New Associations
NEWS, ANALYSIS, OPINION FOR THE PSYCHOANALYTIC COMMUNITY | ISSUE 23 SUMMER 2017
BRITISH PSYCHOANALYTIC COUNCIL

Responding to traumatic events

By Jo Stubley

THE GRENFELL FIRE has been a very painful and difficult trauma for the wider community of London, coming so soon after the Manchester bombing and the two terrorist attacks in London (Westminster and London Bridge). The societal and political implications and ramifications of this particular disaster are considerable and add to the emotional impact. As the lead of the Tavistock Trauma Service I have had many therapists contacting me wondering how they might be able to help. I have also heard about voluntary registers of therapists being set up to offer help to survivors and bereaved, as well as therapists going down to the community and offering therapeutic help in the immediate aftermath.

It is an understandable response, fuelled by perhaps many different reasons. Trauma by its very nature impairs symbolic capacities and stirs up very powerful, primitive emotions. Our ability to think is inevitably impaired, and the push to action is very powerful. One common form of action is through identification, generally within the various positions of the traumatic scenario. As bystanders to this event, many of us may have felt propelled into action, especially in the role of rescuer (a common position for people working in the helping professions). The wish to get involved may also be fuelled by a manic excitement, a vicarious pleasure seen in the slowing down to view the accident on the side of the road. There is also, inevitably, the wish for reparation, often fuelled further by guilt – survivor guilt and in this instance the guilt linked to the socio-political context. All of this can help to explain why there has been such a propulsion into action. However, this wish to help in the early stages often needs to be carefully considered so that precipitous action does not actually make matters more difficult.

There is a process of responding that is built upon experience of previous events and the current evidence base. NICE (National Institute for Health and Care Excellence) guidelines are clear that in the initial phases after a major trauma the following needs to be held in mind:

1. Many people will experience trauma symptoms in the early phases but this does not require expert intervention. It is best managed with 'Watchful Waiting' – a combination of psychoeducation and encouragement to use one's usual supportive network.
2. Debriefing is not appropriate as a general rule, and indeed some studies suggest it may be harmful.
3. One needs to attend to the 'hierarchy of needs' – a safe place, food, clothes etc. are the priority.

Watchful Waiting is the term coined by NICE guidelines to describe the most appropriate response in the first month or so. At its heart is the recognition that the majority of people who are involved in a traumatic event will not go on to develop Post Traumatic Stress Disorder (PTSD). With straightforward psychoeducation, traumatised individuals can understand that the usual response in the early days after the event is to have a variety of symptoms that are likely to settle over time. These symptoms may include nightmares, vivid images or thoughts of the event, trouble sleeping, irritability, low mood, feeling numb or cut off from others, tearfulness, temper outbursts, avoidance of any reminders, and so on. For most people this is normal and with support and care will gradually resolve. The best care involves support from one's usual social and familial network, good basic self care around eating well, not using alcohol or drugs, keeping to a reasonable routine and getting back to life's usual pattern as soon as possible.

There is a higher risk of PTSD developing if someone is socially isolated and doesn't have a good support structure around them, if they have a previous history of trauma or mental health issues, or there is a history of trauma or psychiatric illness in the family. A history of childhood trauma can also significantly increase the risk. Some demographic factors may also increase risk – female gender, low socio-economic group, minority status and low educational attainment. The severity of the trauma and the degree of loss also increases the risk. Any of these factors, especially if there are a few present, may suggest a closer eye should be kept on that individual to ensure their symptoms settle over time. They may require intervention earlier or from a more specialised service if there are concerns.

Local services are already responding to setting up appropriate pathways for care. For this event it is Central and Northwest London NHS Trust. They are likely to institute a 'Screen and Treat' approach which will include gathering data for research, as was done after the London 7/7 bombs by the Traumatic Stress Clinic. One of the findings from their research was that less than 30% of survivors went on to develop PTSD, and for the emergency service personnel involved the figure was much lower (2%). The pathway on this occasion will be local (including NHS and voluntary services as appropriate), and will be a tiered response as only a few will need specialist services.

This event may also precipitate individuals who have a history of traumatisation to experience more symptoms, to have their own traumas, reactivated by this current, very public event which has been so pervasive in the media. Studies from 9/11 demonstrated the potential for vulnerable individuals to be traumatised by repeated exposure to the event through the media, and it can be helpful to think with patients whether they need to protect themselves from this kind of media overload.

'Our wish to help in the early stages needs to be carefully considered.'

