THE THERAPEUTIC CONVERSATION
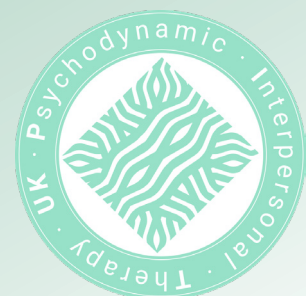
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Editorial

Chris Garvie

Welcome / Kia Ora to the 6th issue of The Therapeutic Conversation.

TTC continues to evolve as a close collaboration between ANZAP and PIT-UK. It is fitting, therefore, to ask you to 'save the date' for the upcoming PIT-UK / ANZAP seminar on 23rd June 2023, which is one of a number of events listed in the new 'Upcoming Events' section:

Amplification, Imagination and Reliving. Zoom seminar with Anthony Korner and Else Guthrie

We begin this sixth edition of TTC with Kath McPhillips discussing her important work regarding the politics of disclosure as this relates both to the individual survivor and to the wider community.

Next, Kiran Lele writes about doctors' coping mechanisms from a psychodynamic perspective, along with two fascinating case examples.

Shaun Halovic then offers us an insight into the specific challenges faced by clinician-researchers, while reminding us why this work is so vital.

Simon Heyland presents a marvellous paper on the use and meanings of gesture, which is based on his January 2023 PIT-UK CPD session.

There is, unfortunately, no film / book review in this edition, however we have exciting reviews in the pipeline for TTC7 and TTC8.

TTC6 concludes with our regular updates on what's been happening within ANZAP, PIT-UK and Westmead, along with our new Upcoming Events section.

Thanks, as always, go to Leo LaDell for his publishing know-how, and to the teams of peer reviewers on both sides of the equator who provide me with much-valued support as editor.

Buona lettura! (Italian for 'happy reading!')

PART I: PAPERS

The Politics of Disclosure: When trauma moves from private safety to public exposure.

Kathleen McPhillips, PhD

Psychotherapist and ANZAP member

Abstract

This article examines the importance and practice of disclosure of personal traumatic experience as a beneficial act by which communities gain insight and develop empathy towards survivors of sexual violence. This provides a pathway to recovery through redress and public recognition but exposes survivors to often intense public view and further trauma. In many cases, disclosure constitutes a second trauma. I will examine the research documenting the experience of survivors who engaged in the recent *Royal Commission into Institutional Responses to Child Sexual Abuse*. Drawing on the work of psychotherapists and other researchers who discuss how and why it is important to politicise the impacts and nature of traumatic experience, I will demonstrate how this process leads to deeper understanding, healing and growth for both individuals and communities who are impacted by institutional child sexual abuse.

Introduction - Going Public and Why it Matters

In my work as a clinical psychotherapist and social researcher of gender-based violence, I have been closely allied to the trauma that the sexual abuse of a child can cause and the impacts of disclosing abuse. In this article, I will discuss the challenges for survivors and communities in the process of going public, as well as the benefits of hearing the narratives of child sexual abuse in the public sphere. I draw on my own and others' research into the politics of disclosure, the forums in which this occurs, and the impacts on those who disclose. I also draw on my ongoing close working relationships with many survivors of institutional child sexual abuse whom I have met in the course of my research. This article was first presented at an ANZAP seminar in August 2022[1] which focused on the politics of privacy in psychotherapeutic settings. While privacy and confidentiality are primary tenets and principles of clinical practice, there are times when individual patients/clients may wish to share their experiences and this in turn may be a benefit to community growth. The challenge to the therapist is then how to support such an action knowing that privacy may be sacrificed in the process.

In many cases, disclosure constitutes a second trauma as not only is the abuse re-lived through the disclosure process, but the subsequent outcomes expose survivors to public scrutiny and the possibility of further betrayal and disbelief (Blakemore et al, 2017). At the same time, disclosure in a public space opens up the possibility of building new narratives of collective empathy, helping to contribute to the knowledge base of the experience and nature of child sexual abuse. This knowledge can and has led to significant changes in policy, law, organisational cultures and clinical understandings and is a valuable resource for moving forward and creating child safe organisations (Herman, 1997). In short, public disclosure is a difficult but important social practice and worthy of our attention as clinicians, supervisors, teachers and researchers. The ethical question is, how do we make disclosure in public spaces a safe practice for victims and survivors? I will begin with understanding the disclosure process as one premised on the principles of social constructionism, that is where public disclosure can be framed as a dynamic social process that involves multiple steps, individuals, communities, and institutions within historical and cultural contexts.

Over the last 30 years the discourse of child sexual abuse has changed significantly and become the subject of intense global scrutiny. While the focus has been largely on familial child sexual abuse, there is a growing interest in the prevalence and impacts of extra-familial or institutional based child sexual abuse (CSA). While it is clear that the impacts of CSA are similar for victims, there is a great deal of variance in how disclosure is managed and redressed but within institutions there are certain problematics that have been identified and which contribute to the distress that victims can experience in the disclosure process. In institutions, the disclosure process is highly politicised.

I will look at two kinds of disclosure: via a court case, and via a public inquiry and the ways in which different institutional settings impact survivor experience. I will discuss these in relation to the Australian Royal Commission into Institutional Responses to Child Sexual Abuse (RCIRCSA) and the way in which it established the survivor community at the centre of its organisational practice. RCIRCSA was able to establish safe processes of disclosure for survivors and engagement with the public and this had significant benefits to survivors and the wider community. This style of engagement process has yet to be replicated in

1   *Individual privacy and collective understanding: The role of the therapist in bridging private and public worlds,* ANZAP Online Education Seminar, 20 August 2022.

other public inquiries (Wright et al, 2017).

I will also consider the therapist as an advocate and their role in assisting clients from the therapy room to the court room. Finally, I will consider the post-Royal Commission landscape of disclosure and especially where the voices of survivors who want to tell their stories are being heard. Some spaces have been more effective than others in validating survivor experience and in providing survivors with the safety needed to tell their stories. Some have been disastrous and had negative outcomes for survivors and their families.

A Double Trauma – Telling Twice

We know from the psychological literature that the sexual abuse of children causes significant personal trauma (Herman, 1996; Keenan, 2012; Middleton, 2004a, 2004b). Indeed, most theorists of trauma agree that the effects last long after the event has happened with many survivors experiencing post-traumatic stress disorder as well as disruption to affective adaption, personal relationships and self-identity. Middleton et al (2014b, p22) reports that two thirds of patients in the mental health system report experiences of childhood sexual abuse, and the Adverse Childhood Experiences Study notes that it remains a causal indicator of poor social and economic outcomes as well as increased risk behaviour, disease burden and early death. Many survivors who told their story to the Royal Commission documented the personal suffering, shame, self-disgust and loss of life opportunity that results from sexual abuse in childhood.

There is a small field of interdisciplinary research documenting the process of public disclosure by survivors of institutional child sexual abuse. In a 2022 article (McPhillips et al), I led a research team that documented a review of this literature, and we made the following conclusions. Firstly, most victims of institutional child sexual abuse, estimated at around 80%, never disclose their abuse. It is likely that this is due to the deep level of shame and subsequent dissociative states that typically accompanies the experience of child sexual abuse (Herman, 1997; Middelton et al, 2014a). A small percentage of children report immediately or soon after the event to either parent, teacher or trusted adult. Late disclosure is the most typical form of telling someone and occurs on average 20-30 years after the abuse has occurred. Men are much less likely to disclose than women and take longer to disclose, and children abused by religious clergy less likely to disclose overall, indicating the deep levels of shame at work (Blakemore et al, 2017; McPhillips et al, 2022). It is not clear what the triggers for disclosure are, but they include: a feeling of safety produced through a lengthy time period from the abuse events, the death or court case of the perpetrator, changes in the process by which the relevant institution manages disclosure, media reports, and accessibility to a public inquiry. Secondly, disclosure can include describing all or part of the CSA experience both informally, to a therapist/ counsellor, peer, friend or family member, and formally, in a statement to legal authorities including police.

Thirdly, disclosure is often a traumatic experience and thus constitutes a double trauma where the original trauma is relived. In general, a survivor will carefully weigh up the impact of their disclosure on family and community as well as themselves, and they are much less likely to disclose if they anticipate disbelief, a negative response or reaction, or understand that there will be punitive consequences or negative implications for themselves or others. Disclosing in an institutional space can be traumatic especially when the processes designed to manage disclosure and remediation are poorly administered and lack clear lines of progress, responsibility, and empathic responses. There were multiple public hearings during RCIRCSA that documented the very poor responses by many organisations to disclosure leaving the survivor feeling alone, disbelieved and unvalidated. In hearings involving the Catholic Church many victims experienced the Towards Healing protocol[2] as particularly damaging and legalistic, with a focus on limiting financial impacts on the Church. Survivors were often disbelieved, and cases took years to resolve. In order to receive financial and other forms of compensation survivors were often forced to sign a legal document known as a `deed of release' (i.e. a non-disclosure agreement) censuring survivors from discussing their case and outcome with anyone, or seeking further legal action. This was often experienced as a second silencing by the institution leaving the survivor vulnerable and hurt. Non-disclosure agreements are typical requirements of many organisations managing revelations of sexual abuse (McPhillips, 2018).

The RCIRCSA found that non-disclosure agreements were largely unethical and often signed under duress. Despite the RCIRCSA recommending that they not be used, they are still common. In my research I have found that the central function of a non-disclosure agreement is to protect the reputation of the institution from damage and to limit financial payments (McPhillips, 2018). In the case of institutions which abuse children, it is extremely rare for organisational leaders to disclose perpetrator activity in public or to the police, and generally they are only detected after survivors speak out and risk their own well-being.

Finally, disclosure is a process that can take place over a period of time involving reflection, discussion, distress and re-traumatisation (Blakemore et al, 2017). It can be a drawn out, messy process. Many survivors chose to give evidence to the RCIRCSA in a private session, which was set up especially as a means of providing a safe space for survivors to tell their story as well as acting as a mechanism for gathering evidence about institutional responses and perpetrators. Over 8000 survivors gave evidence this way. In the final report, RCIRCSA identified that the private session was

2   The Towards Healing Protocol was established by the Australian Catholic Church in 1996 to address disclosures of child abuse by employees of the Catholic Church. It is still available as a pathway for addressing abuse, but has been the subject of serious criticism especially during the RCIRCSA.

a particularly powerful meeting for survivors, many of whom had never spoken of their abuse before. Some therapists were asked to attend a private session with a client. In 2016 I attended a private session to support a friend reporting her abuse at the hands of a Catholic priest, and it was a very impressive trauma informed process.

