

Mental Health: Selected overarching issues

Author: Marcus Tabart (Psychiatrist, Alice Springs)

[Editor: The following chapter is divided into three parts. 'Part 1: Changes to anti-psychotic medication in the CARPA STM' was written by Marcus Tabart, a psychiatrist in Alice Springs. 'Part 2: Personal recovery in psychiatric disorders' was written by Laurie Curtis, Clinical Assoc Prof at the Trinity College of Vermont, Burlington, Vermont, USA and was reviewed by Marcus Tabart and the CARPA mental health editorial subcommittee. 'Part 3: Some ideas on the psychology of cultural relationships' was written by Craig San Roque, a psychologist practicing in Alice Springs.]

Part 1: Changes to anti-psychotic medication in the CARPA STM

Emergency treatment

The Therapeutic Guidelines: Psychotropic Version 4 and the bulk of contemporary Psychiatric Literature now emphasise the harmful extrapyramidal side effects (EPSE) that occur with the use of traditional high potency antipsychotic medications such as haloperidol and trifluoperazine (stelazine).¹

Not only are these side effects (e.g. akathisia, dystonic reactions and Parkinsonian stiffness) unpleasant, they can reduce the likelihood of future treatment adherence. Another unwelcome side effect of antipsychotic medication is Tardive Dyskinesia (TD). This is a disfiguring irreversible involuntary movement disorder affecting oro-buccal-lingual musculature in particular, though the abnormal movements are not necessarily confined to this musculature alone. The incidence of this disorder due to exposure to traditional antipsychotic medications is 5% after one year increasing up to an incidence of 25% with five years exposure. If the patient is over 65 years the annual incidence of TD is a staggering 26%. The incidence with atypical antipsychotic medication (e.g. risperidone, olanzapine, quetiapine and clozapine) is in the vicinity of only 1% per year.¹

We know the clinical course of the majority of people with psychotic spectrum disorders is one of exacerbations and remissions, and medication adherence is a crucial determinant of recovery.

Droperidol is an effective agent to provide rapid and safe onset of sedation in the setting of a psychiatric emergency when behavioural control needs to occur quickly. It is a low potency antipsychotic, and as such is less likely to cause EPSE than haloperidol.² In the emergency setting, with an acutely behaviourally, agitated and disturbed person (whether it be due to psychosis, mania, or excitement states caused by drugs or an acute brain syndrome), the use of droperidol is the current best practice. We are proposing to use droperidol instead of haloperidol in the fourth edition of the CARPA STM for this group of people.¹

Droperidol produces marked tranquillisation and sedation. The onset of action is from three to ten minutes following intramuscular or intravenous administration. With haloperidol, by comparison, the onset of action via the intramuscular route is about twenty minutes. The full effect may not be apparent

for thirty minutes. The duration of the sedative effect is between 2-4 hours. The usual dose is between 5-10 mg IMI.³

Droperidol is rapidly absorbed by the intramuscular route. This is the preferred route of administration. Its elimination half-life is about two hours. It is safe to repeat the dose within 30 minutes of the initial dose if the desired sedative effect has not been satisfactorily achieved. Though the incidence of EPSE is much lower with droperidol than haloperidol one would also give benztropine with the initial dose of droperidol.¹

The current literature is sparse about the effects of combining droperidol with midazolam. One can say that on most occasions, droperidol alone should be sufficient; combination with a benzodiazepine – whether via the oral or parenteral route – will potentiate the sedative effects of droperidol; and the combination is most probably safe. The Royal Melbourne Hospital is currently conducting a trial using such combination therapy (pers. comm., Pharmalab, the manufacturer of Droperidol).

Maintenance treatment

It is recommended that Risperidone is made available to all remote clinics and for it to be the antipsychotic medication of choice for the management of psychotic disorders.

Risperidone can be used to the following circumstances:

- i. In the acute setting where a person is psychotic and agitated but is able to have a tablet and does not require evacuation;
- ii. For longer term use in those people with a psychotic illness such as schizophrenia or delusional disorders.⁴

Risperidone is well absorbed after oral administration, reaching peak plasma concentrations in one to two hours. The elimination half-life is 24 hours and so it can be given as a once-daily dose. The dose for best efficacy and tolerability is 2-6 mg/day (average 4.5 mg/day). Rather than to raise the dose above these levels in agitated patients, partial responders, or acutely ill patients, one should consider instead augmentation with a benzo-diazepine such as diazepam.

