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BRITISH PSYCHOANALYTIC COUNCIL

More Doing and Less Being

By Susanna Abse

Why we need to encourage and authorise our leaders

I do not pretend to be a student of leadership theory, rather these comments come from my experience as a CEO and the other leadership roles I have taken over the years. Also, these thoughts are shaped by my more recent role as an Executive Coach working with leaders and also by being a member of the Executive of the BPC. These musings aren't aimed at analysing the dynamics of our organisations – there are many good thinkers who have elucidated these processes from a systems-psychodynamic perspective. Rather this piece focuses on the need for leadership and why we seem to be struggling first to find leaders and then when we do, we struggle to follow the leaders we have.

There is no doubt that many of us are very concerned about the state psychoanalysis is in. In our psychoanalytic community there is a great deal of anxiety about the future. Can psychoanalysis find its way in the 21st century? Are there patients who want it? Are there trainees who want to train? It seems clear that many of the psychoanalytic institutions are struggling to make the adaptations needed to be relevant to contemporary society. We are behind other modalities in many ways – for instance we are still trying to gather a proper evidence base and we have a long way to go in tackling issues of diversity. We struggle to be "business minded" and we have, until recently, often failed to use modern marketing methods. These resistances to change appear to have led to an enduring decline. There are, of course some green shoots, and real possibilities for growth, particularly as Cognitive Behavioural Therapy (CBT) betrays its promise as a cure all. There is a growing awareness of the importance of good mental health in our society and also growing demand for talking treatments which should make for a favourable "operating environment" for the renewal of psychoanalytic treatments.

I am hopeful that with good leadership the tide will be turned but we're going to need radical changes and leaders who can inspire us with vision, courage and commitment. And we're going to have to change our attitude to leadership too.

I was brought up with the idea that leadership was neither something to be celebrated nor sought. Leaders, I was told, were usually far from benign and frequently self-interested narcissists. There were notable exceptions of course and these were the self-sacrificing heroes (Gandhi was the example here).

What was valued in my family was the idea of "service" – being the servant was "noble" being the boss definitely wasn't. As a woman, I felt very unsure whether taking up a leadership role and the authority that goes with it, was legitimate. I felt guilty and unworthy, so it took time and good mentoring to overcome these inhibitions.

So, I came to my role as CEO of Tavistock Relationships with two rather narrow models of leadership in my mind. Firstly, an idea of the leader as narcissistic and self-serving, seeking power for corrupt and base reasons; or secondly where leadership is a noble activity in which the leader reluctantly agrees to accept responsibility and is in service to others. Interestingly, I think these two notions are also quite prevalent in attitudes to leadership in the therapeutic world. These two polarised views of leadership represent, as we might understand it, a split where on the one hand we have the good idealised (rather burdened) leader/parent figure and on the other the cruel authoritarian bad leader/parent figure.

This split, I suggest, perhaps represents a generalised difficulty with authority and hierarchy and I believe we can see this split at work in many of our organisations. Sometimes it seems to be expressed via a lack of structure. We have institutions that have almost no structure, that resist what is felt to be "bureaucracy" and these can often be chaotic. Here the leaders seem to hate their leadership role and feel very burdened by it. Correspondingly, we have institutions where this split seems to have led to authoritarian, hierarchical structures where power is concentrated in the hands of a very few.

But let me extrapolate on the first side of this split – the kind where the leader is "servant" and where the use of authority is avoided – I shall call this the "no organisation organisation"!

'...we're going to need radical changes and leaders who can inspire us with vision, courage and commitment.'

The "no organisation" organisation will usually have a clinician as the leader. This clinician may have been the founder or perhaps is identified as carrying on the founder's legacy. There is little structure and there are consistent attempts to avoid decisions that might have consequences which would affect individual freedoms within the organisation. The leader may be strongly identified with the "servant as leader" mind set or may be unwilling to really take on the responsibility of leadership at all.

It can appear that collaboration is taking place (and indeed in some instances of course it is), but the refusal of the leader to take up authority and the unconscious anxiety about tyrannical power, leads to the primacy of the individual clinician working in lone, idiosyncratic ways.

Sometimes in this situation the leader is more "Guru" than "servant" but the guru leader still offers little practical leadership at all and is too busy thinking great thoughts! Of course, they may well be developing the technical and theoretical aspects of our work and whilst this work is of vital importance, the "guru" leader can represent such a powerful position in the mind of followers and accrue such authority, they can stand in the way of competent, active leadership which would deal with administrative and corporate needs in such a way as to move things forward.

Within the "no organisation organisation", institutional demands are negated and this undermines potential collaboration around development and progress in favour of stasis.

On the other hand, on the other side of the split, there are organisations within the therapy world which seem classically authoritarian and hierarchical in structure. However, many of these have endless committees which seem to appoint themselves and write their own rules and regulations. Lines of authority are blurred and diffused with committees insisting on autonomy in order to carry out their work. Here too we see little change as the structures seem to exist to "preserve" rather than challenge, so even in this authoritarian structure, leadership cannot lead in a classic "command and control" kind of way. In fact, there are

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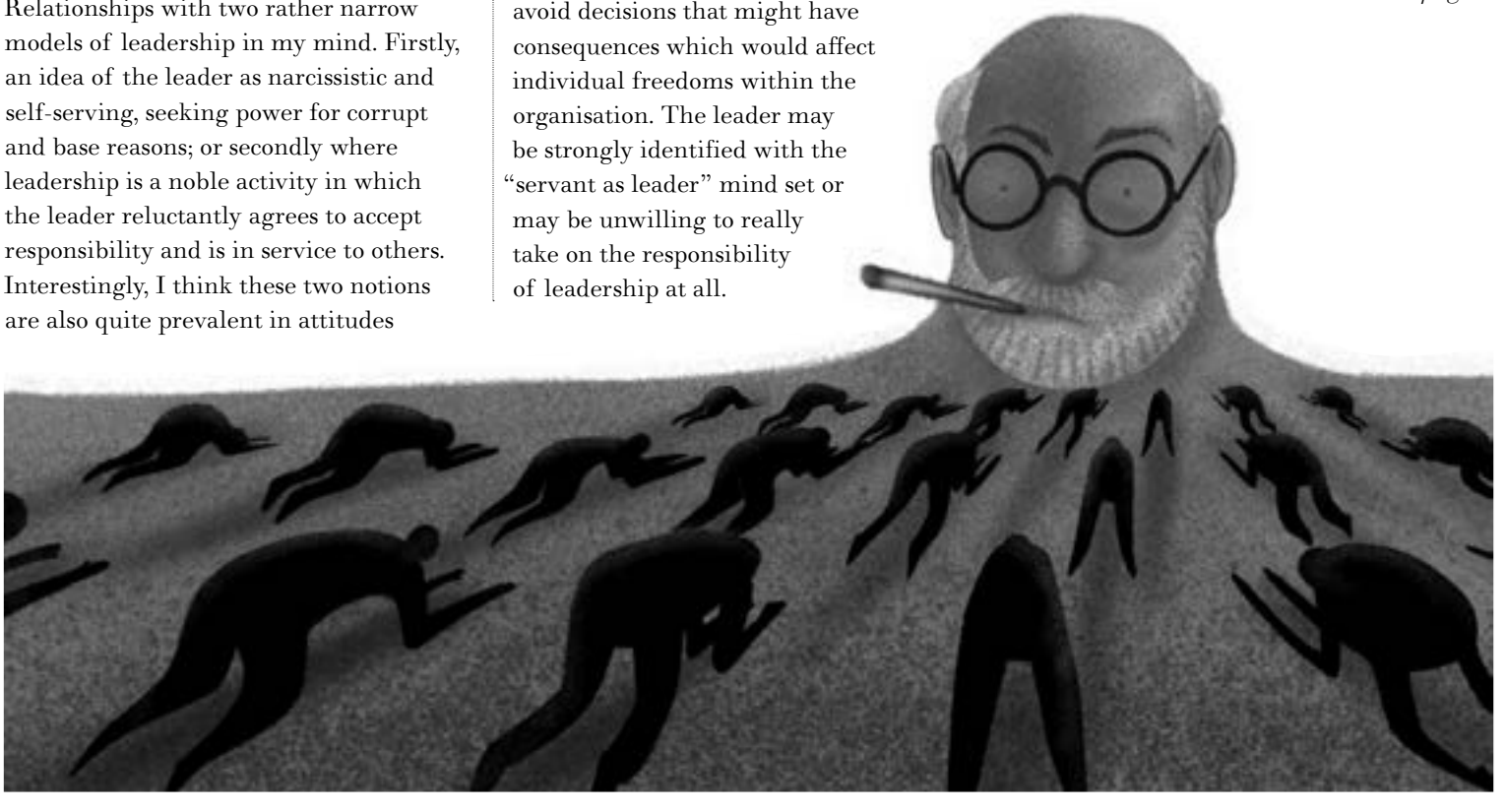

More Doing and Less Being

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too many "leaders". Shall we call this the "Too Many Bosses Not Enough Leaders Organisation"?

What forces are at work here where we either have ineffective leaders who do very little or we have leaders who are constantly undermined by structures that work against change?

Kernberg (2016) suggests that our training systems are to blame. He suggests that too much power and control has been concentrated in the senior analysts – what is generally known as the "training analysts". Kernberg sees this as at the heart of a malaise in our institutions and that this system has discouraged healthy dissent which would bring new ideas and attitudes into organisations. Instead, he suggests that this system of creating an elite of "training analysts" has enabled a small group to accumulate power and create authoritarian structures in which ambitious aspirant psychoanalysts are kept submissive and new trainees are infantilised.

I recognise some of this of course, but this version of training institutions is not universal and I think there is more to our malaise and our difficulties with developmental change and the leadership we need for it than this. But before we go on there is one further aspect of Kernberg's ideas that I think are worth discussion, which is his comment that psychoanalytic theories of organisation have generally failed to think in depth about leadership and about the kind of qualities needed to be a successful leader. Indeed, he suggests that thinking about the individual's personality or qualities is generally discouraged in the psychoanalytic world and the emphasis is rather to think about systems and how systems function and how psychological processes unfold in large and small groups. Whilst understanding of primitive processes in groups has, no doubt been extremely useful in making sense of regressive tendencies in institutions, it has in my view obscured the need to debate the importance of the personality of leaders, the kind of structures that promote good leadership and the required qualities and skills needed for leadership.

Perhaps some of these difficulties with leadership started with our founding father (whatever your modality) – Freud. Freud, it seems, was a good old-fashioned command and control leader and here I quote from Professor Yannis Gabriel –

> *"The founder of psychoanalysis took leadership very seriously, both in his theoretical work and also in his attempts, sometimes successful and frequently unsuccessful, to steer the movement that he founded away from schism, mysticism, quackery and dilettantism. Freud's leadership 'style' inspired great devotion among his followers, at times approaching deification; it also demanded unquestioned obedience, something that led to the alienation and subsequent departure from the fold of psychoanalysis of some of Freud's most creative and original disciples, including C. G. Jung, Alfred Adler, Otto Rank, Sándor Ferenczi and Karen Horney. Behind all of these painful separations, lay a questioning of Freud's authority, something that inevitably led to bitter disputes between supporters and apostates. Instead of being viewed as scientific differences to be resolved through rational discourse, disagreements in psychoanalysis easily came to be viewed as rebellions against the authority of the father figure of psychoanalysis by his supporters and as questioning of his infallibility by his critics."*

These tendencies towards a fear of questioning and challenging things are still around of course. The continuing problem of the unresolved transference of the analysand towards their analyst continues to make "growing up" difficult for clinicians in some of our institutions. We could surmise that some of our malaise may indeed come from our "upbringing" in which the spirit of enquiry, the expression of difference and the pursuit of autonomy from our teachers and supervisors has been experienced as betrayal or a loss of faith, rather than the ordinary natural process of growing up and individuating.

'...one thing that is commonly said about managing therapists is that it is like herding cats!'

So, we've got some ideas about why leadership in our institutions can be over controlling but we are still left with the trying to understand the chaotic and dysfunctional nature of other institutions – the "no organisation" organisations. What is going on there?

Here we must I think turn to the nature of therapy itself and both the personal characteristics required to deliver it well and to the day to day working practices that every psychotherapist is engaged in. If you talk to people attempting to lead psychotherapy or counselling organisations, one thing that is commonly said about managing therapists is that it is like herding cats!