As a final note it is also important to remember there can be a ripple effect, with friends and family as well as workers involved with survivors also potentially experiencing vicarious traumatisation. The need for a supportive, containing network is also

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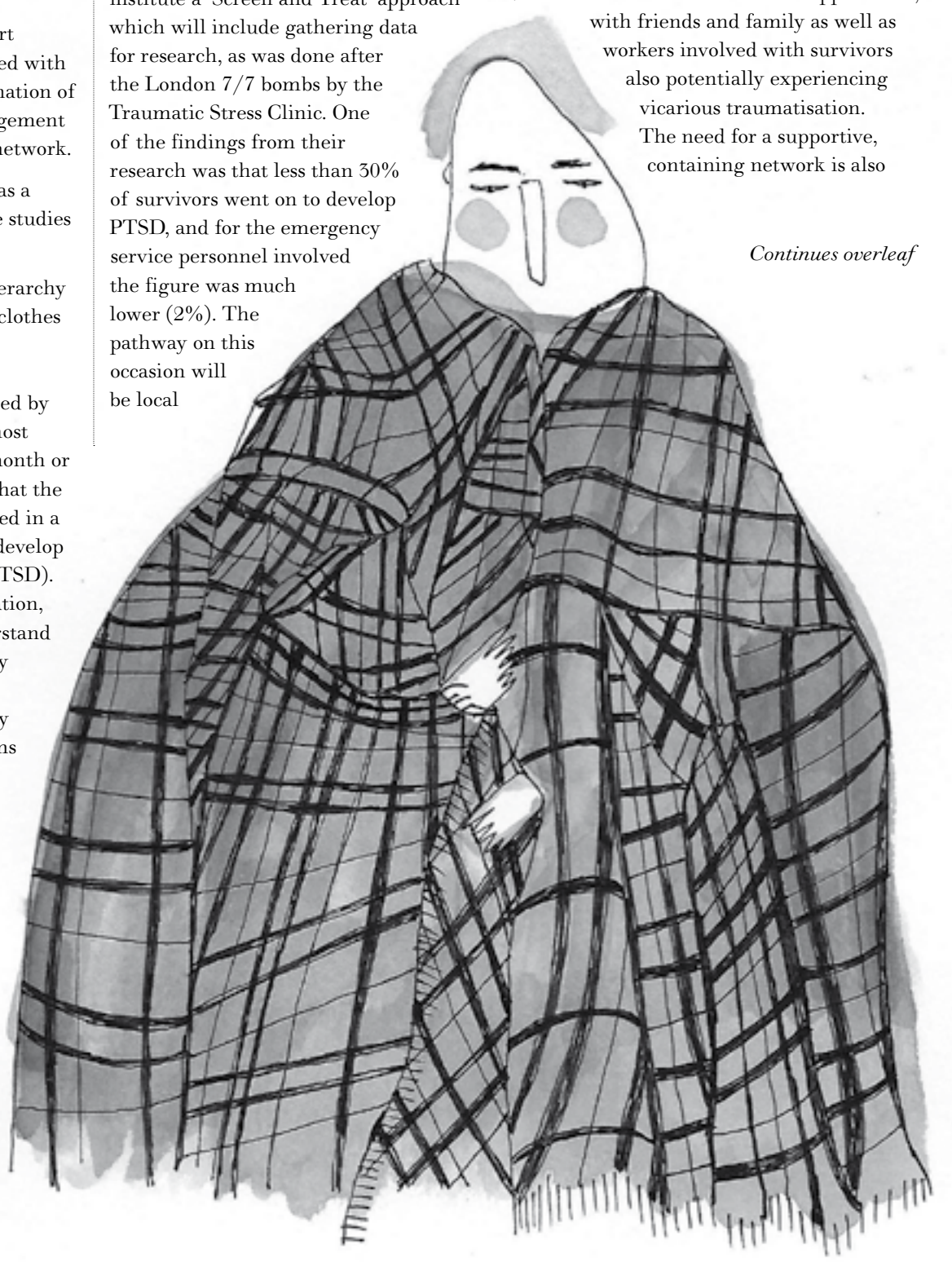

Editorial

An extraordinary and troubling twelve months

By Gary Fereday

TRAUMA SEEMS to be a word that is around everywhere at the moment, and for good reason. It has been an extraordinary and troubling twelve months in so many ways with Brexit, the awful terrorist attacks, and the tragedy of the Grenfell Tower fire. The political landscape feels very different and the world less safe and much less certain than it used to.

Around the world, we are witnessing the rise of the cult of the 'strong leader' with Donald Trump, Vladimir Putin and Recep Erdoğan among others displaying disdain for liberal democratic institutions, diversity of opinion, culture and people. Here in the UK we witnessed the denigration of experts in the Brexit debate, with public sector professionals, civil servants and academics undermined in a 'post truth' political discourse where facts didn't always seem terribly important.