Amongst Risperidone's advantages are:

- i. It is an atypical antipsychotic and has less propensity for EPSE so is better tolerated by people
- ii. Probably has a reduced incidence of Tardive Dyskinesia compared with haloperidol
- iii. Has better efficacy with negative symptoms in schizophrenia than haloperidol
- iv. Possibly reduces cognitive and affective symptoms in schizophrenia more efficaciously than haloperidol
- v. Less weight gain than with other antipsychotic medication
- vi. Well accepted for treatment of agitation and aggression in elderly dementia patients
- vii. Well-accepted treatment for treatment in bi-polar disorders
- viii. A depot preparation will be available towards the end of 2002.⁴
- ix. Risperidone is significantly cheaper than Olanzapine yet both have similar effectiveness.⁵

[Editor: In recent years, droperidol has been reported to cause prolongation of the QT interval.^{a,b,c,d} Discussion with a number of psychiatrists including Josh Geffen (Senior Lecturer, Dept of Psychiatry, University of Queensland) lead to the view that:

QT interval issue is dose dependent so one dose of 10-15 mg droperidol is unlikely to cause QT prolongation. The balance between risk of harm from

medication and risk of not treating was judged to lie with using a single dose of droperidol.

(The review by Glassman summarises the risk as 'Although sudden unexpected death occurs almost twice as often in populations treated with antipsychotics as in normal populations, there are still only 10-15 such events in 10 000 person-years of observation'.^{b)})

We have recommended to leave out extra doses of droperidol and instead use further doses of midazolam, although noting some more risks of respiratory depression with this agent.

An IM preparation of olanzapine is becoming available within 12 months; this will be the preferred IM antipsychotic to use in the emergency situation. However as it is not yet available, it is not mentioned in the STM.

- a. Raftos J, MBBS FACEM. Treating the acutely psychotic patient. Australian Family Physician Sept 2002; 31(9): 813.
- b. Glassman AH, Bigger JT Jr. Antipsychotic drugs: prolonged QTc interval, torsade de pointes, and sudden death. Am J Psychiatry 2001 Nov; 158(11):1774-82.
- c. McAllister, HR, et al. Rapid Tranquilisation: Time for a reappraisal of options for parenteral therapy. Brit J Psychiatry June 2002; 179:485-9.
- d. Reilly JG, et al. QTc-interval abnormalities and psychotropic drug therapy in psychiatric patients. Lancet 2000; 355:1048-52 (NB the QT prolongation with droperidol was obtained from patients on the oral droperidol for a minimum of two weeks).]

References

1. Therapeutic Guidelines: Psychotropics. version 4. Victoria: Therapeutic Guidelines Ltd, 2000.
2. Chambers RA, Druss BG. Droperidol: efficacy and side effects in psychiatric emergencies. J Clin Psych 1999; 60(10):664-7.
3. MIMS Annual. 2001.
4. Stahl SM. Psychopharmacology of antipsychotics. UK: Martin Dunitz, 1999.
5. Emmerson B, Estensen A, Powell J, et al. Strategies to manage inpatient drug costs. Australasian Psychiatry 2001; 9(3):249-52.

Part 2: Personal recovery in psychiatric disorders

Contrary to popular beliefs, worldwide research suggests that many, if not most, individuals diagnosed with serious mental disorders (e.g. schizophrenia, bi-polar disorder) can and do recover.

Recovery may mean that a person becomes symptom-free or it may mean that the person may have symptoms that do not impede their living full and productive lives. In its essence the process of recovery means that an individual is not dominated, internally or externally, by illness or disability, even if symptoms are still present.

This picture illustrates this change.



This is not a quick or easy process for most people. It is common for individuals to get stuck, sometimes for years, on the left side, where they view the world

through the illness and the world sees the illness, not the person. It becomes a self-fulfilling process.

Serious mental illness affects almost every aspect of an individual's life, as well of his/her family and often his/her community. The process of personal recovery also involves careful attention to both internal and external elements of a person's life: home; work/productivity; social/interpersonal; belonging/connectivity; spirituality; beliefs about the past, present, and future; as well as physical health and psychiatric symptomatology.

Appropriately prescribed psychiatric medication is an exceptionally helpful tool for many people. However, it is not the only important tool.

Recovery-oriented mental health treatment helps an individual to gain the knowledge, skills, and tools to help him/herself to minimize or manage distressing symptoms and to meet the challenges of day-to-day living.

Recovery-oriented mental health services are 'do with' rather than 'do to' services. The individual person, often with his/her family, must be full partners in the treatment process and are the prime agents of change. This involves including the individual/family in all assessment, treatment, support, and decision-making procedures.

Factors that help to stimulate and support personal recovery from psychiatric disorder can be divided into 'internal' and 'external' conditions.

Internal conditions

- *Hope*: Belief that positive changes can happen and that life is worth living; focus on strengths, allies, and capacity for change.
- *Belonging/connection*: Feeling a part of something larger than one's self; being accepted by others; having respectful, trusting, and reciprocal relationships.
- *Meaning/purpose*: Finding place and purpose within a community and culture. For some this means work and earning an income, for others this may mean being able to connect with the spiritual world, or fulfill valued social roles.
- *Empowerment*: Exercising autonomy and self-governance; accepting responsibility outcomes of personal decisions and actions; courage and risk-taking.
- *Healing*: Defining self as apart from the illness; recognising strengths as well as limitations; developing knowledge and effective strategies for self-care and symptom relief; greater 'wholeness' and balance.