We generally don't seem to like fitting in with organisational structures; we often ignore rules and directives; we are dismissive of administrative requirements and indeed we can be dismissive of the administrators who are employed to undertake these tasks. When I first became CEO of Tavistock Relationships, and indeed from time to time over the whole period of leading the organisation, every so often I would be condescended to by a colleague (usually ones who behaved with no regard to institutional rules or requirements) and asked if I was enjoying my admin job? This apparent ignorance of the differences between the vital work of administration and the task of leadership was indicative of, I believe, a contempt for professional activity outside the sphere of the consulting, seminar or conference room. Being a CEO was seen by some as essentially a non-intellectual activity, which in their mind involved boring bureaucratic procedures that they felt often interfered or attacked the REAL work of training or clinical work.

But where do these attitudes arise from? In part I think it is to do with the required qualities of a psychotherapist. Whilst the institution may have provided the lights, the heating, the patient and the fee, the psychotherapist must create their own domain; their own micro-organisation in which they are responsible for the management of the case, the containment of the patient and the boundaries of the setting. It is a big responsibility and the very nature of the activity demands considerable autonomy and a strong identification with the needs of the patient and sometimes this feels much more compelling than the needs of the institution.

Further, most therapists do not become therapists to engage with institutions. They are seeking in their work the profound intimacy and emotional engagement that working with patients offers. Most therapists have a strong personal need to care and support. They wish to express and identify strongly with loving, accepting and tolerant aspects of themselves and can have some difficulty (despite the years of analysis) owning and creatively using their aggression. Because of this, leadership roles can present the "loving therapist" with considerable internal conflicts, as leaders must also be in touch with their aggression, and, in some circumstances, their ruthlessness in order to lead effectively.

Another aspect of clinical training can also act against preparation for leadership. Many counsellors and psychotherapists work in modalities in which they strongly support their patient's right to "lead" the work. Training develops the therapist's ability to help the patient to be with themselves and to listen to their own experience. To achieve this the therapist must not be task orientated. In psychoanalysis this stance was best described by Wilfred Bion.

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Editorial

Leadership and the future of the profession

By Gary Fereday

The concept of leadership and leaders has a complex relationship with psychoanalytic psychotherapy and is the theme of this edition of New Associations.

It seems at times to be a profession uninterested, suspicious even, of leaders who are sometimes seen as self-promoting individuals either not to be entirely trusted or to be ignored whilst the 'real business' of clinical work goes on. To avoid this, some leaders adopt a position of the 'reluctant leader', projecting an image of selflessly serving their colleagues only after reluctantly taking up the role, often seeking permission to make decisions. These are some of the issues Susanna Abse tackles in the lead article. In it she argues that if the profession is to flourish then it must embrace leadership and develop leaders with authority to lead; as she neatly puts it, we need 'more doing and less being'.

'...if the profession is to flourish then it must embrace leadership and develop leaders with authority to lead.'

The reluctance to engage with, suspicion even, of leaders is something that can often be witnessed across the profession. Reflection, challenge even, about whether a committee or a Board has the authority to make decisions can often dominate meetings, concluding with the real issues being neither properly identified nor decisively tackled.

In March the BPC agreed to adopt new Articles of Association and move to seek charitable status. These changes have been designed to place the organisation more firmly in civic society, increase the specificity of our aims and objectives and clarity around the respective roles of Council and the Board of Trustees. It's a necessary step to help enable the organisation further to take up its leadership role, with clear authority, whilst at the same time ensuring the views and concerns of Member Institutions and Registrants are properly reflected in our work.

In her article examining regulation, eldership and analytic work, Helen Morgan explores the inherent dangers of idealisation of the elders and the associated tendency towards conservatism and preservation of the status quo. As she argues, there is a strong case for the BPC to take up leadership in its regulatory role to ensure that the profession opens up to the external environment that therapists and patients live and work.

Research must surely be a crucial aspect of that external environment and is explored in the article by Felicitas Rost. In it, she powerfully argues the need for the profession to embrace research whilst at the same time arguing how research needs psychoanalytic thinking if it is to find effective ways of overcoming biases. Jessica Yakeley builds on this argument, exploring how some of the challenges of undertaking research have been tackled at the Portman Clinic.

The views of patients must also surely feature in our understanding of the external environment. But, as the conversation with leading patient advocate, David Gilbert, suggests, the profession still has some way to go to understand how we might do this in an effective and collaborative way.

So, there is much to be done to ensure the profession embraces leadership and becomes better engaged with the external environment. The paradox seems to be that while as a profession we seem to struggle with our own leaders, our understanding and approach to the human mind provides invaluable insight into leadership qualities of others – as the articles by Candida Yates and Lynsey Nicholls demonstrate through their examination of Boris Johnson and Winston Churchill.

'...there is a strong case for the BPC to take up leadership in its regulatory role to ensure that the profession opens up to the external environment that therapists and patients live and work.'

With such invaluable insight it is surely time to support the development and authorisation of our profession's leaders, ensure we engage with the external environment and avoid what Helen Morgan describes as the dangers of becoming 'atrophied, marginalised and seen as irrelevant in a modern world'.

Gary Fereday is the Chief Executive of the British Psychoanalytic Council

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> *"Do not remember past sessions. The greater the impulse to "remember" what has been said and done, the more need to resist it. … Desires for results, "cure" or even understanding must not be allowed to proliferate.'* (Bion, 1967a: 272-3.)"

Bion's central idea here is that the therapist must cultivate a "not knowing" state of mind in order to really be with the patient rather than with a set of pre-learnt theories or ideas. He suggests that therapists need to be patient and borrows from the poet, John Keats the idea of "negative capability" to describe a state of mind of continuous uncertainty rather than jumping to conclusions, decisions and action. Obviously, this "being rather than doing" approach, which has become somewhat reified within psychoanalysis, can be rather at odds with the requirements of leadership, where timely decision making and activity is necessary. Indeed, I would suggest this reification of negative capability has brought about a culture within some institutions where acting is confused with "acting out".

This stance can lead to difficulties in our profession with action and with decision making. Problems are "thought about" and then "thought about" some more. Whilst we need reflective institutions we do not need rumination. In my work as a leader and latterly as a consultant I have seen a lot of poor meeting discipline where the task is forgotten, rumination flourishes and then everyone is frustrated.

'... a competitive spirit with the capacity to use competitive aggression creatively!'

So, we have perhaps these two very different kinds of activities – Leadership where decision making and action are necessities and therapy where reflection and staying with the feelings in the present are required. Leaders do need to reflect – they need to look right (back to past experience), look left (to the future), look right again (to the present – now) and then they need to cross the darned road!

There are, of course, aspects of the training of therapists which are extremely useful in leadership. Listening to and offering containment to a staff group; being able to take the emotional temperature of an organisation and speak to what is going on is very helpful, but the task of leadership does not end there – it must move to action and often very quickly.

So, if we are to have effective leaders within our institutions what qualities do they need? Here again Kernberg (2016) helps us as he outlines the requirements for leadership

> *"On the basis of my experience as psychoanalyst leader of groups (inc therapeutic communities, medical director of psychiatric hospitals, and consultant to mental health institutions I can attempt to describe the desirable personality characteristics for rational task leadership. First is high intelligence, which is necessary for strategic conceptual thinking; second is personal honesty and non-corruptibility by the political process; third is the capacity for object relationship in depth, which is essential for evaluating others realistically: fourth is what might be called healthy narcissism in the sense of being self-assertive rather than self-effacing; and fifth is a sense of caution and alertness to the world rather than a naive credulousness, what someone I once knew called justifiable anticipatory paranoia,"*

I would add two further attributes – firstly, a deep interest in improving things, not just preserving things. This means noticing and minding when things aren't going as well as they could, because that leads to an appetite and interest in innovation and change. And secondly, a competitive spirit with the capacity to use competitive aggression creatively! This links to an interest and engagement with the outside world and a wish to learn from others and compete for resources – funding, trainees, patients etc.

Finally, and perhaps most importantly in our psychoanalytic world I think we need leaders who remind us of our social purpose. We need people who have a fire in their belly and an unashamed belief in making a difference in the wider world, who can help us articulate and develop our mission and who will galvanise us towards action and change. And leaders who are not afraid to make psychoanalytic practice the servant of, not the master of this task ■

Susanna Abse, Couple Psychoanalytic Psychotherapist; Leadership Fellow, St George's House, Windsor; Senior Fellow, Tavistock Institute of Medical Psychology; Winner of the BPC's Outstanding Professional Leadership Award 2017

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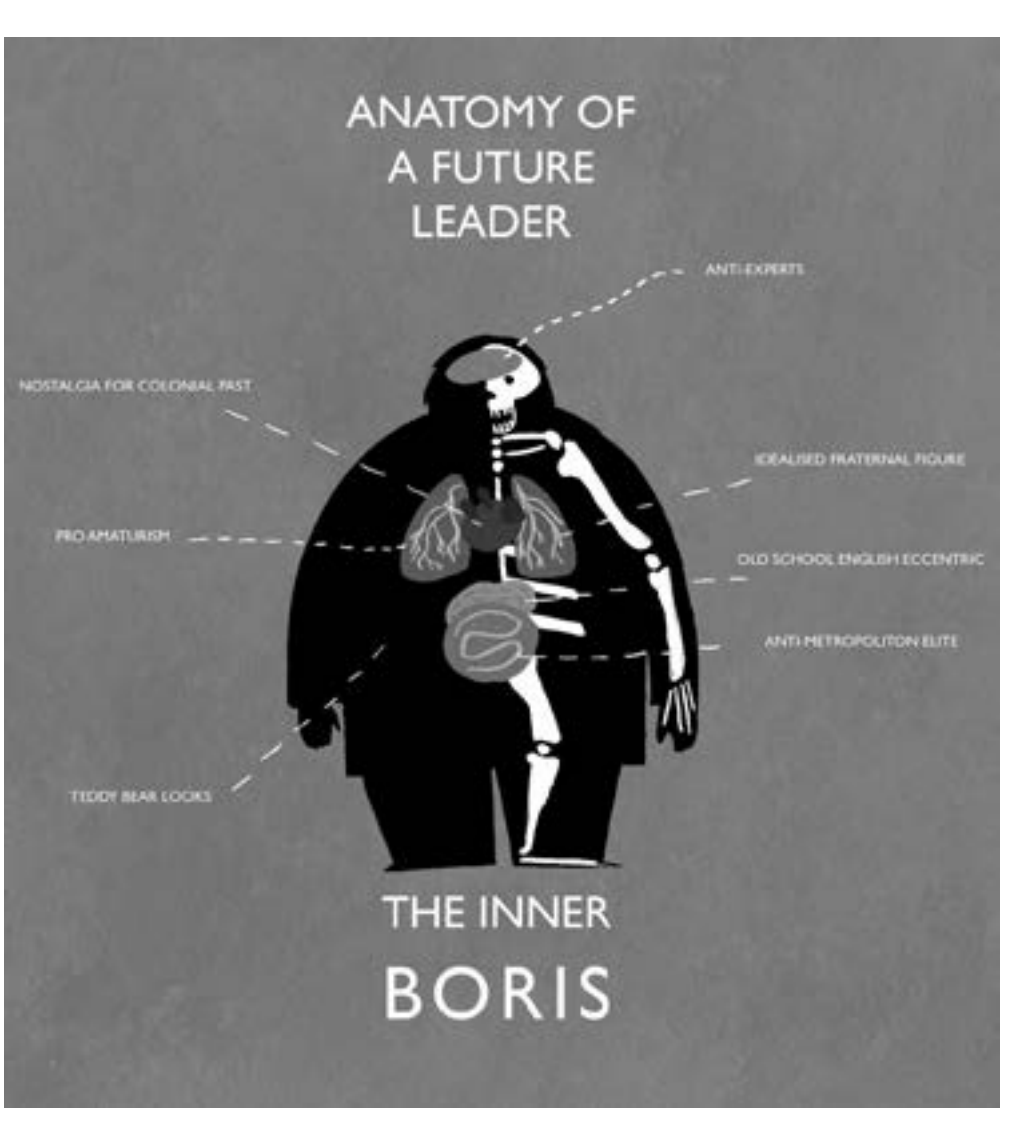
Politics

On the Psychodynamics of Boris Johnson and Brexit

By Candida Yates

Earlier this year, Boris Johnson used his much-trailed Valentine's Day speech to deliver his vision of how the UK should come together, accept the 2016 UK Referendum result, and look forward to all that life outside the EU has to offer. In the lead up to this speech, we were told that he intended it to reach out to Remainers, to reassure them that things wouldn't be as bad as they feared. He urged them - in effect - to dust themselves off, accept 'the will of the people', and start all over again by embracing the new landscape of a post-Brexit Britain (Johnson, 2018). And yet Johnson's playful stab at political courtship, with its mock-psychological references to the problem of 'Brexcosis' failed to hit the spot, leading some to argue that, like a fading music hall act performing at the end of the pier, Johnson had lost his touch and that his cachet as a popular politician was on the wane. Johnson's attempt to flirt with Remainers was probably always doomed, and one suspects that his speech was aimed more at shoring up approval ratings among his existing supporters. Research shows that since 2016, attitudes have hardened on each side of the Remainer/Leaver divide in British public opinion, a split that reflects the polarised and highly emotive nature of contemporary UK politics (Hobolt et al, 2018). A psychodynamic analysis of emotional investment in the Brexit campaign and its leaders allows us to understand the powerful structures of feeling that shape politics today. Johnson played a significant role in rallying support for the 'Leave' campaign in the months leading up to the Referendum. His decision to back the



leave campaign and 'come out as an outer' was taken after months of 'indecision' and 'a huge amount of heartache' (Johnson, 2016).