The psychoanalytic thinking is well placed to help policy makers and politicians better understand this growing anxiety in society and the uncertainty that is so prevalent. Our profession, with its understanding of the human condition and the unconscious, has something important to contribute to this debate and help others think differently about issues such as identity and fear of the other, and to help develop policies to heal what feels like an increasingly divided nation.

Johnathan Sunley's article asks whether truth is really under attack and how the psychoanalytic community could help defend it, while the articles by Adam Danquah and Jo Stubley explore trauma; with Dr Stubley's lead article reminding us that our profession must exercise care in thinking about the best time to offer help to those traumatised by events such as the Grenfell Tower fire.

There is extraordinary interest in psychoanalytic thinking. This is demonstrated by the BPC's flagship conference PP NOW being completely sold out, with 320 delegates booked to attend the conference four months in advance. But, as we have explored on the pages of *New Associations* over a number of years, the danger remains that our profession fails to communicate as well as we need to other professions, policy makers and politicians. As the national professional and regulatory body with a unique focus on psychoanalytic psychotherapy the BPC is working hard to have this dialogue.

'We are working hard to have this dialogue.'

Psychoanalytic psychotherapy remains under enormous pressure in the NHS and the wider public and charity sectors. Sue Mizen's article explores how a group of organisations, including the BPC, are starting to make a new economic case for more investment in longer term and more intensive psychotherapy. A significant event in this debate will be the launch of the National Institute for Health and Care Excellence (NICE) revised guidelines on the treatment of depression in adults. As outlined in the new section NICE are consulting on the guidelines until early September and the BPC has assembled a group of our senior registrants with expertise in research and evidence to help us respond to the consultation.

Sadly, this will be the last time *New Associations* is edited by the BPC's Development Officer, Leanne Stelmaszczyk. During Leanne's tenure, the publication has built its reputation as a magazine that carries high quality articles that stimulate real debate within our community. We wish Leanne all the very best in her new ventures ■

Gary Fereday is Chief Executive of the BPC

Responding

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vital here, and staff may need to find supervision or other forms of reflective practice to consider the impact of the work. The need to consider whether we should take action and in what form requires a capacity to reflect, to consider our motivations, both conscious and unconscious, and to take time to allow survivors and bereaved to recover within their usual supportive networks. As therapists, it is important we recognise that our skills may not be most helpful early on but we may as fellow human beings offer attendance to the hierarchy of needs – a safe place to sleep, food, and comfort. This was, for me, what was most impressive in the early stages after the fire – the capacity for ordinary Londoners to offer what was needed in such a time of crisis. It is a basic requirement of containment, the blanket around the shoulder of the traumatised individual, that is the essence of early care following a disaster. For the therapist wishing to help, perhaps the hardest task is to not act but to be available in a reflective capacity until action may be required ■

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Fax 020 7561 9005
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Three issues of *New Associations* are published each year in the spring, summer, and autumn.

Subscriptions
UK annually (3 issues): £10
Overseas annually: £16

For insertion of advertising materials contact newassociations@gmail.com

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Illustrations Leanne Stelmaszczyk
Printer Blackmore

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Deadlines: The next issue of *New Associations* will be published in November 2017. The deadline for article proposals is 30 September 2017. Contributions and letters to the Editor should reach us no later than 15 October 2017.

ISSN 2042-9096

Conference report

A rent in the fabric: trauma across the lifecycle

By Adam Danquah

The Northern School of Child and Adolescent Psychotherapy hosted a conference on trauma in July, with Greater Manchester Mental Health NHS Foundation Trust and the Institute of Psychoanalysis. Adam Danquah reports.

TRAUMA IS SO fundamental to the inception and development of psychoanalysis that for me it has almost passed out of plain view into the fabric of the discipline. In modern parlance the term is a victim of its own success, ubiquitous, but so broad in scope as to be almost meaningless; more often than not, bandied about to suggest ordinary upset at everyday adversity. Ambivalent as I was, I had looked forward more to last year's Manchester conference on *narcissism*. By the time this conference came round of course, the subject of trauma was in sharper focus: Manchester had been breached by the bombing and London was reeling from a summer of atrocities. The title of the conference was now terribly apposite and there was now more pressure on the sense that might be offered.

I arrived as Lisa Miller, child and adolescent psychotherapist, was setting the conceptual framework for the day, outlining trauma as a deep wound, admixed with violence, that left permanent scarring. She went on to discuss the trauma inherent in childhood mistreatment and abuse, which among other things meant certain rules were broken, leaving the child unable to believe and trust thereafter.