External conditions

- *Valued social roles*: Fulfilling and being honoured for 'everyday' roles and contributions to community as a parent, worker, friend, healer, care-taker, elder, son/ daughter, artist, tenant, participant in ceremony, and so forth.
- *Human rights*: Acknowledgement of human rights and the damaging impact of social and economic marginalisation; respect for personal rights and dignity.
- *Opportunity and access*: Reduction of stigma; increased opportunities and access to needed resources (includes basic resources such as shelter and food, as well as healthcare and other services).
- *Effective mental health treatment and services*: An orientation to a 'positive culture of healing' as the core element of professional services; positive and respectful staff attitudes; access to appropriate medication, physical healthcare and crisis response resources; proactive attention to recovery education and planning, crisis prevention; integrated substance abuse and trauma-informed services.
- *Support*: Friends, family, other consumers, professionals all constitute a web of support that provides help, problem-solving, reassurance, feedback, and positive expectation.

What you can do

As a person

- Self-check your personal beliefs about the long-term course of psychiatric disorders and the process of recovery
- Communicate the expectation of recovery and success, be a 'holder of hope' for others
- Use culturally respectful terms and person-first language (e.g. say 'persons with schizophrenia', rather than 'the schizophrenics'); use terms that highlight valued social roles rather than patient, client, service recipient roles
- Spend more time listening than talking.

In relationship building

- Be a partner or ally for the individual/family, rather than expert
- See people as people, not patients; engage on a person-to-person level with each person and family member
- Allow for alternate ways of seeing or defining the problems, as well as the solutions (e.g. avoid defining the situation or symptoms from solely a medical model or western view-point).

In assessment and care planning

- See individuals as intricately woven into their families, community and culture. These carry meaning, even if the ties appear to be severed or unraveled
- Encourage and provide space for people to 'tell their story.' Listen for meaning in metaphors, perceptions about the causes of problems, previous attempts to cope or problem-solve, strengths and dreams, patterns of symptoms or triggers, community connections, natural supports and resources, how the person gains or loses respect in his/her family or community.
- Ask about domestic violence, substance use, and childhood emotional, physical or sexual abuse. These forms of violence can have lasting impacts that can mimic psychiatric disorders.
- Help individuals identify personal dreams and desired life changes. Collaboratively explore various paths for achieving these outcomes.
- Develop care plans that can be fulfilled by the individual and carers/community. Use mental health resources as a back-up resource.

In care and treatment

- You cannot make someone recover. You can provide information, tools, encouragement and support to aide each person in this process. You can also inadvertently impede the process
- Listen when people tell what has been helpful/not helpful. Integrate this input into planning.
- Take a broad definition of 'therapeutic'. There are many pathways to healing.
- Provide knowledge and information about mental illness, recovery, self-management approaches, community resources, and so forth.
- Use approaches that validate the individual as 'expert' on their own lives. You are an assistant or ally to their process of personal recovery.
- Engage the individual in any decisions about medication. Avoid medication protocols that disrupt valued functions (e.g. hearing the voices of ancestors) or meaningful roles (e.g. sexual functioning).
- Medications are a means to an end, not the end in and of themselves. Focus on the positive life outcomes that come from use of effective medications, rather than the horrors of non-compliance.
- Expect the process of recovery to include crises, setbacks, and new beginnings. It is a spiraling rather than a linear process.
- Collaboratively develop proactive relapse prevention and wellness plans.

In the community

- Avoid removing an individual from their community or personal supports, particularly for an extended period of time. Help individuals retain personal connections during 'away' periods (e.g. during hospitalisation).
- Help each individual construct a personal support network within his or her family, allies/friends, and traditional healers. Professionals may be an element of the support network, but should never dominate it.
- Work to identify positive 'models of recovery' that help to demonstrate that 'people make it'.
- Help individuals find or re-establish valued roles and positions within a community or culture.
- Help individuals find ways to be givers not just receivers. There are many ways people do this in personally meaningful ways: e.g. reciprocal relationships, peer support, volunteer activity, advocacy work, story telling to help inform others.

