New Associations
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BRITISH PSYCHOANALYTIC COUNCIL

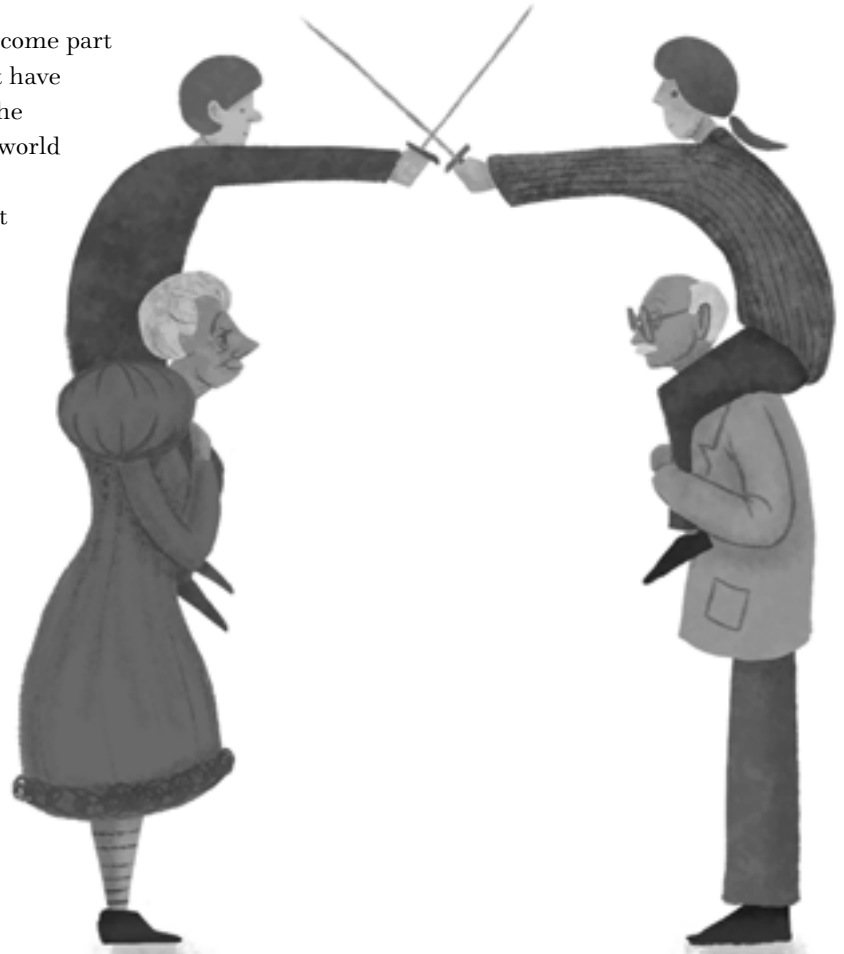
The Impact of Research on Psychoanalytic Psychotherapy

By David Hewison

"The widespread tendency to idealize the psychoanalytic method quickly gives way when a clinician gets involved in research activity"

(Jiménez, 2007 p 662)

Psychoanalytic psychotherapy is self-evidently a therapeutic activity as well as an analytic one – one of its aims is to produce a therapeutic effect, albeit one that is linked to a better understanding by the patient themselves, their relationship to their minds/unconscious, and their relationship to others. The fact that psychoanalytic psychotherapy meets the formal definition of a therapy is helpful as it allows it to become part of the debates that have been going on in the wider therapeutic world about efficacy and effectiveness, about change and about what processes bring about change. This definition is that it is an activity that is (1) based on psychological principles, (2) involving a trained therapist and a client who is seeking help for a mental disorder, (3) intended to be



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helpful for the client's complaints, and (4) adapted to the client's problem (Wampold and Imel, 2015, p 37). This is a very loose definition, but it was designed to weed out the kinds of studies that went on early in psychotherapy research in which the researcher's preferred therapy was compared with something that wasn't actually a therapy, and so did rather better.

In this definition we can note the use of the term 'mental disorder'. The vast majority of psychoanalytic practitioners in the UK are not psychiatrists or psychologists and work privately, rather than in mental health clinics, and we tend to get somewhat uncomfortable when this kind of term is mentioned: it assumes a diagnosis based on ostensibly objective and agreed diagnostic criteria found in the DSM or the ICD. These tend to emphasise the presence or absence of symptoms which may be observed by others, or reported by the patient. They most certainly are not dynamic pictures of someone's internal world. Nonetheless, we know that there are some practitioners doing psychoanalytic work in the National Health Service, who do work in mental health services, and public money is spent to enable them to treat mental disorders. The question that then arises is: are these therapies suitable for these patients with these disorders? Fortunately, where this combination of psychoanalytic mode of treatment with that disorder has been tested, it has been shown that it is, on the whole. The research evidence is clear about this (Fonagy, 2015, Leichsenring et al., 2015, Leichsenring and Rabung, 2008). I don't intend to go into this further. Instead, I want to pick out a few ways in which we may be impacted upon by research about our different psychoanalytic models, about the question of change in psychoanalytic psychotherapy and about the value for the overall psychoanalytic psychotherapy field of further research. I end with a brief note on how research can be helpful to our individual practice.

Research says: it's not about your particular psychoanalytic model

Joan Pablo Jiménez, the past President of the Chilean Psychoanalytic Society, trained as a psychoanalyst in Chile and was schooled in Kleinian thinking and technique. On qualifying, he got a scholarship from the Humboldt Foundation to study psychoanalytic research with the group of psychoanalysts at the University of Ulm – working on the massive amount of data generated from the 500+ sessions recorded of the psychoanalysis of the patient called 'Amalia X' (Kächele et al., 2009). His job over the five years that he was there was to listen to the tapes of Helmut Thomä and to try to link structural changes in the patient with changes in her transference response to breaks. He found a radical contrast between the psychoanalyst he was expected to be as the result of his training and the psychoanalyst he was expected to be in the research institute. The training promoted a regressed and persecuted state in which only one version of reality was allowed. He put it this way:

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> "I believe that a monist conception prevailed in the training group, that is, the assumption of the existence of a "unique" psychoanalytic truth. The monist illusion can only be supported from a dogmatic stance with either of two meanings: (1) absolute confidence (which leaves no place for reasonable doubt) in the knowledge gained by means of the psychoanalytic method and in the effectiveness of such knowledge while dealing daily and directly with patients and (2) total submission (without a personal examination) to certain principles or to the authority that imposes them. In our case, we had to submit to the Kleinian way of doing psychoanalysis. The rest of the orientations were practically left out or subtly disqualified as non-psychoanalytic." (Jiménez, 2005, p 610).

His experience in the German research group, on the other hand, was very different:

> "There, I discovered a psychoanalysis that was active and stirring, with high levels of self-criticism, embedded in the world of culture and socially respected. I was astonished by clinical and empirical research, by the epistemological criticism of psychoanalytic ideologies… There I came to grips with the notion that the problems of psychoanalysis are rather methodological than epistemological – that it is possible to address clinical reality posing questions differently, with a more explicit theory and a more transparent and less ideologically oriented reflection. I learned to value the consensual search for observable referents of theoretical assertions. Finally, I came to the conclusion that we can count with a corpus of theory of technique that spouts not only from the minds of some clear-minded clinical leaders, but also from the systematic study of real psychoanalytic practice." (p 605)

What Jiménez also found was that Thomä brought about psychoanalytic change without using the interventions Jiménez had been taught were the only ones that would work, and which had defined what psychoanalysis was for him.

> "This experience showed me, convincingly, that simple and mono-causal theories about how and why change occurs in psychoanalysis may be intellectually very appealing, but are probably inaccurate and don't fit with the complexity of clinical phenomena. Struggling with feelings of betraying my analyst, I definitely abandoned the illusion of being a "Kleinian" and I gave in to the complexities conveyed by calling myself a pluralist psychoanalyst."(p 612)

There was another significant experience, however: the patients he saw there for analysis got better, despite what he described as his comparatively indifferent German, and his different culture and expectations. He concluded, in line with mother-baby researchers, that it was the establishment of reciprocally-shared emotional states, rather than accurate verbal interpretations, which brought about change. This matches with the findings from psychotherapy research more generally.

Research says: it's not entirely clear what brings about change in psychoanalysis

Mary Minges and colleagues recently reviewed contemporary research into the process of psychoanalytic psychotherapy, looking at mechanisms of change (Minges et al., 2017). They identified a number of high quality studies that looked at particular pathways for change, in an attempt to see how it is that a specific treatment brings this about. They noted that change can be the result of something to do with the nature of the therapist, the treatment, or the patient that exists at the beginning of therapy ('moderators') and aspects of the therapy intervention itself ('mediators'). If you study moderators, you can figure out which people will or won't benefit from which therapy, and if you study mediators, you can figure out what are the active ingredients of an intervention and which are not, and get rid of the ineffective ones and get more of the ones that work. This gives rise to research that tries to break down the therapy process into a causal chain: intervention (which might be an interpretation) which leads to an internal change of some kind (an intermediate outcome, such as insight), which then leads to a change in symptom (such as the ability to sleep at last) – we can compare this with Hinshelwood's excellent work on single case study research (Hinshelwood, 2013). Minges and colleagues suggest that there are five questions that need to be answered in this research:

"Q 1: Is there evidence for change in the mechanism over the course of psychodynamic therapy?
Q2: Is change in the mechanism associated with symptom improvement?
Q3: Is change in mechanism associated

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with symptom improvement in specific subgroups but not in others?
Q4: Is change in mechanism associated with subsequent change in symptoms (evidence for temporal precedence)?
Q5: Is change in mechanism uniquely associated with one treatment modality?" (p 193)

They applied these questions to psychodynamic research about: reflective functioning; insight; defences; alliance as mechanisms, as well as a more complex change process studied by Luyten about epistemic trust and its relationship to the alliance and the patient's subsequent engagement in the therapy and their capacity to mentalize. What they suggested was that all of these things had some effects, but that it wasn't always clear what followed what. For example when looking at changes in defenses in patients sometimes it was the lessening of defenses that led to symptom change and, at other times, it was the other way round with symptom change leading to a lessening of defenses. In the case of reflective functioning, it was the amount of this at the beginning of therapy, rather than changes in it during therapy that were associated with symptomatic improvement. It seemed clear that focusing on micro-interactions gave richer and potentially more useful information about how therapy works than more periodic, or between-session, measurements.

"...There is also a need to develop clearer treatment goals and determine which outcome measures should be used to assess treatment efficacy"

They ended their review by saying that research into what makes psychodynamic psychotherapy work requires more clarity about how these mechanisms are defined, how they can be put into practice, how they can then be studied in action, and what language can be used to describe them"… There is also a need to develop clearer treatment goals and determine which outcome measures should be used to assess treatment efficacy". They go on: "Although there is a fairly wide agreement that symptomatic change is a desirable outcome of any treatment, there is still an ongoing debate regarding the other ways to define a treatment as a success." (p 197). They point to the idea of intermediate outcomes – the things that therapy changes and which lead (possibly) to symptom change – as the area to explore and they note that qualitative research that explores how people make sense of themselves and the course of the therapy is already providing a rich steam of information. Nilsson and colleagues (Nilsson et al., 2007) interviewed patients who had had either CBT or psychodynamic treatment, with equivalent results on outcome measures but who described their experience very differently: the CBT patients were satisfied because they now had the techniques to manage and solve problems in their lives; and the psychodynamic patients were happy that they could see a change in how they related to others and had increased their self-understanding.

Research says: it can be beneficial to the survival of psychoanalysis as a therapy to do research

The experience of Swiss and German psychotherapists is instructive in helping us think about the beneficial impact of research in analytic therapies. These countries have an insurance-based system of funding that pays for analytic therapy of approximately two years of three times a week, and a massive amount of data on a large amount of patients has been collected as a result. The importance of these data for Jungian psychotherapy, for example, have been huge. With the arrival of the evidence based movement in the early 1990s, there was a demand that non-evidence based therapies be dropped from the list of approved treatments in Germany and Switzerland, and Jungian psychotherapy was in the firing line as its collection of interesting case studies written by analysts and patients, were insufficient. Training centres in Zurich, and Berlin set up their own naturalistic studies and gathered evidence of the effectiveness of Jungian therapy over time and the threat to remove it from the list of approved therapies disappeared. As Christian Roesler put it:

> "All the studies show significant improvement not only on the level of symptoms and interpersonal problems, but also on the level of personality structure and in everyday life. These improvements also remain stable after the completion of therapy over a period of up to six years. Several studies show further improvements after the end of therapy. Health insurance data show that after Jungian therapy, patients' visits to doctors and hospitals

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> are reduced to a level even below the average of the total population. Results over several studies show that Jungian treatment moves patients from a level of severe symptoms to a level even below the cutoff where one can speak of psychological health."

He goes on: "These significant changes are reached by Jungian therapy with an average of 90 sessions [out of the 300 available], which makes Jungian psychotherapy an effective and cost-effective method. Process studies support Jungian theories on psychodynamics and elements of change in the therapeutic process." (Roesler, 2018, p 173).