Lisa drew on a wealth of clinical cases to illustrate her points. I was most taken with her first, Eric, a six-year-old boy 'too terrified to collect his thoughts' and thereby given to habitual expulsion and fragmentation. This was a wild boy, who frightened those that were supposed to be responsible for him (e.g. school), and Lisa painted a vivid picture, from a student's observation, of the shortfalls in his care, e.g. his mother sat with an encyclopaedia across her knees as Eric lurched around in bits. I had in mind the whole time my own twenty-something-year-old patient, of whom Eric was the portrait. At the same time as feeling hopeful in the recognition of his condition, I thought about how desperately at times I want to offer the steadiness and attentiveness Lisa said were fundamental to such work, and whether I and the care team were up to it.

My own children were never far away in this respect, and Lisa referenced the reliable state of mind necessary to deal with the lower key but cumulative trauma of childhood, with its 'muddle and misery', as well as its joy – this state of mind being the 'soil in which the ego is planted'. As rich as the further examples proved, I had become rather attached to Eric and was sad when we were moved on. Something else Lisa articulated for me was the sense of trauma blowing away the boundary between dreaming (nightmares) and reality, so that unreality, either for a time or a lifetime, is a feature of waking life.

I think I came to the conference in something of the dream I have been in since recent events and, having been gorging on newsfeed, it took me some time to re-adjust to the quality of analysis and just the articulacy of the speakers. Trauma often presupposes that of the 'railway accident' sort, described by Balint (1969), i.e. 'an event that hit the individual unexpectedly from outside, coming from objects of his environment with which he had hardly any, or no, contact before' (p. 431). Ariel Nathanson, consultant child and adolescent psychotherapist, talked about his work at the Portman with male patients who had been sexually abused as children. Ariel distinguished the inherent relational trauma here from the railway accident sort in pointing out how this trauma came repeatedly and not necessarily unexpectedly from a significant other, so that it is contiguous with all other aspects of that relationship, not easily separable or walkaway-able from in the way our incredulity ('Why does he take that?' 'Why doesn't she leave him?') often suggests.

He provided us with one patient's analogy of the process of abuse as the slow mixing in of 'dark cordial' into the relationship, so that eventually one cannot easily separate freedom and oppression. I find this subject fascinating but unfailingly oppressive, and cordial is also a wonderful metaphor for the sickly sweet dimension of the 'too muchness' (Shengold, 1979) of childhood sexual abuse. And yet we benefited from Ariel's working through of his work in this area, in receiving a dense but perhaps darkly illuminating paper on working in the midst of such terrible mix-ups. Enactment is of course the lingua franca of this realm, and Ariel referred to the challenge for the clinician of sadism being 'unbound' in such patients. The clinician helps in his acknowledgement of the patient's entanglement in an oppressive structure and through his general stance, i.e. that the patient has the right to freedom and holding on to this hope.

At the same time, I thought Ariel was also making a case for insight being necessary but not sufficient. Moreover, his statements, 'without action any resistance stays within the realm of the oppressive regime,' and, 'people cannot be groomed into freedom, but have to choose and to fight for it,' highlighted the potential pitfalls of individual therapy, especially in not helping the patient to free himself from the relationship. Ariel talked about how, as clinicians, being mixed up in it ourselves, we still sometimes had to act with authority, to help the patient in their entanglement in an oppressive structure. I was unclear what authority we could make recourse to, but I thought there was a sense somehow in which we had to invoke the very parental authority that had been undermined so devastatingly in the first place.

'By the time the conference came round the subject of trauma was in sharper focus.'

Part of the clinician's work is in ascertaining just to what extent he is oppressed, internally and externally. There was, I thought, a shudder of recognition across the room when Ariel talked about being groomed as an employee of the NHS. We labour under an illusion of freedom (or being able to free ourselves, at least), while our sense of the reality and autonomy is steadily diminished by the marketing of lies as truth and the attrition of our constantly acceding to small requests to 'believe' this reality.

It was good to have some thinking space after two such dense papers. Rajni

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Rent in the fabric

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Sharma, consultant child and sdolescent psychotherapist, was sensitive and able in helping us to channel almost a flood of responses to not only what we had just heard, but also our clinical work, working in and despite the NHS, recent national events (e.g. Grenfell tower), and personal traumas. This was the first space I had shared with a group, to make sense of all the fragments and people loosed around and inside me by the bombing in Manchester. In hearing about some of the work of staff in acute medical care in response to the casualties from the bombing, I was reminded of what we are capable of. The ability of medical staff to respond immediately may have stirred anxiety and envy in many of us, wondering just what we are for, while we waited for our work to begin. In thinking space we discussed the disposition required for such work, how to respect this difference and support our colleagues.