Johnson's vacillations around the EU campaign hark back to a deeply flirtatious style of politicking rooted in his time as London Mayor, as I discuss elsewhere (Yates, 2014, 2016). Johnson continues to draw on the familiar, playful routines that worked so well for him during that period, which one might see as his 'heyday'. All this helps to shore up his power base as a potential leader in waiting, but, as his prevarications around Brexit show, it is not easy to square such ambition with his public reputation. His flirtation with voters on the theme of Europe provides an example of his seemingly spontaneous, authentic un-spun qualities that in the past have been key to his ability to connect with the public. Johnson's communication skills have been honed over the years in various media settings, and his celebrity status on television and in political debates is such, that he is still regarded by some as 'political box office'. Johnson has constructed a persona as a benign, old-school English eccentric, who refuses to identify with superego figures of authority such as those who were eventually labelled in pejorative terms as the out of touch 'metropolitan elite' following the Brexit campaign, or as 'faceless technocrats' of EU leader, President, Jean-Claude Juncker's ilk.

In the past, psychoanalytic studies of leadership have focused on the processes of fantasy around politicians as idealised parental figures, where the vertical structures of identification shape our relationship to them as objects of the political imagination. Today, however, western democracies are influenced by a loss of faith in the old structures of authority where the hierarchical Oedipal identifications in public life have been challenged by the social and cultural forces of late modernity. The increasing influence of social media across all levels of society has also undermined the old symbolic order of paternal identification and often leads to more horizontal, 'sibling' structures of identification. The popularity of Johnson's playful persona invites such fraternal rather than paternal identification, providing a perfect foil for perceptions about the 'faceless authoritarian' figures of the EU and the 'elitism' of its governing bodies. With his teddy bear looks and public gaffes, Johnson is for some a seductive figure – a comical toy with whom the electorate can play. Any notion of governance associated with his role as a senior politician is thus undercut.

In some ways, Johnson's image has allowed the electorate to identify with him as a version of Winnicott's (1953) 'transitional object', providing a sense of safety in an age of profound insecurity and crisis, thereby also illustrating the changing psycho-political dynamics of fantasy in public life. Winnicott's theory of transitional phenomena has, of late, been applied to the experience of relating to the objects of contemporary media and popular culture (Bainbridge and Yates, 2014), and the unconscious investments in Johnson as a psychological object of political culture is an example of how this works. Winnicott's theory of transitional phenomena and cultural experience can be deployed to explore the public fascination with figures such as Johnson. The public interaction with him – or at least the interaction with his persona as a cultural object – often mirrors the pleasurable dynamics of playing with a transitional object or toy, and Johnson's comedic image helps this process along. Aided by his appearance on various media platforms, including lively interactive social networks, Johnson also seems very good at taking part in the game of celebrity politics (Yates, 2014).

'...like a fading music hall act performing at the end of the pier, Johnson had lost his touch.'

His apparent lack of deference to the establishment sits well with an electorate who are increasingly cynical and disenchanted with politics, and he manages to ward off any potential envy of his position as an elite politician by representing himself as an un-impinging figure that people can enjoy. Throughout the Brexit campaign, Johnson often appeared to gently mock the pomposity of those in the establishment who were too negative and too often called on the authority of 'experts'. By contrast, Johnson's very traditional English trait of celebrating amateurism and of refusing to take things too seriously, taps into his populist appeal, allowing him to associate himself with a nationalist fantasy of 'home'. In this rendition, the 'England' in question is one that belongs to a less complicated and secure pre-globalised age symbolised by flag-waving street parties, jammy dodgers and comics such as The Beano. And yet, in this realm, psychosocial and political relations were also underpinned by the values of empire and the injuries of 'race', gender and social class.

The use of nostalgia as a defence against the losses and uncertainties of contemporary culture has been discussed at length in psychoanalytic and cultural studies, and the desire to turn back also taps into deep-rooted concerns about change and of being 'left behind' by the forces of modernity (Yates, 2015). As research shows, for many, such anxieties played a key role in motivating them to vote to leave the EU, and Johnson's image and leadership style resonates in that respect (Eaglestone, 2018). A cultural desire to look back, or at least to turn away from contemporary malaise and to identify instead with the retro style of Johnson, can be seen in this broader cultural context, but it is also framed by the experience of social and economic precarity.

From a psychoanalytic perspective, this turning back also brings to mind Christopher Bollas's (1987, 1992) theory of object relating, where he contrasts the 'conservation' of objects with their potential to bring 'transformation'. Bollas develops Winnicott's theory of transitional phenomena to argue that just as we seek objects that may hold and reassure us, providing a bridge between inner and outer worlds, we are also changed by those objects, as part of an on-going process of transformation. Each time we experience an object, 'subjectivity is newly informed by the encounter, its history altered by a radically effective present' (Bollas, 1992, p. 59).

Nonetheless, as Bollas argues, alongside the creative aspects of transformation, there are also more defensive and reactionary ways of relating, when objects are used in the service of warding off the risks, and we can extend this to think about the losses that come with cultural change and the fragmentation of late modernity which are also linked to the dynamics of Brexit (Yates, 2015). Bollas's discussion of the relationship between the 'conservation' of objects and 'malignant' moods is evocative when thinking about the mood of Brexit Britain. Bollas (1987, p.102) likens the 'special state of a mood' and the emotional work that takes place within it, to that of a dream, as the mood works as an environment through which the emotional work of object relating takes place. He distinguishes between 'malignant' and 'generative' moods: the former is used as a way to block object relating and is linked to an inability to work through the 'unthought known', those aspects of history that have yet to be properly processed and integrated (1987, pp. 100-101). At the collective level, history is returned to and remains unmourned, as, for example, in idealised accounts of Britain's place in the world as a colonial power.

Bollas's insights throw light on what we see within the hopes and aspirations of those who wish to leave the EU – a desire for some kind of positive transformation in the form, say, of greater sovereignty, a desire to shape one's own laws, remove unnecessary European regulations, develop a more sustainable eco-environment and so on. Johnson's upbeat performance as the leaver's champion may for some evoke such sentiments. Nonetheless, the wish for transformation in the Brexit campaign has often been underpinned by a mood of conservation grounded in illusions of nostalgia for a Britain of an earlier era, when the old hierarchies were in place and where cultural differences were less pronounced.

Whilst Johnson likes to talk in an upbeat way about transformation, his speeches and Telegraph column are often awash with signifiers from an earlier era of nation and empire, evoking a kind of Boy's Own style of masculinity, often with some Winston Churchill references thrown in, to convey the threat posed by the 'European powers' to the border shores of Britain. He conjures up a picture of the electorate as helpless infants faced with the threat of an all-engulfing Brussels 'Nanny' who has lulled us into a passive state of acquiescence, and he encourages British citizens to 'be brave', to wake up out of their slumber and imagine 'an independent future' (Johnson, 2016).

However, as we have seen, one now can detect a number of tensions between Johnson's comical Just William persona and his role as a more serious politician who is currently the British Foreign Secretary with ambitions to lead the UK after severing ties with Europe. More and more, as the contradictions of his public persona are tested and his mask of authenticity fails to convince, the public grow impatient with his lack of integrity and of being tantalised by the play of his shifting political loyalties and policy positions. Today, Johnson can no longer profit from his performance as the popular politician as jester and instead, as an aspiring leader, must manage the hate and disappointment that increasingly comes his way ■

Candida Yates is Professor of Culture and Communication in the Faculty of Media and Communication at Bournemouth University, UK

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Leadership and Governance

Regulation, Eldership and Analytic Work

By Helen Morgan

Over the time since taking on the role of Chair in 2015, I have come to know the work of the three committees that are responsible for carrying out the regulatory work of the BPC – Registration, Professional Standards and Ethics. This has led me to expand on earlier thoughts I wrote about when I was Chair of the British Association of Psychotherapists (BAP) on the relationship between matters of Governance and the analytic institution. At that time, we were all working towards statutory regulation, a process which was aborted when the coalition government came into power in 2010. The BPC was then asked to take on the role of Voluntary Regulator under the authority of the Professional Standards Authority (PSA) and we now have considerable experience of managing this function. The following describes something of my thoughts on this work.

The Analytic Couple

Analytic work takes place within a container, a *vas hermeticum*. Working in private practice one has the privilege of being able to explore the therapeutic relationship in a relatively uncluttered, protected, boundaried place and time. The free associating of the patient[1], the reverie of the therapist[2] and the play between them can only happen in a space where confidentiality and privacy are secure and trusted. The analytic couple must be alone for therapy to take place. However, in this aloneness each becomes vulnerable to the other, and privacy can slip imperceptibly into dangerous secrecy. The deeper, more intensive the work, the greater the danger. Boundaries may crumble, and unconscious vengeful or erotic forces overwhelm, leading to the loss of the therapist's empathic, ethical and analytical attitude and resulting in retaliation and acting out. It is, therefore, also imperative that this analytic couple are not alone.

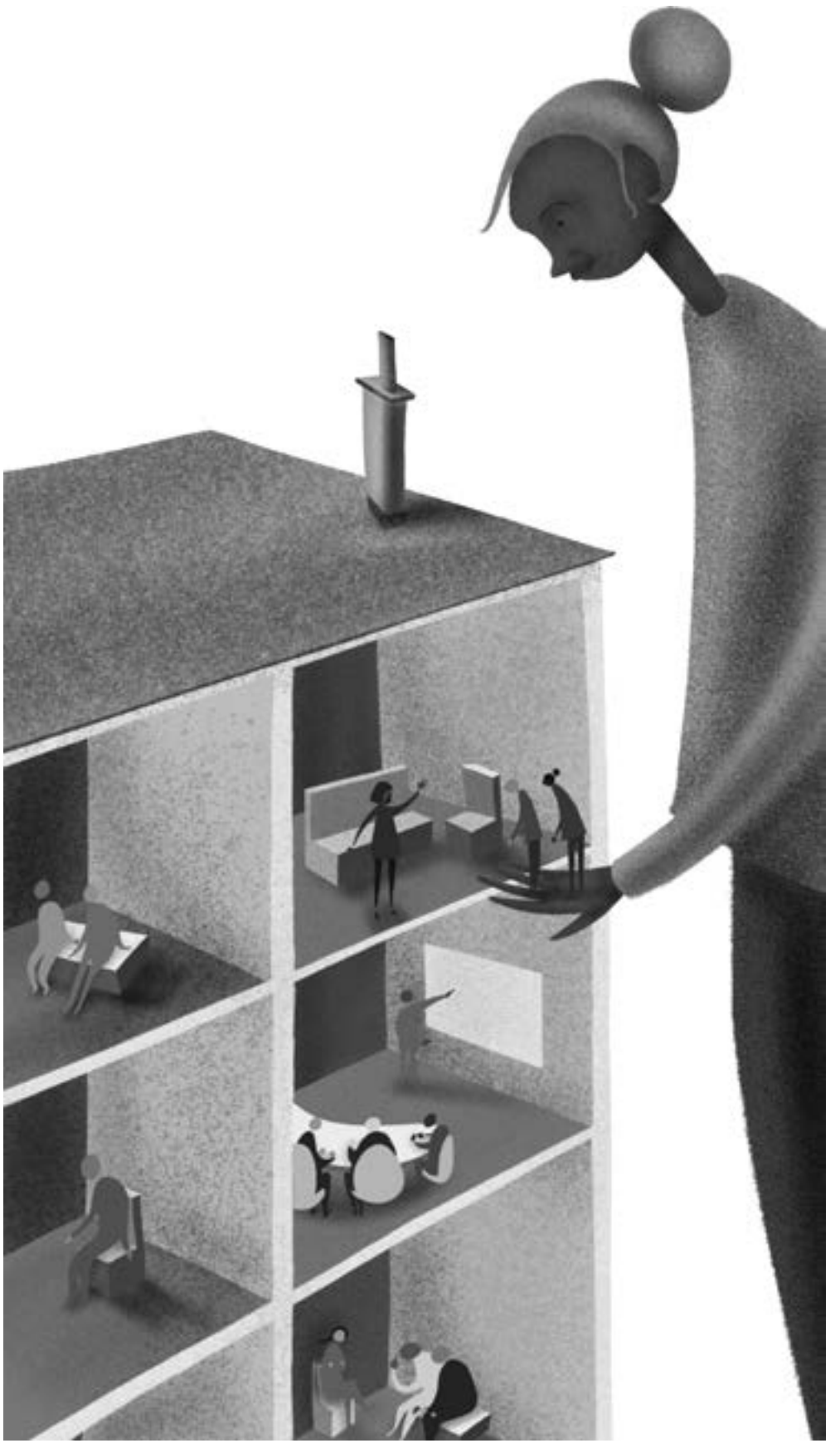
Winnicott proposes that the capacity to be alone is a crucial aspect of healthy development and that this happens through the infant being able to be alone in the presence of the mother[3]. As he states:

> *Here is implied a rather special type of relationship, that between the infant or small child who is alone, and the mother or mother-substitute who is in fact reliably present even if represented for the moment by a cot or a pram or the general atmosphere of the immediate environment.*
> (Winnicott, D.W. 1965, p.30)

Winnicott is, of course, speaking of the individual infant alone with its mother. When he writes, albeit sparingly, about the paternal role he also hints at a notion of this 'nursing couple' itself being alone in the presence of a third. This 'third' is the 'other' in whose presence the mother/infant couple are alone. This 'other' has the dual role of protecting the couple from external impingements, but also of intervening at times of stress between them.

For the sake of this discussion I suggest it can be helpful to read the following passage from Winnicott and replace the term 'infant' with that of 'the analytic couple':

> *It is only when alone (that is to say in the presence of someone) that the infant can discover his own personal life. The pathological alternative is a false life built on reactions to external stimuli. When alone in the sense that I am using the term, and only when alone, the infant is able to do the equivalent of what in an adult would be called relaxing. The infant is able to become unintegrated, to flounder, to be in a state in which there is no orientation….. The individual who has developed the capacity to be alone is constantly able to rediscover the personal impulse, and the personal impulse is not wasted because the state of being alone is something which (though paradoxically) always implies someone else is there.*
> (Winnicott, D.W. 1965. p.34)



How then, can the profession be organised so that it can be the facilitative, concerned and benign 'other' in whose presence the analytic couple can find an 'aloneness' which allows them to 'rediscover the personal impulse' rather than the 'pathological alternative' of 'a false life built on reactions to external stimuli'? This 'other' is made of a series of concentric circles of colleagues (especially those in a supervising role), member institution and the regulating body. As regulator the BPC itself is accountable to our own regulator, the PSA, as well as to the law of the land, and our work is to manage the external demands and to ensure our systems and requirements foster authentic, trustworthy and autonomous professionals able to bear anxiety, hopelessness, powerlessness, to not-know and yet to keep on thinking.

'Working in private practice one has the privilege of being able to explore the therapeutic relationship in a relatively uncluttered, protected, boundaried place and time.'

Whilst other professionals operate in a more open forum so their work is publicly available to be judged, the very privacy of this one makes evaluation a more intricate affair. The analytic profession has existed in relative isolation, containing within it a number of theoretical approaches,

1 Or 'client'. The term is also used to refer to the couple or family where relevant

2 The term is used to include psychoanalyst, Jungian, analyst, psychotherapist or counsellor

3 The term 'mother' here refers to the primary caregiver

a variety of 'truths' each avowed by different groupings with historical and current conflicts between them. We have internal systems of professional authority and responsibility, held by people who are assumed to know their craft. They are the 'Elders' who hold authority in the realms of gate-keeping, assessment, teaching, etc. because of their experience and expertise. Having not had the sort of oversight direct links to academia can offer, the profession has been arranged hierarchically as an hermetically sealed system unaccountable to any external body. The profession has, perhaps, itself been left too much alone for too long.

The Ego Ideal and the Super-Ego

In his paper 'The Analytic Super-Ego' Warren Colman refers to the similarity between analytic training and initiation rites and the tendency this creates for candidates to: *'remodel' themselves in the image of their community's ideal. The candidate's ego-ideal is thus transformed into an analytic ego-ideal to be monitored by an analytic super-ego identified with the analytic community at large* (Colman, 2006, p.1)

Rycroft's Dictionary of Psychoanalysis defines Ego Ideal as: *'The self's conception of how he wishes to be. Sometimes used synonymously with the super-ego, but more often the distinction is made that behaviour which is in conflict with the super-ego evokes guilt, while that which conflicts with the ego ideal evokes shame'* (Rycroft, 1996, p.45)

Colman goes on to say that…:
….idealisation and identification can create considerable difficulties if they remain unmodified. Since it is the job of the super-ego to monitor and even police the ego in relation to the standards of the ego-ideal, the more idealised and therefore unattainable the ego-ideal becomes, the more persecutory will be the functioning of the super-ego (Newton, 1961).. These pressures, in addition to those…. arising out of the counter-transference to the patient's distress, all contribute to a tendency to compensate for feelings of helplessness and powerlessness by elevating the psychoanalytic 'parents' into super-powerful, magically effective, larger than life beings. (Colman, 2006. p.5)

It is inevitable that there is a degree of idealisation of those who, after all, we spend a great deal of time and money training to become like. However, the greater the gap between the ideal and the reality, the greater the threat of shame and the harsher the super-ego response. If the qualities of these Elders, the training analysts, the supervisors, the teachers, are assumed but not defined, and the criteria for assessing the various stages of career development not explicit and transparent, then qualification and later progress becomes a haphazard business of unknown factors and/or the benign regard of those with power. Thus, the training institution is dominated by a form of cabal, internally focussed and run by Elders whose position seems to be a matter of anointment. This can result in a re-enforcement and amplification of such an elevation as described by Colman and leaves the analytic couple vulnerable to the intrusion of the judgemental, shame-inducing analytic superego.

Here the role of a regulator such as the BPC can be helpful as a container which requires greater openness and clarity about training standards, assessment procedures, ethical codes etc. Finding the right level at which to do this is not easy. On the one hand, behind this apparently rational process seethes a ferment of old and new battles over territory and hierarchy with all the concomitant resentments and determined held on to positions. A sort of 'My-Elders-are-better-than-your-Elders' stand-off. Historic and current conflicts rise up in their most primitive form tearing into the profession, the institution and the individual practitioner. On the other hand, the analytic couple must also be protected from invasion by an over-anxious system of regulation which has little capacity to trust this aloneness and wants to manage and control it quite directly by intruding into it.

A profession which relies too heavily on its Elders will, inevitably tend towards conservatism and a preservation of the status quo. I suggest it is more productive to shift the focus from that of 'Elders' with all the implications of an idealised aristocracy or elite, to the concept of 'Eldership' as a functional attribute or quality essential to any profession. Eldership includes the particulars of the craft, the theoretical framework, its moral code, its wisdom. Whilst represented by certain individuals at any one time, its ownership and development need to be accepted as the responsibility of all members – including candidates in training. In the wider profession, in any analytic institution, and also in any individual practitioner, both functions of Eldership and of Governance need to operate in respectful relationship to each other.

Regulation, Eldership and the External World

Like all other regulators, the BPC has taken on a function on behalf of society as directed by the PSA. This function is described as the 'protection of the public' and it means that we are working to ensure that we minimise the possibility of malpractice and infringements of the ethical code. We need good, well-regulated trainings and the obligation that all clinicians present and discuss their work with colleagues as well as ensure they keep on learning throughout their career. And this is as essential for the 'Elders' as it is for the newly qualified, as complacency and arrogance can be as dangerous as inexperience – if not more so. This is an increasingly urgent demand given the average age of the profession and our difficulties in facing the decline, both of ourselves and that of others.

All systems have a tendency towards closure. A closed system is isolated, exchanging neither energy, matter or information with its environment, whereas one which is open maintains its boundary but is able to interact with, and be changed by, the world outside of itself. We can think of the system' as analyst, the analytic couple, the member institution the BPC or the profession itself. Each can live in their own echo chamber guaranteeing they hear only what they already know. It takes active commitment to work against this tendency towards closure, and the BPC as regulator, charged as it is with the demands of society, and required, therefore, to face outwards as well as inwards, has an important role to play here.

It is here where good governance structures and a proper use of regulatory requirements can be helpful in ensuring that practitioners open up to input from the environment in which we (and our patients) live and work. We all should be making sure that we are familiar and up-to-date with research findings both in our own profession and in other related fields such as neuroscience. If we are to be effective and available to work with patients from a diverse, multi-cultural society where matters of sexuality and gender are undergoing a form of revolution, then training curricula and post-grad events need to offer opportunities for all to undertake the work of addressing the racism and prejudice that arise within us as individuals and in our institutions. Such interventions will not always be welcomed and establishing ways of doing this need discussion and thought if they are to be effective. However, given the history and the tradition we inherit, I believe that good 'Eldership' has sufficient confidence in the value of the traditional to recognise it is strengthened by opening up to inputs from outside of itself, and it is this that good regulation can and should support. If we fail to do so then the analytic couple becomes sealed off and isolated, and analytic thinking generally becomes atrophied, marginalised and seen as irrelevant in a modern world ■

Helen Morgan is a Jungian analyst and Chair of the BPC

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Theory and Pratice Today: Research

Psychoanalysis needs Research and Research needs Psychoanalysis

By Felicitas Rost

Is it fair to say that psychoanalysis and empirical research do not speak in different dialects, but speak different languages altogether? In fact, it has even been asserted that they descend from and belong to very different cultures. If so, then this begs the question of whether their diverging heritage forecloses the possibility of any form of alliance. The gulf between the two is striking, with worrying consequences. What is needed is a middle way, where neither imposes its tongue on to the other, but where both can continue to hold on to their principles and values whilst gradually allowing the effects of the encounter to shape a novel way of conversing and hence gaining knowledge. As such, I argue that psychoanalysis needs research as much as research needs psychoanalysis.

Let me start with an illustration. Working on the Tavistock Adult Depression Study (TADS)[1], a pragmatic randomised controlled trial (RCT) investigating the effectiveness of 18 months once-weekly psychoanalytic psychotherapy for individuals suffering from severe, treatment-resistant depression, I entered our communal kitchen one morning to find not one but three coffee machines. I also noticed a variety of instant and freshly ground coffee, a large container of caffeinated tea and two family-size bottles of cola! What I suddenly woke up to was the realisation that investigating particular complex human conditions and its treatment can impact the research in particular ways. Bear with me – I will return to this point shortly.