One of the other consequences of the threat and how it was managed was that trainees in these centres had to learn about research and join in the study of their own interventions. Research around therapeutic change became embedded in the training, and the training institutes are combining data to form a large-enough dataset for inquiry. Roesler's conclusion is clear and salutary: "In the long run, this aims at creating a more open attitude to empirical research in the coming generations of Jungian analysts [and] aims at stabilising the currently comfortable position Jungian therapy has in the German health care system for the future by delivering empirical results about the effectiveness of the methods...' (p 184)

In the UK, with the dominance of NICE-determined recommendations for psychotherapies for specific disorders in the NHS, the kind of evidence produced by Jiménez and his colleagues in Ulm, the process studies reviewed by Minges, and the successful outcomes of Jungian therapies described by Roesler, are relevant only in the degree to which they give us cause for annoyance that NICE does not consider them as appropriate evidence.

This gives us three possible routes of travel. The first route is that we adopt the criteria required for NICE and do Randomized Controlled Trials for specific disorders with a very close eye on NICE's quality criteria. The more we publish – as long as they have enough participants – that compare a well-enough defined psychoanalytic psychotherapy with a well-enough defined alternative therapy, preferably CBT, the better for us. This doesn't seem attractive or particularly possible in our real life settings.
The second route is that we develop detailed case study reports like those mentioned by Mattias Desmet & Jochem Willemsen in the 2018 Phil Richardson Memorial Lecture on "The Return of the Case". They argued for a tight design in which change can be shown to be attributable to the therapy provided and that alternative sources of change can be ruled-out. The Association for Child Psychotherapy and the Association for Psychoanalytic Psychotherapy in the NHS Education Trust have established criteria for 'Evidence Based Psychoanalytic Case Study', which can be with any of our particular client groups. The fact remains, though, that most BPC clinicians are not going to do these kinds of single case studies, just as they are not going to do RCTs. So what is left of research to benefit from? The third route, based on the idea that some therapists are more effective than others, is 'Deliberate Practice' (Rousmaniere et al., 2017).

Research says: get better at what you do (whatever it is)

Scott Millar and colleagues have recently pointed out that the outcomes of therapy have not improved on average over the past 40 years, even though we've had RCTs, Evidence-based Therapies, the development of hundreds of specialist therapies as well as the increasing demands of training, supervision, and CPD requirements (Miller et al., 2018). This lack of improvement is not the same as in other fields and they suggest we individually raise our game, by systematically identifying which interactions with patients we do badly and repeatedly practicing them until we can do them better. Mark Hilsenroth and Marc Diener have outlined a model for psychoanalytic supervision that develops this for our field, including the supervision of trainees (Hilsenroth and Diener, 2017).

"the potential impact of research on our field of psychoanalytic psychotherapy is huge"

In summary: the potential impact of research on our field of psychoanalytic psychotherapy is huge, but it is not always going to be in the way we think it will be, or the way that we like. ■

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References

Fonagy, P. (2015) 'The effectiveness of psychodynamic psychotherapies: An update', *World Psychiatry*, 14(2), pp. 137-150.

Hilsenroth, M. J. and Diener, M., J (2017) 'Some effective strategies for the supervision of psychodynamic psychotherapy', in Rousmaniere, T., Goodyear, R.K., Miller, S.D. & Wampold, B.E. (eds.) *The Cycle of Excellence. Using Deliberate Practice To improve Supervision And Therapy*. Chichester: John Wiley and Sons, pp. 163-188.

Hinshelwood, R. D. (2013) *Research on the couch. single-case studies, subjectivity and psychoanalytic knowledge*. Hove: Routledge.

Jiménez, J. P. (2005) 'The Search for Integration or How to Work as a Pluralist Psychoanalyst', *Psychoanalytic Inquiry*, 25(5), pp. 602-634.

Jiménez, J. P. (2007) 'Can research influence clinical practice?', *International Journal of Psycho-Analysis*, 88, pp. 661-679.

Kächele, H., Schachter, J. and Thomä, H. (2009) *From Psychoanalytic Narrative to Empirical Single Case Research. Implications for Psychoanalytic Practice*. New York & Hove: Routledge.

Leichsenring, F., Luyten, P., Hilsenroth, M. J., Abbass, A., Barber, J. P., Keefe, J. R., Leweke, F., Rabung, S. and Steinert, C. (2015) 'Psychodynamic therapy meets evidence-based medicine: a systematic review using updated criteria', *Lancet Psychiatry*, 2, pp. 648-60.

Leichsenring, F. and Rabung, S. (2008) 'The effectiveness of long-term psychodynamic psychotherapy: a meta-analysis', *Journal of the American Medical Association*, 300(13), pp. 1551-1565.

Miller, S. D., Hubble, M. A. and Chow, D. L. (2018) 'The quesstion of expertise in psychotherapy', *Journal of Expertise*, 1(2), pp. 121-129.

Minges, M. V., Solomonov, N. and Barber, J. P. (2017) 'What makes psychodynamic psychotherapy work? A review of five perspectives', *Psychoanalytic Inquiry*, 37(3), pp. 191-201.

Nilsson, T., Svensson, M., Sandwell, R. and Clinton, D. (2007) 'Patients' experiences of change on cognitive-behavioural therapy and psychodynamic therapy: A qualitative comparative study', *Psychotherapy Research*, 17, pp. 553-566.

Roesler, C. (2018) 'Research on the effectiveness of Jungian psychotherapy: State of the art', in Roesler, C. (ed.) *Research in Analytical Psychology. Empirical Research*. London: Routledge, pp. 173-186.

Rousmaniere, T., Goodyear, R. K., Miller, S. D. and Wampold, B. E. (eds.) (2017) *The Cycle of Excellence. Using Deliberate Practice To Improve Supervision And Therapy*. Chichester: John Wiley and Sons.

Wampold, B. E. and Imel, Z. E. (2015) *The great psychotherapy debate: The evidence for what makes psychotherapy work*. 2nd edn. New York: Routledge.

Working with Research Ambivalence: response to David Hewison

By Ann Scott

David Hewison has astutely identified aspects of our ambivalent response to research in our field. In this brief response I want to speak to that ambivalence with a word about my experience, over a number of years, of teaching research seminars to psychotherapy trainees. There my consistent experience was of encountering ambivalence (if not negativity) at the outset, and of observing a significant shift over the life of the modules. I want to suggest that it is by engaging with trainees' negativity, while standing firm over a commitment to research, that it is possible to work through a large part of the ambivalence and reach a state of mind, in the group, in which trainees become curious about what research has to offer. It is a curiosity that allows them to cathect a new object (research), and to begin to identify with that offering.

I'll illustrate this with a brief sketch of my teaching experience in one of the settings in which I have worked. I would always start with a 'gathering in' of views about research. These ranged from 'a fear it might tell me something I don't want to hear' (Hewison's point exactly), to 'it's difficult to digest and can be dry', to 'research measures what's measurable and it can be harmful and distorts reality'. If, however, I stood my ground and illustrated research-mindedness in practice by means of a series of exercises in the seminars and selected empirical studies from the analytic literature, it was almost always the case that trainees' attitudes would modify. In five-week modules I saw significant changes in the inner stance towards research, a much greater openness to its language and its conventions. The idea of a difference between anecdotal evidence and a systematic study began to embed, as did the idea of a knowledge gap. By asking (and discussing) a series of questions, it was possible to work through much of the ambivalence and negativity

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that characterized the start of the seminars. How can we link a 'mass of data' with your individual experience as a therapist? Does audit data from your training organisation unsettle you? Does the audit capture the nature of the work?

"I saw significant changes in the inner stance towards research"

Qualitative papers from recent analytic journals consolidated the students' understanding that knowledge could be meaningful outside the dyad. A paper on pre-assessment questionnaires as a predictor of psychotherapy engagement, which introduced students to a way of using the type of clinical data they routinely saw in their own organisation, gave them the tools to design a small study. Interesting proposals were put forward, with research questions such as: 'Does a therapist's break provoke clients into threatening termination or actually finishing their therapy abruptly?'; 'How useful is the verbatim text as a learning tool in psychotherapy training?'; 'How does a change in the therapist's appearance change the dynamics of the session?'; 'What are the unspoken concerns that trainees are left with at the end of a supervision session, in the first two years of training?'

What characterized these imagined studies was a capacity to think outside the dyad, while using the experience of the dyad as a crucial starting-point, and deploying a research language in doing so. Such topics – and their wordings – showed how far the trainees had moved, from their initial reservations and mistrust.

At the same time, of course, concerns might remain (research can be 'dry'). So it is important to bear in mind that in the closing panel of PP NOW 2018, Stephen Grosz argued powerfully that it is 'the capacity to convey "being there"' – in the room, in a 'highly specific, saturated' way – that is what convinces us about a clinical account. If this essential principle is held in mind when planning, executing and writing up analytic research, a research account should be equally convincing. ■

Ann Scott is a Senior Member of the British Psychotherapy Foundation (Psychoanalytic Psychotherapy Association), in private practice. She is Editor-in-Chief of the British Journal of Psychotherapy. *A member of the BPC's Research and Evidence Base Advisory Group, she taught seminars on research awareness to trainees of the BAP/BPF and WPF Therapy over a number of years.*

This account appears with the permission of the training organisation concerned.

Editorial

Ensuring what we do makes a difference

By Gary Fereday

Research, evidence and supporting innovation is something that the BPC takes very seriously and is something we want to put at the heart of what we do.

Yet our psychoanalytic profession has not always valued research or measuring outcomes. Indeed, it has, at times, appeared to view research and evidence as almost antithetical to psychoanalytic thinking.

However, things are changing and the BPC is looking to drive and support this change. Our flagship PP NOW 2018 conference and this edition of *New Associations* are part of that work.

My own experience of working with the profession for over a decade has suggested to me some of the reasons that research and evidence isn't as central as it should be. The reasons are complex and mixed but I often characterise them into three main concerns:

1. that, as research usually requires asking patients how they feel, this will interfere with the therapy.

2. that it undermines professional integrity, questioning whether individual clinicians are any good themselves.

3. that measuring outcomes is bureaucratic managerialism and cannot capture what psychoanalytic psychotherapy is about.

When the American psychiatrist, Dr Robert Spitzer, was commissioned in the 1970s to produce the third edition of

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the *American Psychiatric Association's Diagnostics and Statistics Manual of Mental Disorders* (DSM-3) almost all mention of psychoanalytic principles disappeared at the expense of 'evidenced' pharmacological treatments.

Published in 1980, DSM-3 was (and still is) highly controversial but the reality was that the psychoanalytic profession hadn't marshalled its evidence sufficiently to make its case. The publication of DSM-3 arguably was a key driver of the retreat of the profession in the USA and a similar retreat here in the UK.

Interestingly, Robert Spitzer had trained as a psychoanalyst yet, the story goes, he had become so disillusioned he drove out all mention of psychoanalytic principles and installed what he saw as evidence-based concepts in their place.

Thirty years later, in 2010, a psychologist and academic from the University of Colorado, Jonathan Shedler, published an article in the *American Psychologist*, entitled 'The Efficacy of Psychodynamic Psychotherapy'. The paper concluded that: "The perception that psychodynamic approaches lack empirical support does not accord with available scientific evidence and may reflect selective dissemination of research findings."

The article, of course, went on to become acclaimed as a seminal paper that started to establish psychodynamic psychotherapy as an evidence-based treatment. Jonathan gave a powerful key-note presentation at the PP NOW 2018 conference, convincingly arguing that the evidence is very clear. He is also 'in conversation' with BPC Registrant Dr Jessica Yakeley, in this edition of *New Associations*.

This edition's lead article, by Dr David Hewison, eloquently explores the impact of research on psychoanalytic psychotherapy. David spoke on the subject at PP NOW 2018 in a wide-ranging and highly thought-provoking presentation.

The BPC has an Advisory Committee on Research and Evidence, chaired by the Director of the Portman Clinic, Dr Jessica Yakeley. The Committee includes a number of other senior BPC registrants, including Ann Scott, Editor of the *British Journal of Psychotherapy*, who responds to David Hewison's lead article. The Committee provide expert advice to the BPC on the latest developments in research and produced a series of briefing papers for Registrants. This edition of *New Associations* and the PP NOW 2018 conference very much come out of the work of the Committee.

The BPC is also a partner in the coalition of organisations that came together to lobby NICE about their guidance for the treatment of depression in adults. The BPC, along with our coalition partners, has serious reservations about the methodology that NICE used. Methodology that resulted in CBT again being the preferred treatment of choice at the expense of others.

"we have to conduct research and understand our evidence base"

The coalition, led by Dr Felicitas Rost, President of the UK Chapter of the Society for Psychotherapy Research, has succeeded in making NICE rethink the guidance and, in an unprecedented move, NICE have delayed publication to consider the issues the coalition has raised. Felicitas and Dr Susan McPhearson, senior lecturer at the University of Essex, provide an update on that campaign in the news section.

The BPC is solely psychoanalytic/psychodynamic in our outlook and so uniquely placed to make the case for our modality. We will be increasingly looking to better promote the work our Registrants do. We will do so in partnership with others so that we can help the public, the media, policy makers and commissioners understand what psychoanalytic and psychodynamic psychotherapy is and how it is a crucial modality in a wider range of psychological therapies. Therapies that need to be available if we are to respond to the huge unmet psychological distress in our society.