Bibliography

- Anthony W. Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation J* 1993; 16(4):11-23.
- Curtis LC. Moving beyond disability: recovery from psychiatric disorders. One person's perspective. In Towson MD. The capstone. The Council on Quality and Leadership in Supports for People with Disabilities, 2000; 17(2):8-9.
- Curtis LC. Practice guidance for recovery-oriented behavioral healthcare for adults with serious mental illnesses. In Towson MD. Personal outcome measures in consumer-directed behavioral health. The Council on Quality and Leadership for Persons with Disabilities, 2000; 25-42.
- Deegan P. Recovery: the lived experience of rehabilitation. *Psychosocial Rehabilitation J* 1988; 11(4):11-19.
- Estroff SE. Self, identity, and subjective experiences of schizophrenia; in search of the subject. *Schizophrenia Bulletin* 1989; 15(2):189-96.
- Harding CM, Zubin J, Strauss JS. Chronicity in schizophrenia revisited. *Brit J Psychiatry* 1992; 161:27-37.
- Jacobson N, Curtis LC. Recovery as policy and practice: how states are implementing the concept. *Psychosocial Rehabilitation J* 2000; 23(4):333-41.
- Jacobson N. Experiencing recovery: dimensional analysis of recovery narratives. *Psychosocial Rehabilitation J* 2001; 24(3):248-56.
- Ridgway P. Re-storying psychiatric disability; learning from first person recovery narratives. *Psychosocial Rehabilitation J* 2001; 24(4):335-43.

Part 3: Some ideas on the psychology of cultural relationships. 'Black and White and the things between us'

[Editor: This paper does not offer an explanation for a particular protocol or clinical action, but is included as it may help remote practitioners gain some useful insight into their own experience as a practitioner, and hence be sustaining. In the authors words:

In short, taking care of one's patients and taking care of oneself may involve becoming more professionally aware of how projection and transference operate as subliminal communications.]

. . . therapy must remain an obstinate attempt of . . . people to recover the wholeness of being human through the relationship between them. (RD Laing¹)

Introduction

This paper can be linked to the subject of self-care [Editor: for practitioners]. It reveals another aspect of the self-care picture and introduces an idea on how

relationships between people of different cultures can be thought about, drawing on the experience of psychotherapy.

It suggests that more attention be given toward understanding the psychological nature of experience in remote area Indigenous life. Also, that the mental health of Aboriginal people and of non-Aboriginal health professionals might be supported and understood better if key workers and administrators made the effort to become systematically aware of the way mental life actually operates.

The dynamic relationship between Black and White people is shot through with partially unconscious desires, expectations and communications, as well as subliminal attempts to change each other's bodies, beliefs, behaviours and uses.

The demands made upon a person by self, family, work, administrative and political agendas are entangled, complex and sometimes dehumanising. Managing this often unconscious dynamic is confusing and emotionally exhausting and may contribute to the particular kind of 'burnout' and dissatisfaction experienced in remote-area work.

However, I also suggest that effort to analyse inter-cultural, psychological transactions would be worth proper attention. This might include a study of the mental operations of transference and projection as it applies to what happens between people of different cultures, especially in Aboriginal country. This is an entirely new field.

Part 1

Intercultural 'static electricity'

Therapeutic workers of all kinds often find that, because they get so close to the feelings, bodies, injuries and events of many traumatised people, they pick up emotionally charged 'static electricity' from their patients and the working environment. Absorbing the emotions associated with exposure to trauma is probably a part of being human. Our capacities for sympathy and empathy are brought into play. It is commonly understood that de-briefing, good supervision and a well managed support team can help to 'wash out the static' and maintain a high standard of therapeutic effectiveness and humanity.

If we take the psychiatrist RD Laing's point about honouring and working therapeutically within the relationship, we have to remind him that therapeutic work within intercultural relationships has a very special twist to it. Especially when it is happening in and on Australian Indigenous country.¹

In remote-area work the 'emotional static' we pick up has a special twist to it because of the way life is lived in 'remote areas' and because of the different ways people of White and Black cultures work upon each other, psychologically.

The difficulties of work in those regions and the difficulty of putting good supervision or psychological support into place may mean that the work becomes hard to bear. One's therapeutic capacity becomes dulled, or hard to manage, normal defences against pain and confusion may become exaggerated or distorted. Psychologically justified paranoid defences of dissociation and dehumanisation may take over as an individual struggles to survive a (psychic) inter-cultural situation which may be only barely understood, despite the endless hours of repetitive dinner table or camp fire gossip about 'us' and 'them'.

Some of the 'static electricity' generated between persons is generated by the clash of peoples, a clash that has taken place historically in Australia, and is still taking place. This clash or abrasion is not always straight out physical assault or conflict. It may have an elusive, sideways, understated, easily deniable quality to it which may have something to do with the way Indigenous people manage conflict, combined with the way those of an Anglo-Australian mentality have managed the bureaucratic takeover of the continent.

It is not my job here to carry out a political/historical analysis. The problem for us as professional health workers, however, is that the psychological consequences of that historical conflict and the misunderstandings of the

relationships of conquest may come to a head in our own work spaces: in hospital waiting rooms, accident and emergency wards, remote area clinics, drug and alcohol settings, police vehicles, court rooms. I am speaking not only about family conflicts and violence displayed in public spaces, but also about a much more subtle, almost subliminal tension, which is generated by and between persons when they meet in such spaces, apparently to help each other and be helped. Sometimes the slow procedural boredom of the institutional settings makes the deep inner story of Australian life seem dull and of no consequence. But out bush the drama, tragedy and tension is stark and visible, but sometimes the very drama of it makes it hard to think. There are many things, which happen between us, which are difficult to think about and difficult to speak about.