Disclosure is A Political Process – Judith Lewis Herman

In her influential and ground-breaking study of *Trauma and Recovery,* US psychiatrist Judith Herman documented the historical development of trauma in modernity, and how victims of sexual abuse can recover. She argues that communities often manage distressing collective traumas such as child sexual abuse through a process of cultural amnesia or forgetting (1997). In a similar vein, Russell Meares (2000) describes this process as a typical trauma response for individuals which operates as part of a traumatic memory system where traumatic events exist beyond conscious awareness. This is the nature of trauma itself whether for communities or individuals, which is characterized by a dialectic, moving between remembering and forgetting, between speech and silence, and knowing and not-knowing (McPhillips, 2017).

Herman (1997) gives the example of the rise of public knowledge concerning the sexual abuse of women and children in the early 20th century under the influence of the emerging psychotherapy movement. She documents how it became too difficult to keep such a phenomenon conscious without a political movement to support it, and so it fell into collective forgetfulness. It was not until the 2nd wave women's movement in the 1960s that child and female sexual abuse came to public attention again and, with an organised campaign over the last 60 years, awareness has increased. The most important element here is the process of articulating the trauma and miscarriage of justice of the affected cohort to themselves and the wider community. This typically happens through lobby and support groups which are largely comprised of survivors and supporters. *Bravehearts,* a group based in Queensland, and the *Blue Knot Foundation* are good examples of survivor support and lobby networks.[3] Thus it is survivors who are largely responsible for telling their stories and creating a social narrative of suffering that the public can engage with, widening the trauma into a collective space. This certainly describes the way in which RCIRC-SA was established: numerous groups comprised of survivors, their families and supporters put continual and significant political pressure on government bodies over many years to respond to the ongoing stigmatization and injustice that survivors were experiencing, developing a narrative of the impact of sexual abuse and the need for institutions to take responsibility.

3   Bravehearts Child Protection and Prevention https://bravehearts.org.au/ Blue Knot Foundation for recovery from childhood trauma https://blueknot.org.au/

In Herman's account of recovery, the methodology for both individual and collective healing from trauma always begins with establishing safety and building a shared language that can describe the trauma and explain the impacts. Recovery involves the processes of remembrance, validation and restorative justice. This needs to happen in both large and smaller public spaces.

Two Different Public Spaces: The Court Case and the Public Inquiry

Once a survivor makes the decision to disclose in a public arena, there are multiple hurdles. If it has been many years since the abuse occurred, there may be legal time limits on reporting abuse (for example, a statute of limitations in state law), although many of those have been removed following recommendations from Australian public inquiries. The survivor may need to give evidence to the police or investigating bodies, and they may need to confront the members of the institution in which they were abused. The perpetrator may still be alive or may have died. Their families might not support them, and their communities might reject them. It is a fraught road.

There are two central public spaces in which survivors tell their stories: as evidence in a court case and/or to a public inquiry. There is a large body of research into the impacts of criminal and civil court cases on witnesses who are survivors and the ways in which legal systems manage this (Blakemore et al, 2017; Cashmore et al, 2017). Survivors are likely to be cross examined by legal representatives and their accounts tested and even disbelieved. Many people who attend court are re-traumatized. Court systems are based on adversarial legal processes and are designed to test the evidence. I have sat through multiple court cases involving child sexual abuse in institutions and they are sites of serious stress and trauma. Even when legal systems attempt to set up trauma informed court systems, they can often go awry. For example, in the 2018 Melbourne criminal hearings against Cardinal George Pell involving historic child sexual abuse against two complainants, witnesses were allowed to give evidence from video links and all the evidence was held behind closed doors in line with a policy of standard practice for contested hearings involving sexual abuse allegations. However, a number of witnesses, including the ABC journalist Louise Milligan who gave evidence, criticised the closed-door policy saying that a lack of public scrutiny allowed the prosecutors to intimidate and traumatise witnesses, including herself (Wootton, 2020).

Recently, there have been multiple attempts at legal reform in the area of sexual assault, to make the court experience less traumatic, especially for vulnerable groups such as children who appear in the criminal justice system. In New South Wales (NSW) children can give pre-recorded evidence and not appear personally in court. However, for adult survivors giving evidence in NSW criminal courts it can be a harrowing process and a clear deterrent to coming forward. It is a very difficult situation to be in, as most victims and their families want the abuser to be stopped and other children protected. Victims want their day in court,

and justice for themselves and their families. But the trauma of coming forward to court, the length of time it takes, and the low levels of successful prosecution are often too much to bear. The idea and importance of a trauma informed process to help victims manage court is definitely being discussed, although a long way from being effective (Cashmore et al, 2017).

The second space in which survivors tell their story is the public inquiry. While still a formal legal structure, it is a completely different experience to the court case. In Australia, there have been over 80 public inquiries into the status of children in institutions since the early 1800s (Wright et al, 2017). Forty of these inquiries have been held since 1980 indicating a the rising awareness that the care and safety of children in institutions is problematic. In the few years prior to the RCIRCSA, which ran from 2012-2017, there were state inquiries into child sexual abuse in NSW, Victoria, South Australia and Queensland. Since the 1990s a number of Royal Commissions have examined: the plight of child migrants; the adoption system and children who were taken from unmarried mothers; children, crime and prostitution; youth detention centres; and First Nations children who were forcibly removed from their families. There is currently a public inquiry running in Tasmania (Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings[4]) focusing on government responses to disclosures of child sexual abuse in schools, health care settings and youth detention centres. All of these inquiries have, or are, investigating historic child abuse.

A public inquiry is always called after the fact. That is, after there has been a lengthy and significant miscarriage of justice. The aim of public inquiries is to investigate: what has happened and the specific organisational mechanisms by which child abuse was facilitated; the impacts of child sexual abuse on victims, families, communities and organisations; processes of remediation for living survivors; and how to make existing institutions child safe.

RCIRCSA is the largest public inquiry investigating sexual abuse of children ever held in Australia and arguably the world. It had bi-partisan support, a budget of half a billion dollars, and a large staff including 6 fulltime Commissioners. It was instigated by former Prime Minister Julia Gillard, following years of lobbying and political activism by survivor and support groups, and a growing concern that current child institutions such as sporting clubs, schools, health services, arts clubs and religions had not dealt effectively with complaints - and in many cases had protected perpetrators. It established beyond doubt that for much of the twentieth century, Australian institutions demonstrated a catastrophic systematic failure of care towards children. Drawing on previous inquiries into child abuse in Europe, Ireland, Scotland, England and Wales, the RCIRCSA Commissioners were able to design a process that could avoid the mistakes of past inquiries, while building an effective structure for

reporting disclosures and redress. In the RCIRCSA final report, over 400 recommendations were aimed at increasing child protection and safety, better policy and legal advances, and changes to organisational culture.[5] In my research I have noted that it is organisational culture that seems to be particularly resistant to change (McPhillips, 2017).

From the beginning RCIRCSA was set up to hear the accounts from survivor witnesses and responses from organisational leaders. It positioned survivor testimony at the centre of evidence gathering and established a trauma informed communication protocol allowing anyone who wanted to contact the Commission and tell their story to do so in a safe and contained manner. This was unique and has yet to be replicated in other public inquiries. For example, the inquiry into child sexual abuse in England and Wales (IICSA) included survivors but they were positioned organisationally in an outer circle of the Commission called The Truth Project, which led to criticism from survivors that their stories were not central to commission proceedings. This damaged trust between the survivor community and the inquiry.

The Australian RCIRCSA structure was unique in that it ran a public case program investigating institutions which members of the public could attend, or watch via live stream, as well as a private session option. In every public hearing, survivors gave their stories first. Their accounts were validated by the Commissioners and investigators, and many noted this was the first time that they had been believed. The RCIRCSA had a strong media team which ensured that communities were continually provided with updates and reports, and the ABC reported via online and TV everyday of its tenure. It was premised on trauma informed organisational principles from the beginning, and thus able to hear clearly both the impacts of abuse and investigate the causes. In this sense, it was able to build the blocks of healing: remembrance, validation and restorative justice (Herman, 1997).

One of the ways that it did this was through a healing process called Message to Australia[6], an online (and physical) book of over one thousand responses from those who gave evidence at the RCIRCSA. For example:

Thank you for providing a space to bear witness to a torrid time in my life. The commission has encouraged me to step onto the path of healing. Your wonderful staff made me feel safe and supported (Message to Australia, 3/1054)

Glad I spoke to the Royal Commission but it has opened a pandora's box in my head, I feel dangerously angry it scares me a lot but I'm ok, you just ask me. Substance abuse is helping. What a lie to live with. Please don't let this happen to others. (Message to Australia, 5/1054)

When I left my private session, I felt relieved that I was able

4   https://www.commissionofinquiry.tas.gov.au/home

5   https://www.childabuseroyalcommission.gov.au/

6   https://www.childabuseroyalcommission.gov.au/message-australia

to tell you my story. I hadn't spoken about it beforehand. My children never knew. It affects your whole life. (Message to Australia, 15/1054)

The RCIRCSA wasn't a perfect institution by any means and has been subject to criticism on a number of fronts. From survivors, the RCIRCSA's exclusive focus on sexual abuse was problematic. The fact that the RCIRCSA did not include physical, emotional and psychological abuse was difficult especially for those who grew up in orphanages, boarding schools, and out of home care, where multiple forms of abuse, often from multiple perpetrators, was common. Survivor witnesses felt only a part of their story could be told.

The therapist as an advocate in a public space

RCIRCSA provided free counselling for survivors giving evidence in public hearings and attending private sessions. Psychologists, social workers and therapists were employed both directly and indirectly by the Commission during its tenure and their role was to help ensure a safe environment for people giving evidence and attending. At the public case hearings, counsellors sat with members of the public who attended each day and reached out to anyone who was distressed. They also worked with the RCIRCSA investigators who put together the public case hearings, and survivors who attended private sessions.

The role of individual therapists/counsellors was central to many survivors in managing the experience of giving evidence. Therapists helped clients prepare for public hearings and private sessions. More broadly, therapists managed the trauma clients experienced from being exposed to narratives of sexual abuse through multiple media sources. Hence the role of therapists is central to public hearings. A therapist is often the first person that a survivor will disclose to, and often following years of therapy. Sometimes, a client will decide to proceed into court or a public inquiry and the therapist may be called upon to attend with their client, or even to provide evidence.