But, to make our case, to drive innovation in service delivery and be clear when psychoanalytic interventions are the best intervention, we have to conduct research and understand our evidence base. The BPC will look to support our profession to do this. ■

Gary Fereday
Chief Executive

Practice Today

Psychotherapy and the NHS

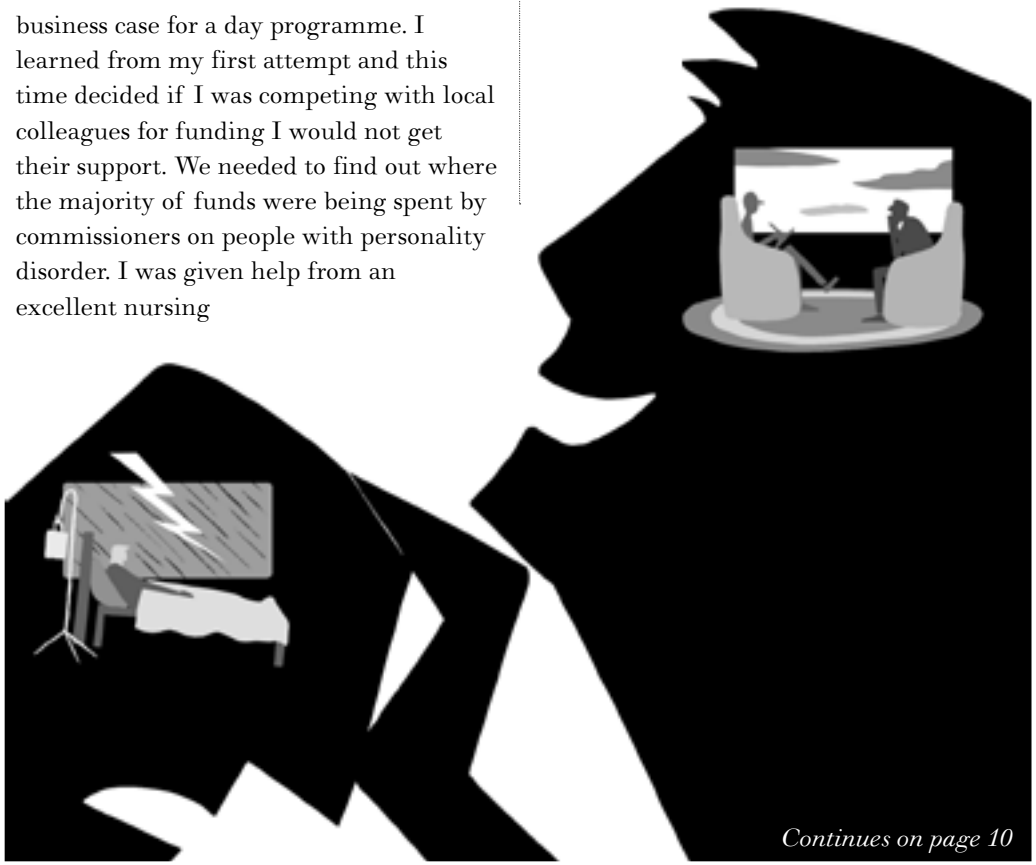
By Sue Mizen

The working life of a psychotherapist in the NHS

Most psychoanalytic psychotherapists will have had some experience of working in the NHS, either as honorary psychotherapists during their training or in adult psychotherapy, psychology or medical psychotherapy posts once qualified. Those of us who have worked in the NHS over the past 30 years have witnessed a huge change in culture. I trained at the Society of Analytical Psychology and the Cassel Hospital and have worked as a Consultant Psychiatrist in Psychotherapy (Medical Psychotherapist) for 21 years at Charing Cross Hospital and then Exeter. In Fulham,the psychotherapy department, staffed by myself and the equivalent of three full time psychotherapists, served the population of Hammersmith, Fulham, Shepherds Bush and White City. It was quickly clear that about 2/3 of the patients referred had personality disorders as severe as those I had worked with at the Cassel but with little or no access to a similar level of therapeutic help. Even at that time it was clear to me that I was likely to spend most of my working life seeing people that I knew I did not have the resources to help. So I wrote a business case for a psychotherapeutic day hospital spelling out what it would cost to run and the savings that would be made across the system through reduced service use elsewhere in the mental health system.

Making the case for developing therapeutic services

The commissioners were very interested in the economic side of this proposal but my psychiatric colleagues were rightly apprehensive that a redistribution of funds to a new therapeutic programme would reduce their already limited resources. At around that time I moved to Exeter to a consultant post in the psychotherapy service. The same limitations of resources existed there and I was surprised to find that personality disorder was no less common in a rural population. The Chief Executive asked me to write another business case for a day programme. I learned from my first attempt and this time decided if I was competing with local colleagues for funding I would not get their support. We needed to find out where the majority of funds were being spent by commissioners on people with personality disorder. I was given help from an excellent nursing colleague to find the highest cost patients with personality disorder across the whole health and social care system in Devon. As an example we found the 55 people who attended the local district hospital most frequently with psychosomatic complaints. We found that the cost of the lifetime service use of these 55 people was £6.2m. I studied these 55 patients in detail and had seen most of them for psychotherapy



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assessments. I discovered 70% of those had an underlying personality disorder. It is well known that such long term psychosomatic presentations are commonly associated with traumatic childhoods and sexual abuse, my study confirmed this. A more surprising finding was that about a third of these 55 people had been young carers looking after mentally or physically unwell relatives during childhood. They went on to work in the 'caring professions' and at some point this became unsustainable and they became patients in the form of chronic severe psychosomatic complaints.

"Psychotherapists have an enormously valuable contribution to make to the NHS but we have to be able to demonstrate that value to those who have difficult decisions to make about the health and social care priorities"

We also looked at those patients who were sent to locked therapeutic placements out of area for personality disorder. At that time the commissioners were spending £5.6m per annum on these placements for people with personality disorder. Once they left hospital the local services, starved of resources had little to offer them so admissions were long and outcomes poor.

Finally after a decade of trial and error the health economic argument won the day and the commissioners offered us £1.5m per year to fund a psychodynamic day and outpatient programme as an alternative to locked out of area placements. The programme opened in 2011 and has been running for seven years. Personally speaking, I have to say designing it, setting it up, establishing the staff team, and therapeutic culture from scratch and then keeping it open in the face of the numerous threats of closure and cuts is probably the most difficult thing I have ever done. It has also been the most interesting. The therapeutic team made up of psychosocial practitioners (psychodynamically trained and supervised mental health staff) adult psychotherapists, group analysts, family therapists and cognitive analytic therapists undertake the daily demanding task of providing a containing setting and psychotherapy for patients who under other circumstances would be inpatients. They are at times determined to destroy themselves, often responding to voices especially when talking to their therapists. On top of their suicidality they commonly suffer from anorexia and psychosomatic symptoms, some are using drugs and alcohol and others are on the autistic spectrum.

Developing a therapeutic model

This combination of risk and complexity would exclude them from most psychotherapeutic help and most specialist units. Such units are designed to work with one diagnosis at a time not all of them together. Even the Cassel Hospital where I trained would not accept either those who are acting on their suicidal feelings to an extent they could not leave hospital nor those who were restricting their food intake to this extent. So we set out to adapt the therapeutic model at the Cassel to treat the patients we had been commissioned to provide a service for. I have called the new model the Relational Affective Model. In short it is based on a combination of current neuroscience findings and psychoanalytic theory, particularly Ron Britton's thinking about projective identification. The model describes the contributions from neurobiological deficits, disordered relating during development and psychodynamic defences to the complex presentations of the most severely troubled PD patients (Mizen, 2015). It also sets out the adaptations of technique and the model of team work required to contain intense anxieties, spitting and projection in the therapeutic team. We have treated 240 patients since the service opened and have learned from our experience. We have some preliminary outcome data all of which shows positive change and reduced dependence on services.

Of relevance to the work of the Talking Therapies Task Force (below) an important finding is that the service has reduced the number of patients treated out of area from its peak in 2010 of 37 patients to the lowest point in 2016 of 7. This represents a saving of around £4 for every £1 invested in the service. We are undertaking a fuller health economic analysis of the service for publication. For the future we need to write a practice guide (manual)

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describing the model so that we can conduct a clinical trial.

Why psychotherapy services in the NHS are in decline

The 2014 BPC/UKCP survey established that waiting times for therapy in the NHS had increased along with the complexity of cases. More services had been closed, psychotherapists were being appointed with less experience and senior posts were being cut along with the time allocated for supervision. Those currently working in the NHS will be all too aware that since 2014 services have faced 20% cuts annually, whilst the need for psychotherapeutic help particularly amongst young people has significantly increased. This is a depressing picture but to understand how it has come about and what might be done to remedy it we have to get to grips with some rather dry facts. During the 2015 and 2017 general election campaigns when the question of public sector psychotherapy provision was raised, politicians offered just one response; the increased investment in IAPT services was one of the good news stories for mental health. It was as though the gap in therapeutic provision for people with severe mental health problems was invisible. Indeed within the current operational framework in health services the problem remains invisible. Where in the past services were set up on the basis of local initiatives and interest, now a national framework identifies commissioning and strategic priorities organised centrally at NHS England, and delivery of those priorities being devolved to local commissioners.

If psychotherapy services are to be commissioned the patients they serve must be identified as a priority in the next NHS England Ten Year Forward View which will be implemented in 2020/21. If the current commissioning arrangements are still in place local commissioners will be left to decide how this is to be achieved. They will be more inclined to do so if services are recognised to be clinically effective, helping them meet the budget shortfalls and if services measure activity and outcomes. Commissioners will fund services which they can be confident they can recruit to, so local therapy training programmes and a register of trained psychotherapists is important. This is the national infrastructure IAPT (Improving Access to Psychological Therapies) developed when it was first funded. This infrastructure and the strength of outcome research in CBT means that whenever investment in psychological therapies is considered IAPT is really the only option considered. Whatever doubts may be expressed about their outcomes, this is a success story and we must learn from it.

The Talking Therapies Task Force

In 2016 six leading psychotherapy and counselling bodies (APP, BACP, BPC, the Medical Psychotherapy Faculty at the RCPsych, SPR the UKCP*) came together to form the Talking Therapies Task Force (TTTF). The aim was to form an organisation large enough to develop a national infrastructure to promote the commissioning of psychotherapy for people with complex mental health needs. The first priority was to develop the health economic case for investment just as Richard Layard did in 2006. Some preliminary evidence suggested that a few patients with severe attachment disorders were admitted to mental and physical health beds for greatly extended periods. It was suspected significant funds were expended on these admissions with little therapeutic benefit. We wanted to make the case for investment in psychotherapy for this most complex group because if their outcome improved the money saved could then be reinvested in psychological therapies for others. The TTTF has been meeting for two years. We are undertaking a Health Economic study locating the high cost outliers in one rural and one urban Mental Health Trust and have commissioned the Centre for Mental Health to write a report. The first results indicate expenditure in excess of £40m on two hundred high cost patients. The report is due for publication in the summer of 2019. The next step will be to provide evidence that psychotherapy services adapted to the needs of such complex patients can safely and effectively provide an alternative to long term hospitalisation. We are currently designing the study to demonstrate this and gathering evidence from sites which are undertaking this work.

We are working on developing the National Data Collection system. We have been meeting with the providers of platforms for outcomes measurement and national experts who have developed the systems currently in use. We plan to put together a specification for the system during the coming year. We have started to think about the competence framework required to develop a national register of qualified and competent psychotherapeutic practitioners.

We have been meeting with politicians to inform them of our work which has

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attracted considerable interest. Our political strategy will have expanded as we approach the launch of the first health economic report. Finally, we cannot undertake all of these projects without funds. The Cassel Hospital Charitable Trust has just joined us as the seventh member organisation and we are about to start fund raising to pay for our research, the data collection system and the costs of developing a website and establishing a presence on social media.

Had someone told me when I started chairing the Task Force two years ago that we would have made such progress I would not have believed it. All six organisations have collaborated with great commitment and energy. I think we are all aware of the parlous state services are in and that patients in serious difficulty are unable to get help no matter how extreme their circumstances.

Psychotherapists have an enormously valuable contribution to make to the NHS but we have to be able to demonstrate that value to those who have difficult decisions to make about the health and social care priorities. We also have to make ourselves heard amongst a noisy crowd of articulate advocates for other important causes. Finding the right argument, the evidence to support it and making sure it reaches the right audience is key. We have reason to hope we are on the right track.

*The Association for Psychoanalytic Psychotherapy in the NHS, The British Association for Counselling and Psychotherapy, The British Psychoanalytic Council, The Medical Psychotherapy Faculty at the Royal College of Psychiatrists, The Society for Psychotherapy Research, The UK Council for Psychotherapy. ■

Sue Mizen is a Consultant Medical Psychotherapist and SAP Jungian Analyst, currently leads the Devon Personality Disorder Service and is developing a neuroscientific psychotherapeutic Relational Affective Model, for teams working with people with severe Personality Disorder. She is the Chair of the Medical Psychotherapy Faculty at the RCPsych and the Talking Therapies Task Force.