I ask you to consider if it is worth spending time to think carefully about such matters as the difference in the psychological make up of people raised in such unique ways as the Indigenous Australian and the settled/immigrant Australian (no matter what the countries of origin may be). We do have different origins and purposes and yet we have become uneasily entwined. We are expected to safeguard each other's health and wellbeing, and yet the evidence or experience suggests that the health of Indigenous people is barely improving and the health of many of the non-Indigenous workers suffers. What is going on? What are we doing to each other? Could it have anything to do with our difficulty in recognising, feeling and working with the differences?

If we think of a typical bunch of people who might find themselves in treatment or at work in a typical bush clinic then we may have a mixed bag of concepts of sickness and cure, cause and effect. The nature of the 'healing contract' may be interestingly different. Indeed the very basis of the sense of self may be different. So too, the sense of family identity, morality, ethics, spirituality and the role of the country in the formation of the mind. Indeed, the sense of the location of the mind and the boundaries of the mind may be quite different.

Our languages, for instance, are very different in structure, history and uses and thus the way our thoughts are put together can't help but be different. The metaphors and images in which our languages are based are different and thus the pictures in the mind, which words help create, will be different for people who have been born into such different language beds as, say, the Warlpiri and the English. If language is about communication, and the mutual understanding of language is uncertain, then the communications will be vague, uncertain and simplified. We might get by with talk about objects and so called concrete realities, but talk about feelings, ideas, meanings, causes, and depths of human experience . . . what then?

I suggest that the varieties of the difference between Black and White (or 'us people' and 'you other people') ought to be understood and appreciated more fully and systematically than most of us have so far managed. Appreciating similarity and unity has its value, so has recognition of uniqueness and difference.

I am introducing the idea here that stress, trauma and burnout in remote-area practice may be partly caused by our failed attempts to handle the differences between us. Managing inter cultural relationship is about self awareness and self-care as much as it is about taking care of others. Self-care manuals may show you how to handle and even get rid of the 'static electricity' from your system. (By 'static' I mean, the worry, the somatic symptoms, the exhaustion, the confusion, and the aftermath of 'flight and fight' reactions experienced when working in a threatening, culturally strange environments.) This subject is well covered in the CRANA sponsored booklet, 'Stress: On surviving burnout in remote areas'.² Essential reading. By the way, I have yet to come across a manual, written by Aboriginal people, with a title something like 'Burnout: On surviving White people in our own country.'

Intercultural transference and projection

If we were to take the matter one step further than the (valuable) stress prevention manuals we might want to draw upon the insights of those two famous psychological explorers, Sigmund Freud and Carl Gustav Jung. The key subject for us is their psychoanalytic work on transference/counter transference and projection. This is a complex subject, and I will not be able to do it justice here, but I can place before you a few ideas, as a kick-off.

When I suggest that a kind of psychological static electricity gets generated between people who work in cross-cultural settings I am talking about eruptions of love, hate, envy, fear, contempt, confusion, shame, anxiety, grief. Suchlike deep emotions are stirred up between persons, whether the relationship is a professional one or a personal one. These emotions generate bodily reactions, they set off behaviours and they start up psychological images, stories and scenarios in mind and 'heart'.

'Transference' means 'carrying something over from one place or one time or one person to another'. It has technically complex meanings in psychology, but basically 'transference' is about the way emotional reactions, images and ideas behave as we shift them about between ourselves.

'Projection' is the way we send mental and emotional images and messages to each other. Traditional sorcerers/witchdoctors know about projection and use it to affect people 'magically'. The 'electric tension' in a relationship is created as we shift about and send between us bundles of emotionally charged ideas, images, feelings and reactions.

When transference and projection kick in, so too do memories, fantasies, false stories, unreasonable expectations, imagined wrongs, paranoia . . . Most family feuds and vengeance cycles are kept going through psychological procedures like this. People may not stop to sort out the truth but keep piling more and more emotional fuel on the fire, shifting blame, fantasy and fear around from person to person until no one person can think or act for themselves. This happens in Aboriginal communities and between families, and it happens in government organisations.

Freud and Jung's idea about the transference and projection transactions that get going between people (and organisations) is that dangerous business starts when we don't really know for ourselves what we are doing and thinking. When the reactions are unconscious to us, ourselves. When we don't know our own mind and do not stop to think.

My paper is about starting up the idea that we might just be able to learn how to process the particular kind of reactions that get stirred up in remote-area work settings. To do this we might be able to learn from Freud's mob.