Therapists can also be called to give evidence in support of perpetrators who are clients or to provide their notes on sessions, which can be a challenging process. As a therapist you want to support your client but you are also aware of how gruelling the experience can be. In this case, the therapist can be concerned for their client and how they might manage the public disclosure processes and they themselves may also experience vicarious trauma either through listening to the experience or attending court. Whether it is court or a public inquiry, it is a daunting experience. This is where it would be really helpful for therapists to have access to supervisors who are trained in the nature and impacts of what it is like to disclose publicly.

Post RCIRCSA: the ethics of survivor voices in the public spaces?

The overwhelming positivity that most survivors of child sexual abuse experienced during the tenure of RCIRCSA has been noted above, but the aftermath has been very uneven. Historic and current disclosures continue, as do court cases of perpetrators. There have been some important public events marking the significance of the injustice associated with institutional child sexual abuse. A National Apology was made in federal parliament in October 2018. Some organisations also made formal apologies. There is a whole politics about how to apologise meaningfully, and some organisations have failed dismally in this regard. Apology is an important part of the healing process as noted by Judith Herman (1997), so it does matter very much - from how it is worded, to what level of responsibility is acknowledged, and especially the authenticity of the delivery.

Although over 400 recommendations were made by the RCIRCSA, many have yet to be enacted and some have been poorly dealt with. In large part, the federal and state governments have enacted new policies and laws including processes to manage redress for survivors and ensure current child protection and safety measures are in place. These include a National Redress scheme, changes to mandatory reporting laws, increased sentencing periods for perpetrators, and legislating new laws to prosecute organisations and individuals who fail to report criminal behaviour against children. They also included establishing the National Office of Child Safety and a system of continuous reporting on responses to child safety in organisations.

The implementation of some recommendations has, however, been controversial. For example, the national redress scheme has been rightly criticised for a litany of problems including a complex application form requiring a lawyer or social worker to complete; taking too long to process inquiries; capped amounts of financial recompense and a maximum of $5000 for lifetime psychology help; and a technical, hierarchical definition of what constitutes sexual harm rather than addressing the trauma impacts for individual victims. The redress scheme has been the subject of two parliamentary inquiries and an independent review. Had the federal government acted on the original advice of the original Redress advisory panel, comprised of experts in the field, these expensive reviews would have been unnecessary.

Court cases remain the central mechanism by which perpetrators are bought to justice. Without doubt, the trauma of sharing one's story in the public domain remains, especially where this involves giving evidence in court. To continue doing this, survivors need high levels of support from family, community and professionals. Survivor advocacy remains an important process of awareness building and support. In Newcastle, where I live, there are a number of active survivor groups. I have had involvement with one of these groups over a long period of time in my capacity as a social researcher, reporting to them regularly on my research projects and outcomes, and engaging in projects together. I would like to share with you two projects aimed at providing spaces for survivors and community members to share their stories of child sexual abuse. Both are supported by the Interdisciplinary Trauma Research Network that I lead at the University of Newcastle.[7]

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7   https://www.newcastle.edu.au/research/centre/csov/networks

The first is a project called the *Survivor Story Project*.[8] Following the end of RCIRCSA, I began receiving emails and phone calls from survivors across the country asking me to help them tell their story to a public audience. While I wasn't in a position to help people write memoirs or do media work, I applied for a grant to do a podcast where local survivors of Church based institutional CSA were invited to tell their life story and the impacts of the abuse on their relationships, work and life. The interviews were then uploaded and are available for anyone to listen to. Ethically, it would be very difficult to keep identities confidential so all participants agreed to speak on the basis that they may be identified.

The second project is an art exhibition titled *Loud Sky* which was open to the public from 31st March to 21st May 2023, in Newcastle.[9] The Loud Sky exhibition is a trauma informed art response to the crisis of institutional CSA in the Hunter region which has been described as an epicentre of abuse. It includes a committee made up of the artistic director of the Lock-Up art gallery, two art curators (including myself) and two survivors. We report regularly to the survivor community. In 2022 the committee organised 3 community art programs for survivors and those in the community impacted by institutional CSA which was funded by the Anglican and Catholic churches. They included painting, drawing and photography workshops, and were run by trained art therapists. These works were then exhibited in local libraries.[10]

The main exhibition which opened on 31st March 2023 featured the work of 5 contemporary artists who have worked in consultation with the survivor community across the Hunter region to create artworks around the four themes of *remembrance, survival, resilience and healing*. The 5 artists have engaged in a preparatory trauma training workshop and have access to counselling services. A separate Timeline exhibit shows the major events and people engaged in this issue. As part of this there is also a photographic display of school photos of survivors, and a word map built from responses to a short survey from the adult children and family members of survivors whose voices are rarely heard, but who have been without doubt profoundly impacted by their parent's experience.

There are multiple other ways in which survivors continue to tell their stories in the public sphere, with some being more productive and trauma informed than others. They are necessary processes to keep the public awake to the ongoing reality of child abuse and to provide spaces in which survivors can speak and act.

Conclusion

I believe we are in the midst of a national reckoning concerning unacceptable levels of sexual and gen-dered violence in the community, both historically and currently. The positive outcomes of this are that we are able to hear the stories of victims in public spaces without long episodes of collective amnesia, indicating significant psycho-social change. The work of courageous survivors including Grace Tame, Brittany Higgins and Saxon Mullins in coming forward and telling their stories and narrating the impacts of sexual abuse on their mental health is slowly contributing to shifting public perceptions of CSA. The challenges are still significant in that institutions tend to be primarily concerned with limiting reputational and financial damage rather than managing violence within institutions. A focus on victims rather than perpetrators is also problematic particularly as victims can be easily stigmatized in public discourse, and perpetrators protected by organisations. While there is some anecdotal evidence that disclosure rates of CSA have increased, it is hard to know the real impacts of elevated public awareness, policy and legal reform on survivor health. What we do know is that given the length of time it takes most victims to report abuse as a child, we likely won't know how well the new policies and laws are working until early 2040. By then, I hope disclosure processes will have evolved into better systems that can hear survivor narratives without judgement, can act to ensure justice and appropriate redress, and focus on perpetrator behaviour and culture. For therapists, their work in reforming the system, especially around redress and validating the experience of their clients both clinically and publicly, is a vital part of moving forward.

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Perfectionism in doctors: a psychodynamic perspective on doctors' coping mechanisms

Kiran Lele

Psychiatrist

Abstract

The personality styles and coping mechanisms of doctors span the whole gamut of human diversity. There are no specific coping styles that can be attributed to doctors as a whole cohort, nor is it likely that any early life circumstances could entirely explain a person's decision to study medicine. Nevertheless, the study and practice of medicine is demanding and rewarding in very unique ways; and we can wonder if some patterns in coping styles that draw people to the profession may be identifiable and may become maladaptive later in some doctors' lives.

This essay will first review the literature on the personality characteristics and coping styles of doctors and will then seek to review the characteristic of perfectionism from a psychodynamic perspective, using the language and theory of the conversational model. Two case examples, including brief excerpts from psychodynamic therapy with doctor-patients, will then be drawn upon for illustration.

Introduction

The mental health of doctors has been in sharp focus in recent times. This is particularly the case in Australia following deaths by suicide of several junior doctors in 2017. This was the impetus for state based Junior Medical Officer (JMO) Wellbeing initiatives, including in New South Wales[1]. In the same year Beyond Blue released an update to the landmark "National Mental Health Survey of Doctors and Medical Students" which showed substantially higher rates of psychological distress, suicidal thoughts and death by suicide compared to the Australian population and other professionals[2]. There has also been rising awareness of increasing rates of burnout over the last decade, which has undoubtedly been heightened over the last year in the context of the COVID – 19 Pandemic (Dobson et al., 2021; Tait D. Shanafelt et al., 2015; T. D. Shanafelt, Sinsky, Dyrbye, Trockel, & West, 2019).

Efforts to conceptualize the etiology of these problems have been many and diverse. In the United States, The National Academy of Medicine has been instrumental in conducting research to build this understanding (Brigham et al., 2018), and has acknowledged its multifactorial contributors. While the impacts of the nature of the work, the work burden, and the problematic aspects of medical culture have been acknowledged and researched, less is known about doctors' internal psychological vulnerabilities and their contributions to the larger crisis of wellbeing.

This is readily understandable. Essential to the free exploration of distressing affects is an atmosphere of safety. Medical culture has thus far not provided an environment in which a free exploration of vulnerability could be conducted without an undercurrent of judgement giving rise to defensiveness. Historical notions of the 'omnipotent' doctor and a culture of medical paternalism have also stood in the way of doctors expressing any vulnerability (Henderson et al., 2012). A separation between doctors and patients in an 'us and them' mentality, and the general stigma still pervading our society about mental ill health and its association with 'weakness', has also been unhelpful. Thankfully, there has been a steady evolution in the approach to doctor-patient interactions, with increasing emphasis given to shared decision making and intersubjectivity which both recognize the shared humanity of both doctor and patient. It has become more normalized for doctors not only to express vulnerability, but that this can even be helpful for patients within the appropriate bounds of self-disclosure (Malterud, Fredriksen, & Gjerde, 2009).

In that vein, in the same way that providing a play space to integrate dissociated elements towards a more coherent self is the focus of an individual therapy, perhaps the opportunity to introspect without fear or favor could also foster coherence and growth for the profession and the doctors within it. An honest appraisal of our internal workings may also provide for more targeted approaches. Given that doctors' mental ill health has been shown to impact patient outcomes (Panagioti et al., 2018), beyond the humanistic and ethical objectives of healing the healers there is also an economic and utilitarian imperative to do so (Hall, Johnson, Watt, Tsipa, & O'Connor, 2016; Panagioti et al., 2018).

Personality vulnerabilities with worked examples

Both case examples are heavily modified and deidentified to protect confidentiality. Clients gave written informed consent to be included in this manuscript.

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1 https://www.health.nsw.gov.au/workforce/culture/Publications/jmo-support-plan.pdf
2 https://espace.curtin.edu.au/bitstream/handle/20.500.11937/90008/89832.pdf?sequence=2

Ethics approval was provided by the Western Sydney Local Health District Human Research and Ethics Committee.