Since psychiatry broke away from psychoanalysis in the late 1970s, treatments based on these principles have become gradually less available. They continue to disappear from national treatment guidelines and are currently under enormous threat to remain a treatment of choice in our national health service. Moreover, charities, such as the Camden Psychotherapy Unit, whose crucially important effort is to offer psychoanalytic therapy to those who cannot afford it, struggle more than ever to raise the necessary funds. A further concern is the increasing average age of psychoanalysts and decreasing number of patients seen (only 15% of the members of the American Psychoanalytic Association (APsA) are under the age 50, and the average number of patients seen is 2.75[2]). These figures speak of a noticeable lack of a new generation of psychoanalytic clinicians. It is indisputable that psychoanalysis is not blameless in finding itself in this perilous state of affairs. It has a history of insularity[3] that led to a distancing from other psychotherapies and disciplines, giving them, as Peter Fonagy[4] points out, "a place at the table of evidence-based practice" whilst finding itself on the side line. The profession's scepticism of systematic research and reluctance to move beyond single-case reports in providing evidence for its theories and practice, has been a serious problem. The argument made by some that psychoanalysis would thrive best when in "loyal opposition" or when it is "optimally marginal"[5] – or indeed the claim that the profession need not to worry as "there will always be patients who want and need an analytic approach and why there will always be therapists who need to learn it"[5] – I find difficult to comprehend. As someone who believes about the necessary integration of psychoanalytic concepts into other psychological treatments as well as the survival of it as a treatment model, I see the task at hand in needing to join the scientific community as an active participant. As Jeremy Safran[6] points out, it is there that the standards of practice are discussed and implemented, and I believe being part of it allows the profession to contribute directly to the dialogue and negotiate the terms and conditions. But in order to do so, the profession needs to play the game following its existing rules. But there is also another reason why psychoanalysis needs to engage much more in systematic research. That is, like any other professional body offering a service to individuals who are suffering, it has a social responsibility in respect to providing evidence of the effectiveness of its treatment models. In that I agree with Jean Knox[7] that it is a "rather dubious ethical position" to keep relying on ideological beliefs and authority. I also think that the profession has a responsibility to its members in providing opportunities for it to grow and develop by questioning its concepts and techniques in a systematic manner as well as in adapting to the various societal changes that are happening. It has been well established that we human beings cannot rely on our own judgements given our tendency to seek confirmation of what we already believe and to over-estimate our own competencies[9]. Thus, as Fonagy[4] reminds us, psychoanalysis, like any other discipline, needs another, an outsider who is not caught up in the transference and counter-transference processes, to become more scientific.

The dualistic view that psychoanalysis is concerned only with hermeneutics not science, or is only idiographic not nomothetic, is most unhelpful, as clearly it embraces and needs both. There is no doubt that the evidence base for psychoanalytic treatments is growing. However, much more is needed; the profession has been very slow in replicating trials and carrying out studies with larger sample sizes that are needed to strengthen and solidify it. It is important not to take the plug out of the bath whilst the tap is running and to continue accumulating that kind of evidence. RCTs are equipped in answering important questions other research designs cannot provide, and anecdotal and published[10] accounts of participating analysts shows that the fears and prejudices they had about the psychoanalytic process being intruded upon, violated or even distorted by the constraints of research – for example always having a "third" in the room when being recorded – were either unwarranted or could be worked with. I assume, the fear for some might be of a much more existential nature: the fear of being proven wrong or of change. The question is, as Mary Target[11] highlights, whether psychoanalysts can be confident and trust that any resulting change may not destroy the discipline's firm foundation, but may instead allow for a creative adaptation. She underlines her point by emphasising that Freud himself was flexible and creative to change his mind and model several times, and her plea to adopt such an attitude might be worth contemplating.

Having said that, it is important to acknowledge the various limitations of RCTs and to keep in mind that they are only one part of the research cycle[12]. Other research methodologies are equally important, and I never understood the need for such stern polarization as in the case between empirical research and psychoanalytic case studies. The particular psychoanalytic concept of splitting helps me in trying to make sense of it - after all we are all prone to defensive reactions when feeling threatened or perhaps persecuted by those wanting to impose authority. The reinforcement of an illusory hierarchy of evidence that elevates RCTs above observational studies[13] is as restrictive as the claim that case reports are the only methodology of true psychoanalytic value. We might do better in investing our anxiety-coloured energies in building bridges between the various methodologies and employing them in conjunction. If we are striving for the best approximation of finding the truth, would we not do well by taking the perspectives of all three into account: the participant's, the therapist's and the observer's? Surely, shining light on one perspective only would leave a looming dark shadow.

'These figures speak of a noticeable lack of a new generation of psychoanalytic clinicians.'

In fact, many of the bridges have already begun to be built as evidenced by the adaptation of research trials to allow studying the complexity of the clinical situation, the research participants and the treatment modality[6]. For empirical findings to become meaningful, they need to be integrated into clinical practice. Thus, the focus on mechanisms of change, the incorporation of important moderator and mediator variables, the importance paid to therapy process as well as outcome are only a few examples of emerging forms of research that psychoanalysis has now at its disposal. Similarly, formal qualitative methodologies have been developed that incorporate psychoanalytic principles of free association and the importance of the dyadic researcher-researched relationship and the dynamic unconscious during the research interview in the process of data analysis[14, 15]. Case study methodology, too, has undergone important developments in that they have become more systematic[16, 17]. The TADS serves as a good example of a research study that successfully managed to match both the complexity of severe, chronic depression and the long-term psychoanalytic psychotherapy by combining a robust outcome trial with formal qualitative research methodology and clinical case studies.

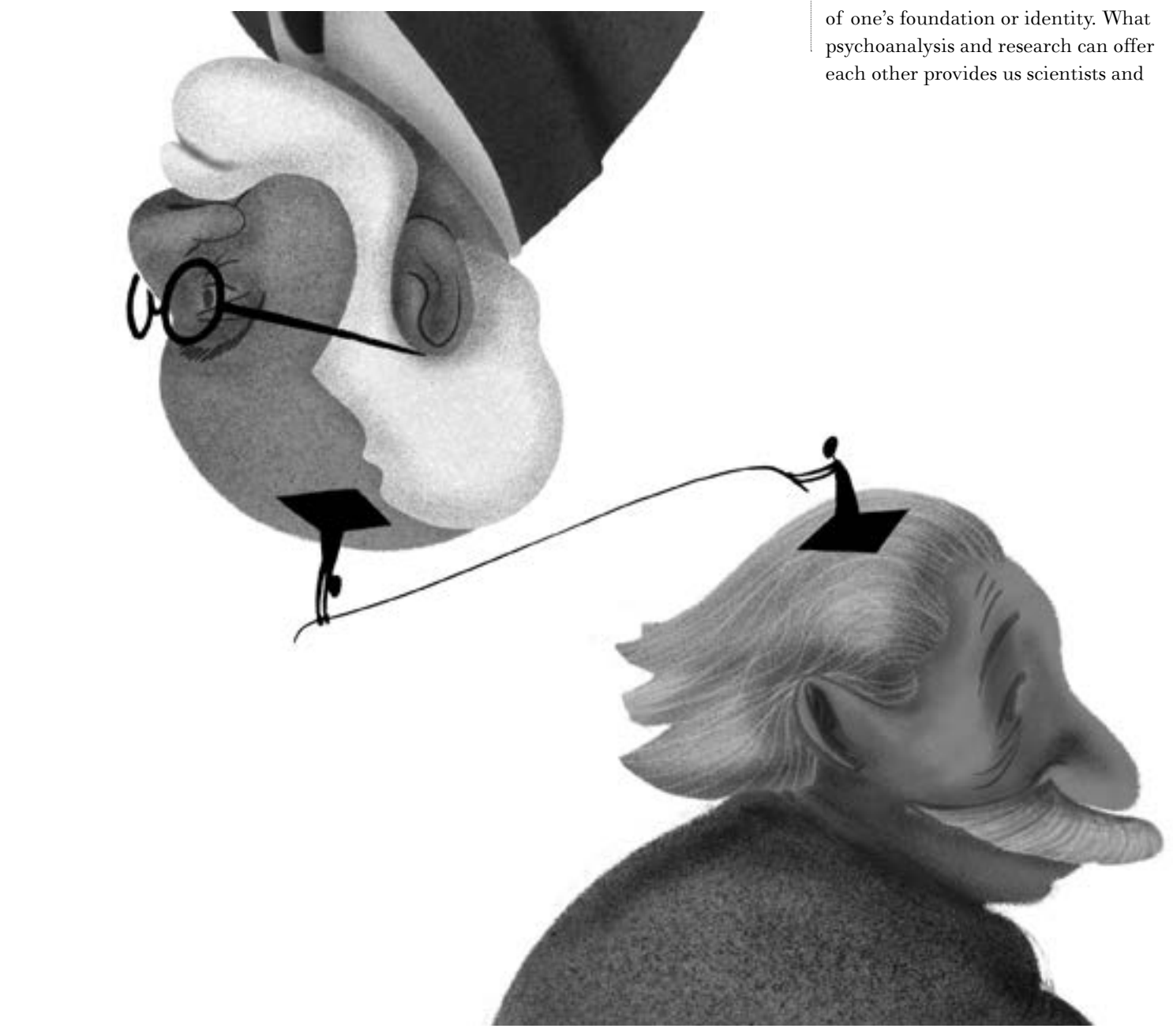
The National Institute of Clinical Excellence (NICE) is following a restrictive model of science, and are in need of a re-visioning[18]. It needs to draw on a diverse range of evidence to inform treatment recommendations, and research efforts should be much more directed towards what treatment works for whom in what particular context and point in time. However, there is also a serious lack of cohort or case control studies as well as services and individual psychoanalytic practitioners who routinely collect outcome data (and if you think that there are not any meaningful outcome measures available, please have another

search, and encourage the development of new measures). Thus, whilst we need to continue to challenge treatment guideline developers and policy makers for their rigid adherence to and their continual attempts of subordinating psychological treatment to medical science, the psychoanalytic community needs to engage with more research of all kinds. However, one might argue that research needs psychoanalysis just as much.

That empirical research is reminded of its biases and blind spots as well as keeping a constructive critical stance towards its methods is a healthy scientific attitude[19]. With that in mind, I would agree that a position of psychoanalysis "in opposition"[20] might be advantageous. However, the adoption of such a position is not exclusive to psychoanalysis, but could also be inhabited by any therapeutic approach. To my mind, research needs psychoanalysis because of its unique approach to understanding and engaging with the human mind. With sufficient time and space, psychoanalysis offers, as Target puts it, the unique experience of being "deeply known, progressively uncovered while being held carefully in mind"[11]. Whilst these experiences might indeed never be measured adequately[11], the particular psychoanalytic stance, however, might help shape research to become more meaningful, in-depth, and all-encompassing. On a concrete level, it might challenge the current trend of searching for and advocating ever quicker solutions, be it in the various efforts to shorten questionnaires or treatment modalities. Time also plays a crucial factor in the consolidation of change after treatment ends and all psychotherapy studies need to include a long-term follow-up. On another concrete level, psychoanalysis might remind the scientific community about the crucial need to keep a position of equipoise, which David Taylor[21] likened to Bion's concept of 'negative capability' – the researcher as much as the psychoanalytic clinician need to hold on to an impartial position with regard to the outcome "whilst being prepared to be disturbed within limits" and tolerate uncertainty. The effect of the researcher allegiance and publication bias are serious problems that the research community is in need of addressing. Most importantly, however, research in its practical conduct would benefit from the psychoanalytic understanding of the impact of unconscious processes and transference and counter-transference phenomena. Let me now return to the illustration I provided earlier.

'...research needs psychoanalysis because of its unique approach to understanding and engaging with the human mind.'

I came to understand that by consuming exaggerated amounts of caffeinated substances, we, the researchers, unwittingly tried to cope with the counter-transference, in particular the feelings of hopelessness and being tired of living that most of the TADS participants experienced. One of the challenges for every research study is to keep the attrition rate low, in other words to have as little missing data as possible as well as to have as few participants dropping out as possible. The challenge lies in finding a way of achieving that without coercing the participant in any way. What psychoanalysis brings to it is an understanding of the various possible ways the researcher contributes to it unconsciously. For example, the TADS participants' belief that "nothing has helped" and "nothing ever will help" was often palpable during research interviews and at some point we noticed we started to feel similar: the doubts in the usefulness of the interviews we carried out became more frequent, the near accidents in deleting precious recordings of therapy or research sessions closer to realisation, and the forgetting of arranging follow-up interviews recurrent. Whilst these experiences can be incorporated in the sense-making of patient qualitative interview data[22], inhabiting a psychoanalytic stance and supervision provides a space to become aware of and think about the possible parallel processes that can get evoked when studying a particular condition in order to help mitigate these challenges
I strongly believe that diverging heritage does not foreclose the possibility of union, and that adapting to a different culture does not mean annihilation of one's foundation or identity. What psychoanalysis and research can offer each other provides us scientists and clinicians with a real opportunity for creativity and progress. Whilst there is a pressing need for the psychoanalytic community to engage, encourage and fund more research if it wants to survive, the research community needs to engage with psychoanalysis to find effective ways of overcoming biases and to open up to become more meaningful, in-depth, and all-encompassing ■



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

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Theory and Practice Today: Research

Implementing research in clinical practice: our experience at the Portman Clinic

By Jessica Yakeley

In her article, Felicitas has cogently argued for the integration of empirical research with psychoanalytic psychotherapy practice, not only to ensure the survival of the psychoanalytic community, but to provide a platform from which research and practice can flourish through a process of mutual enrichment. In this piece, I would like to illustrate some of the challenges that she describes in implementing such research within an NHS psychoanalytic psychotherapy service, the Portman Clinic, and how to counteract experiences of imposition of commissioner-required outcomes, measurements, and databases that may seem irrelevant to clinical work, by creating our own 'evidence-base' that is meaningful to both our internal and external worlds.