The psychological 'static electricity', or the transference projections that you may pick up, may come to you as odd feelings, visceral or bodily reactions, strange ideas and images, sudden emotional charges, dream fragments, late night thoughts and intuitions. These reactions may be seen as eccentric aberrations or signs of 'nervous breakdown', 'bush fever'. But these reactions can all be decoded and identified. Some may be transference communications between one's client/patients and oneself; some may be subliminal dream-like intuitions about a situation in the community. Some may be about deep shifts in one's own psyche. In short, transference and projection process can be used as a diagnostic tool and as a self-educative process.

However, the skill in collecting and decoding elements of intercultural transference and projection is a genuine skill and it does have to be worked upon. Special practice has to be developed to decode and interpret transference processes between people in normal therapeutic relationships, in protected consulting rooms, or in-group process. But imagine how difficult it is when the relationship is between a 'doctor' and a 'patient' of different cultural and epistemological backgrounds. Some remote-area workers manage this difference amazingly well and we could learn from them. Such people may have the skill and

experience to be seated in the camp of the pragmatic health scientists and at the same time be seated in the venerable camp of the pragmatic spiritual animists. You could perhaps name a few Aboriginal and non-Aboriginal people who are good at this 'two-way thinking', being able to sit in both camps at the same time.

In summary, I suggest that much of the heartache, misunderstanding and stress generated between Aboriginal and non-Aboriginal workers has to do with our mutual naivety and mutual inability to process what is being communicated between the two camps. Few health services have taken the beneficial step of implementing psychologically attentive work incident discussion as a self-reflective way of relieving stress and decoding intercultural process. Most such interventions are after-the-fact, as post trauma debriefing, and are not carried on as a professional development opportunity. This may be because 'stress' is seen as an aberration to quickly recover from, rather than as indication of something to learn from.

Part 2

Reciprocity of psychic life

. . . Any technique concerned with the other without the self, with the behaviour to the exclusion of experience, with the relationship to the neglect of the persons in the relation, with the individuals to the exclusion of their relationship, and most of all, with an object-to-be-changed rather than a person-to-be-accepted, simply perpetuates the disease it purports to cure. (RD Laing.¹)

This little sermon from RD Laing, an experienced and revolutionary psychotherapist, affirms the values of attending to people as fully human even while they are being treated scientifically. In his writings he also introduces the idea of reciprocity of psychic life; that we catch things from each other as persons; even if we think we are protecting ourselves and remaining professionally detached while treating people as patients or as 'objects' to be cured.

Laing, like Freud and Jung before him, discovered that being a part of the therapeutic profession lays one open to influence from one's patients and the situations or conditions in which they live. Working in primary health care definitely means being personally immersed in the conditions of one's patients because primary health care workers and front line public health workers are living in the very situations that are making their patients sick or distressed.

Being part of the mix of life and death on a remote Aboriginal community lays the psyche open to influence in very specific ways. The influences can be creative, instructive, confusing, destructive, exhausting and life changing . . . all at once. Decoding and understanding what goes on in the day-to-day situations in intercultural therapeutic transactions could be part of routine professional debriefing. It usually happens, unfortunately, that making sense of our experience together is often sidelined into backbiting gossip cycles and understanding is, in this way, diminished and degenerated.

Psychoanalysts developed the notion of 'transference' and 'counter transference' as a way of explaining the peculiar ideas, sensations, feelings and images that occur to patient and therapist when they are in each other's presence. They developed this process into a therapeutic tool. They make a systematic study of interpersonal projection by noting carefully their own reactions while in the presence of the other (the so-called patient). This observation includes giving careful attention not only to the patient's signs, symptoms and reactions but also to the therapist's own bodily sensations, images, feelings, ideas and the afterthoughts that arise spontaneously when in the presence of the other person, the so-called patient. This observation includes noting, for instance, the varied sensations of love, hate, fear, uncertainty, unknowingness and misunderstanding which occur when with the patient. These sensory clues may be seen as signs of the

patient's psychological problem as well as signs of the cultural or environmental conditions in which the patient and the therapist are situated. One has to think a bit like a detective.

I want to open up this idea and invite you too to learn to be observant of the range of ideas, feelings, impulses, desires and actions which come to you when you are immersed in the presence of persons of another culture. DW Winnicott, an English paediatrician and psychoanalyst, became fascinated with what he called the 'area of overlap' between a mother and child. He called this space of sense and feeling between a parent and child a 'potential space', because there is so much potential there and so much could happen in it. Others, like the Australian psychiatrist Russell Meares, are tuned in to what psychologists call the 'intersubjective space'. Those of us who work in the overlapping intersubjective/potential space between people of Aboriginal background and those of mostly European or Asian background may have something to learn from Winnicott, Meares and company. We may have something to teach them also. I am inviting people of Aboriginal and non-Aboriginal descent to seriously look into this matter of what goes on, psychologically, between us, while we work.