An adaptive trait during medical education is an above average degree of conscientiousness or perfectionism (Myers & Gabbard, 2008). This is largely sanctioned by the culture at large. The popular media has published articles which conceptualize an elimination of medical errors as a realistic goal, and some have argued that the recent "zero suicide" initiative may also give the false impression that suicide is always a preventable phenomenon (Mokkenstorm, Kerkhof, Smit, & Beekman, 2018). This internal coping strategy, that is often externally encouraged, is also well known to be a risk factor for the later development of psychopathology (Shafran & Mansell, 2001):

> Jake was 32-year-old medical registrar who was in his second year of training. After growing dissatisfaction with his career, he approached his manager about resigning. His manager agreed with little argument which precipitated an existential crisis. He felt lost in the uncertainty of what to do next. He had very poor sleep, would wake up with panic attacks, had lost more than 10kg in the subsequent 2 months, had long circular phone conversations with his family and friends and was looking back on all his previous career decisions with intense regret.

> Jake had been highly focused on his studies since early primary school. He was pushed into playing piano by his parents which also felt like a task, but which he pursued with dedication. His mother had a hoarding disorder with little insight, and they had an emotionally distant relationship "she always focused on what I achieved, but never who I <u>was</u>". His father was 70 years old at the time of his birth, but Jake remembered him as a very warm man who took great interest. Jake remembered fondly that his father was playful and could enjoy life but was also impressively intellectual and fit. Jake had several close friends, but in late high school after his father died, he became solely devoted to his studies.

> Jake pursued medicine with the belief that it would offer a stable income, job security and be a good fit based on his capacity for study. However, at work he found it very difficult to delegate, often deleting and rewriting the written notes of his juniors. He preferred to spend an inordinate amount of time with one patient until all the problems were 'properly' worked up. He would chastise himself and feel shame whenever making consults to medical teams with incomplete information. His life out of work was limited, having very rarely taken vacations, and spending time on weekends on research and study. He played golf, but would only hit balls at the driving range, striving for the perfect drive until his hands bled. He had never had a romantic relationship, feeling that although he had several opportunities no one was "girlfriend material", friends also were "great people, but there just isn't that connection".

It is understood that a complex interplay between a caregiver's psychological traits, the genetically inherited temperament of the child, and the 'fit' between caregiver and child contribute to a child's early development (Gabbard, 2017). Jake had a genetic predisposition to an anxious temperament, given his mother's hoarding disorder, which may have contributed to a greater need to be soothed. His mother's own anxiety may have subtly but consistently thwarted these needs leading to distorted internal representations of self as someone who is 'defective' or 'inadequate', and early representations of the other as someone who is 'rejecting'.

Attachment theory proposes that an infant's survival is completely dependent on its caregivers providing for its basic needs. When in distress an infant will utilize a series of 'attachment behaviors' to stimulate caregivers to meet those needs. When the 'fit' is good enough, the infant has an internalized sense of security and can explore its environment and play (Main, 2000). In Jake's case, an early experience of increased caregiver attention when he 'achieved' rather than when he expressed distress may suggest that his striving to 'achieve' was itself an attachment behavior. His 'impressiveness' temporarily reduced attachment related anxiety as his complex internal distress was transiently soothed.

Hewitt et al. (Hewitt, 2020; Hewitt, Flett, & Mikail, 2017) have described the adult interpersonal consequences of this pattern as the Perfectionism Social Disconnection Model (PDSM). They suggest that the more rigidly achievement is relied upon as an 'attachment behavior' the less space one has for new and fulfilling relationships. Hence, as Jake became increasingly absorbed by his studies, his social life became less rich. The loss of his father, during the key adolescent years of usually strengthening peer relationships, caused him to regress and double down on his drive to achieve. The lack of internal security curtailed his exploratory capacity which remained apparent in the current scarcity of vacation time or playful enjoyment.

According to this model, an experiencing of the other as rejecting may also create an expectational field where peers experience those who are perfectionistic as unable to 'play' or even 'boring'. In this case, Jake may have faced intolerable rejection leading to avoidance of deeper relationships; or there may have been a reversal in which others who did not meet impossibly high standards were rejected (Meares, 2005). Either way,

the result was social isolation in the face of a poignant yet misdirected desire for connection.

These patters were apparent in the minute particulars of the therapy with Jake.

> As Jake recounted his presenting complaint on our first encounter, he began describing his current predicament from late high school and detailed events in chronological order. As I allowed him to speak uninterrupted, his voice grew in volume, speed, and intensity, seeming more and more urgent. The content was devoid of emotional tone. His gaze shifted to a point on the wall, and I noticed a sense of irritation growing within me as I felt superfluous. As he mentioned the death of his father I said, "what a blow" and he stopped, looked at me and tears started to form. He proceeded in a soft voice to recall how they would read together and do his homework. It seemed to me not quite play, but was still an atmosphere of warmth and connection.

Jake was stimulus entrapped for much of our first session and recounted his history as a chronicle. The need to accurately and 'perfectly' outline his history seemed to reflect the attachment behavior in the transference. The expectational field created by his experience of the other as rejecting was felt within me as a countertransference sense of irritation that was on the cusp of bringing forth a critical or dismissive comment. This dissociated state resolved when we connected over the memory of a relationship where there was a greater sense of security. His capacity to explore in the ether of this security was felt in the transference as a greater flexibility of vocal tone, a lessening of intensity and a sense of greater ease.

Jake's choice to pursue medicine makes sense. It provides a societally respected avenue for intense study and absorption in work. Doctors with Jake's coping strategies may find that these strategies are positively reinforced and there may exist an attitude of 'why would patients want anything else?'. Unfortunately, perfectionistic doctors have higher rates of burnout and psychopathology (Craiovan, 2014). In keeping with Jake's sense of exhaustion, and the feeling that he is doing it to survive rather than as expression of his true self, it is likely not sustainable.

Therapy with Lalita

> Lalita was a senior cardiologist and professor in a large teaching hospital. She was highly respected as a competent clinician and was known for her pioneering of new interventional techniques. She was also known to have a brusque manner and had been the subject of multiple complaints by junior staff and patients. After an episode of shouting at a social work-

er in front of a patient's family, her managers had briefly suspended her. She was advised to attend psychotherapy.

> At our first session, several months later, she described owning two investment properties in the "rich" part of town and having a collection of over a thousand wines in her underground cellar. She described her fast rise to a professorship, her several publications in peer reviewed journals, and the success of her new surgical techniques. Descriptions of the hospital system were highly disparaging; "the only plan is that they have no plan", complaints about her behavior were dismissed, and her description of her outbursts were that she was the only one that has the courage to "tell it like it is". Nevertheless, she acknowledged that if she did not change, she would lose her job.

> Lalita was raised in a wealthy family where both parents were doctors. She gave very little information about her early life other than that her father was a very stern but intelligent person who was "always right" and would often correct others' mistakes. Her mother was warm, hardworking, and felt undervalued by her workplace.

> Lalita was married with no children and spoke very little of her partner or any friends, other than their enjoyment of drinking wine together. The sessions involved a great deal of complaining about the "incompetence" and "disorganization" of the hospital.

> In the fourth session she revealed the extent of her despair when she was suspended, including that she had suicidal thoughts. She was more hesitant, vulnerable, and softly spoken than usual. As I assured her that our sessions would continue regardless of her employment, she whispered "thank you" while looking away. She later mentioned that the sessions had been useful to "help me think about my anger". She attended sessions on time and agreed to a frame of 15 sessions. It was made clear that her superiors would not be aware if she attended or not.

The limited depth with which Lalita felt able to reflect on her interpersonal relationships likely reflects a dismissive attachment style, borne out of predominantly anxious avoidant childhood attachments. Due to a problem with fit, or due to her experience of her caregivers as critical and stern, she may have lacked the opportunity to turn to them with distressing affects and to have them soothed. This may have amounted to a selfobject failure, where the ability to self soothe did not form, and therefore Lalita needed to look for external sources to perform this function.

In Kohut's self psychology the infant is thought to have grandiose-exhibitionistic tendencies which are mirrored by an empathic other through early development. Under these optimal circumstances the infant internalizes the empathic other as a self object which can then internally meet these needs, thus lessening the external expression of the grandiose-exhibitionism. Through an insufficient development of this function, Lalita's adult self-regulation remained reliant on the empathic mirroring of others (McLean, 2007).

Lalita's achievement could then be conceptualized as an attachment behavior, as in Jake, but also as a device to elicit external validation. Minor disruptions were akin to a traumatic disruption of the entire self-system, leading to disorganization and rage. Nevertheless, with the mirroring function being provided by an empathic other in therapy, Lalita's self-system became more organized, allowing her to relate to the other as separate, rather than merely a provider of the selfobject function.

Lalita's perfectionism, as well as being an internal driver, was also externally oriented. Her expectations of others were unattainably high, and these reversals were both more pronounced and longer lasting than in Jake. It is likely that the unstable self-system became identified with the critical and stern caregiver, especially when external validation was not forthcoming, as in the period when complaints were being made.

Conclusion

Doctor's mental health has become an increasingly urgent priority in the context of rising rates of burnout and the clear association between doctors' ill health and patient outcomes. Contributors to doctors' ill health are multifactorial but can include personality vulnerabilities that may have been adaptive at earlier stages of development. Perfectionistic traits are often reinforced by the practice and culture of medicine but are associated with increased rates of psychopathology. In this essay two cases of psychodynamic therapy with perfectionistic doctors were reviewed, showing the developmental antecedents and functional consequences of this common trait. It is hoped that through building a richer understanding of doctors' mental health issues more appropriate and targeted interventions can be made available to assist them and their patients.

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Scientist Practitioner vs. Scientist or Practitioner: The Challenges of Conducting Research as a Clinical Psychotherapist

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Abstract

Clinician-lead research is important to further the development of various psychotherapeutic methods. The applied experiences of clinicians, in their treatment of their many clients, can be fed back into the scientific literature on psychotherapy and thus further develop evidence-based practice. However, clinician-researchers often face unique challenges in their research endeavours which are not encountered by their academic colleagues. We discuss some of these unique barriers to clinician-lead research and offer some suggestions for overcoming those barriers. Some of these solutions involve accessing some of the resources of larger institutions, even when a clinician doesn't hold any official affiliation with those institutions. Some involve the formation and maintenance of inter-collaborative communities of clinician-researchers. Finally, we discuss the role that more localised journals play in communicating the clinician-researcher's findings to their clinician peers, who will hopefully benefit from the knowledge in their own psychotherapies with their own clients. We aimed in this article to inform clinicians and clinician-researchers on the existence of some resources they might not even know they could access.