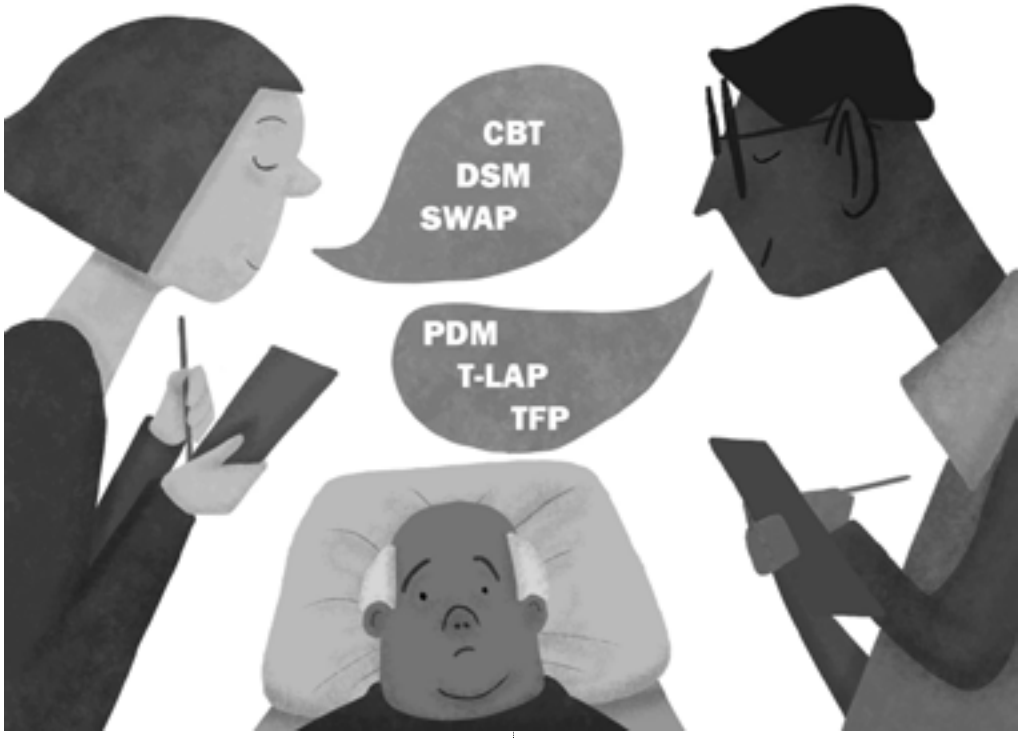
Reference

Mizen, C. S. (2015) Neuroscience, mind and meaning: an attempt at synthesis in a Relational Affective Hypothesis. *Psychoanalytic Psychotherapy* 29: 4. 363-381.

In Conversation With

Jonathan Shedler on Evidence and the Profession at Large

Jessica Yakeley in conversation with Jonathan Shedler



Jessica Yakeley *Your 2010 paper in the journal* American Psychologist *'The evidence for psychodynamic psychotherapy' has received international acclaim and continues to be much cited. How did you become interested in research in this area?*

Jonathan Shedler I was fed up with the false narrative that we hear over and over, that psychoanalytic therapy has been scientifically discredited and so-called evidence-based therapy is scientifically proven and superior. I knew the research, and I knew that the public, policy makers, and mental health professionals were being sold a bill of goods. I also knew from first-hand experience that "evidence-based" therapy – which is typically a code word for brief, manualized CBT – fails enormous numbers of patients. I was supervising in a university-based psychiatry clinic and saw them every day. Someone needed to set the record straight.

There is also a personal backstory. I was disillusioned with the academic world and done writing journal articles. It is thankless work, for reasons I could go on about. Bob Wallerstein, with whom I worked on the first edition of the *Psychodynamic Diagnostic Manual* (PDM), asked me to write an article on psychoanalytic outcome research, supposedly for a special issue of *American Psychologist* on psychoanalysis. I told him I was done writing journal articles and declined.

He called me every week, for months. In the end, I relented. I took on the project, more out of a sense of obligation to the profession than anything else. I gave the project an acronym, T-LAP, which stands for The Last Academic Paper. That's still how I refer to it with friends.

One more irony is that *American Psychologist* never intended to publish a special issue on anything psychoanalytic. It was all a misunderstanding. The other papers submitted with mine were shot down immediately. There was such prejudice against anything psychoanalytic that the journal could not even find an editor willing to handle my manuscript. Psychoanalysis is so marginalized that mainstream journals don't publish papers on psychoanalytic topics. T-LAP was a unicorn.

JY *How would you describe the current state of research in psychoanalytic and psychodynamic psychotherapy?*

JS There's excellent work being done by a number of psychoanalytic researchers. But we still don't have a culture in psychoanalysis that is genuinely supportive of research. Few psychoanalysts read the research – even those who speak of its importance. Some analysts say research is important, not because they see intrinsic value in contributing to psychoanalytic knowledge, but only to justify ourselves to outsiders. Psychoanalytic researchers sometimes walk a lonely road. They are marginalized in the academic world

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where "everyone knows" psychoanalysis is not a legitimate research topic, and they are viewed as outsiders by some in the psychoanalytic community: not really "one of us."

JY *In the UK, all NHS services are required by commissioners to carry out on-going outcome monitoring to demonstrate the safety, quality and effectiveness of their treatments. This can present difficulties for psychotherapy services, not just in the time and expertise that is necessary, but also in making outcome monitoring into a meaningful exercise, rather than just something carried out to satisfy commissioners. As you know, at the Portman Clinic, with your guidance, we have been using the SWAP and have found it very informative as a diagnostic and outcome measure of personality disorder and traits for our particular population of patients with paraphilias. The positive results that we have achieved to date in demonstrating that over the course of long-term treatment the majority of patients show improvement in the severity of personality pathology has helped in ensuring the on-going commissioning of our psychoanalytic psychotherapy service. We see this as an example of practice-based evidence as opposed to evidence-based practice. How would you encourage psychoanalytic and psychodynamic practitioners to become more involved in modest pieces of research like this given all the pressures of managing and delivering services?*

"Psychoanalysts will start to see outcome research as meaningful when, and only when, we assess outcome in ways that are relevant to what we do"

JS You've put your finger on it. Many psychoanalytic clinicians approach outcome research holding their noses, and with good reason. One problem is that there is often a profound mismatch between the aims of psychoanalytic therapy and outcome measures used in research. The outcome measures tend to focus on acute symptoms – for example, DSM diagnostic criteria – and little else.

Psychoanalytic therapy has other goals. We are trying to change underlying psychological processes – what psychoanalysts have historically called "structural change." When psychoanalytic treatment is successful, it is not just symptoms that change, the person changes. The person becomes a different and better version of himself – someone more comfortable in his own skin, someone who is able to live life more freely and more richly. Psychoanalysts will start to see outcome research as meaningful when, and only when, we assess outcome in ways that are relevant to what we do.

Your research at the Portman clinic is a wonderful example of psychoanalytically-relevant outcome research. You are using the Shedler-Westen Assessment Procedure (SWAP), which my co-author Drew Westen and I developed to assess personality in psychoanalytically-meaningful ways. The SWAP is not a questionnaire completed by patients. It is an instrument completed by a clinician, based on the clinician's in-depth understanding of a patient. The SWAP assesses unconscious mental life reliably and validly. For example, it addresses intrapsychic conflict, defences, fantasy life, compromise formations, unconscious motives, internal and external object relations, transference propensities, self-experience, and ego strengths and deficits, among other things.

When we study the outcome of psychoanalytic therapy with the SWAP, we see things like reduction in intrapsychic conflict, a shift from relatively rigid and primitive defences to more mature and flexible defences, more integrated self- and object-representations, development of healthy psychological resources and capacities, and so on. These intrapsychic changes dovetail with outwardly observable changes.

Ultimately, research must help us to understand our patients more deeply and work more effectively. If not, what is the point?

JY *Coming to your clinical work as a therapist yourself, what would you describe is your theoretical orientation? In the UK, although there has been much emphasis on the plurality of psychoanalytic theoretical schools, arguably Kleinian and post-Kleinian ideas continue to exert the most influence within psychoanalytic training, at the expense of other approaches such as the British Contemporary Freudian or Independent traditions. Moreover,*

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in my experience, although the work of Otto Kernberg is well known, many psychotherapy trainees here have little exposure to other psychoanalytic schools that have been prominent in the US such as ego psychology and self psychology, let alone developments that have emerged in more recent years such as the relational or intersubjective schools of psychoanalysis. Do such theoretical distinctions sound to you like the narcissism of small differences, or have they been relevant to your own training and practice?

JS It is hard to think of anything more destructive to our profession than this idea that we should choose a theoretical orientation. Critical thinking comes to an end when ideas are no longer considered on their own merits but instead become litmus tests of group loyalty or signifiers of ingroup/outgroup status. That is not scholarship, that is tribalism.

New theories arise to address limitations of existing theories. As analysts encountered new clinical phenomena, they developed new theories to address them. We can and should ask, which theoretical concepts fit this particular patient at this particular juncture and why? Are we dealing primarily with intrapsychic conflict? With unintegrated or malevolent self- and object representations? With difficulty maintaining a coherent or positively valued sense of self? The more versatile we are with respect to theory, the more effective we can be with a broader range of patients.

Unfortunately, theoretical concepts that were originally developed to address specific kinds of patients and issues morphed into all-encompassing theories and became schools and movements. These movements arose in reaction against existing orthodoxies but then they became new orthodoxies. This pattern has been strikingly cyclical.

When our own identities become too closely tied to a theoretical orientation, we run the risk of forcing patients into the Procrustean bed of our preferred theory, whether it fits or not.

JY *You describe yourself on your website as a psychodynamic psychotherapist rather than a psychoanalytic psychotherapist. Why is this, and how would you explain the difference between psychoanalytic psychotherapy and psychodynamic psychotherapy, which may be confusing for the general public?*

JS I use the terms psychodynamic and psychoanalytic interchangeably. Most people don't know the history of the term psychodynamic. It became widespread in the U.S. after a conference on medical education after World War II, where it was used as a synonym for psychoanalytic. I am told that the intent of those who adopted the term was to secure a place for psychoanalytic education in psychiatry residencies without unduly alarming American training directors who may have regarded "psychoanalysis" with some apprehension. In short, the term psychodynamic was something of a ruse.

Unfortunately, the term psychoanalytic has taken on negative connotations for large segments of the public. It does not mean to them what it means to us. It conjures up negative stereotypes and pejorative preconceptions. When I communicate with the public, I tend to use the term psychodynamic. When I communicate with colleagues, I am more likely to say psychoanalytic.

JY *Linked to this, there are many different therapeutic modalities, often identified by three letter acronyms or 'brand names', that may be classified under the broad umbrella of psychodynamic psychotherapy, particularly for research purposes. However, this may also leave patients as well as many psychotherapists, including myself, confused as to the merits of one psychodynamic psychotherapy over another. Do you think this is a helpful situation?*

JS We have an alphabet soup of non-analytic therapies that are known by three- and four-letter acronyms. Frankly, it's an embarrassment. Surely, there are not so many completely distinct approaches to treatment. I would feel better if students of psychotherapy mastered foundational principles and built on that foundation.

As for psychoanalytic/psychodynamic "brands", it is possible to group them under broad themes or currents of psychoanalytic thought. A solid background in the major currents of psychoanalytic theory – drive theory, ego psychology, object relations, self-psychology, relational psychanalysis – provides a framework to understand how the treatments fit in the bigger picture. Each brand offers its own emphasis and vantage point, but there is value in thinking about them integratively, as parts of a whole. Instead of thinking of competing voices, we could think of them as elements of a symphony.
Here's an example of what I mean by