Joanne Stubley, psychoanalyst, reminded us that predictors of the most problematic responses to trauma were a childhood history of trauma and social isolation. Joanne invoked Freud's conception of trauma as the piercing of the protective shield around the mind, so that it becomes flooded by external stimuli and mobilises internal anxieties, far beyond its capacity for bailing anticathexes. Joanne took us onto the 'relational' nature of any trauma, following Klein; that is, our from-the-first and fundamental object relatedness framing any catastrophe as within relationship, so that something bad happening is always someone, an object, doing it to me and/or failing to protect me. The 'oh yeah' moment I experienced in response to Ariel's clearing up of relational trauma became 'er…' again with Joanne's foregrounding of the developmental-relational nature of our response to any trauma. This is a particularly important contribution that psychoanalytic theory has to make to this area. Indeed the ubiquitous trauma of infantile helplessness we all somewhere know was for me a binding, discomfiting undercurrent of the conference.

Joanne went on to describe her clinical work. In keeping with the rich and varied lunch we had just been treated to, there was an embarrassment of good experience and insight. It was important to me that Joanne referred to how much we would have been filled up by now. I thought back to Eric and wondered in attachment terms how many cases one can deal with: in a conference day, and more generally in professional life. I also thought about the cavity that must form as a direct result of trauma – traumas always involving loss – and whether the 'too muchness', as awful as it is, works as a kind of manic defence against depressive anxiety. Joanne talked about her experience of patients who cannot bear the trauma of silence. I was given pause to think about the lack of silence at the conference up to this point, and associated to Garland's (1998) observation that Freud's (1926) primary anxieties are united by a single crucial feature; namely, 'separation from… anything that is felt to be essential to life' bringing 'the individual closer to a psychic recognition of death' (p. 16).

I was at times pulled violently out of my reverie / detachment by certain moments in a case history. Joanne was suddenly, it seemed, telling us about a child's waking to his father's repeatedly slapping him in the face in the middle of the night, and night after night, without explanation or later (daytime) acknowledgement. I felt choked by the utter violation of trust and helplessness and there being no-one to go to now. I looked around. We might have all come-to at several such instances – just being at an utter loss. Coming to time, Joanne had to leave off with so much remaining. She put up a final slide of important issues for our consideration. I felt overwhelmed by information, not the bullet points themselves, but all each one denoted. I experienced palpitations and smiled wryly at a point somewhere in the middle: 'the body keeps the score'.

During lunch, we had been able to pour outside into uncharacteristic Manchester sunshine and, by now, someone had thought to open the doors; these brought considerable relief. I was thinking about the discipline's focus on containment and my feeling sometimes I need permission to try not to process, to empty out. Working in the NHS especially, do we let ourselves know enough when things are beyond containment?

Judith Bell, clinical psychologist, reminded us that we are in organisations that are set up to work with trauma and are therefore routinely susceptible to secondary traumatisation. Judith discussed the readiness to project into organisations at times of trauma and the ability of the organisation itself to hold onto and contain these projections. Judith talked about her work consulting to organisations, wherein someone with influence recognised that they were not doing or could not do this. Whether through fear of not getting it right or just trying to 'move forward' with employees' trauma unrecognised and unresolved, Judith said she sometimes witnessed the organisation's 'frozen immobility', which needed to be dealt with as much as the primary task.

Judith took in such examples as 9/11 and the 2011 Norway attacks in Olso and Utøya to show how trauma could be carried from one organisation to another, and how an organisation could continue to focus on its primary task even in the wake of such devastation. Discussing the task the Norwegian Labour party were faced with after Utøya, Judith talked about the 'double helix' of keeping strategic and future-focused (continuing the election campaign) and supporting its members' recovery from trauma through such things as awareness of group processes and making space for grief (e.g. 'time out' rooms) in the workplace.

Judith discussed how such work sometimes required the restoration of trust in brutal, opaque organisations. I thought about my and others' struggles to trust our own organisations. One delegate helpfully voiced the obvious irony of many of us working for NHS 'Trusts'. Were there more murmurings here than in response to the other papers? Due not to its quality, but rather because our own NHS organisations had been invoked and we thought we heard Judith 'sticking up' for them. Strategy and future focus however necessary, somehow at odds, in tone at least, with thoughts of sedition and angrier, collective action stirred during Ariel's paper.

'Organisations that work with trauma are susceptible to secondary traumatisation.'

One delegate asked how one approaches an NHS institution that appears to have lost its reflective function. Judith maintained, 'through dialogue'. What if they don't want to talk? Apart from the delegate's obvious dissatisfaction with this answer, there was remarkably little disagreement throughout the day. Thinking back to that child in the dark with his violent and silent father, I realised I had vacillated between identification with both. Perhaps with sadism unbound, we worked even harder at amenability, so as not to be hijacked by such impulses. Thinking about my anticipation of the conference, I had thought narcissism easier to identify with than trauma, because – however distasteful – it at least betrayed defensive coping with trauma rather than identification with the small and helpless victim. Identification with the aggressor – 'one of the ego's most potent weapons' (A. Freud, 1992, p. 110) – is still so easy 'forget'.

