult complaint, that had us not doing well as an organisation. We were losing members, we were running at a loss year after year, and heading into insolvency fast. We had to make some brutal decisions, and at times our meetings were long, tough, and heated. We pulled out of hearing complaints as we thought we were too small an organisation to hear complaints regarding our own members. We also pulled out of Psychotherapy and Counselling Federation of Australia (PACFA). They saw themselves as the peak body for psychotherapy and counselling, but we realised we didn't fit with them. This decision caused some consternation amongst some members, while others cheered for us leaving.

These decisions could only have been made with an MC that could work well together, and the angst of it all was worth it. We continue to have a well-functioning MC, we are financially strong, with a strong and popular training that is of very high calibre. We have a future as a leading psychodynamic psychotherapy organisation with our CM training - within ANZAP, and via Sydney University - being recognised as a valid treatment for BPD and intractable depression. I feel very proud to be on the MC, and to be a member of ANZAP.

I started as secretary, worked very hard on an ethics working group, I became the professional development chair after I handed over the secretary position, and then I took on the presidency 3 years ago. I have been a part of this rich and wonderful family, and I have learnt that I have capabilities that I never knew I had. I'm so grateful to have been on this journey with ANZAP and that you have entrusted me to guide her in these years. I intend to stay on the MC for another year, and I will continue to hold the conference committee chair.

Westmead Wonderings

A 'new regular' addition to The Therapeutic Conversation

Anthony Korner and Loy McLean

This year has seen consolidation of our online teaching and the suite of degrees and certificates available through the University of Sydney, Western Clinical School. 2022 will see our second graduating group in the Master of Medicine / Science in Medicine (Trauma-Informed Psychotherapy) Degree program. It has also seen the first graduate of the Graduate Certificate (Trauma-Informed Psychotherapy) program. In addition, a 2-year program, the Graduate Diploma is available. The re-working of the Westmead curriculum over the last 4 years has seen the establishment of teaching in Short-Term Dynamic Interpersonal Psychotherapy, developed at Westmead, and Psychodynamic Interpersonal Therapy, developed in the United Kingdom. There has also been increased collaboration with ANZAP and PIT-UK. One feature of closer ties with ANZAP has been the institution of automatic trainee membership of ANZAP for Westmead trainees. Another has been submissions to The Therapeutic Conversation occurring with some regularity.

We have welcomed several new members to the Westmead Faculty in recent times. In addition to Andi Szasz, Deborah Chisholm, Bill Moloney and Jag Andepalli who have worked with us for a few years, we have added Karen Druce, Robert Sainz, Duncan Loasby and Nicky Abitz, all enriching the teaching and supervision ranks. We look forward to an ongoing process of renewal within the faculty. The last 12 months have also seen the retirement from the Westmead Faculty of two of the original teaching cohort, trained by Russell Meares in the early 1980s. Michael Williamson was farewelled late in 2021 and this year we say farewell to Janine Stevenson, who retired from the faculty recently. Both have made a huge contribution not only to the Westmead Program but also to the development of the Conversational Model. Janine's research with Russell Meares in the early 1990s really put the Conversational Model on the map in terms of the international research literature. We owe both Michael and Janine a debt of gratitude for their many years of service to the program.

We have also continued to develop a small PhD cohort and currently have a couple of students associated with the Program, who have both done the CM three-year training earlier. Those projects are building on our ongoing collaborations with David Butt and Stephen Malloch. We are hoping to continue that close nexus between practice, teaching and research that has enriched the CM model since its inception and are delighted by mutterings about PhDs in the current Masters cohort. We will also put out our annual call shortly for our "scholarship program", that supports clinicians within our local health district to do a year's training with us in the CM, with a focus on a short-term model clinically. This has been a satisfying way of seeding these skills in the local service and psyche.

ANZAP Faculty Report

Nick Bendit

Faculty is at the busy time of the year. We have just celebrated the graduation for the graduates from last year, which was held during the October

conference. It was a wonderful experience, with inspiring and fascinating dissertation presentations by the four graduates who could attend, witnessed by quite a few faculty members and many of the current trainees.

In fact, the whole preconference workshop, conference, graduation and group supervision weekend was filled with the buzz of excitement of trainees actually meeting face-to-face. There seems to be a hunger, after the pandemic, to get together in the same room together.

We are also saying goodbye to our current year three trainees, having had the last formal teaching seminar last night. In the next two weeks the viva exams will be conducted for all three years and the end of year essays marked. This will lead to a full day faculty meeting on Sunday, September 4 to discuss the progress of all the trainees in the three years.

Next year is likely to be even busier. We have already had 14 applications for next year, and will need to cap it at around 22 year one trainees. I suspect we will have double that number of applicants. With many of current year one and year two trainees continuing, I expect we will have around about 50 trainees next year.

United Kingdom Updates

Comments from PIT-UK Chair

Simon Heyland

Greetings from a chilly UK! After a long summer (sweltering in 35 degrees at one point – something us Brits are not accustomed to…) and a very mild autumn, finally we have some ordinary seasonal weather to grumble about. But thankfully no return to covid lockdown conditions, and I am sure I am not the only person here who has been delighted to be allowed to meet colleagues en masse again, at face-to-face conferences and large meetings. A reminder if ever we needed one that we as humans we must spend time together in an embodied way in order to feel truly alive.

But when that is just not possible, let us be grateful for the new opportunities that the online world provides for us. In May this year we had the second joint ANZAP/PIT-UK Seminar via Zoom, and I found it every bit as rewarding as the inaugural 2021 event. This time our focus was on listening to the voices of service users, and we had the huge privilege of hearing from three women about their journeys through suffering and into various forms of psychotherapy and beyond. It was inspiring and humbling to hear how they have all coped, and I felt very fortunate to be in discussion with them that day.

May 2022 also saw the restart of our introductory course at The University of Manchester, led by Richard Brown. It was fantastic to be delivering a face-to-face training course again, and will spur us on with the much larger task of setting up the practitioner training in PIT, planned to take one year to complete. We are currently exploring whether an NHS training centre may be the best host for this. Apologies to those of you who have been waiting and waiting for confirmation that you can apply for the practitioner training – covid and other factors have all played their part in slowing us down!

In July and September we held our regular bimonthly online PIT-UK CPD sessions, the July meeting on aspects of using the conversational model in inpatient settings (led by Laurence Regan and Paul Culatto), and the September meeting led by Emma Mullins talking about her extensive experience of brief PIT for self-harm. Look out for articles based on those talks in future issues of the journal.

Our other online news is that whilst work continues on the functionality of our new website (in preparation for new PIT-UK membership benefits) I am pleased to be able to say that the site is now up and running thanks to the tireless work of Frank Margison. If you want to have a browse head over to www.pit-uk.org.uk

On our horizon next is our Annual Training Day

on 25th November. Our topic is using 'reliving' as a therapy technique, led by Else Guthrie. It is sure to be a rich learning experience, and what's more it will be the first face-to-face PIT-UK event since covid-19 began… so plenty of space is being planned into the programme for attendees to catch up with each other and re-establish their connections as people, having conversations together, in a room. I am looking forward hugely to seeing people there in Manchester.