Introduction

Mental health clinicians are on the front lines for providing psychological/psychiatric treatments to those in need. They also have a long history of contributing their applied insights and experiences to the accumulation of mental health research. Freud (1938) looked at patterns across his patients when developing psycho-analysis from, in essence, a collection of case studies. Oliver Sacks (Sacks, 1985; 1987) continued this method relatively recently, devising post-hoc explanations of the experiences of his patients. Meares and Hobson (1977) advocated the value of repeatedly analysing the experiences of psychotherapy clinicians in fine detail, as a way to progress the understanding of the complex dynamics contained within psychotherapy.

Looking at the patterns that different groups share (e.g. need for validation) and the patterns that distinguish between different groups (e.g. presentations of different mental illnesses) furthers our understanding of complex psychological systems. Clinician-led research contributes valuable insights to the academic world of psychotherapy research. The words of the client before the therapist's action shows the contextual cue for the psychotherapist, and what happens next shows the consequence of the therapist's interaction. These captured moments provide evidence of psychotherapeutic process in action. The clinician-researcher's use of these clinical vignettes in their published research can be used to further knowledge on a wide variety of psychotherapy related topics, such as; the continued development of language in psychotherapy (Korner, 2022; Meares, 2020), the efficacy of model specific components of psychotherapy (Haliburn et al., 2018; Morando, 2021), the explanation of psychophysical mechanisms that may be encountered in psychotherapy (Kozlowska et al., 2015), and the shortening of long-term psychotherapies to fit the financial capabilities of the majority of clients (Barkham et al., 2017; Haliburn, 2017; Stevenson et al., 2019). Clinicians need to know *how* to carry out psychotherapy and the body of psychotherapy research contributes to the way that clinical work is carried out. Models of psychotherapy are then required to show efficacy in peer reviewed research before they are advocated for by the governing body for psychologists in Australia. We call this evidence-based practice.

Wearing Two Hats

The American Psychological Association have made it clear that they expect practicing clinicians both to apply scientific evidence into their applied work and, in turn, to produce more scientific evidence via research from their clinical practices (LeJeune & Luoma, 2015). This is a reasonable expectation from the standpoint of the profession of psychotherapy. Clinical practices are continually updated by the publication of new research. By extension, clinicians are educated within a framework that places emphasis on the importance of life-long learning, based on the evolving scientific evidence. Evidence-based practice changes over time.

Wearing the hats of both scientist and clinician affords some opportunities and some difficulties within psychotherapy. Clinician-researchers have the opportunity to collect a great deal of complex, detailed data from each of their client-participants (e.g. psychotherapy transcripts, recordings of the therapy), and that data

may change over long periods of time in response to the intended purpose of psychotherapy. The client and clinician-researcher sit in the same room together, exploring different threads of the client's experiences, possibly finding connections between their thoughts and feelings with other unconsidered experiences. Clinicians develop an astute understanding of their clients, with this process usually taking place over many years. This extended timeframe is probably more time than most academic-researchers would be able to invest into each participant. In a way, the client and therapist conduct a version of qualitative analysis through their therapeutic conversations where, together, they methodically explore the meaning underlying the various experiences of the client. Clinician-led research is important for capturing and reporting on what actually happens within the psychotherapy room, the process of psychotherapy, the role that the therapist played in that process, and how that role may have changed over time. Whilst the therapist theoretically learns from their accumulating professional experiences, most clinical work is conducted in private, protected by the confidentiality of the psychotherapy room (Korner, 2021). The clinician thus has limited opportunity to learn from other clinicians, who may be struggling with the same issues in their therapies with other clients. Clinician led research can be used as a proxy teacher, with which to further develop their clinical skills. Understandably, clinicians are more interested in research that will help them become better clinicians (Tasca et al., 2014). Clinician-led research on *how* the psychotherapy was applied - with real clients and the consequent effects - is of particular use for other clinicians.

Wearing both hats involves a delicate balance between the roles of scientist and practitioner. Maintaining this balance can be difficult. The clinician not only has dual responsibilities to the client and the scientific method, but they also experience dual motivations through the course of psychotherapy. The clinician-researcher wants to help their client *and* collect meaningful data for their continued research. The duality in the clinician-researcher's motivations can be seen in their choice to either reframe the client's experience in a more positive light or to explore the unpleasant experience further. There is clinical benefit to drawing out the positive alive part of the client's experience, but there is also scientific benefit for understanding their emotional suffering by exploring it further, even if that exploration will trigger further unpleasant feelings. Whilst there is substantial overlap between academic thought and clinical practice, they do involve distinct, and sometimes oppositional, ways of thinking (Edwards, 2007). The main aim of scientific methods is to make the boundaries around some form of truth clearer, separating that piece of knowledge from other information that does not hold such truth. Ideally, this can be shown through rigorous methodologies, specifically designed to control for the influence of other confounding variables (e.g. double-blind, placebo-controlled, randomised-controlled trial). However, applied psychotherapy research rarely fits the stringent parameters of such gold-standard designs. In contrast, clinical work blurs the boundaries around a truth, so that it may apply to a wider variety of clients.

Our research team recently experienced these two, sometimes-oppositional, perspectives during our research on the psychotherapeutic efficacy of Conversational Model Therapy (Halovic et al., 2021). We followed our client-participants over the duration of one year of Conversational Model Therapy. Our client-participants completed a battery of psychometric questionnaires when they started psychotherapy, and then again after one year in therapy. We also invited them in to have an interview with myself at both time points. This interview was designed to replicate the process of an initial assessment for psychotherapy, following the template of: their mental health difficulties, work capacity, social relationships, cognitive functioning, health service utilisation, etc. When we analysed the psychometric questionnaire data across our client-participants, we found that they only improved on a single metric (psychoticism scores on the Brief Symptom Inventory) over one year of psychotherapy. However, when they were afforded the opportunity to describe their experiences of psychotherapy in their own words, 72.7% of our client-participants reported that they had improved over the course of the psychotherapy. The clinician-researcher may conclude that their client has improved substantially despite no significant change in their psychometric scores. The experience of the client matters more to the clinician-researcher than to the academic-researcher. Furthermore, the clinician's use of blurred boundaries around symptomatic experiences also carries the implication that there is the possibility of further change in the client's experiences. Academic pursuits are fundamentally exclusionary whilst clinical pursuits are inclusionary. It is difficult to serve two masters.

Required Resources for Research

Research must satisfy many requirements before a study can be published. Time and money are the two resources that easily come to mind. However, there are other aspects of the research process that are just as important. More specifically, the appeasement of standard ethical procedures, and the increasing publishing standards of peer-reviewed journals. I will briefly discuss each of these types of resources below.

Time

Quality research requires much more time than the lay person realises. The clinician-researcher needs to invest a substantial amount of their time to reading the breadth of scientific literature on a pertinent issue before they can develop an advanced enough understanding to make a meaningful contribution through their research paper. It can be difficult, though, to know how much to read before you are ready to write your paper. No matter how much you may have read, there is more that you may need to read. This is true for both aca-

demics and clinicians. All researchers also need to have time to think. Like in clinical work, thinking is how researchers develop their ideas, figure out how their work may contribute to the scientific literature, notice holes in their arguments, find and consider potential solutions for those holes, and figure out the best way to communicate those ideas to their readership. They also need time to address the logistical requirements of research (e.g. obtaining ethics approval, obtaining informed consent, management of research data, specific journal submission requirements). They need time to collect the required data, analyse that data (quantitatively and/or qualitatively), to interpret and make sense of the results of those analyses, write the study up and then submit it for publishing. A great deal of time needs to be invested before a research paper might be ready to be published in a journal.

Furthermore, the majority of submitted research is rejected by the reviewers, with a median acceptance rate of approximately 25% (Sugimoto et al., 2013). This peer review process can be sufficiently demoralising that many clinicians give up on any motivation to publish their own research. This is especially so for a clinician, who may rest more emotional importance on their single study, as opposed to the multiple concurrent projects that academics might be working on. When a paper is rejected by one journal, the clinician researcher will need to spend time considering why their work was rejected, how they can overcome those criticisms, and develop a stronger paper to submit to another journal. Moreover, other journals may have different submission guidelines (e.g. word limits, reference systems, submission of data and materials), and thus the paper needs to be modified to fit those manuscript requirements. This process may be cycled around many times before a journal accepts the paper as strong enough to publish. The peer review process can be intimidating for full-time academic-researchers, let alone part-time clinician-researchers.

Money

For every hour invested into their research, the clinician-researcher experiences a decrease in their earning potential. Clinical work can be emotionally and intellectually taxing. Consequently, once a clinician sees their last client of the day, they may not consistently feel like they have the required intellectual and emotional resources to also work on their research. It is understandable that many clinicians may choose to prioritise the taxing work that results in remuneration over the taxing work that doesn't - especially when considering the increased living expenses disproportionate to the increase in income during the economic instability seen through the COVID-19 pandemic. Clinicians may feel the need to prioritise their immediate finances over the non-monitory pursuits of research.

Furthermore, unless you are employed by a university or a specialised research centre, researchers don't get paid to conduct research. They don't even get paid

when they complete and publish their research. Clinician researchers are compensated for their efforts with prestige and professional recognition, which may translate in more clients seeking them out for psychotherapy. Some clinician researchers contribute their research to science as an altruistic act, for the continual development of their profession and the many people that are helped by the clinicians in that profession.

However, conducting research costs money in other ways. The literature that fuels scientific research is often hidden behind the paywalls of individual journals. To access those research papers, which may or may not be useful for the researcher's work, the clinician-researcher is required to pay a subscription charge for each journal, or to pay for access to individual papers. The costs of both add up very quickly. The researchers that are nestled within larger institutions, like universities and hospitals, often have wider access to journal subscriptions. Thus, researchers who have access to these wider resources are likely to be more informed when developing their research.

Furthermore, many journals have - or are transitioning to - open access publishing standards. Instead of signing the copyright of the published paper over to the journal, which is then compensated by the journal subscribers, in open access the researcher pays a publishing fee upfront and they retain the copyright for their published article. Open access journals have higher acceptance rates (Sugimoto et al., 2013), which may be attractive for the time poor clinician-researcher. However, open access publishing fees are often in the thousands of dollars (Van Noorden, 2013). Research publication sharing sites, such as ResearchGate, have been developed in recent years, possibly as a kickback to the costs of publishing. Despite these sharing sites publicly reinforcing their commitment to maintaining copyright licences, most researchers are quite happy to share their research if they are contacted directly.