Over the course of the conference, we had been taken from the misery and muddlement of childhood through to the employee in relation to the organisation. Both the maturation and panning perspective brought a certain relief, though of course infantile anxiety remained pronounced and present throughout. It was good, then, to come to consideration of the necessity of an organisational secure base, on from being painfully reminded that our ties to work are in large part trauma bonds. My forlorn hope for the former was given a much-needed boost by meeting a number of previously unfamiliar colleagues from my Trust here – previously separate and now, perhaps, a psychoanalytic critical mass?

The conference also provided the opportunity to meet local practitioners I already knew, remind ourselves how many of us work this way, and share a constructive (now) response to the recent atrocities. The conference, months in development, obviously wasn't supposed to be a debriefing session; we had even more to try to unpack in such limited time, but it shouldered this additional burden well. Personal, professional and political matters were deftly weaved, within a conference that was well held and unobtrusively chaired. It is another good demonstration of trans-Pennine collaboration between the D58 Manchester staff group and the Northern School of Child and Adolescent Psychotherapy, which I hope continues ■

Adam Danquah is a Lecturer in Clinical Psychology and a Psychodynamic Psychotherapist.

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Putting post-truth on the couch

By Johnathan Sunley

Is truth really under attack and, if so, can psychotherapy help to defend it?

IT IS FAST becoming a truism that we are living in an era of 'Post-Truth'. Oxford Dictionaries made this their word of the year for 2016 and now an assortment of books has begun appearing with titles like *Post-Truth: The New War on Truth and How To Fight Back* and *Post-Truth: How Bullshit Conquered the World*.

Their approaches vary. For some authors the problem is essentially one of technology, the ease and speed with which what purports to be news can be circulated through social media, making it practically impossible to know when it's fake. For others, it is about unscrupulous politicians like Trump or Putin saying whatever they think they can get away with – and discovering that there are almost no limits on this.

In this article I want to explore what we as psychoanalytically-oriented psychotherapists think about Post-Truth. We probably feel that a firm commitment to truth on our part, though continually tested in sessions, is what our work with patients depends on and that without it we would be of little use to them. Yet taking sides in a war to defend truth may still strike us as a strange idea. For one thing, isn't it said that truth is always the first casualty of war?

Truth as a 'bad object'

To begin with, it may help to clarify what if anything is different about the hard time truth is going through. Lying in public life is nothing new. Countless examples from history could be given to show when this was done to advance an individual's interests, his faction's, or indeed the state's. But generally these figures knew they were lying and took pains not to be found out. Whereas nowadays it's as though there is nothing to find out because true and false no longer exist – those are just categories clung to by what an adviser of George W. Bush famously dismissed as the 'reality-based community'. To Trump it seems that truth is for losers. And in the run-up to the Brexit referendum it sometimes felt that facts were regarded as the last refuge of the unpatriotic. But truth is also under assault from the left: on some American university campuses, objectivity has been condemned as a white supremacist myth.

'How has truth become what we would recognise as a "bad object"?'

When and why did truth itself turn into a target? How has it been become what in our profession we would recognise as a 'bad object' – not so much ignored because inconvenient, but actively despised and denigrated? These are states of mind we also recognise from our consulting rooms. But while a patient may indeed convey that this is how he feels about his object(s), as psychotherapists we will be alert to other feelings – disappointment, perhaps, or fear – he may be less conscious of.

Consider, then, the opening sentence of Nietzsche's great polemic about the possibility of truth after the death of God, *Beyond Good and Evil*. 'Supposing that truth is a woman,' he writes, 'what then?' With mocking sarcasm, Nietzsche proceeds to belittle philosophers before him for imagining they could somehow win the favours of truth through flattery and putting her on a pedestal. He's going to take a much more direct and even brutal approach – and if readers are shocked by that (which they were) then too bad.

What makes this metaphor even more charged is that several times during the course of his life Nietzsche suffered painful rejections by the women he admired. If it is not 'wild analysis' to speculate how those experiences may have contributed to turning him against the feminized ideal of truth that had previously been sacrosanct to Western culture, then I wonder whether the widespread contempt in which truth seems to be held today doesn't stem from similar feelings of bitter disappointment – towards all those conventions of honesty and civility on which liberal democracy rests but which it is widely believed cannot protect us from unemployment, globalization, migration or anything else that might fuel a sense of insecurity.