The Portman Clinic, part of the Tavistock and Portman NHS Foundation Trust, is an outpatient forensic psychoanalytic psychotherapy clinic in London offering assessments and treatment to children, adolescents and adults presenting with enactments of violence, problematic sexual behaviours, criminality and delinquency. The Portman also offers psychoanalytically-informed consultations, risk assessments, and teaching and training to professionals working in a wide range of settings including health, the criminal justice system and social services, and is involved in a number of research studies. With this brief, the Portman effectively straddles two 'cultures', the culture of psychoanalysis and the culture of the modern NHS. On the one hand, the Portman identifies with the tradition and culture of psychoanalysis, which focuses on unconscious processes and intrapsychic change. On the other hand, the NHS increasingly emphasises accountability, monitoring and evaluation of interventions, and the development of an evidence-base to guide the choice of treatment.

The Portman has a longstanding interest in research, and some of the psychoanalysts who have worked here have developed and published innovations in theory and technique in working psychoanalytically with perverse and violent patients. One of the most notable psychoanalysts in this respect was Mervyn Glasser, whose conceptualisations on violence and perversion, in particular the notion of the 'core complex', which emerged from the violence research workshop which he developed and ran for many years at the Portman, continue to exert a significant influence on our understanding of the psychic functioning of our patients and related challenges they present with in therapy.

In more recent years we have been involved in a number of research projects. These include research by Rob Hale, Stephen Blumenthal and Stan Ruszczynski at Ashworth High Secure Hospital in which they found that weekly consultation to the staff increased the number of personal engagements between staff and patients; a qualitative study that I did with Heather Wood where we interviewed patients to ascertain their experiences of psychotherapy at the Portman and their views on what changed and how; and research by Heather Wood and Stephen Blumenthal in offenders at Grendon Prison Therapeutic Community on the Implicit Association Test, in which they identified that an implicit association between violence and enjoyment (sadism) is associated with offenders who are more antisocial, advancing our understanding of risk. More recently we have become involved in a large pragmatic multi-site randomised controlled trial, led by Peter Fonagy at University College London, which is evaluating mentalisation-based treatment (MBT) for violent offenders under the supervision of the National Probation Service at 14 sites located within probation premises across England and Wales, a study which builds on a much smaller scale non-randomised study of MBT for ASPD that we initiated 10 years ago at the Portman Clinic.

However, conducting a RCT such as the MBT/ASPD study is a large enterprise requiring considerable expertise, coordination, staffing and funding, and is very difficult to do solely by clinicians in psychotherapy services without the involvement of dedicated academics and researchers. A more realistic enterprise is to shift routine outcome monitoring required by commissioners into smaller scale, more pragmatic research studies, for example naturalistic longitudinal outcome studies which measure chosen aspects of the patient's difficulties (e.g. depressive symptoms) before and after treatment, which may not fulfill the requirements of the 'gold-standard' methodology of the RCT, but are more easily implemented within clinical practice and may nevertheless represent significant changes in the patient's psychopathology and functioning.

Some of the complexities encountered in researching psychoanalytic treatment concern questions of what constitutes change and how to measure this. One of our challenges at the Portman has been finding a validated and widely used measure that both describes our patients' psychopathology and captures therapeutic change within a psychoanalytic framework. One measure that we have found relevant, and have been using on all patients accepted for treatment since 2010, having persuaded our commissioners to accept this as a Commissioning for Quality and Innovation (CQUIN) goal[1], is the Shedler-Westen Assessment Procedure (SWAP-200, Westen & Shedler, 1999). The SWAP is a psychoanalytically-informed clinician-rated assessment of personality disorder as well as personality functioning. A unique strength of the instrument is its ability to describe and quantify aspects of internal experience central to personality pathology, such as psychological conflict or internal contradictions, representations of self and others, motives, and intentions. In a sample of 164 men with a range of paraphilic disorders and problematic sexual behaviours referred for treatment to the Portman, our results to date show that roughly two thirds of these patients are diagnosable with traits of one or more personality disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), and one third were diagnosable with categorical DSM-5 personality disorders. These rates of problematic personality traits and personality disorders are dramatically higher in our sample than the prevalence rates of 6-10% found in epidemiological studies of personality disorders in the general population, both in the US and in the UK.

The SWAP also generates scores for 12 trait dimensions, which were derived via factor analysis of the SWAP item set. In this study, we found clinically elevated scores for the trait dimensions of Psychopathy, Hostility, Dissociation, Oedipal Conflict and Sexual Conflict. These factors highlight features consistent with the clinical model of paraphilic disorders which we find effective in practice: a model that recognizes the association of sexuality with anxiety, aggression and disgust; that stresses the use of sexualisation as a defense against difficulties in forging and sustaining intimate relationships; and that acknowledges the aetiological significance of trauma or abuse, with dissociation a common response to such experiences. On the basis of these results, we propose that in some cases, paraphilias are not just constellations of fantasies and behaviours, but may be considered diagnostically to be disorders of personality in their own right. This clearly has implications for future assessment and treatment of these disorders.

Our vision for the future is to develop the Portman into a research clinic, in which every consenting patient participates in qualitative and quantitative research. We are extremely fortunate in having appointed Felicitas in 2015 as our Researcher at the Portman Clinic. Under her leadership we have developed an ambitious battery of clinician and patient reported measures that we piloted on a few carefully selected patients currently in treatment, and which we are now implementing with all consenting patients accepted for treatment. We have chosen these particular measures as they seemed to be the most appropriate in capturing the diagnostic profile of our patients, their psychopathology, changes in symptomatology, problematic behaviours, and personality traits through treatment, as well as measuring the nature of the therapeutic relationship, the therapists' countertransference experiences and the patients' own experiences of their psychoanalytic treatment. We hope that this will in time give us sufficient data to apply for research funding to conduct more rigourous studies, including an RCT, on our treatment. This will clearly involve a lot of work but we feel very fortunate in having Felicitas' expertise and previous experience of coordinating and researching the Tavistock Adult Depression Study (TADS) RCT, which has been one of the most important trials in recent years to demonstrate the efficacy of psychoanalytic therapy for depression.

At the Portman Clinic we have a unique population of patients whose actions harm themselves and others, provoke outrage and rejection yet who suffer and have suffered deeply, and who deserve a better understanding of their pathology and the mechanisms through which psychoanalytic therapy may alleviate their suffering. We hope that our continuing research endeavours will go some way in achieving these aims, and will support and inspire other NHS psychotherapy services to engage meaningfully in psychotherapy research ■

Jessica Yakeley is a Consultant Psychiatrist in Forensic Psychotherapy and Director of the Portman Clinic, Tavistock and Portman NHS Foundation Trust; and a Fellow of the British Psychoanalytical Society

1 CQUINs were introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.

In Conversation

David Gilbert on Involving Patients

Gary Fereday in conversation with David Gilbert, mental health service user with over 30 years of experience both as a patient and a leading public engagement practitioner.

Gary Fereday. *We have known each other professionally for many years David. In that time, I have seen you passionately articulate your experiences of being a mental health patient and the need for better engagement and involvement of patients. What brought you to this arena and what keeps you going?*

David Gilbert. Well, I will never forget many years ago crying alone on a psychiatric ward while under 24/7 suicide watch clutching an old teddy bear and the kindness shown by staff (admin and clinical) and fellow patients that showed me true partnership is possible. I keep going because of my admiration for fellow travellers who are working to raise the voice of patients and seeing the slow and steady rise of a patient movement – one founded on the wisdom and insights of those affected by health conditions.

I also recognise the challenges we face. About twenty years ago, I was sitting on a psychiatric ward with nothing to do – the lunch had been awful, the Occupational Therapist had been sacked (so no activities that afternoon) and the ward seemed full of screaming folk. A doctor strolled onto our bay and gave a perfunctory nod before gingerly pulling on the curtain rail beside my bed. Even in my disturbed state, I could see his behaviour was odder than mine. I asked him what he was doing: 'Just checking to see if you could do anything stupid', he replied and then walked back down the corridor. I was left contemplating my suddenly increased range of treatment options!

Fast forward ten years and I was Head of Patients and the Public at the Commission for Health Improvement, the then statutory health inspectorate. I was reading the National Patient Safety Agency standards on mental healthcare. One of them was to decrease in-patient psychiatric suicides to zero by…. removing all non-collapsible curtain rails! I was gobsmacked – talk about hitting the target and missing the point. I thought of Jennifer-Anne who had choked to death on her food while unsupervised after she had left the psychiatric unit and gone to a nursing home. I thought of Dave who had gone to his caravan and hanged himself and of Laurie who had drowned himself in a reservoir. All those deaths had occurred away from the in-patient environment. I don't think any of those would have appeared as stats during inspections and the unit would have ticked the box on removal of ligature points.

'I keep going because of my admiration for fellow travellers who are working to raise the voice of patients.'

GF. *Powerful reasons, although I notice that you say we are seeing a 'slow and steady rise of a patient movement'. Are things really changing to bring a stronger patient voice to the table?*

DG. Patients can be true partners for improvement and change. They can help identify what matters, rethink problems, generate solutions, model better relationships, promote better decisions and improve practice. But, at the moment I fear we are all hamstrung by bad habits. The way we think about patients' contributions is stuck in a time warp, our mindset constrained by an outmoded view of what patients can or cannot bring. Moreover, the way we do patient and public engagement fails to have any real impact because it is outmoded and unfit for purpose. In part, it was never designed to bring real change, but to buffer it and maintain the status quo. If we really want solutions, this needs to change. I would argue that the task is fourfold:

1. Learn to value what patients can bring – see patients as partners
2. Change how engagement is done – rethink engagement processes
3. Support people's capabilities to better work together – develop the right skills
4. Develop new opportunities for patients to influence decision making – create new roles.

GF. *Of course, in psychoanalytic psychotherapy the emphasis is on partnership and long-term relationships between clinicians and patients. How do you see the ideas being applied in the psychoanalytic field?*

DG. I have seen many excuses in my time for patients being marginalised from 'engagement'. But the ones in the psychoanalytic field are often unique. I was once told that a therapist had cancelled appointments for their clients because a chair in a corridor had been moved and that this would 'disrupt the therapeutic process'. So, no wonder some clinicians think that one of their client's being involved in discussions (let alone decisions!) about the way they practice would disrupt things.

My hunch is that this is the psychanalytic profession's problem, not the patients'. That it is more about power. I wonder who is projecting upon whom. As a former psychoanalytic client, I doubt there would have been anything very disrupting if I had gone to a focus group, participated in a workshop or been part of decision-making process. My serious point is that, if this is the way that psychoanalytic psychotherapy draws its hard borders, perhaps they need to be softened. This would be a fascinating discussion to pursue. Maybe the BPC could hold an event on it?

By the way, I worked with the Tavistock and Portman NHS Trust on its user involvement strategy with their Chief Executive, Paul Jenkins, and their wonderful user engagement lead, Anthony Newell. They have done great things and have a thriving user engagement strategy. They seem to be able to overcome many of these challenges.

'I think the 're-humanising effect' of creating spaces for difficult conversations about policy and practice could be beneficial to all sides.'

Moving to mental health in general. I am concerned that many staff are becoming unwell due to stress of the work environment, resource and regulatory pressures. That they often have more in common with people who use mental health services than previously. I think the 're-humanising effect' of creating spaces for difficult conversations about policy and practice could be beneficial to all sides. As a professional, I run workshops in this space. As a poet, I want also to get into more creative forms of engagement. I am getting old and tired of the traditional NHS field. I have set up 'Re-Verse' – a programme of work and hopefully another new organisation (I never learn!) designed to use reading and writing poetry to heal relationships between staff and users. Maybe the future is poetical as well as political.