Moreover, the clinician-researcher may be at further risk from predatory publishers. Predatory publishers are sham open access journals that offer the publication of a research paper after an illusionary peer review process. These predatory publishers will scan the literature to find researcher's contact details and then request the researcher to submit a paper for their journal. I almost fell victim to a predatory publisher. However, I had noticed that some of my paper had been modified after the review and the peer review comments didn't seem very insightful. I then looked further into other papers published by the journal, the frequency that they published, and how well those studies were cited. Enough red flags went up that I retracted my paper from the journal. It would be understandable for time-poor clinician-researchers to be seduced by the promise of publishing their study. They may not have the time to research the journal nor be sufficiently practised in recognising poorly cited work. Nevertheless, the dangers of predatory publishing can be easily mitigated now by the development of databases 'outing' the pred-

atory publishers (e.g. Beall's list, Directory of Open Access Journals), assuming the clinician-researcher is aware of these resources.

Academics also have access to other resources that may be beyond the capabilities of the humble clinician-researcher. They usually delegate portions of the required work to post-graduate students and research assistants. Whilst post-graduate students may be plentiful in the university environment, they are less plentiful in the context of the clinician's private practice. Furthermore, supervising psychologists are likely to work with Masters students. Although these students have a research component to their training, the majority of their work is applied to the clinical space. Academics, on the other hand, primarily supervise doctoral students, with the main priority for these students being research. Naturally, academics are going to benefit more from the same invested supervisory time because the full-time student-researcher will publish more papers than the part-time student-clinician-researcher over the same time period. Research assistants, on the other hand, require money to pay their salaries. In academia, these research assistants may be paid from acquired grant funding or by the academic school itself. Clinician-researchers don't have access to the same number of personnel available within the larger academic institutions. The best that most clinician-researchers might hope for is a current psychology student who may be working as an administrator for their private practice. That student-administrator may be willing to also work as an impromptu research assistant in return for experience in the research process and authorship on the final published paper.

Moreover, research often requires the purchase of, or access to, technologies that may be required for any given research (e.g. eye tracking systems, statistical analysis software, psychometric questionnaire licenses) and these technologies are often expensive. One way that the academic community finances their research is to obtain grant funding, which is incredibly competitive. Of the 4421 grant applications submitted to the National Health and Medical Research Council (NHMRC) during 2022, only 658 applications were successful (14.9%) in obtaining funding (NHMRC, 2023). Furthermore, 99.7% of those rewarded grants were for research conducted in universities, research institutes, and the health and hospital sectors. Obtaining grant funding usually requires researchers to be well published already, whilst also collaborating with other well published researchers (including clinician-researchers) from other institutions (NHMRC, 2018). Furthermore, NHMRC funded research is more likely to be published than non-funded research (NHRMC, 2018). Psychological clinicians are less likely to have nurtured professional relationships with more established researchers so that their clinical experience is valued in ongoing research endeavours. Obtaining funding from grants is sadly out of reach of most full-time researchers, let alone part-time clinician-researchers.

LeJeune and Luoma (2015), perhaps idealistically, argued that some of the profits from the clinician's private practice can be funnelled into the research endeavours of the clinician-researcher. However, that would require the private practice to be successful enough that they can afford the many costs of research, after living expenses of course. Mental health clinicians are already over-worked and under-funded, whilst they are exposed to high levels of stress and vicarious trauma (RANZCP, 2023). Only the very dedicated clinicians are likely to sacrifice a portion of their financial stability for the pursuit of non-monitory rewarded research.

Conducting ethically approved research

All research with human beings needs to be approved by a Human Research Ethics Committee (HREC; NHMRC, 2018). HRECs review the quality of the science and ensure ethical practices are used by the researchers (e.g. recruitment, informed consent, data security). Most journals and grant committees insist on evidence that the research has been HREC approved before they can consider funding and/or publishing the article. Clinicians in private practice may be unaware of how they could gain HREC approval without having some professional connection to an institution that is large enough to employ a HREC committee. In fact, they can submit their research to any HREC at any institution (e.g. university, health district). The clinician need only to contact a HREC to find out how to submit their research for approval. It has been my experience that the HRECs are pleased to assist and advise potential applicants because it not only improves research practices, but it also avoids the extra work of multiple HREC rejections before the study is judged to be satisfactorily planned. Alternatively, LeJeune and Luoma (2015) posited that multiple private practices can band together to create an independent research review committee. The NHMRC (2018) outlines the conditions that need to be satisfied when establishing a new HREC. This includes having the necessary expertise to review potential research projects, the ability to communicate well with the submitting researchers, not charging fees where it might discourage the research review process, and having a thorough understanding of the National Statement on Ethical Conduct in Human Research (2018).

The HREC review process can illuminate some ethical dilemmas between psychological research and that of clinical practice. In particular, the types of data likely to be utilised by a clinician researcher and how it can be ethically handled. It is relatively easy to deidentify quantitative data because numbers camouflage the personal story of the client-participant. Clinician-researchers, on the other hand, do not typically have access to the large pool of potential participants that universities have, thus are more likely to conduct qualitative research where fewer participants are needed (e.g. case studies). The standard data for these types of research

designs often comprise of the transcripts of psychotherapy sessions. Whilst the confidentiality of these transcripts is extremely important for both the clinician and the researcher, they are protected in different ways. Firstly, detailed transcripts of psychotherapy sessions are very difficult to de-identify completely, especially if the researcher is also the client's treating clinician. Knowing the client's story, which can include information not recorded in the transcripts, will likely influence the qualitative analysis process (Halovic et al. 2018). The transcripts also provide enough personal details that the identity of the client might be deduced by anyone who is aware that the client is seeing the clinician. Furthermore, the client may feel implicit pressure to provide informed consent for the research, because withholding consent might potentially harm the therapeutic relationship with the clinician. HREC reviews will often insist on the separation of the clinical process from the research process to protect these potential client-participants. One way around this problem is by recruiting potential participants from clinicians who are not associated with the research. This solution may be more difficult for the sole clinician in an isolated private practice compared to the clinician with multiple research collaborators within, and external to, their private practice.

Research Publication Standards

It is becoming more common for journals to insist on the provision of public access to the research data, usually within a public data repository. The aim of this journal process is to improve research transparency, allowing other researchers to view the data and verify the way the data was analysed and the subsequent conclusions from those results. Whilst I applaud this more recent addition to the peer review process, it does run into some problems for the clinician-researcher and their use of qualitative data. Psychotherapy session transcripts include deeply personal narratives and publishing these transcripts would violate the confidentiality of the client in a clinical context. Furthermore, these transcripts could potentially be subpoenaed by solicitors for the nefarious benefit of people associated with the client (Halovic, 2019). Most journals currently provide the option to explain why the researcher is unable to publish their research data, such as the violation of therapist-client confidentiality. However, the ongoing push for research transparency may soon reach a point where the requirements of research will directly conflict with the requirements of clinical work. Both research and clinical disciplines will be compromised at that point.

Whilst the bar for publishing research seems to be getting higher and higher, there are also more opportunities for a clinician to publish their research because more and more journals are being formed over time. These new journals strive to publish strong research, directed at a particular target audience, all whilst hoping they are not confused as a predatory publisher. These articles are easily distributed over the internet now, thus negating the start-up costs associated with traditional hard copy publication. Whilst the idea of having more published research, with easier access, is indeed seductive, there is a risk that the article will not reach the desired target audience because that information is competing with a whole sea of information published elsewhere (To & Yu, 2020). If the clinician-researcher's work is not being read by the people it was written for, then the clinician-researcher's altruistic intentions remain unfulfilled. Equally unfulfilled are the clinician-researchers who publish to further their professional reputation. The clinicians who are most likely to benefit from the clinician-researcher's hard work may never be aware that the research they might be looking for has already been published. Smaller, localised journals can potentially solve some of these problems. Localised journals may not have the high impact factors or citation rates of larger, more prestigious, journals; however they do aim their research publications at the localised psychotherapeutic communities. Clinician-researchers are more likely to hear from other clinicians first-hand on how the published article may have assisted some of their peers in their work with their own clients. Their professional reputations are also advertised to the very people who may support the clinician-researcher's private practice by referring clients who present with difficulties congruent with their published expertise. Finally, awareness of the clinician-researchers peer-acknowledged work, through their published research, can assist in the forming and maintenance of collaborative communities with other clinician-researchers. Some of the barriers that individual clinician-researchers face don't seem so difficult when shared with others who are working towards the same goal.

Conclusion

Whilst clinician-led research is important for the development of evidence-based practices in psychotherapy, clinician-researchers face a number of challenges that their academic counterparts do not. Unique challenges require unique solutions. The aim of this article was to draw attention to some of the unique barriers that clinician-researchers face, and to suggest some potential ways in which those barriers could be overcome. Some solutions involve the benefit of accessing the resources of larger institutions, even though the clinician may have no other professional association with those institutions. Some involve the forming and maintenance of an inter-collaborative community with other clinician-researchers. Finally, localised journals - with strong support from the local psychotherapeutic community - play an important role in communicating the valuable insights to be gained from the clinician-researcher's work to other local psychotherapists.

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The use and meanings of gesture

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Abstract

This paper is based on a talk given at a PIT-UK online CPD session on 20th January 2023.

Introduction

A young woman sits across from me, it is the first time we have met. The assessment started half an hour ago. As she talks about traumatic experiences from her adolescent years her arms become wrapped more and more tightly around her middle, and I notice she starts wincing. She shifts uncomfortably in her seat. As her distress mounts she begins crying in pain, and through her tears tells me about all the fruitless hospital visits, the doctors who have sent her away, and the tablets which have made no difference to her terrible abdominal pains.

A man smiles at me in a saintly way, then makes a gesture with both hands half-extended in front of himself, forearms slightly crossed at the wrists, his fingers fanned out. He rounds his shoulders and slightly lowers his head at the same time. 'What am I witnessing?' I wonder silently. His movements seem ambiguous to me – I'm not sure if he is knowingly trying to show me something, or reaching out, or collapsing, or maybe unknowingly warding something/someone off. I let my imagination loose and see an image of a wizened kung fu master stood patiently, waiting to receive some opponent... maybe his fate? But I have no idea really. I have been seeing this man for several weeks now for weekly psychotherapy and this is the first time this has happened.

The two vignettes above illustrate some of the richness of an essential but perhaps slightly neglected aspect of psychotherapy: the patient's gestures, made knowingly or unknowingly, and our responses to them as therapists.

What is gesture?