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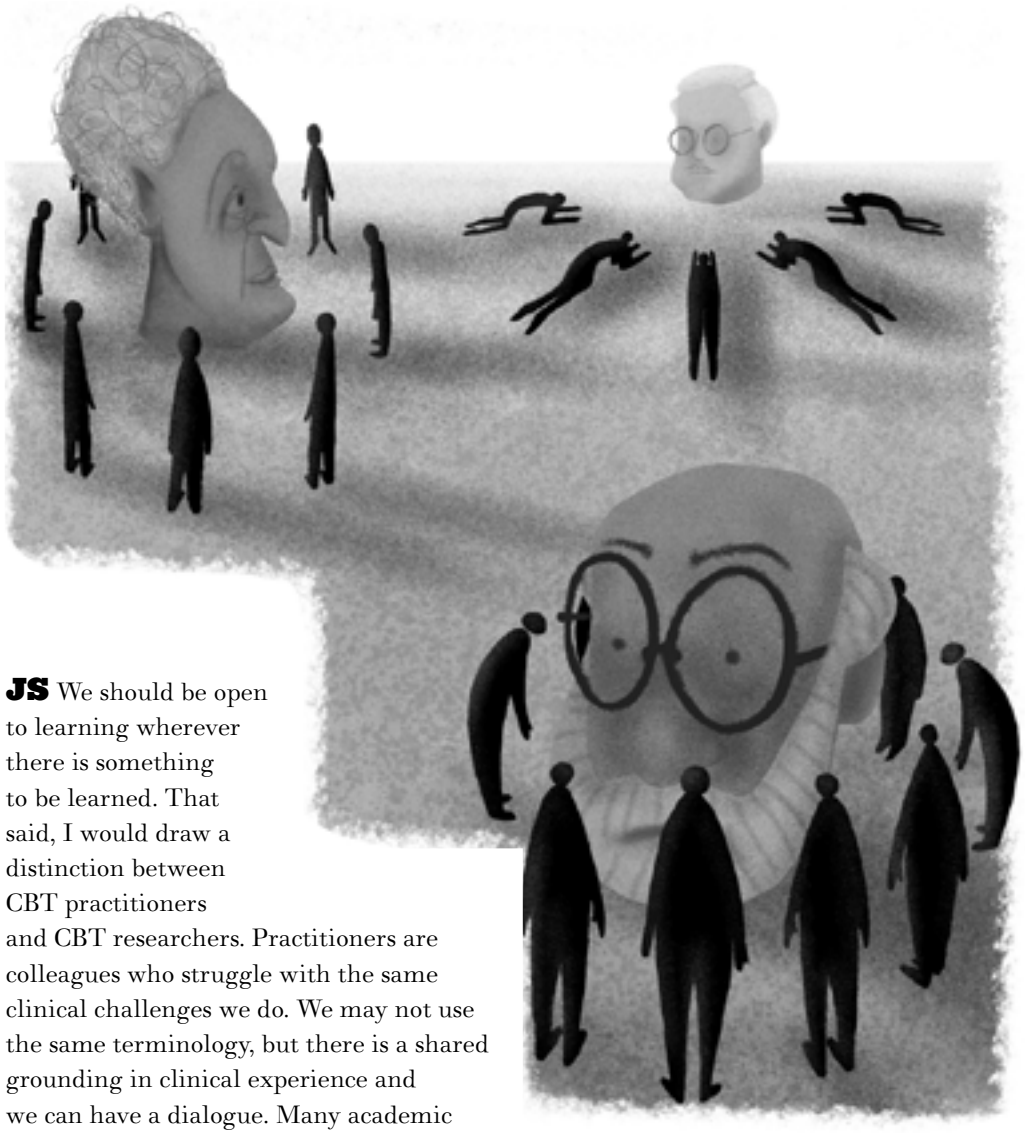
integrative. The concept of splitting is central to Kernberg's object relations approach to severe personality pathology (which they now call Transference Focused Psychotherapy or TFP). Many relational psychoanalysts detest the concept of splitting but embrace the concept of "dissociated self-states". Now there's something to think about. Are they describing the same phenomena or something fundamentally different? What do we gain or lose by adopting the terminology of one model versus another? Different analysts may come to different answers but I think there is value in wrestling with the questions.

This kind of integrative thinking underlies the SWAP instrument. We made a point of including the theoretical concepts of all of the major psychoanalytic traditions and expressing them in clear, jargon-free English. This allows us to study psychoanalytic concepts in ways that cut across theoretical divides.

But I realise I haven't answered your question. You asked if the emergence of psychodynamic/psychoanalytic therapy brands is helpful. I'm of two minds. It contributes to a certain amount of confusion. On the other hand, much of our psychoanalytic terminology is so off-putting to students and trainees that they turn off as soon as they hear it. Our language is the opposite of user-friendly. We end up alienating trainees who would otherwise be interested in our ideas. To reach future generations, we may well have to find new ways of communicating. One reason trainees gravitate to CBT is that it is simple to grasp. Beginning therapists are anxious and often desperate for structure of any kind.

"To reach future generations, we may well have to find new ways of communicating"

JY *Do you think that we as psychoanalytic and psychodynamic psychotherapists can be too dismissive of CBT without acknowledging its significant benefits for some patients, as well as emerging areas of overlap with psychodynamic psychotherapy in theory and technique?*



JS We should be open to learning wherever there is something to be learned. That said, I would draw a distinction between CBT practitioners and CBT researchers. Practitioners are colleagues who struggle with the same clinical challenges we do. We may not use the same terminology, but there is a shared grounding in clinical experience and we can have a dialogue. Many academic researchers, on the other hand, have little meaningful practice experience. They are the ones pushing for brief, one-size-fits-all manualized therapies. Some are openly disdainful of the notion of clinical expertise. Their vision for the future of psychotherapy is one where treatment is delivered by minimally-trained technicians who follow instruction manuals.

I take the "10,000 hour rule" seriously – the finding that it takes 10,000 hours of practice experience to develop mastery.

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This is true for musical performance, athletic performance, writing, computer programming, and pretty much every other skilled activity that researchers have studied. The idea was popularized in the book Outliers by Malcolm Gladwell. Ten thousand hours of experience does not guarantee mastery but it is a prerequisite. A real clinician with 10,000 hours of practice experience is a colleague who probably knows something I can learn. An academic researcher with no meaningful practice experience? I'm not so sure.

JY *In relation to differences in psychotherapeutic technique, a controversial issue that has gained prominence over the past 20 years or so is the use of the therapist's self-disclosure in relation to their countertransference to the patient. In your 2015 article in* Psychology Today, *'The therapy relationship in psychodynamic therapy versus CBT', you give a brief vignette of a woman who is seeking therapy, whom you describe as elegant, educated and successful but who has not being able to achieve an intimate relationship and who suffers from depression. She has attempted therapy several times but reports it has never really changed anything, and her therapists always end up wanting her approval. You state that colleagues trained in CBT and other "evidence-based" therapies rarely attach much significance to patients' comments about their past therapy relationships.*

If I may quote you, you state "Some venture that Caroline may need a "secure" therapist who won't be intimidated by her looks or status. From a psychodynamic perspective, it is irrelevant whether Caroline's therapist is personally secure or insecure. She doesn't need a secure therapist. She needs a therapist with the self-awareness and courage to notice that twinge of insecurity in Caroline's presence, treat it as information, and use it in the service of understanding.

Such a therapist might say: "You know, you have come here for my help and yet in many of our interactions, I am aware of a vague feeling of wanting to impress you or gain your approval, which of course doesn't help you at all. I'm trying to figure out what it means, and whether it could be a window into understanding something about what happens in your relationships more generally. Perhaps this is something that feels familiar to you."

In this vignette, you directly reveal to the patient the feeling that is evoked in you by her i.e. a feeling arising from your countertransference. I think many BPC therapists would hesitate to speak openly of their countertransference feelings about the patient to the patient, but instead use these feelings, and subsequent understanding, about her object relationships to inform an interpretation such as "I wonder whether you worry that I might want to impress you or seek your approval like you feel your previous therapists did" which doesn't expose the therapist's own feelings. These differences in technique may sound subtle but I think they are important and may be a source of confusion, particularly for therapists in training, and so I would be very interested in your thoughts on this, and the rationale as to why the therapist's self-disclosure here might be more effective as a therapeutic intervention than a transference interpretation in which there is no self-disclosure.

JS There was a time when I would not have disclosed what I did, and would likely have said something along the lines you suggested. But my thinking has changed.

Before I comment on the specific intervention, let's acknowledge the elephant in the room: our field's problematic relation to change. All disciplines grow, evolve, and change. What is not growing is dying. But in the culture of psychoanalysis, some view change not as evolution but betrayal.

I felt it myself. I had a very classical analysis. When I began treating patients, I practiced as my own analyst practiced because that was "real" psychoanalysis and I wanted to be a real psychoanalyst. I soon discovered that this way of working was often unhelpful to my patients and sometimes harmful. To help them, I had to learn to do things differently. But somehow, doing things differently did not feel like learning. It felt like betrayal of my own analyst, supervisors, and teachers – people I respected and even loved. But let's face it – "my teacher did it this way" is not an intellectually sound basis for clinical decisions.

Now, let's return to "Caroline." To be clear, I do not advocate indiscriminate self-disclosure. We are discussing disciplined, considered disclosure in the service of the analytic work. I do not disclose about just anything. What I disclose is my reaction to what is happening in the room, in the here-and-now of our interaction.

The patient and I are enacting something. It is not purely intrapsychic, it is also inter-psychic. It is in the interaction between us. It takes two. In other words, the therapist

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is already a participant in such enactments, wittingly or unwittingly. Some would use the term intersubjective to describe this aspect of the encounter.

Suppose I said what you suggested: "I wonder whether you worry that I too will want to impress you or seek your approval." This would not have brought the specific enactment into focus. The patient might have said, "No, I wasn't worrying about that with you," or perhaps, "You're a famous doctor, I don't think you would need to impress me." The patient is not in fact worried that I will react this way. It is ego-syntonic for her. It's just how she experiences the world, as natural and invisible to her as water to a fish.

When I say "I am aware of a vague feeling of wanting to impress you or gain your approval," I am stating a fact that must be reckoned with. It is not a speculation about her experience. It is a fact that this is how I am experiencing our interaction. I am also mindful of why the patient has come to treatment: something gets in the way of intimate relationships. Here is an example of that "something," right here, right now. The comment serves the function of a clarification and confrontation. It clarifies something that would otherwise escape notice and directs the patient's attention to it with the expectation that she will reflect on it. It's also an invitation to think together about its meaning. There is a meta-message that the work is a collaboration. I am not going to interpret her experience to her. When we arrive at an interpretation, and we will, it will be our understanding, not just my understanding.

JY *You say you take pride in helping people who have not found the help they need from other professionals. How do you think you are able to do this?*

JS It's an accidental specialty. I realised that virtually all my patients had had previous treatments that had not helped, or helped only minimally. Many had multiple prior treatments, psychotherapy and pharmacotherapy both.

Let's face it, there is a lot of bad treatment out there. At least in the U.S. there is. A therapist who works psychodynamically, who develops a strong case formulation, who involves the patient as a collaborator, and keeps his eye on the ball of what the patient wants from treatment, is likely to be successful.

"A therapist who works psychodynamically, who develops a strong case formulation, who involves the patient as a collaborator, and keeps his eye on the ball of what the patient wants from treatment, is likely to be successful"

JY *Finally, what would you wish for the future of psychoanalysis and psychoanalytic therapy and how might this be achieved?*

JS We are not good communicating to the public, or policy makers, or other mental health professionals about what we do. We have been far too insular and far too preoccupied with internecine disputes. Psychoanalysis has historically turned inward. Proponents of other therapies have filled the void with their own (often false) narratives, using psychoanalysis as a foil or strawman. We now have to learn how to engage with students and colleagues outside of our own relatively closed circles. We also have to learn how to communicate in English, not jargon. All of this means changing the culture of our profession. That's not an easy thing. ■

Jonathan Shedler, PhD, U.S. psychologist is known internationally as an author, consultant, and master clinician and teacher. His article The Efficacy of Psychodynamic Psychotherapy won worldwide acclaim for firmly establishing psychodynamic therapy as an evidence-based treatment.

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Psychoanalytic Psychotherapy NOW 2018

Innovation and Evidence

Innovative practice supported by research and evidence platformed at the BPC's conference PP NOW 2018

Hearth

By Geraldine Ryan

About icap

icap (Immigrant Counselling and Psychotherapy) is a charity founded to address the mental health needs of the Irish community and other migrant groups. We provide culturally sensitive psychodynamic psychotherapy at centres in London and Birmingham and through a series of ten outreach therapy services. In 2017-18 we delivered 7,485 hours of therapy for 443 individuals.

87% of icap clients are Irish. The Irish community is the third largest migrant community in London and has the oldest median age. 75% of clients report significant childhood trauma. Poor physical health, poverty and social disadvantage are common and can compromise access to mental health support. Many clients live with long term conditions including heart disease, diabetes and cancer.

Our outreach programme reflects our commitment to providing psychotherapy for those in need and our desire to reach excluded sections of the Irish community. Delivered on site with partner agencies, the services offer individual time-limited psychodynamic psychotherapy and specialist psychosocial support for a range of vulnerable groups including older Irish men, Traveller women, homeless people and survivors of institutional abuse.

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Hearth

Hearth is a domiciliary therapy service for older, housebound members of the Irish community, originally delivered in partnership with the Irish Chaplaincy Seniors Team, an advice and befriending service.

The model delivers a twelve session psychodynamic intervention at the clients' home. This 'home' can include residential care and hospital settings. There is no cost to the client or partner agencies. The project is funded through charitable donations.

People who use the Hearth service are housebound for a variety of reasons including physical frailty, an inability to use public transport or a lack of access to respite for those with caring responsibilities.

Conscious of the stigma attached to mental health within the Irish community, the service and publicity materials have been framed in an accessible and culturally appropriate manner avoiding the use of therapy "jargon" Fig 1.

Fig.1

The service has been operational for 19 months and 144 therapy sessions have been delivered to 19 individuals resident in nine London Boroughs. 26% of people seen were men, 74% women. 95% of clients seen were aged over 60 and 56% were aged over 80 years.

The focus of the work is often on end of life issues, on disappointments and losses, on grief and rage. In speaking about that which has been unspeakable, people gain a sense of ownership of their stories and begin to construct a sense of meaning as they move towards the end of life. Connections can be understood between past experiences of deprivation and neglect and present feelings of loss and grief.

One therapist worked with a client who suffered a stroke. The work continued through her hospitalisation, her move to residential care and up to her eventual death. Through her relationship with the therapist she felt more able to connect with her past experiences to gain a sense of self and, at the end, a measure of ownership of her life.