In other words, Trump, fake news or 'alternative facts' are not themselves the illness but symptoms of a deeper malaise, one that could be thought of as a kind of eating disorder. Since words themselves won't feed us, who cares how they relate to reality or even if they make sense at all?

Whose side is psychoanalysis on?

If this seems like an interesting and even plausible interpretation of what's currently going on in the world, that doesn't make it true. This is a problem that psychoanalysis has always been faced with, though for us it starts nearer to home: namely, how to account for what goes on in the room between patient and therapist, in such a way that it might be possible to know when an interpretation we make is true as opposed to interesting or just well-intentioned. Is it a matter of a patient coming to know some truth about himself he didn't know before? Or is that exaggerating the importance of truth in a formal sense in the work we do – when at the heart of it are no less profound emotional truths like, say, the experience of coming to feel better about oneself or those one is meant to be close to? Perhaps, indeed, we are slightly more sympathetic to the notion of Post-Truth than we had thought.

Ultimately, of course, it depends on how the term 'truth' is defined – and whether a definition of it is possible. You certainly won't find one among the entries in Rycroft's *A Critical Dictionary of Psychoanalysis*, nor in the more philosophically-inclined *The Language of Psychoanalysis* by Laplanche and Pontalis. Does this imply that psychoanalysis has studiously ignored the whole subject of truth? That is what psychotherapists who favour a more existentialist approach sometimes allege. But it could also be argued, it seems to me, that from its inception psychoanalysis has been deeply concerned with the truth and indeed with nothing but the truth – in the sense of why knowing and speaking it matter as much as they do to humans, yet why these are often difficult and sometimes impossible. And here much can already be gleaned from the terms in Rycroft's dictionary on either side of where an entry for 'truth' might have gone: 'trust v. basic mistrust' and 'turning against the self'.

Perhaps it might be fair to say, then, that as psychoanalytically-oriented psychotherapists we are always working with the truth – just not Truth with a capital T. Where that leaves us in terms of the Post-Truth debate I think is less clear.

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Post-Truth

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The author of one of the books mentioned earlier about this tricky term contends that psychoanalysis is partly to blame for the intellectual ground lost by truth over the course of the twentieth century, being something like the missing link between Nietzsche's notorious 'perspectivism' and the head-spinning relativism of post-modern thinkers like Derrida and Rorty. According to the journalist Matthew D'Ancona, 'In psychoanalysis, claims and counter-claims are assessed pathologically, in reference to personal neuroses, rather than forensically, according to traditional notions of truth and falsehood. The imperative is to treat the patient successfully, not to establish facts.'

Start on the couch with Freud and you end up in bed with Breitbart… the case D'Ancona makes against psychoanalysis is crude and far from forensic. Still, charges of this kind are reminiscent of those that were made more systematically and with much greater effect during the so-called 'Freud wars' of the 1990s. Then it was not just the scientific credentials of psychoanalysis that were called into question but its integrity. Taken either as a body of knowledge or as a form of treatment, was psychoanalysis founded on an assumption that truth wasn't as important as people made out – that there were some things which were more important: the unconscious, for example, or psychoanalysis itself?

This is a delicate question, and I raise it not to reopen the wounds of those wars but because I am not sure they have ever healed – and that this goes some way to explaining the confusion experienced by some of us who think or practise psychoanalytically when confronted by Post-Truth.

For it strikes me that out of an understandable desire to defend our field, we have ended up narrowing our focus to issues that arguably address some of the concerns of our critics while failing to meet the main challenge of their argument. I'm thinking here of what appear to have been our principal preoccupations over the last ten to twenty years: things like neuroscience, the search for an evidence base, statutory regulation, diversity. None of these is not relevant to the future of psychoanalysis and depth psychology more broadly. But if these have become our 'good objects', what about truth? Or are we of the view that these are synonymous with truth nowadays?

Restoring truth to its rightful place

That is certainly a tempting conclusion to come to. It lets us off the hook of having to think a great deal about truth in the abstract when we perhaps feel that is a task for philosophers. The trouble is, as D'Ancona rightly points out, contemporary philosophers don't have much time for truth either. For many of them, truth is a subject that has had its day – a day that came to an end as long ago as the mid-nineteenth century. Sure there are lots of 'small' truths we can pick out. But these depend on the area or activity under consideration. Mathematics has its truths as does painting as does cooking. No doubt there are truths of a kind in psychotherapy as well.

In my opinion, this is where Post-Truth comes in. Far from doing away with truth, it welcomes its proliferation – and it can be hard for those of us living in pluralistic, democratic societies not to go along with this, little realising that this is precisely what makes truth untenable.