The Oxford English Dictionary (OED) defines gesture primarily as *'a movement of part of the body, especially a hand or the head, to express an idea or meaning'* e.g. placing palms together to mean 'thank you'. I do not disagree with that definition but from

our perspective as psychotherapists we might see it as a bit narrow in emphasis and in scope. The narrowness on emphasis arises mainly from the exclusive focus on cognition, on thought, as the thing that the person is seeking to express by their gesture. One might argue that expressing an idea carries with it the feeling associated with the idea, but to do so still places much more emphasis (and thereby value) on the explicitly iterated 'idea', and less value on the implicitly present or underlying 'feeling'. The incomplete scope of the definition is its exclusive attention to movement of the body. I think gestures can also be made in stillness.

From the perspective of the Conversational Model, I would want to define gesture more broadly than the OED does. To try to capture a broader range of phenomena, and to emphasise the feeling aspect of the patient's communication via gesture, a more inclusive definition of gesture, based on the OED, might be *'any aspect of the patient's physical appearance or behaviour, perhaps particularly movements of parts of the body, which may express an idea or a feeling'*.

Broadening a definition in this way risks making the term more diffuse, vaguer. It might even stretch the word gesture beyond its generally understood limit, and be considered idiosyncratic. But I think this risk is worth taking if it makes us as therapists more likely to notice a patient's gesture and to consider what it may be telling us. I think this is important, because gestures can tell us things that our patients cannot yet put into words. Gestures are visible manifestations of personal feeling language.

We could say that gesture is another modality of language, alongside words. People use gesture to emphasise spoken language, to add vibrancy and to illustrate their words. Spend a day with Italian people and you will quickly see how gesture can be employed in this way – as a culture they are famous for their (to British eyes) flamboyant gesticulations as they converse, and the gestures certainly emphasise the feelings behind the words!

People also use gesture as a standalone form of communication i.e. not just to emphasise the spoken. We can use gesture on its own. This can be knowingly or unknowingly: deciding to use gesture, or doing so without realising that we are doing so.

Where does use of gesture fit in the CMT/PIT therapist's skillset?

One of the unique features of the Conversational Model is our microscopic focus on therapist

speech and the way we listen. Novice therapists are often preoccupied with the issue 'What do I say now? How do I say it?', and the Conversational Model has much to say about that.

When listening we also pay extremely close attention, this time to precisely how our patients express themselves:

> It is important that the therapist listens out for key phrases or ways of describing experiences or symptoms that may have personal meaning for the client. The more deeply and personally an individual describes their experiences, the greater the likelihood they will use personal meaning language. Language that not only describes their physical or emotional experience but language that also contains symbolic imagery. (Barkham et al, 2017, p. 116)

In this paper, however, our focus is on what we see and do, not what we say. What I want to draw attention to is that therapy also involves a lot of looking (and being looked at!). Sometimes, observing with our eyes can be just as important as listening. There is a whole language of the body to be attended to. If we use the PIT framework of therapy skills then we could categorise this under 'Picking up non-verbal cues', an introductory-level skill. Such cues include facial expression and demeanour, eye contact, and body language (Barkham et al, 2017, p. 60). I would add to that list: clothing (a slogan on a t-shirt can be a potent gesture), tattoos, personal items (i.e. anything brought into the room such as a bag or book), and behaviour outside the therapy room.

I take this list as encouragement to use my eyes as well as my ears right from the start of my first contact with a patient, which for me usually happens in the waiting room of an NHS psychotherapy service. I try to take it all in. Not just whether the person looks at me when I greet them, but also how quicky do they look at me? Do they hold eye contact or slide away? How are they dressed? What impression does that make on me? Do they move towards me with urgency, or reluctantly, or timidly, or assertively? Am I expected to hold doors for them until they pass through the doorway, or do they reach out and take the door from me? If they are carrying a phone, or a bag, or a stick, how is it used, and to what end? Once seated, is anything held or bundled up in their lap, to be caressed or repetitively tapped on or picked at, or rubbed? Or is its purpose to create a physical barrier between them and me? And once we start talking, what gestures accompany (or perhaps

replace) the words spoken to me?

I am seeking to understand the symbolic significance of the gesture itself. Hobson (1985) encourages us to try to take in all this, and more, in striving to maintain a symbolical attitude, *"… endowing words, gestures, experiences, and dreams with value; regarding them not only as communications of formulated messages but also as living symbols. They are intimations of, and a means of apprehending, what is as yet unknown"* (p. 199).

So, words themselves - and experiences and dreams shared with us by means of words – are not the only sources of metaphor and symbol. When they are used to describe feelings gestures can also perform that function.

In the Conversational Model we prize metaphors partly because of their ability to bring immediacy and vividness to expressions of feeling (Hobson, 1985, p. 199). It is the picturing quality of metaphor which does this. It enables us to 'see' something of the feeling. Gesture has a picturing quality too. Quite literally, in fact, as gestures are things we see with our eyes, painted right in front of us in three dimensions by our patients. Gestures – like metaphors – are images which can connect us directly with emotions and so are particularly powerful in how they represent mental states to ourselves and others:

A patient and I were exploring his excessive compliance with authority figures, and although he struggled to find the words what he did show me was a gesture. Whilst talking about his boss asking him to do something he suddenly folded his right arm so that his hand was in front of his mouth, and then vigorously flung that hand away from himself. His arm movement vividly symbolised the way his compliant responses to his boss would come spilling out of his mouth: immediately, rapidly and forcefully as soon as his boss made any request (no matter how unreasonable). His facial expression (another part of the gesture) showed something of the blind panic which arose in him at those moments and caused his compulsive compliance.

A developmental perspective

Meares (2005) reminds us that words are the most <u>usual</u> currency of the exchange between therapist and patient (p. 176). This is undoubtedly true. Meares' developmental framework also points to the importance of gesture as a constituent of the <u>original</u> currency of exchange between mother and baby, arising at a stage in the baby's life when words are not possible. The mother responds to her (pre-verbal) infant by firstly joining with the

baby's positive emotional state, attuning with the baby by linking up with and participating in the experience. Secondly, she values the baby's experience by showing warmth or delight. And, thirdly, she 'names' the baby's experience by representing it on her own face (Meares, 2005, p. 172). Part of this shared experience is recognising the baby's gesture, perhaps particularly of hand and of face. Another part is generating her own gesture with her own face and hands.

As an analogy for psychotherapy we can readily relate this invaluable developmental perspective to our use of <u>words</u> in response to our patients' <u>words</u> – i.e. the usual currency of exchange. Less readily relatable, perhaps, is how our response to our patients' non-verbal gestures needs to include our own use of gesture. Not just words. We can make therapeutic use of this aspect of the original currency of exchange between mother and baby - one which adds that vitality and aliveness of communication by means of which we hope to help the patient grow their sense of self (Moorey & Guthrie, 2003).

The therapist's use of gesture

In the published example below the therapist is trying to understand the patient's fear and distress, and makes use of gesture as an intervention. The therapist notices a hand gesture made by the patient and seeks to represent it with a gesture of her own:

T: A feeling in your body… perhaps.. A tenseness?

P: Yes… a shakiness… [Makes a fluttering gesture with her hands.]

T: It's there a bit now?...this shakiness [makes similar fluttering gesture]

P: Yes…[noticeably more anxious]

T: … with the tenseness and the shakiness… there's a fear…

P: Yes…[breathing more heavily]…that she's going to die…Hayley's going to die…

      (Barkham et al, 2017, p. 71)

The therapist's gesture shows the patient that something has been taken in. There is an attempt by the therapist to understand something that is beyond just the words that have been spoken. The shaky hand gesture tells the therapist something more about how the patient is feeling. The word 'shakiness' itself does not seem unusual as we

read it on the page, but the word with the gesture makes this a unique communication, something that could only be said/done by this particular person. And the therapist responds using both words and gesture – joining with the patient, making use of both the original (non-verbal) and the most usual (verbal) currencies of exchange between people.

This is a reminder that it makes sense to think about how we can communicate our experience to others bodily as well as verbally. Our patients are always simultaneously showing us their experience of themselves by bodily and by verbal means, by gesture and by words. Their descriptions of their bodily experiences can tell us about their feeling states. Words about the body tell us about more than just the body. And gestures made with the body can tell us about feeling states too. Body movements tell us about more than just the body.

It is a lot to consider, in a language we may not feel familiar with. So, we must not put too much pressure on ourselves as therapists to understand the meaning of our patients' gestures from the outset. It is much less important to know what a gesture means than to first be looking and noticing, and then letting the patient know that you are noticing 'a something'. We can communicate our basic 'noticing' by using words or gestures ourselves.

One of my favourite examples of this is in the well-known video of Bob Hobson interviewing a patient he was asked to see during one of his visits to Australia. Early on in this interview there are two moments where gesture is important in his efforts to establish a shared feeling language with her. One he responds to with words, the other with his own gesture. The first moment is when he notices right at the start how she is perched on the edge of her chair, and he suggests that she is feeling pretty much 'on edge'. Her postural gesture, how she is sat, can be linked metaphorically – by words - to the feeling state of being on edge. Neither hand nor face nor movement is necessary for this to be a gesture that a therapist can notice and respond to.

A little later on, as the patient describes her functional neurological symptoms, Hobson sees another gesture. This time it is a movement: a movement of her legs which seems to somehow illustrate what she's saying. Part of Hobson's response is to make a gesture of his own, a similar movement with his own legs. And the conversation then develops into an exploration of her left-sided weakness, the side of her which is unknown, or sinister (Latin for 'left'). I won't attempt to summarise the whole clinical interview, but given the remarkable

progress that is made by the end it might be tempting to assume that Hobson had somehow immediately divined the meaning of this leg gesture and that this revelation had guided him to an understanding of the symptoms with which she suffered. I am not convinced, however, that this was the case. After the patient leaves the room the camera keeps rolling, and there is a brief moment when Hobson turns towards the camera and remarks that early on in the interview he didn't feel that it was going to be possible to get anywhere! I've always felt that this indicates that when the patient started to move her legs Hobson did not know what her leg gesture meant. But perhaps he sensed that it might be helpful to show that he had seen her gesture and that it *might* matter. It mattered enough for him to respond in kind with a linked gesture of his own, regardless of what thought he was able to have about it.

Using gesture ourselves in this way shows the patient that we are listening <u>and</u> noticing. In and of itself without any accompanying words we can see this kind of intervention as a form of understanding hypothesis by the therapist. Just as the patients' gestures add vividness and immediacy to what they are communicating, so too our own gestures can add the same to our responses. An additional benefit is that the active use of gesture by the therapist (arising from an attitude of seeking to notice the body and to use one's own body as a means of communication even in a talking therapy) both enriches dialogue and enlarges the potential for communicative exchange between therapist and patient. It might even increase the likelihood that we will be an embodied presence in the room, and therefore more fully present with our patients.