Not least among the challenges raised by this setting is how to respond to the traditions and rituals of hospitality. Refusing food and cups of tea can bring alive past experiences of shaming rejection, of not having anything 'good' to offer. The therapist's ability to respond thoughtfully and in the moment is crucial to the individual work and to the success of the therapeutic model.

"With the support, understanding and knowledge of my therapist, I have been able to start unravelling the pain that I have carried alone for years."
Quote from icap client survey (2017) ■

Geraldine Ryan is a psychoanalytic psychotherapist. She is Clinical Director of icap.

Evaluation of a Co-Delivered Model of Training: Working with Women with Personality Disorder

By Julia Blazdell and Anna Motz

How can frontline workers including prison officers, nurses and offender managers work effectively with women who have severe difficulties in forming relationships, managing violent feelings, and trusting others? Women who have experienced multiple trauma and adversity in early life can often develop deep distrust, not wanting to make contact with those tasked with helping them; workers in turn, can feel helpless, confused and frustrated, while, the women can be left with unmet needs for containment and understanding.

Self-harm is a major problem for women with personality difficulties in the Criminal Justice System; in 2017, the rate among women was 2,093 self-harm incidents per 1,000 prisoners, nearly five

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times higher than the rate of 445 per 1,000 prisoners in the men's estate (MOJ, 2018) Self-harm, verbal and physical aggression, and other expressions of distress profoundly impact on staff, as well as on the women themselves. Female prisoners are more than twice as likely as male prisoners to report needing help for mental health problems, 49% and 18% respectively (MoJ, 2013).

Laura d' Cruz, Lead for the Women's Offender Personality Disorder Programme clearly identified that 'staff working on the women offender personality disorder pathway will require specialist gender specific training that gives them the skills, knowledge and confidence they need in order to work most effectively, and in a psychologically informed way, with female service users. Staff will also require supervision, reflective space and support to help keep themselves healthy and motivated .' (d'Cruz, 2015:49)

To address this need for gender sensitive, trauma-informed training for staff innovative, evidence based programmes were co-designed and co-delivered by a psychoanalytic psychotherapist/clinical psychologist (AM) and an educational consultant with a lived experience of personality disorder (JB). The BSc module, Understanding Women & Personality Disorder and the training programme, WKUF+, are two components of the Knowledge and Understanding Framework for Personality Disorder, originally developed as part of a partnership between the Institute of Mental Health, The Tavistock and Portman Clinic, The Open University and Emergence.

The training has now been delivered to over 600 practitioners in the criminal justice system, mental health and voluntary sector settings working on the Women's Offender Personality Disorder Pathway. The students include practitioners with backgrounds in psychology, psychiatry and nursing alongside probation officers, prison officers, third sector managers, workers and arts therapists. This mix makes for a lively and engaging student group, where criminal justice, health and community settings are all represented. The eight day BSc Module has a written component in which students are able to reflect on their own practice and integrate their learning on the course with their own experiences of working with women with complex presentations and traumatic histories; there is also a plenary at the end of each day that allows students to engage critically with the ideas, including controversial areas like gender identity, female sexual abuse and female psychopathy.

The trainings draw on attachment theory, using psychoanalytic concepts, sociological perspectives on gender identity and criminological data on the experiences of women within the criminal justice and secure mental health systems. The students are encouraged to recognize relational aspects of the development of difficulties, and self-reflection, considering how to prevent re-enactments from occurring. The co-production and co-delivery of the model, by a consultant clinician and service user is key to the impact of the training: Understanding that there is hope for people with personality difficulties, that lives can be transformed with the right help and support, is a key message in the training which is embodied in the service user trainer. (Blazdell & Morgan, 2015: 58) The model of training integrates theory and practice alongside experiential learning that is evaluated to see whether students have developed this enhanced understanding; preliminary analysis is promising, as demonstrated by the following data (Duke & Thomas, 2015) demonstrating that noteworthy improvements in knowledge and perceived ability to work with the challenges of personality disorder were seen in students completing the module. Participants also reported significant increases in their knowledge of the diagnosis, clinical features, pathogenesis and the psychological models of Personality Disorder. They gained a greater understanding of how Personality Disorder could be linked to offending and believed that they were more able to apply psychological models of PD in their work and thus the necessary skills to work with this client group.

Preliminary findings suggest the efficacy of this co-delivery model of training and the utility of the Questionnaire designed for the purpose of evaluation, the Personality Disorder Knowledge Attitude and Skills Questionnaire (PD-KASQ: Bolton et al 2010), presented below, alongside open-ended survey questions. While the design of the evaluation could be further nuanced, the preliminary findings suggest that this module, and the shorter WKUF+ training offer practitioners the opportunity to reflect on the dynamics of working with a complex population whose needs are often overlooked and presentation misunderstood.

For more information please contact: anna.motz@oxfordhealth.nhs.uk ■

Anna Motz, Psychoanalytic Psychotherapist, Clinical and Forensic Psychologist and Author, Oxford
Julia Blazdell, Service User Consultant, Trainer and Facilitator

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References

Blazdell, J. and Morgan, L. (2015) Developing personality disorder training — a collaborative process (Co-production as a Process for Developing and Provoking Learning), *Prison Service Journal*, 218 : 54-59.

Bolton, W., Feigenbaum, J., Jones, A. and Woodward, C. (2010). *Development of the PD-KASQ*. Unpublished manuscript. PD-KASQ questionnaire.

D'Cruz, L (2015) "Implementing a Personality Disorder Service for Women', *Prison Service Journal*, 218 : 47-53

Duke, Louse Hare, and Thomson, L. (2015) Evaluation Report BSc Module: Understanding Women and Personality Disorder (North) Institute for Mental Health.

MOJ (2013) *Gender differences in substance misuse and mental health amongst prisoners*. https://www.gov.uk/government/publications/gender-differences-in-substance-misuse-and-mental-health-amongst-prisoners

MOJ (2018) *A Whole System Approach for Female Offenders: Emerging Evidence*, London: HMSO.

Tavistock and Portman Primary Care Services

By Tim Kent

The Tavistock and Portman's Primary Care service has two teams providing 'Free Clinics' of Psychoanalytically informed assessment, treatment and consultation in primary care surgeries. Our focus is on work with complexity, Medically Unexplained Symptoms, Iatrogenesis, trauma and the variously co-morbid aspects of Personality disorder, chronic pain and the gap between IAPT and secondary care services. The Hackney service will be 10 years old in 2019, suggesting it is now more than just a 'project'. One of our biggest reasons for thriving is the feedback and benefits felt by GPs themselves who do much to support emotional disturbed and vulnerable people but who often receive very little care or consultation themselves.

Our first research study 'Managing Patients with Complex Needs' in 2014 with the Centre for Mental Health showed significant benefit to patient's bio-psycho-social health and health economic impact with reduced cost. Between 2015 and 2017 our NEW service TAP (Team Around the Practice) was evaluated by The Office of Public Management, (OPM) again with positive outcomes for patients and GPs. (Please email us for further information.)

For 2018/19 we have a NEW TAP Health Economic study with an independent external evaluator Cordis Bright AND a Longitudinal follow up study with CFMH looking at our 2014 cohort of around 200 patient's but four years later. We expect this to be the first longitudinal study of Primary Care Psychotherapy.

We have around 40 staff across Camden and Hackney offering a service in up to 70 GP surgeries. Patients are seen either individually, in groups, couples or together with their GP in a three way or joint consultation. Freud wrote in 1910 it is as important for the poor man to access help for neuroses and mental struggle as for physical illness and symptoms and it is in this spirit that we offer a high quality psychotherapeutic service at the front door of population health care access.

Increasingly NHS commissioners are euphemistically seeking to find and demonstrate 'savings' across services in order to balance their books. We believe that Psychotherapeutic services have an important place for many people who do not feel helped by IAPT but may also not reach a secondary care threshold or be able to pay for a private treatment.

It is more a revived rather than new concept as such. However, we have given much passion, thinking and time to pushing forward a model of applied psychoanalytic work at the entry to publicly funded health services. The service often reaches the most psychically and socially deprived alongside much trauma and maltreatment masquerading through parallel symptoms of equivalence.

As well as offering brief psychotherapeutic interventions we also run Balint type groups for GPs AND practice staff such as receptionists and administrators who are often overlooked as part of a health care eco-system. Some of our clinical applications stand out as innovative, in particular:

- Joint consultation where a clinician joins GP and patient in the room for a three way consultation to shift a stuck relationship and re-formulate difficulties with thought to unconscious processes.
- A horticultural therapy group delivered in mother tongue by a Turkish speaking group therapist in a city farm setting.
- A psychodynamic support group for people waiting for treatment.
- A therapeutic Photography Group – recently celebrated in our 'State of Mind'; exhibition at the CLR James Library in Dalston, E8 and in the press.
- Effective and meaningful service user involvement in services design with six weekly groups.
- Group and individual supervision of clinical staff, a stimulating weekly and yearly diary of clinical academic seminars with visiting lecturers.

For further details please contact; Tkent@tavi-port.nhs.uk ■

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Tim Kent, Primary Care Service Lead, Consultant Primary Care Psychotherapist and Social Worker

Living Together with Dementia – a psychosocial intervention developed at Tavistock Relationships

By Andrew Balfour and Richard Meier

Research shows that the quality of the relationship between partners where one of them has dementia is of crucial importance to both people involved. So much so, in fact, that lack of intimacy and reciprocity between the couples are associated with depression and predictive of moves to residential care and even mortality rates.

Despite this, there is a dearth of interventions (and therefore evaluation evidence) which seek to support the couple relationship where one partner has dementia. Indeed, the NICE guideline on dementia recently concluded that it could not make any recommendations – positive or negative – about psychosocial interventions for dementia on account of a lack of evidence.

Living Together with Dementia has ambitions to plug this evidence gap. We hope to show that by working with couples affected by dementia to improve their quality of life and mental health, we can prolong the time people with dementia can maintain their independence, remain active and preserve an intimate and familiar relationship with their partner – thereby reducing the partner's/carer's burden and health impacts.

The aim of the intervention is to assist communication and understanding, using shared involvement in everyday activities as a basis for enhancing emotional contact between the partners, helping them to hold onto emotional meaning and shared activity in the face of challenges and pressures towards withdrawal and loss of contact that can be so characteristic of dementia. Living Together with Dementia draws upon therapeutic methods developed in working with parents and children which emphasise observation and use video as part of their focus. The intervention uses everyday domestic activities as opportunities for shared endeavour and involvement for the couple. The focus is upon the emotional meaning and potential of these everyday activities to support inter-dependency between the partners and so to address some of the relational impacts which are identified by dementia research as linked to negative outcomes for both partners. Although the use of video-taped interactions between the partners may make this intervention look far from psychoanalytic, it is rooted in the importance of containment, emotional contact and understanding, and draws on attachment-informed approaches developed in parent-infant psychotherapy applied to the caring dyad at the other end of life.

So far, sixty people have participated in our Living Together with Dementia intervention, in Camden, Hackney and Bristol. Once engaged, there has been minimal drop-out, indicating the acceptability of the intervention and the feasibility of using video-based intervention with people with dementia and their partners. Standardised psychometric measures are collected pre- and post- intervention to evaluate the outcome of Living Together with Dementia for couples, looking at carers' 'burden' and stress, communication, relationship quality, cognitive functioning, and quality of life. Qualitative interviews also looked at couples' experiences of the intervention – including at one-year follow-up.

Despite the worsening picture of cognitive decline consequent on the progressive nature of the illness, our pilot of the intervention shows that it supports the stability of the couple relationship and, most strikingly, reduces the perceived burden in the carer role. That is, data showed that a significant number of those 'carer' partners who were in a 'high-burden' group at the start moved to 'low-burden' at the end of the intervention. The proportion of "improvers" in our sample was statistically significant ($p=0.045$). This is a very interesting and potentially important finding, which we would like to test on a larger scale, and including a control group, or matched comparison group in order to better evaluate overall impacts. ■

Andrew Balfour, Chief Executive, Tavistock Relationships

Richard Meier, Policy & Communications Manager, tavistock relationships

Professional Heritage

Knowledge is of Two Kinds

By Saven Morris and Ewan O'Neill

"Knowledge is of two kinds. We know a subject ourselves, or we know where we can find information upon it. When we enquire into any subject, the first thing we have to do is to know what books have treated of it. This leads us to look at catalogues, and at the backs of books in libraries."
Samuel Johnson (Boswell's *Life of Johnson*)

Dr Johnson's words, often misquoted as "The next best thing to knowing something is knowing where to find it" have been a librarians' motto for generations, but the questions of where and how to find information have been particularly relevant to the Archive and the Library of the British Psychoanalytical Society over the last few years, during which both have undergone great changes.

"one of the most extensive and complete collections of psychoanalytic material available"

The Library's main role is to support the members of the British Psychoanalytical Society in their research and professional activities, and is one of the most extensive and complete collections of psychoanalytic material available, with over 20,000 items ranging from the 19th century to the present day. Our collection includes donations from the private collections of many leading psychoanalysts, notably Ernest Jones, James Strachey and Donald Winnicott.