GF. *You clearly feel the profession has some way to go. The BPC is seeing how lay involvement in our structures bring benefits and I'm look forward to the organisation building on this. But we have yet to work out how best to enable the views of patients to help inform the development of the profession. Do you think that patient involvement will eventually change services for the better?*

DG. On the whole patient and public engagement has changed little. The engagement 'industry' has largely focused on inputs, activities and processes (the methods of gathering data, how to capture views, etc) over impact and outcomes. The approaches and methods have used two main 'styles'. The first is that of feedback: patients are invited to fill in questionnaires, attend focus groups, or tell their stories at board meetings. The focus is what happened to them in the past, the meaning of their data is left to professionals to assess through their own lenses, based on their own assumptions and often narrow institutionalised thinking. The approach mirrors traditional medical paternalistic models – you tell us the symptoms, we will provide the diagnosis and treatment. It is stuck in child-parent mode. The second style is 'scrutiny'. Whenever there is a governance committee, an advisory group or the like, the call goes up for lay representatives. But without clarity of role, support or training, the lay representative is expected to 'bring the patient perspective' to the decision-making table.

I was once asked 'so David, what do patients think'. 'What, all of them?' I thought. In search of credibility and leaning on what we know, we tell our stories – half the people in the room applaud this 'telling truth to power' and the other half fall asleep ('another patient with an axe to grind' or 'personal agenda' they mutter later in the corridors). Yet if we arrive at the meeting brandishing data or outcomes, those that were awake last time fall asleep and accuse us of 'going native'. The consequence of failed representational mechanisms is that committees lapse into a default 'us and them' mode. Frustrated, marginalised and unprepared 'reps' start finger-wagging or fall silent. This is adolescent-parent style engagement.

Continues on page 14

On The Ground

Welsh Dragons, Snowdonia Mountains and the Unconscious

By Arthur Niesser

In April 1995 I was on the train home to Porthmadog in North Wales after I had attended a conference in Edinburgh on psychosomatic disorders. During a conversation with fellow passengers one of them remarked, 'surely, there is no need for psychotherapy in North Wales'. My reply was, 'There is a lot of need but little demand'. This assessment seems still valid. As a German national, I came to live in North Wales to marry my (English) wife. After I had completed my training as a general practitioner in Germany, I had obtained a psychotherapy qualification under the training requirements of the German Medical Chamber. and I had been working in my own psychotherapy practice in Germany until 1992. I had hoped to establish a private psychotherapy practice in Porthmadog and to make a good income from it, but this proved difficult. While working predominantly as a GP, I completed my Jungian analytic training with the Association of Jungian Analysts AJA) in London and I established a small private analytic practice.

One major reason to prevent potential patients from accessing psychotherapy is the lack of funds. According to the Office of National Statistics, the county of Gwynedd had the third lowest average wages in the UK in 2017. The median gross weekly earnings were as low as £421. This makes longer term psychoanalytic work so expensive that it is unaffordable for most residents. I therefore charge comparably low rates, for some patients not more than £25 per session. My training patient was living on benefits at the time and accordingly the fee for three times weekly analysis had to be very low.

Another factor are long distances. My geographically closest patient lives 23 miles away, the furthest 35 miles. Face-to-face analysis more than once a week is therefore impractical for most patients. And finally, there are language and cultural obstacles. According to the 2011 census, 65.5 percent of the population in Gwynedd are Welsh speakers. The language is of very high cultural value in this area. As a GP I only once experienced outright hostility for not being able to speak Welsh, but there is some reservation to engage in an intimate trusting relationship in a language that is regarded as a threat to one's own culture.

There may be other cultural and religious issues. The Welsh population in Gwynedd tends to live in traditional communities with little natural inclination to change. Most people have a network of family living locally and by and large, problems are kept within the family. I observed that talking about conflicts within the family was easily perceived as disloyalty. Furthermore, a retired Anglican vicar and good friend of mine pointed out that there is a belief that suffering is virtuous and leads to redemption.

When I worked as a GP, I often heard expressions such as 'oh, never mind' or 'grin and bear it'. While these sayings accepted a reality without hanging on to unrealistic expectations, they also express a resigned attitude, which does not demand change. Quite often I thought to myself – and on occasion I said it, 'I wished you would mind'. Analytic therapy works towards change and the desire for a more liberated life. In contrast, the culture in North Wales is based on continuity and tradition. To illustrate my observations, here are a few figures from my practice over the past two years. 11 of my patients were English, four were Welsh with English as their main language, two were European and only one was a predominant Welsh speaker, all be it one who had lived in an English-speaking environment for many years.

Living in a small community can raise problems of confidentiality. My office is next to the local primary school. I avoid session times, which start or end at the same time as the school opens or closes. Over 20 years ago, my wife and I went for a rare night out at the local cinema, after we had managed to find a babysitter for the night. It was not before my wife and I had snuggled up to one another that I suddenly realised that my training patient was sitting right behind us!

Right from the moment that I had moved to North Wales, I missed the contact to professional analytic colleagues. My GP colleagues often looked blank when I tried to explain to them that I was working as an analytic psychotherapist. In all the years I only once received a referral from a GP colleague. Over time, though, I found other likeminded psychotherapy colleagues and I became one of the founding members of PIG, the Psychotherapy Interest Group. For years we met once a month for case discussions and presentations of general interest within the field of psychodynamic psychotherapy. To this day I am the only BPC registered therapist in North Wales. I am happy to say though, that a colleague and friend, who cofounded PIG, is now in the advanced stage of her training to be a Jungian Analyst.

After I had completed my training and as a way out of professional isolation, I pushed early on for AJA to purchase audioconferencing equipment, which would allow me to participate in the life of AJA. Technically, the equipment was basic, but I could keep contact with my analytic colleagues.

It came as a real breakthrough when videoconferencing facilities were advanced enough to use them in group settings. AJA members are now living in many different parts of the UK. The use of videoconferencing facilities has proven inclusive. Nowadays many out-of-London members attend meetings, which previously would have been inaccessible to them. Council and various committees work predominantly online. This is important for a small organisation, which can only exist through the committed participation of members, regardless of their location. Naturally, meetings by videoconferencing are complemented by face-to-face encounters. I am afraid that in the past the patience of AJA colleagues gathered in AJA's seminar room was tested to breaking point when we faced yet another technical hiccup.

After I had qualified and become member of AJA, I continued my own analysis with an analytic colleague by phone. Likewise, for many years all my supervision was on the phone. Through my own experience and my increasing confidence in using videoconferencing equipment, I started to offer sessions online. Initially this was used in special circumstances only, such as when poor road conditions prevented patients from coming to the office. Increasingly, however, I now work with a combination of face-to-face meetings and videoconferencing sessions. This enabled some patients to have twice or even three-times weekly sessions. I am still in the process of evaluating the effect of online work on the analytic process. I observe myself even more for my own countertransference reaction and how engaged I am with a patient, who I can see but who is not actually physically present. I watch out for manifestations of the unconscious, which might indicate how working by videoconferencing changes the relationship. More recently I became particularly interested in the effect on erotic transference. Online work guarantees a 'safe' distance, which at the same time facilitates and hinders the emergence of erotic transference and countertransference. I think that a lot more research is necessary in this field. My supervisor is invaluable for my way of working. Then there are synchronistic events, when power cuts or service disruptions occur just in the very moment when the patient talks about a particularly sensitive issue, as if the inner difficulty manifested itself in the outer electronic reality.

Modern Information Technology gave me the opportunity to serve as Chair of AJA for the past four years, despite living so far away from London. This position included meeting analysts from other Jungian organisations, particularly through the Umbrella Group, in which representatives of London based Jungian societies come together regularly. I also got to know overseas colleagues through gatherings of the International Association for Analytical Psychology (IAAP) and I am involved in an AJA supervision project for Ukrainian colleagues in training. I am member of a supervision group including a colleague in California. Suddenly Porthmadog in North Wales does not appear so insular any longer and when, on a sunny day as today, I look out of the window of my consulting room on to the Glaslyn estuary and the range of Snowdonia mountains, I feel very fortunate to live and work here ■

Dr Arthur Niesser is a Jungian Analyst in private practice and Chair of the Association of Jungian Analysts

Cultural Review

Churchill and his Darkest Hour

By Lindsey Nicholls

Joe Wright's film 'Darkest Hour' covers the time period between Winston Churchill being appointed as prime minister (10 May 1940) to his famous speech in parliament, 4 June 1940, '… *we shall fight on the beaches, we shall fight on the landing grounds, we shall fight in the fields and in the streets, we shall fight in the hills; we shall never surrender…*'. Ending here, the film portrayed Churchill as winning over a divided parliament and the nation, preparing them for the inevitable battle with the menacing German forces. The film highlights the choice that Churchill was given at that time; to begin peace negotiations with Hitler, which was endorsed by his war cabinet, or to enter into a fight against seemingly insurmountable odds. The film celebrates the decisions that Churchill made and the power of his rhetoric in gathering parliament and the 'people' of Britain behind him to fight Hitler, '*whatever the cost may be*'. Is this film a depiction of the true nature of leadership, or, is its success representative of the longing for the kind of leadership that stirs a country to unite against…the enemy?

'Is this film a depiction of the true nature of leadership…?'

I have focused on some key moments in the film where Churchill's leadership could be understood with theory-in-mind, by using Grint's (2005) thoughts on 'problems, problems, problems…' (pg.1467), Bozalek's work on privileged irresponsibility and Young's (2003) thoughts on depressive position leadership. One issue I would not seek to question was Gary Oldman's winning the 2018 Oscar for best male actor. Not once during the film did I feel as if I was watching Mr Oldman act as Churchill.

Grint (2005) offers a three stage understanding of the way problems are presented to people that can then justify the actions that leaders take. Here he looks at a typology of problems, those that are 'tame' and those that are 'wicked' (pg.1473). Problems which are 'tame' require process solutions (he gives the example of timetabling trains) and those that are 'wicked' are complex and intractable, solutions often lead to more problems. Here he looks at the role of leadership in making decisions that may involve a 'collaborate process' (pg.1473) rather than providing answers. To this he adds a third type of problems, 'critical' (crisis) problems in which the leader needs to take command and provide immediate decisions as to what is to be done. There is no time to collaborate or deliberate. Perhaps this is what the film 'Darkest Hour' demonstrates, Churchill, a newly elected prime minister, had a matter of days to make a decision that would affect the whole country, to go to war or to make peace.

To this typology of problems Grint (2005) includes a social constructionist view of leadership, suggesting that the way problems are explained to the public can justify the actions leaders take, he suggests that some problems are presented to the public as if the solution offered is inevitable. Grint does not imply that all leaders attempt to manipulate the public through using 'spin' but his work does enable us to think critically about how problems are 'sold' to the public as needing leaders to act in a 'command and control' fashion. Did Churchill manipulate parliament and the public by saying he had 'spoken to the people'? In the film this was covered by an annoyingly patronising portrayal of people on the tube, obsequiously pleased to have their opinions sought by the prime minister.

This brings me to the work of Robert Young (2003) and his paper on the 'depressive position' (pg.431) leadership of Lincoln and Mandela. Young suggests that these two great leaders understood that their decisions and actions would cause injury and death to many on both sides of the war, and they agonised over this loss of life while believing that it was the only way forward. Young, quoting Winnicott, states depressive position leadership involves, an 'acceptance of responsibility for all the destructiveness that is bound up with living, with the instinctual life, and with anger and frustration' (pg.432).

In the film we see Churchill falter in his decision to wage war upon seeing a telegram stating that 4,000 British men had been sacrificed in Calais. This was portrayed as Churchill's dark night of the soul; in the film he is comforted by his wife and visited by the King (George). Clemmy (Churchill's wife) says, while kneeling at his side, that he is strong because he has struggled, that he is wise because he has doubts and that people trust him, testimony indeed for a depressive position leader. I wondered what other influences gave him the seemingly overbearing moral authority to take a country to war.

There are two scenes in the film which reminded me of Bozalek's (2014) work on 'privileged irresponsibility', one takes place in the toilet where Churchill calls President Roosevelt to ask for help, and the other is the aforementioned scene on the tube. Bozalek, who draws on the work of Joan Tronto (1993) begins her chapter with a quote; 'One of the privileges of the privileged is to be able to be oblivious to the life experiences of the subjugated' (pg. 51). As Churchill states in the film, with some measure of pride, he has never caught a bus, used the tube but believes he could 'boil an egg'. Did the privilege he had, related to his gender, class and education, give him a sense of entitlement and self-righteousness that made his manner one of an imposing leader? Sure of himself and his decisions, impervious to the opinion of others because in his mind, they were of little consequence and their opinion did not count? What then of the scenes in the toilet and on the tube?