Gesture as technique

I think it is well worth reflecting on one's own practice with regard to our use of gesture. How do you use your body as a therapist in the room with the patient, and how much attention do you give to your patients' gestures? Are you even aware of your own use of gesture?

These are questions for us as individual practitioners. There is also a broader question worth debating: to what degree do all psychotherapists inhibit themselves physically when they are in the room with a patient? If we are in the habit of restricting our physical movements when we are in the therapist's chair - playing the 'therapist' role - might we also inhibit ourselves from attending to and/or commenting on our patients' gestures?

How well versed do we feel in gesture as a form of language, of communication?

And, lastly, if we want to consciously and deliberately adopt a practice of noticing and using gesture as part of our therapeutic technique, how do we do so? And, as teachers, how do we teach this? I'm not sure it would be meaningful to try to teach trainee therapists some sort of gesture vocabulary. I suspect we would end up with something slightly stereotyped with a fake feeling to it (such as the way modern senior politicians appear to have been coached in how to use hand gestures to emphasise their words).

Use of gesture is an aspect of psychotherapy technique which needs more attention. A good starting point when we are responding to our patients is to simply remind ourselves to look and to move, as well as to listen and to speak.

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Meares, R. (2005). *The Metaphor of Play: Origin and Breakdown of Personal Meaning* (3rd ed.) Routledge.

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Call for Papers

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 up to 6000 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's Report

Anthony Korner

The new year has brought with it a change in atmosphere with the February Intensive and Graduation largely being held in person, the first time since 2020 that both have been held together and in person. As a community it does seem that we are gradually finding the new normal, as our politicians and media have definitely taken Covid off the front page, much as we are aware of its presence amongst us. Collectively, for most of us, it no longer takes centre-stage in our consciousness. The Graduation, held at the Mary MacKillop Centre, included the large intake for 2023 and some senior trainees, with more than 50 people attending the intensive. There were three high-quality presentations from the graduating group, Ingrid Gunby, Mran-Maree Laing and Simone Walsh, covering a range from love to hate and equine-assisted therapy! It was noted that the Editor of The Therapeutic Conversation was very quick to approach all three presenters about possible contributions to the trinational journal, now into its sixth issue.

Over the last three months, there has been a review of the fee structure in ANZAP, with agreement that fees should be reduced, whilst benefits will be maintained, or even increased in some cases. We have also initiated the category of Research Member, to be offered on an 'invitation only' basis. Research Members will have equal standing in the organization with full Clinical Members. This represents an effort to maintain the close connection that ANZAP has always had with research in the field of psychotherapy.

This year, the Annual ANZAP Conference promises much with visiting keynote speaker, Professor Mark Solms, with a theme of The Embodied Mind: Conversations between Mind, Brain and Body in Psychotherapy. We will again be offering the opportunity to meet in person at the Margot Kimpton Hotel in Sydney (formerly the Primus, Pitt St). As now tends to be the norm, it will be a hybrid event, available online to those who can't attend in person. Unlike 2022, the conference will be followed by a dinner on the evening of 21st October (there will be an additional charge for dinner). Watch your emails for further updates.

There has been ongoing activity between ANZAP and PIT-UK. A joint seminar will be held on June 23rd from 6pm-8pm Sydney time (8-10pm NZ time) with Else Guthrie and Anthony Korner presenting. This will include a Robert Hobson interview, previously unseen in Australasia, with Else facilitating the presentation and discussion. I'll be talking about the importance of Carl Jung in the development of the Conversational Model. More details will be circulated soon. Also discussed is a proposed seminar planned for September 13th, 2024. This will be a seminar commemorating the passing of 25 years since Robert Hobson's death and will focus on Hobson and his contributions to the CM.

Westmead Wonderings

Anthony Korner

The Westmead Program continues to operate in parallel with the ANZAP training program. Enrolments have increased in recent years and we are working to include Westmead trainees as much as possible in ANZAP activities. A further step taken in this direction is the agreement that in 2024 Westmead Graduates will be invited to present at the ANZAP Graduation, making it a combined event. It has also been agreed that Westmead Graduates will be eligible to become Graduate Members of ANZAP in the same way as ANZAP Graduates.

In February we had a hybrid first day of semester, giving a number of students the opportunity of meeting staff in person. As part of the emergence from the Covid-era, further in-person meetings are planned for the end of semester and in the second half of the year. We have also welcomed new members of faculty onto the Westmead team, including Nicky Abitz, Jan Egan and Michael Williamson (of course for Michael, this is a welcome back after eighteen months absence). We also had a boost with the return of Bill Moloney after a 12-month absence. Sadly, we said farewell to Janine Stevenson in the second half of 2022. Many ANZAP

members will be very much aware of the enormous contribution that Janine has made to the CM, particularly in the area of research.

As part of the ANZAP – Westmead – PIT-UK dialogue, we are looking into organizing a seminar focused on Psychodynamic Interpersonal Therapy involving a direct link with some of our UK colleagues. Hopefully we'll announce more about this before year's end.

ANZAP Faculty Report

Nick Bendit

We have 17 trainees in year one, 15 in year two and 15 in year three. The intensive training was back to face-to-face for the first time in three years. It was held at the refurbished Mary McKillop Centre in North Sydney. I must admit, it was the best intensive we have run, partly due to the hunger for face-to-face collegial contact, partly due to the beautiful new facility at Mary McKillop, and partly due to the hard work that Kim Hopkirk and I did to coordinate it. Kim and I had lots of help from other faculty members with teaching and organization (particular thanks to Cecile Barral, Geoffrey Borlase, Michelle Rousseau, Andrew Leon, Colette Rayment and Linda Bragg). The graduation ceremony was held during the intensive and was simply wonderful. Many thanks to our new president, Anthony Korner, who attended and presided over the graduation ceremony. Presentations by Simone Walsh (on "hate"), Mran-Maree Laing (on "love") and Ingrid Gunby (on combining animal assisted therapy and CM) were wonderful and several year 1 trainees came up to me and said they found those presentations inspiring. Alex Strachan tried to present his dissertation via Zoom from Adelaide but, unfortunately, we could not get the technical aspects to work.

The teaching so far seems to be going well, although trying to organise 48 trainees into individual and group supervision was daunting and fraught at the beginning. This is the biggest cohort of trainees we have had, and so we have expanded faculty and accredited supervisors doing the supervision. We welcome Michael Ossher, Elana Cohen and Annie Vidler as new accredited supervisors providing supervision to year 1.

UNITED KINGDOM UPDATES

Comments from PIT-UK Chair

Simon Heyland

Since the last issue PIT-UK has taken a significant step as an organisation and become a corporate entity registered with Companies House as PIT-UK Ltd. It is our intention is to function as a social enterprise. Prompted by this organisational change we will be seeking to expand the PIT-UK committee as we clarify various roles and workstreams in the following areas: finance; training & education; external relations; CPD events; membership; research & evaluation.

The current members of the committee are myself (chair), Frank Margison (vice chair), Mary Lewis (treasurer), Laurence Regan (CPD coordinator), Rebecca Hughes, Kath Sykes, Liz Murphy, Else Guthrie, Wendy Macdonald, and Richard Brown. If you would like to get involved (or just to ask what it entails) please email me at s.heyland@nhs.net The 'entry criteria' for joining is a sense of commitment to the Conversational Model and a willingness to help us develop and disseminate it. No special skills required!

One specific significant task of the committee in recent years has been trying to find a new home for the existing Introductory (level 1) course, and a first home for the much-anticipated Practitioner (level 2) course. Having evaluated several options, we have decided that the costs and inevitable restrictions of having the courses hosted by an external body (eg university or NHS trust) would be prohibitive for PIT-UK. So we will be running both courses ourselves, and are delighted to be able to announce that the first intake for the Practitioner training has been proposed as January 2024. The course will be based at Gaskell House Psychotherapy Centre in Manchester, which is fitting as this building is the home of the model in the UK. There is naturally still some work to be done on finalising the curriculum and timetable (as well as the drier tasks of writing policies and procedures!) but I am sure that our start date will

help sharpen our minds.

In terms of existing events, in November 2022 we had our first face-to-face event since 2020. Our Annual Training Day was on the topic of 'reliving' as a therapy technique, expertly led by Else Guthrie who illustrated her presentations with videotaped examples of Bob Hobson in practice. It was a fantastic reminder of a perhaps underused technique for bringing alive key moments from a patient's past, making the feelings accessible in the here-and-now. As well as enjoying the content of the day, it was also great to see so many people in person – and my thanks again to Else for leading the day, to Frank Margison and Mary Lewis for running workshops, and to Laurence Regan for coordinating the event so skilfully.

So far in 2023 we have had Zoom seminars on the topics of the use and meanings of gesture (a modified version of which appears as a paper in this issue), love & loneliness (led by Rebecca Hughes) and the self as illustrated by the persona of Marilyn Monroe (led by Frank Margison). Our next two events are the June joint seminar with ANZAP, and then a special visit from Tony Korner who will be joining us face-to-face at Gaskell House on 7th July for a seminar discussing the Conversational Model as a long-term psychotherapy for borderline personality disorder. Personally I cannot wait to hear from Tony about this subject. To book for either event email laurence@lregan.com

Coming up this autumn - on 8th September we have a Zoom seminar with Anna Phillips who will be presenting a PIT perspective on the emerging field of psychedelic-assisted psychotherapy. And our 2023 Annual Training Day will be led by Dan Beales who will discuss introductory resources and transtheoretical issues in PIT.

Upcoming Events

Please save the date in your diaries for the following events:

23rd June 2023
Amplification, Imagination and Reliving
Zoom seminar with Anthony Korner and Else Guthrie

7th July 2023
Conversational Model therapy for borderline personality disorder
Face-to-face seminar with Tony Korner
Gaskell House Psychotherapy Centre, Manchester

8th September 2023
A PIT perspective on psychedelic-assisted psychotherapy
Zoom seminar with Anna Phillips

30th September 2023
Talking Bodies: A New Language for Psychoanalysis
and the Silence Between the Words
Zoom seminar with Doris Brothers and Jon Sletvold

24th November 2023
Introductory resources and transtheoretical issues in PIT
Annual PIT-UK Training Day with Dan Beales
Gaskell House Psychotherapy Centre, Manchester