Until recently the Library's ability to access its own material was limited and haphazard: as late as the mid-1990s we used a card index, and the electronic catalogue that replaced this index was unsuitable for our needs. To increase our knowledge of, and ability to manage, our heritage, the Library's library management system was replaced.

Additionally, the Library received a grant from the Institute's Innovation and Development Fund between 2015 and 2017 for a cataloguer to update titles that were not properly catalogued. The existing electronic records were often inaccurate and usually gave few details: this was obviously undesirable, and the cataloguer corrected, standardised and enriched the data. The newly enhanced records, providing much more bibliographic information on authors, editors, subjects and publication details, have vastly improved our capacity to search the database.

At the same time, we used this process to take a careful look at the books and journals we were holding. The re-cataloguing process involved a lot of reorganising and winnowing, and because the Library's working space is approaching

capacity, we now focus on books of clinical and theoretical interest, although books on applied psychoanalysis, or from different psychoanalytic traditions, are also included.

We overhauled our journals, filling gaps in our collection where necessary and possible, while binding and cataloguing those we decided to retain. We also deaccessioned many foreign-language, unused or non-psychoanalytic journals, and

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those runs of journals which were very incomplete.

We have donated thousands of books and journals, in line with our established collecting policy, to the International Psychoanalytic University in Berlin, to the Bodleian, to the Wellcome, and of course to other psychoanalytical societies and trainings. Additionally, we have used online booksellers to sell duplicate, foreign-language and non-psychoanalytic items of little value; we even held our own second-hand book sale at the start of 2018 with great success. However, the lack of space in the Library continues to be a pressing concern, and further deaccessioning is necessary.

The Archive, too, has recently undergone great changes. In 2017, as part of the remodelling by architects Caswell Banks of the basement consulting rooms here at the Institute, the Archive store was relocated and enlarged to provide us with 40% more storage. This was very welcome; our previous store was posing significant risks to our collections, which include the papers of many eminent psychoanalysts including Ernest Jones, Marion Milner and Joan Riviere. We are pleased to report that our new store is a safe environment with structural qualities that protect our collections from fire, water, theft and other hazards. Both the Archive and the Library catalogues have been made available online, and it is now possible to search our primary holdings via the Institute of Psychoanalysis website.

Serving increasingly as a research centre, the Archive and Library are receiving many more visitors, requests and enquiries: along with the perennial lack of space, this has forced a serious and lengthy examination of how best to manage our holdings and our heritage, making them more accessible, finding ways to preserve the at-risk items, and considering ways to strengthen our research offering.

At the moment, approximately 4,000 books, journals and pamphlets have been set aside for possible deaccessioning from the main Library collection. Many of these are valuable, or of significance to the development of psychoanalysis and so it has been agreed by the Archive and Library Committees to select items to form a Special Collection.

The objectives for this project are ideally to:

- Establish a Special Collection that supports the mission statement of the BPAS, complements the existing Archive and Library collections, and supports further research
- Balance costs (both short term and long term) against resources
- Make the collection available digitally
- Establish a shared management programme for the Collection between the Library and Archive

This project aims to deliver a number of benefits for the British Psychoanalytical Society:

- To build on the Society's position as a leading academic research centre for psychoanalysis in Britain and internationally
- To increase the depth of research possibilities within our collections
- To enhance access and promote the collections

Due to their age and the fact that many of the items were stored separately from the main Library collection, their catalogue records are still of variable quality: listing the material is our first task, to ensure an accurate inventory of every item and to allow us to carry out a review process. Direct inspection of these items and their bibliographic data will be essential, and the subsequent review process will necessitate rigorous selection that considers some combination of the following six elements: rarity and scarcity, date and place of publication, provenance and physical or intrinsic characteristics, bibliographic and research value, market value, and condition.

Developing our selection requirements will provide an opportunity to invite input from bibliographers, subject specialists or others, such as university faculties, in assessing the suitability of items for transfer.

Once selections have been made, we can then consider donating or selling the remaining items to alleviate the pressure on our storage capacity.

To assess conservation requirements, we are working with the National Conservation Service; we recently commissioned a sample survey of around 230 of the items set aside for possible deaccessioning. Unsurprisingly, acid paper deterioration is prevalent; generally manufactured during WWI and WWII, this paper is vulnerable to temperature shifts, humidity and light if not stored carefully. Much of this material needs treatment or restrictions on access, while some of the sample was identified as highly unstable, requiring immediate remedial conservation work.

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However, conservation costs have the potential to be very high and need to be balanced against our available resources. Packaging the items to archival standards is also required to protect those that are already damaged, weak, and/or at risk, and this affects considerations such as storage space availability and the choice of storage location.

Meanwhile, to ensure that all risks to the materials are assessed and where possible removed, we are completing a benchmarking exercise with the National Conservation Service to develop our collection care standards and support collections management.

We are looking forward to this process: our challenge will be to make careful and informed selections, and then balance these against the aims of the Society and the costs of caring for, storing, and providing access to the Special Collection. ■

Mr Saven Morris, Head Librarian, British Psychoanalytical Society

Mr Ewan O'Neill, Archivist, British Psychoanalytical Society

On the Ground

A Week in the Life of a 'Retired' Psychotherapist

By Liz Standish

Why am I placing 'retired' in inverted commas? In July 2014, I said goodbye to my last psychoanalytic patient, who had been kept on beyond other patients so that she could finish her training without having to change therapists at this late stage. This is the sort of thing which can complicate the process of closing down a practice. I had taken the decision to make a clean break with patients rather than allowing for 'natural wastage', but in the event, it wasn't quite possible. I have written elsewhere (Standish, 2015) about the painful process of closing down a practice after some twenty-five years. I decided to continue group and individual supervision, as well as writing.

In this present financial climate, we hear much of people complaining that they are going to have to work until they are 70. Not so with psychotherapists! In fact, until recently, there has been a great reluctance in the profession to discuss the matter at all, but that is changing. Of course, there are many other occupations where people don't retire because they are still enjoying and inspired by what they are doing – we have only to think of David Attenborough – but I believe psychotherapists are a special case. As Junkers (Junkers, 2013) says 'Personal discussions with colleagues have convinced me that our choice of profession is influenced by early mental

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A Week in the Life of a 'Retired' Psychotherapist

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suffering that disrupts our "continuity of being"' (Winnicott, 1960, p. 591). I believe the reluctance to talk about it, and indeed to do it, is furnished by fear. What am I without being a psychotherapist? But, maybe more than that, and even more unspoken, is the fear, will I break down if I'm not doing this work? I thought therefore it might be interesting for colleagues still working (as well as those already retired) to paint a picture of how life is for me in my semi-retirement.

Monday. I'm hurriedly packing my bag for my art class, and thinking, why didn't I do this last night? I reflect on how it feels like childhood Monday mornings, back to school, when I would also have been packing my bag at the last minute. Have the years of therapy had any impact? At least these days I usually get there on time. The class itself is rather like a mindfulness meditation, though harder work. It's impossible to think about anything else. Back home and my daughter arrives. In the afternoon, she wants to leave her toddler Jemima with us for a short while. I have a supervisee arriving. I need to shuffle Jemima off with Grandpa to a room where they can't be heard. This feels like a reprise of working from home when my own children were young!

My supervisee needs a room where she can see children. The problem is that she can't take on child patients till she has a suitable room, but can't afford to rent a room until she has patients. This process can be reversed when gradually closing a practice if the consulting room is rented. Is it viable to rent a room for one or two patients? I was fortunate in having a consulting room in my house.
In the evening I go to my yoga class, which I love and try to fit in a practice most days. I'm fitter than before, less sitting, more walking (we have a lively dog).

Tuesday. I visit a colleague for peer supervision. We discuss the difficulties of seeing patients for colleagues who are ill, where the outcome is unknown. The patients may require intensive work, but is this best in this possibly short term, uncertain situation? Afterwards, I have some playtime, meet a friend for lunch, have my hair done. In the evening, I go to a Community Choir – a good sing, directed by an inspirational teacher.

Wednesday. A colleague has asked for a consultation on whether he should be retiring. A patient has suggested it, pointing out his 'failings'. Was this driven by transference (she has good historical reasons to be angry) or does she have some valid points? He decides he needs more supervision.

Meantime, my daughter reports that Jemima, known as Mima, has for the first time recounted something from the past. The previous day, she went on a 'teacup' ride at the fair. At bedtime, remembering, she says 'Mima, round and round, teacup' – a big developmental step at 21 months. I remain fascinated by the development of the infantile mind – my very own infant observation, although I'm hardly objective!

In the evening, I host a clinical discussion group. We hear about an intransigent case, where the therapist is left feeling battered. I'm reminded what a heavy toll such work can take. Possibly for the first time I feel truly glad to be free of that.

Thursday. Unusually, there are no external commitments in the daytime. Can it be true? I check my diary again. Without my former regular structure of patients, I'm anxious that I might forget someone. I'm pleased I can get down to my own writing, after the usual stack of emails. I manage to get out into the garden and plant 25 bulbs – a testament to the future. I'm reminded of Monty Don talking of the benefits to mental health of nurturing the soil.

In the evening, I attend an inspiring talk at the Oxford Psychotherapy Society. The speaker is John Alderdice, who was involved in the Good Friday agreement. A psychiatrist and psychotherapist before he was a politician, he explores what light those disciplines can shed on our conflict-ridden world. He talks of how people under great stress revert to the timelessness of the unconscious, so that the collective memory of past generations' trauma becomes present experience. I think of Jemima developing a sense of time past.

Friday. I see another supervisee. She is a psychotherapeutic counsellor but not a psychotherapist. I'm struck by the falseness of the divisions we make, the hierarchy of trainings and the assumption that a psychotherapist does 'better' work than a counsellor, although it does of course depend on the intensity of the work required. The quality of this person's work is excellent and she uses supervision well. She brings a highly anxious young woman who says she wants to be dead. My supervisee has done a careful risk

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assessment and we agree that this does not appear to be a serious suicide risk.

On Friday evening I go to my other choir, a more serious undertaking, harder work than my Tuesday choir. This is not play. The weekend, although busy (poetry group, grandparenting, out to dinner, seven mile walk with friends) still feels different from the week. I wonder if it will when I stop supervising.

"by creating more space in my life, from time to time, it happens, I forget myself, being creative or just gazing at the trees"

Part of my motivation for stopping clinical work was the sense that there was an imbalance in my life. In common with many (most?) psychotherapists, as Junkers (ibid) asserts, I came into the work because of early wounds, driven by an urge to understand, probably attempting to 'cure' my parents – and myself. Somewhere along the way, I forgot how to play and wanted to rediscover it.

What is play? Winnicott famously linked it with creativity. By definition, one cannot work at it. But by creating more space in my life, from time to time, it happens, I forget myself, being creative or just gazing at the trees. My grandchildren are great teachers. ■

Liz Standish is a retired Psychoanalytic Psychotherapist, now supervising, teaching and writing. She has contributed papers to the British Journal of Psychotherapy, *amongst other journals.*

References

Junkers, G. (2013). Later, perhaps. In G. Junkers (Ed.), *The empty couch, the taboo of aging and retirement in psychoanalysis* (pp. 17 – 31). East Sussex: Routledge.

Standish, E. (2015). A postcard from the other side: Or, the challenges of retiring as a psychotherapist. *Psychodynamic Practice*, 21, 4, 335-339.

Review

African American Jungian Analysts

African American Jungian Analysts – on Culture, Clinical Training/Practice and Racism, Confederation for Analytical Psychology, Ninth Andrew Samuels lecture, 13 October 2018

By Jane Johnson

It was a new, and profoundly stirring experience for me, as a white person, trained in and belonging to predominately white psychotherapy institutions, to be part of a gathering of around 150 delegates where black and Asian therapists were well represented, and where thinking about, and creative engagement with, the emotive and often painful issues of culture and racism in clinical training and practice was led by black therapists and analysts. This CAP conference, organised by Andrew Samuels and Ruth Williams, addressed important issues for Jungian analysts, but also for those working in in-depth psychology, relating to the cultural wound of colonialism and slavery and the implications for therapeutic work if the unconscious transgenerational transmission of this legacy goes unrecognised.

The opening event, a live interview with the author, broadcaster and editor-at-large for *The Guardian*, Gary Younge, was conducted by Rotimi Akinsete as part of his 'Black Men on the Couch' series. He began the interview with a viewing of the overnight sensation 'This is America' by Childish Gambino (10 million views within 24 hours of release), asking Gary Younge to comment on this confronting portrayal of black dance, media culture

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African American Jungian Analysts

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and urban violence before leading him through an engaging and moving account of his life and work. Born and brought up in Britain, but also having lived and worked in America, Younge's experiences set the scene for the transatlantic links made throughout the day.