In the prime minister's privy, Churchill calls Roosevelt for help, his voice falters as if he feels ashamed of the request. I wondered if this was part of his colonial past and class legacy, that to 'give' was to be seen as powerful, to ask for help was to be seen as weak. Churchill was not portrayed as someone who asked for advice from others, he told them what to do, and later through his speeches in parliament, told them what to think. Is this the signature of a great leader or someone whose privilege has occluded their knowledge (or creative imaginations) of how 'the other half' lives?

Churchill had, in an earlier part of the film, described Hitler as '…that corporal, that boy, that… house painter!' and later, somewhat misrepresents the passengers views to his outer cabinet – does he do this to justify a decision he has already made? Bozalek (2014), using Tronto's work on race, states that 'In considering the power that racism confers on a majority group, she [Tronto] coined the phrase 'privileged irresponsibility' by which she meant the ways in which the majority group fail to acknowledge the exercise of power, thus maintaining their taken for granted positions of privilege' (pg.52). Was Churchill demonstrating his privileged irresponsibility when he stated the '*policy was to wage war, the aim is victory*'? Had he understood the suffering he would cause to the conscripted service men and women, and the city populations who would have to withstand years of air rades and bombing?

There are three occasions during the film when the camera leaves the intimacy of a close up to move away and upwards as if taking in the 'bigger picture'. Perhaps that is what we have with the film, a backward look at a situation that was 'critical', that the leadership shown was commanding and that Churchill did mobilise the common man through his oratory skills and stubborn self-belief. Perhaps the cost of these decisions was symbolically (under)portrayed by the women in the film, through the tears of Miss Layton (his PA) whose brother was killed in France, and Churchill's wife who states about herself, 'Here is a woman who is always tired, she leads a life where too much is required'. The film glorifies Churchill's decisions and although it is called 'Darkest Hour' it took many years of war and loss before that hour ended ■

Dr Lindsey Nicholls is an occupational therapist and senior lecturer at University of Essex

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I'd argue that we are entering the third wave of patient power in healthcare politics. The early rights-based user and civic movement focused on accountability gave way to a more institutionalised form of patient engagement focussing on 'feedback' and 'representation' that aimed to improve quality. Now, we are starting the see the emergence of 'patient and community leadership' and what we bring as people individually and collectively. This is giving rise to myriad forms of engagement – 'patient entrepreneurs' inventing apps, online fora to harness collective voices, community and health champions bringing in the marginalised, peer support workers and patients/carers influencing healthcare design, research, education and training. The old rules of engagement are breaking down. People affected by mental health problems, want to be trusted equal partners in their own care, and perhaps more significantly in co-designing and co-delivering services.

'...we are entering the third wave of patient power...'

My current role as Patient Director (the first role of its kind) may usher in a new model. At Sussex MSK Partnership (Central), we have a clinical Director, managing director and patient director as the 'exec' team. My role is to ensure we keep the focus on what matters to people who use our services, through hard wiring the culture and systems to be more 'patient centred'. This includes having a group of paid, supported and trained 'patient and carer partners' who have an influential role in both improvement and governance work. We are slowly getting somewhere.

We can help reframe problems, bring our insight to bear so as to develop new solutions, shift policy and practice, change dynamics and model a new form of collaborative leadership. This will help accountability, transparency, quality and safety. But only if we are valued.

GF. *David, thank you for being as candid and outspoken as ever. I look forward to your thoughts generating lots of ideas and responses* ■

David Gilbert is Patient Director at Sussex MSK Partnership (Central), Director of InHealth Associates www.inhealthassociates.co.uk and blogs at www.futurepatientblog.com. He is Writer in Residence at The Bethlem Gallery and his collection of poetry about coming through mental health problems, 'Elephants (Fragile)', is available from Cinnamon Press. His views expressed here are his personal views.

Gary Fereday is the Chief Executive of the British Psychoanalytic Council

Diary

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

MAY – JULY

May 1 – July 17
THE POLITICAL MIND SEMINARS 2018 – THE ROLE OF THE UNCONSCIOUS IN POLITICAL AND SOCIAL LIFE
Sigmund Freud Lecture Theatre, Institute of Psychoanalysis, 112a Shirland Road, Maida Vale, London W9 2BT
https://psychoanalysis.org.uk/civicrm/event/info?id=686&reset=1

JUNE

June 2
SPIRITUAL EXPERIENCE: JUNGIAN ANALYSIS AND THE VEDANTA
Speakers: Marcus West and David Sagar.
SAP – 1 Daleham Gardens, London NW3 5BY
www.thesap.org.uk/sap-events

June 7
ALCOHOLISM AND THE FAMILY
Speakers: Sally and Henry Maybury of the Lost Days Charitable Aid Trust.
Lecture Hall at 120 Belsize Lane, London NW35BA
www.thesap.org.uk/sap-events

June 8
KEEPING STAFF IN MIND: THE PSYCHOANALYTIC CONTRIBUTION TO MENTAL HEALTH WORK
This symposium follows the publication of a book, *Psychoanalysis, the NHS, and Mental Health Work Today*, edited by Alison Vaspe (Karnac 2017).
The Cassel Hospital, Ham Common, Richmond TW10 7JF
www.routledge.com/mentalhealth/posts/13317

June 9
SELF-CARE FOR THE WOUNDED HEALER
Speaker: Alf McFarland.
Quaker Meeting House, 40 Bull St, Birmingham B4 6AF
www.thejungiantraining.org.uk/lecture2018-06.html

June 29
WORKING WITH THE COUPLE RELATIONSHIP THROUGH THE ADOPTION PROCESS
Tavistock Relationships, 70 Warren Street, London W1T 5PB
https://tavistockrelationships.ac.uk/forthcoming-events/1143-couple-relationship-through-adoption

June 30
BRITISH PSYCHOANALYTIC ASSOCIATION (BPA) SUMMER SCHOOL 2018: BODY AND MIND, BEDFELLOWS?
Queen Mary University, London
www.eventbrite.co.uk/e/bpa-summer-school-2018-body-and-mind-bedfellows-tickets-44333721354

JULY

July 2
TAVISTOCK RELATIONSHIPS' SUMMER SCHOOL
Tavistock Relationships, 70 Warren Street, London W1T 5PB
https://tavistockrelationships.ac.uk/forthcoming-events/1127-summer-schools-2018

July 6
GROUPS IN ACTION – GROUP AWARENESS FROM A CONTEMPLATIVE PERSPECTIVE
With Jale Cilasun and Lawrence Ladden.
IGA, 1 Daleham Gardens, London NW3 5BY
www.groupanalysis.org/EventsandWorkshops/EventsandWorkshops.aspx
events@igalondon.org.uk

July 7
ATTACHMENT AND SPORT
With Arturo Ezquerro.
IGA, 1 Daleham Gardens, London NW3 5BY
www.groupanalysis.org/EventsandWorkshops/EventsandWorkshops.aspx
events@igalondon.org.uk

AUGUST

August 5
PSYCHOLOGY, IMAGINATION AND THE ARTS – SUMMER COURSE
The Champernowne Trust with the C.G. Jung Club, London.
www.bpc.org.uk/events-calendar

SEPTEMBER

September 11
SPOTLIGHT ON THE ARCHIVE – ALL ABOUT....ALMODOVAR
Evening salon that explores the links between cinema and psychoanalysis.
www.theijp.org/film

September 28
ENGLISH SPEAKING WEEKEND CONFERENCE 2018
Royal College of Physicians, 11 St Andrews Pl, London NW1 4LE

NOVEMBER

November 15 & 16
GAMES AND THRONES: THE SYSTEMS IN WHICH WE LIVE
ROYAL COLLEGE OF PSYCHIATRISTS IN SCOTLAND MEDICAL PSYCHOTHERAPY FACULTY CONFERENCE
Speakers: Rowena Davis, Marcus Evans, Molly Ludlam, Dr Christopher Scanlon.
Atholl Palace, Pitlochry, Perthshire PH16 5LX
More info:
Susan.Richardson@rcpsych.ac.uk

News

SCoPEd

BACP, BPC and UKCP are jointly working on a groundbreaking project to set out the training requirements and practice standards for counselling and psychotherapy.

Many members will be aware of the collaboration between BACP, BPC and UKCP. One of the most important strands of this work is a project to map professional competencies for our professions.

Here we give a brief explanation of what the work is, why we are doing it, and the professional context in which it is being undertaken.

What the work is:

The Scope of Practice and Education for the counselling and psychotherapy professions (SCoPEd) is a collaborative project being jointly undertaken by BACP, BPC and UKCP.

The project is systematically mapping existing competences, standards, training and practice requirements within counselling and psychotherapy. It is using an evidence-based approach to identify the different and overlapping competences between them.

The initial mapping has been completed and has now moved on to working with an Expert Reference Group. The Group comprises members who have been nominated by each partnership body, allowing equal representation of interests. The Group has an impartial, independent chair.

The Expert Reference Group will advance the mapping process by consulting the counselling and psychotherapy literature to ensure that gaps are identified and that further evidence is sought. This will enable the Group to produce the final, evidence-based competence framework.

Why are we doing it:

Counselling and psychotherapy are largely regulated by professional bodies, a number of which are themselves regulated by the Professional Standards Authority (PSA) under its Accredited Registers programme.

The PSA sets minimum standards for organisations that hold a register in a health or social care profession, and the focus of their programme is public protection.

The PSA-accredited registers in the field of counselling and psychotherapy each has its own distinct standards of training and practice. There are also no agreed common entry or training requirements to enter the field.

This causes confusion for the public, for clients/patients, for employers and commissioners of services about what training and experience to expect when employing a counsellor or psychotherapist. There is also confusion amongst those who are considering training in this field as there are disparate standards, with a wide range of courses available at differing academic levels geared to different client groups and professional roles, and sitting within different qualifications frameworks

And why now... the professional context:

We are undertaking the ScoPEd project now because it is simply time to do this work. There was complete agreement between BACP, BPC and UKCP that a proactive leadership role was needed in the development generic standards for the counselling and psychotherapy professions. The Department of Health recently held a consulation seeking views on proposals to reform the regulation of healthcare professionals in the UK. While no one knows where this will lead, we will be in a better place to navigate any future changes if we do this work now ■

GDPR is coming!

The General Data Protection Regulation (GDPR) replaces existing data protection legislation in the UK.

The BPC have put together a briefing that we hope Registrants will find useful when planning their individual compliance. The new legislation will be enforced on 25 May 2018.

The briefing is available on the BPC web site at **www.bpc.org.uk/resources/gdpr-briefing**

Letter to the Editor

Dear Editor,

A brief comment in relation to the politics, as opposed to the psychoanalytic politics, in Joanna de Waal's account of the PP NOW 2017 session Political Engagement with Andrew Samuels and myself: "She was specifically critiquing Britain, in contrast to her own country of origin – Norway." It is true that, in that context, I emphasized the distance between 'the elite' and 'the people'. Though I perceive the degree of class-based hatred as specifically British, in contrast to more egalitarian countries, it would be ironic indeed if I was heard as idealizing Norwegian society. I have in a number of writings, and in previous conferences in the Psychoanalysis and Politics series, focused on nationalism, ethnocentrism, racism and xenophobia both internationally and in a Norwegian context. In the recent years, post-Breivik and with a right-wing populist and racist party in government, the situation has deteriorated. In Norway hate speech has become normalised under the banner 'freedom of speech'. The title of a one-day conference I put on in Oslo in September 2017, 'Normalization of racism' captures a serious problem which I will continue to address in the years to come.

Sincerely, Lene Auestad

Lene Auestad is an author, and a Doctor of Philosophy from the University of Oslo

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despinacatselli@yahoo.co.uk

The Institute of Psychoanalysis invites applications from across the UK to The New Entry Scheme and New Entry Affiliates Scheme.

The New Entry Scheme is a pathway into training with The Institute of Psychoanalysis open to BPC registrants who have completed a Freudian Psychoanalytic Psychotherapy Adult training and have had a four or five times a week analysis with a member of the Institute of Psychoanalysis.

There are two entry points to joining the New Entry Scheme:

A) Direct entry for BPC registrants who meet all the criteria of acceptance.

B) Entry via the New Entry Affiliates Scheme which is for BPC registrants who do not yet meet all the criteria for direct entry, but would like to develop to that stage.

For further information please visit our website: **http://psychoanalysis.org.uk/what-is-the-best-route-of-training-for-me/new-entry**
Or contact Katerina Tsami-Cole: **Katerina.tsami-cole@iopa.org.uk** or **020 7563 5011**.