Some technicalities: The movies in our heads

As we have already noticed, transference is about 'psychological stuff' that gets passed from one person to another. Sometimes we feel and see and understand this 'stuff' with no trouble. Mothers are often very good at reading their kid's transference, without even noticing how clever they are when reading their child's secret signals, hungers, and cries. Lots of psychological 'stuff' gets passed back and forward between husbands, wives and family. Sometimes, however, it is very hard to decode this psychological stuff and we react to it without understanding it and get into trouble.

Transference operates partly through projection. Projection can be understood as a way in which our 'internal' mental/ emotional movies are projected upon the screen of other persons, places and situations 'outside' us. This capacity for projection is a part of being human. It is a form of communicating. Things are OK when people can check their scripts against each other's version, but sometimes people can't see that they are reacting to their own movie and they don't do a reality check. They react to their own projected movie as though it was reality and not created by them. It's easy to see other people doing this. Not so easy to catch oneself. One of the ways to see how projection works is to track cycles of blame and revenge.

Different cultural groups have different basic 'cultural movie scripts' that are created by some mysterious process of cultural consensus. These are the creation myths or primary cultural ideologies. Swallowing cultural ideologies is part of the deal of being part of group life. It is these ideologies which we communicate subliminally and use as patterns to shape our personal transactions with each other.

Transference and projection can be a very useful part of creative human relationship. But some transference projections, which are unconscious and given no chance to be thought about, can cause deep harm. Intense destructive unconscious projection turned on another person can create madness. Between Black and White, transference and unconscious projections can create a state of madness. If the projections are tracked, by doing work on what is happening, the intercultural madneses to which we subject each other might just have a chance of being lightened, loosened and cured.

Five senses, a brain and three psychological capacities

There have been a hundred years of psychoanalysis. We can't squeeze everything learned about the human mind into these pages, but the following few points might help your thinking on this subject.

We have five senses: sight, hearing, touch/sensation, smell and taste.

As we turn our senses upon the world our brain does things with these sense impressions. The brain works by transforming senses into brain messages and gathers them together to make meanings. It is the capacity to make meaning out of the impressions that come through our skin, eyes, ears, nose and mouth that is so amazing about humans.

We have three incredibly useful capacities that help us to make meaning out of sense data.

One is the capacity for psychological integration of experience. The ability to collect bits of information and put it together and then do mental work on those collected bits so that it makes sense. Some of this seems to happen spontaneously but some of this mental work has to be done by thinking and by doing psychological work. (i.e. W Bion's alpha function, philosophers and scientists are good at this)

The second capacity is our ability to transform experiences or change the shapes of things in our minds. This capacity is related to symbolic process and thinking. Artists are good at this.

The third capacity is our ability to communicate.

When these three capacities are in action they are influenced by members of the 'family' of primal emotions. Love, hate, envy, sorrow, grief, contempt, disgust, anger, fear, rage.

Mixed in with all this mental and emotional activity is purpose, intention or desire.

When taken together, the combining of sense impressions, the brain's transformative actions, emotions, intention and desire, and communication, gives us our basic psychological motor. The basic parts are simple but what they do when they combine is very very complex.

Communication transference

Transference projections might have several main 'intentions'. I am selecting two for the purposes of this paper. The first is the effort at communication.

When this form of projection/transference is operating interculturally, it is about how persons from one culture are trying to pass something to persons from the other culture. These 'I'm trying to tell you something' procedures might be straight out or indirect, ironic, polite or confused. The communication may not even be particularly conscious. The people involved may not know how to put it to each other or the other may not understand or know how to listen and receive.

Ralph Fold's honestly observed book, *Crossed Purposes* (UNSW Press 2001) is full of examples of cross-purpose communications between Pintupi and European Australians. His stories are worth studying for this reason.

When something cannot be communicated and understood between humans, then other ways have to be found. Misunderstanding and the fact that the message does not get across means that people get more and more dissatisfied with each other, perhaps passive or aggressive actions are taken and desperate measures of emotional or physical violence ensue. Taking care of oneself in intercultural work means learning how to attend to and decode culturally formed communications and also how to process the emotional impact of failure.

Metamorphosis transference

These procedures are about (psychological) effort to change someone's shape.

When people get into a relationship a dynamic often comes into play whereby one or the other is trying to change the other. In intercultural work you may not be too clear about what the other is trying to change you into but you may feel some pressure to take on a shape with which you may or not be happy. Distress arises

when you have to resist and defend against having your shape changed or protect the shape of yourself, your psyche or your identity from being pushed into ways which you are not happy about.