The notorious middle passage between West Africa and the Americas was one such link recalled in the succinct and powerful video account of the historical and enduring global implications of colonialism and slavery: *Witnessing the Wound*, shown in the session lead by founding members of BAATN (Black African and Asian Therapy Network), Eugene Ellis and Jayakara Ellis. I wish I had known more about BAATN when working on a BPF pre-clinical course (2008-17). I was aware that when black or Asian students dropped out, or struggled to do well, there were factors in this that for me as a white person, in a mainly white organisation, were difficult to understand or name and to address with them. I think this continues to be the case in my organisation, which I believe is not alone, and where we could do well to make use of the range of valuable resources that BAATN offers. The website at www.baatn.org.uk is well worth a look as it includes podcasts, videos, booklists, gatherings, events and forums for those working psychologically with black, African and Asian people. Culturally sensitive support and mentoring for those in counselling or psychotherapy training is also offered. The part played by such mentoring in improving the experience and success of black students is underlined in an article by Guiffida et al (2018). A copy of this was circulated at the conference and is also freely available online. Although rooted in research with university students, the forms of support, mentoring and advocacy the authors suggest improves the experiences of black, Asian and minority ethnic students are, I think, directly applicable to those in clinical training.

"a constructive, energetic and inspiring engagement with an emotive topic that remains hard, but essential to grapple with"

The experience that stirred me most profoundly during this conference occurred in the reflections and questions following a response by Helen Morgan, senior member and fellow of the British Psychotherapy Foundation, to the presentations of African American Jungian analysts, Dr Fanny Brewster and Dr Alan Vaughan. Fanny Brewster had given a poetic meditation on the experiences of her enslaved African ancestors, feeling into, and putting an archetypal framework around this to bring alive the implications of these 'binding legacies' for the therapeutic couple. Alan Vaughan had given a scholarly critical evaluation of Jung's limited view of African America, drawing on archetypal African embodiments of Truth and Justice within the American constitution, and noticing that while Jung's visits to America in the 1920s and 1930s occurred at the time of the Harlem Renaissance (a burgeoning of black culture including intellectuals, artists, writers and musicians) he showed no apparent appreciation of this aspect of African American culture. Helen Morgan's thoughts and feelings in response to these presentations, had been given with an honest and open engagement with her white cultural heritage, and a recognition of the desire, and struggle, to engage across a racial divide. Both speakers were appreciative of the response, but it was Fanny Brewster who voiced a felt response with its roots in the enduring cultural wound, when she described the deeply historic and familiar wariness felt as a black person when faced with an offer of interest and engagement from a white person. It was this honest, sensitive and brave exchange that was most profoundly stirring for me, and which captured the spirit of this conference: a constructive, energetic and inspiring engagement with an emotive topic that remains hard, but essential to grapple with if our British training institutions are to remain relevant. ■

Jane Johnson is a psychotherapist and Jungian Analyst working in private practice in Hampshire. She is a member of the British Jungian Analytic Association and a past director (2008-2017) of the MSc Psychodynamics of Human Development (Birkbeck College and BPF). She gives seminars on Cultural Diversity, Racism and Difference for the BPF and for the BJAA clinical training.

References

Childish Gambino (2018) *This is America* [video online]. Available at https://www.youtube.com/watch?v=VYOjWnS4cMY [Accessed 31 October 2018].

Ellis, E. (2018) *Witnessing the Wound: Healing Through Connection, Community and Culture* [video online]. Available at https://vimeo.com/262194819 [Accessed 22 October 2019].

Guiffrida, D., Boxell, O., Hamell, S., Ponicsan, I & Akinsete, R. (2018) *Supporting black British university students: Understanding students' experiences with peers and academic staff.* University and College Counselling, 6:3.

Diary

For full event listings, visit the BPC's Event Calendar via their website: www.bpc.org.uk/events-calendar

JANUARY

12 January 12 2019
LOOKING FOR LOVE: HOW THERAPY CAN HELP WITH PARTNER CHOICE WITH ANNIE POWER
10am – 4pm
WPF Therapy, 23 Magdalen St
London SE1 2EN

MARCH

30 March 30, 2019
WORKING WITH SURVIVORS OF VIOLENT TRAUMA WITH ANDY KEEFE
10am – 4pm
WPF Therapy, 23 Magdalen St
London SE1 2EN

9 March 9 2019
WORKING THERAPEUTICALLY WITH DISORDERED EATING & EATING DISORDERS
10am – 4pm
Gloustershire Counselling Service, Alma House, 52-53 High St, Stroud GL5 1AP

16 March 2019
THE SANDLERS: SOME INTERNAL OBJECTS REVISITED – JORGE CANESTRI, MICHAEL FELDMAN, SUSIE ORBACH, ROSINE JOZEF PERELBERG, JONATHAN SKLAR, PETER FONAGY
UCL's Psychoanalysis Unit and the Anna Freud National Centre for Children and Families, University College London, Gower Street, London WC1E 6BT

APRIL

27 April 2019
UNDERSTANDING AND WORKING WITH AUTISTIC SPECTRUM DISORDER IN COUNSELLING BY DR ANNA PRESTON
Gloustershire Counselling Service
10am – 4pm
Alma House
52-53 High St, Stroud GL5 1AP

MAY

11 May 2019
ADOLESCENCE BY MARGOT WADDELL
10am – 4pm
Gloustershire Counselling Service
Lansdown, Stroud GL5 1BB

18 May 18 2019
THE FUTURE OF NEUROSCIENCE, ATTACHMENT AND MENTALIZING: FROM RESEARCH TO CLINICAL PRACTICE
10am – 5pm
University College London, Gower St, London WC1E, UK

News

Guidelines for Depression

Professionals, service users and MPs unite to hold NICE to account as a world leader in guideline development

By Felicitas Rost and Susan McPherson

On 3 October 2018, registered stakeholders in the NICE guideline on Depression in Adults received notification that the new guideline would undergo a third revision. This decision follows pressure from stakeholders, ongoing since the first draft was made public in July 2017 and which led to an exceptional second consultation on the second draft in June 2018.

As part of the second consultation, a joint stakeholder position statement was signed by all major UK mental health professional bodies as well as the patient organisations MIND and NSUN, demanding a full revision. The *British Medical Journal* reported on the campaign (Thornton, 2018)[1] and in July 2018, thirty-four MPs and Peers including a former Minister for Health, wrote to Sir Andrew Dillon, CEO of NICE, urging them to address our concerns.

In the position statement, stakeholders noted that their most serious comments on the first draft had been completely ignored. Six key methodological changes were outlined which, if not adequately addressed, will render the guideline not fit for purpose[2]. These were to look at long-term outcomes of treatments; to

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Guidelines for Depression

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review service user experience research; to reconsider the obscure classification of complex and long term depression; to use appropriate methods of classifying severity; to use appropriate methods of synthesising findings; and to look at quality of life outcomes. For a more detailed critique of the draft depression guideline, see McPherson, Rost, Town and Abbass (2018)[3].

As recently noted on BBC3 "You and Yours"[4], when one builds a house with a shaky and uneven foundation, everything built on top of it will inevitably be skewed. The methods used to produce the guideline provide a very weak foundation, rendering the resulting treatment recommendations invalid. This would result in sub-standard care for millions of people suffering from depression. There would also be damaging effects on health services, the professional workforce and the shape of future research.

These methodological points have been made repeatedly since the very first UK national depression guideline was drafted in 2003. Over the last 15 years this critique has been dismissed and down-played as inter-professional quarrels over which treatments get recommended. It would be a mistake for the NICE guideline committee to assume each professional group simply want the house painted a particular colour. We are jointly and in unison pointing to the foundations, in order for us to have confidence that the resulting recommendations are the very best that the scientific method can offer to patients in need of care.

"stakeholder consultations appear to have served as proofreading exercises"

The process by which stakeholders have tried to make their case heard over the last 15 years, and in particular the efforts required to have won a second and now third consultation, raises serious issues around the routine quality assurance procedures within NICE. The NICE manual clearly states that stakeholders are "a vital part of the quality assurance and peer review processes" and form "an integral part of the guideline development process"[5]. In practice, stakeholder consultations appear to have served as proofreading exercises. It is also apparent that in negotiating stakeholder concerns, NICE have tended to try and find an acceptable combination of paint colours. It is also therefore incumbent on us as stakeholders to continue to press for changes to NICE quality assurance procedures in order to address this weak link in the scientific process.

The revised scope of the third draft revision will be published in December. It is not yet clear if this will include an intention to address the six methodological points raised. ■

Dr Felicitas Rost is the research lead at the Portman Clinic and President of the Society for Psychotherapy Research (SPR) UK

Dr Susan McPherson is a senior lecturer at the School of Health and Social Care at the University of Essex (see www.essex.ac.uk/people/mcphe54701/susan-mcpherson)

References

1 Thornton, J. (2018) Depression in adults: campaigners and doctors demand full revision of NICE guidance. *British Medical Journal*, 361: K2681. doi: https://doi.org/10.1136/bmj.k2681.

2 Rost, F. and McPherson, M. S. *Stakeholder position statement on the NICE guideline for depression in adults*. https://cdn.ymaws.com/www.psychotherapyresearch.org/resource/resmgr/docs/NICE_stakeholder_position_st.pdf. June 2018.

3 McPherson, S, Rost, F., Town, J. and Abbass, A. (2018) Epistemological flaws in NICE review methodology and its impact on recommendations for psychodynamic psychotherapies for complex and persistent depression. *Psychoanalytic Psychotherapy*, 32(2):102-121.

4 https://www.bbc.co.uk/programmes/b0b90pvm

5 https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/consultation-developing-nice-guidelines-the-manual

News: From the BPC

New Chair for the BPC

After three years as BPC Chair, Helen Morgan's term of office ended in September 2018 and the new Chair Susanna Abse took up the reins. The departure of one Chair and the arrival of a new one is often a period of uncertainty for any organisation but the transition from Helen to Susanna Abse has gone smoothly and Susanna, as an existing Board member, is already very much up to speed on the key issues the BPC is working on.

Commenting on her appointment, Susanna said:

"It is with great pleasure and anticipation that I am now taking up the role of BPC Chair. I am looking forward to working closely with clinical colleagues, the team at the BPC office and continuing my close working relationship with our Chief Executive, Gary Fereday, on the things that I think matter to all of us. I would say these concerns must include how we revitalise and spread the influence of psychoanalytic thought; how we ensure that the business of our institutions are thriving; how we develop our profession so that we represent the society we inhabit and finally how we push policy makers to rethink the provision of talking therapies so that it is actually fit for purpose. We have a lot of work to do and we definitely cannot achieve much of these things alone but must work closely with other stakeholders and our partners in the world of talking therapies.

And of course, whilst we continue to tackle these wider issues, we must continue to develop BPC itself so it can provide the services and support that the psychoanalytic community needs to practice and thrive in an ever-more complex world.

But, taking up this role involves facing a significant loss – and that is the departure of Helen Morgan as Chair.

I have worked with Helen since I joined the BPC board and will miss her greatly. Helen has been an incredibly containing chair. Firm in meetings when we drift too far off task but always enabling of all voices. She has extraordinary integrity; is deeply serious and committed to the BPC and its work but can be funny and irreverent too. Her achievements as a member of the board and as Chair are too many to list but her particular contribution has been the way she has facilitated enormous developments around some of the more contentious and undeveloped aspects of our community. In 2015 she set up four task groups – one which explored and challenged us about how we relate to lesbian and gay concerns, one which facilitated our research profile, one which worked on ethnicity and one which tried to facilitate and encourage development in the regions.

These four task groups seem to me to represent Helen and what she really cares about – and I very much believe that our registrants and institutions care about these things too. The work undertaken which is and must be ongoing, have had wide ranging impacts and must continue to do so as these developments are far from complete.

So, I'll miss Helen and her wisdom greatly, and want to thank her for her selfless contribution to the BPC and the psychoanalytic world."

Gary Fereday, BPC Chief Executive said:

"I'm looking forward to working with Susanna who brings considerable strengths and experiences to the organisation. Susanna has been a BPC Board member for several years, was the Chief Executive of Tavistock Relationships for a decade during which the organisation saw huge growth and development, has been a member of various Government and other national committees and advisory groups and is, of course, a BPC Registrant of many years standing.

I'd like to pay tribute to the significant achievements that Helen made during her term of office. Under Helen's leadership the BPC: significantly developed our thinking and work around diversity issues (sexual, gender and ethnic diversity); made real inroads into articulating the evidence base for psychoanalytic and psychodynamic work; established the 'PP NOW' conference as the flagship annual conference for our psychoanalytic community; engaged Registrants and Member Institutions better into our work; and adopted new articles of association (our constitution) that makes clearer the role of the Board, and of our Council that gives us the governance structure to take the organisation forward. I will miss Helen, who I have greatly enjoyed working with, and wish her all the very best for the future." ■

BPC Registrants

British Psychoanalytic Council

Don't forget to record your CPD activities undertaken this year (January to December 2018) to ensure that you are included in the 2019/2020 register.

Improved Registration and CPD Process Online

Please note that the **online BPC annual registration** will open for **all categories** (full/practising registrants, pre-retired, teaching, supervisor, deferred, NHS etc.) The registration and CPD submission will be available online and **paper forms will no longer be valid**.

Another important development is that the BPC will be taking **direct payment** of your Registrant fee via the online process. Some Registrants are already paying the BPC directly but, from this year, we will be collecting the fees **directly from everyone**.

The changes are part of simplifying the registration process for you, the BPC and your membership Institution. It is important to note that your membership Institution will collect their own membership fee separately and that this will no longer include your BPC Registrant fee.

Soon, you will also be able to update all your contact details by logging into your BPC account.

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