Again, Ralph Fold describes this process with clarity. He uses examples from a Western Desert community of some revealing philosophical and practical tussles about, for instance, what 'being the boss' means to the White administrator and to the Pintupi. He describes pressures upon himself (as a supposed 'boss'), from Pintupi men to behave in the manner of a 'boss', as they see it. The Pintupi version of the boss's job is to provide for everyone, not restrict use of resources and finances, but arrange for the sharing of them among the appropriate people. He describes the impact upon himself of pressure to make him into a specific kin/skin relative and therefore fulfil the obligations which go with it. He describes the pressure upon Pintupi to change the shape of family life and tribal priorities to satisfy the desires of various, varying, consecutive often contradictory administrators, agents, advisers and health workers. The subliminal shape-changing pressure generated by administration has buried within it philosophical, religious and psychological manipulations. It is, in a sense, a propaganda war between the Pintupi and the Europeans that Fold's book describes. Ideological conflict between Black and White is not fought on any grand battlefield. There is no declared war in Australia. It's just that the psychological conflict rolls on in an understated, somewhat messy way in the background, all the time, like some low-grade chronic illness.

You will be familiar with the desperate and perplexing psychological resistance battles that turn around the use of money, or a vehicle, a sewerage system, food, a water source, a piece of country or an injury to a body. And, of course, sex. In the process we try to push each other into shapes which make sense in our own cultural patterns and images. We tend to feel quite justified in doing this. Internal disturbance and aggravation occurs as one or the other resists.

In short, taking care of one's patients and taking care of oneself may involve becoming more professionally aware of how projection and transference operate as subliminal communications. And how projection of implicit patterns and transference of unthought out passions operate to force changes in each other's shapes. Physically and mentally we may be trying to invest persons of another culture with our own patterns; and be trying to get them to fit our own possibly unconscious purposes and desires. They will be doing the same to you.

Stress and distress arises between humans when they misunderstand each other's communication or when people feel themselves being changed into shapes and shoved into patterns which are alien to them as persons and contrary to implicit cultural desires. Black does it to White and White does it to Black. Some of it is planned, as in a war. Some of it is unconscious.

Drunkenness and intoxication add a further dimension of disorder.

Three other things to worry about

Efforts at communications and shape changing (metamorphosis) can be coloured by three main types of desire: creative desire, destructive desire and preservative desire.

You may have noticed how such and such a person in the community has the persistent/consistent desire to make something new or useful out of other people. This might present as the desire to serve, to love, to cure, to educate, to help, to save; or to learn from. Many of the communications from that person serve that purpose. This creative shape-changing effort can end well, or badly. It may lie behind much health service/missionary effort.

The desire to change another may actually contain in it an (unconscious?) desire to destroy, break down or dispose of the other. The shape-changing effort and the subliminal communications are intended to ruin, dissolve, disperse or otherwise destroy body, mind or integrity.

The desire for preservation, containment or holding may come across in many ways as a desire to be held, taken care of, or to take care of others. It may have in it the wish to hold something steady and constant. It may, for instance, be about culture preservation. Usually this is thought of as a good thing, preserving the life of one's people, culture and country. In work within the Indigenous world this desire may pervade many actions and reactions between Black and White. The communications will be about it, as will efforts to prevent, resist or outwit the non-Indigenous 'shape changers'.

Creation, destruction and preservation seem to be archetypal processes in life. The combination of these three patterns plays out in interesting and mysterious ways, especially in the bush.

Conclusion and a wish that this subject could be developed

You might never have the slightest chance, in a busy bush clinic, to sit around the table and do a reflective analysis on all this stuff. Who has time for that? But you never know, maybe one day some health administration will set up the conditions where staff can systematically learn from the intercultural experience and develop the capacity to analyse our situations. Why? Well, perhaps to develop some compassion and patient tolerance for each other's bungled efforts at communication.

Psychoanalysts have learned that therapists must analyse their own preconceptions and partly unconscious expectations, otherwise they unwittingly impose false solutions and false cure upon their patients. Part of the stress of working in remote areas and on Aboriginal country is brought about by confusions in communication, in expectation, in projection. There may be profound differences between the psyches of persons raised in European, Asian and Indigenous Australian cultures, but these differences may be worked with in a conscious and systematic manner by health professionals. It is surely a part of the ethics of the practice.

Our mutual interventions in each other's lives cure and also destroy. Bearing the pain and humour of this complexity and contradiction may be a test of maturity as human beings. As Laing suggests, we could become 'obstinate in our attempt to recover the wholeness of being humans in relationship' . . . and not perpetuate the disease which we purport to cure.

Key references

Fold R. *Crossed Purposes*. Australia, UNSW Press, 2001.
San Roque C. *On Cultural Transference*. University Western Sydney, 1999. Unpub PhD. Contact: roq@ozemail.com.au

1. Laing RD. *The Politics of Experience*. England: Penguin, 1990.
2. Kelly K. *Stress; On surviving burnout in remote areas*. Alice Springs: CRANA, 1999.