Today it is virtually a given that truth varies according to time and place. But until a few hundred years ago in the West (and even now in some traditional cultures) truth was understood as being that which is beyond change. In one sense that made it very hard to speak about, as anything found in nature or made by man to which truth might be compared is subject to change. That, though, was – and still is – the point. If truth exists, and even Post-Truth presupposes it does, it is not like other things. It is what makes their existence and our knowledge of them possible. For this reason truth must have a capital T.

'Today it is virtually a given that truth varies according to time and place.'

This may be starting to sound rather metaphysical and far removed from the work we do with patients. I am not so sure. Near the end of *Memories, Dreams, Reflections* Jung writes, 'The decisive question for man is: Is he related to something infinite or not? That is the telling question of his life. Only if we know that the thing which truly matters is the infinite can we avoid fixing our interest upon futilities, and upon all kinds of goals which are not of real importance.' And if Jung is not to your taste then you may prefer a paper by David Bell on how psychoanalysis, in spite of its adherence to subjectivity, refuses to relativize truth as post-modernism does – ostensibly out of a celebration of choice and many-sidedness but where 'what manifests itself as freedom is, I think, an enslavement to narcissism.'

But I want to leave the last word to a philosopher who holds that modernity and even post-modernism are not necessarily

ill-disposed to truth – and whose recent book on the subject, *Truth*, I would recommend as summer reading to anyone who wonders if there might be some life in this term after all. For John Caputo, life is fundamentally what truth has always been about, and this demands of us that we love truth as much as we do life itself, regardless of the fact that we will inevitably have a range of other feelings towards both. Interestingly for us, he defines this basic disposition as 'the *eros* or desire for truth'. And though the word may be an ancient one, the attitude itself need not be. 'The love of truth belongs to the postmodern condition no less than to Greeks now long dead. But by love of truth I mean the excitement posed by the future, the openness of what we know to all that remains unknown, living on the border between knowing and un-knowing, truth and un-truth, the possible and the impossible' ■

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Provision

Making the case for investment

By Susan Mizen

THE LAST TWO decades have seen a steady decline in relational therapies in the public sector, particularly psychodynamic psychotherapy and counselling. Aside from some notable exceptions such as Mentalisation Based Therapy and Dynamic Interpersonal Therapy, many psychotherapy departments in mental health services have shrunk or integrated with other services, in some instances petering out or disappearing altogether. Most psychotherapists trained in these services and some have worked in them. Many leading thinkers in psychoanalysis and psychotherapy worked with people with severe mental health problems in the public sector and developed their thinking in this context.

Maintaining a flourishing psychotherapy culture in the public sector would seem essential to the vitality and intellectual life of the organisations in which psychotherapists and analysts train and develop professionally. From the patient's perspective, the lack of psychotherapy offering in-depth, long-term work can be a matter of life and death. Many others revolve through repeated episodes of care and hospital admissions, with little prospect of understanding their difficulties or grasping the repetition which drives them. If public sector spending is cut further still it would seem this situation can only worsen.

Around eighteen months ago six professional bodies joined forces to address this issue, forming the Talking Therapies Task Force: the Association for Psychoanalytic Psychotherapy in the NHS, the British Association for Counselling and Psychotherapy, the British Psychoanalytic Council, the Medical Psychotherapy Faculty at the Royal College of Psychiatrists, the Society for Psychotherapy Research, and the UK Council for Psychotherapy. Our task has been to promote a second national investment in psychological therapies for those with the most severe relational disorders. Following the example of IAPT, the Task Force set out to develop a national infrastructure to support the commissioning of psychotherapy by making the Health Economic case at the opposite end of the severity spectrum. As Lord Layard made the Health Economic case for CBT for mild to moderate anxiety and depression, we are making the case for investment on the basis of those most intensive users of inpatient care, emergency services and primary care.

'We are making the case for investment on the basis of the most intensive users of care.'

The Task Force has commissioned a health economic analysis of the cost of this small population of people to mental and physical health and social care from the Centre for Mental Health. Our outcomes working group is developing a national outcomes framework. This is particularly important. Without national outcome reporting, the needs of people with the most severe mental health problems remain invisible to politicians and those deciding on commissioning priorities at NHS England. Local commissioners will not commission services without routine outcome measurement. The outcomes working group will be surveying psychotherapists and counsellors working in the NHS to understand the obstacles to measuring outcomes. If we are to compare like for like with IAPT, we will need to aim at measuring outcomes for every patient who attends.

We have identified pilot sites nationally in which we can test the effectiveness of therapeutic pathways for patients who are most difficult to discharge from inpatient mental and physical health settings. Early indicators suggest that investing in such services saves £3 for every £1 spent. We are also developing reflective practice interventions for multiagency teams working with frequent attenders in primary care and emergency services.

Local commissioners are being given the task of improving services with reduced budgets. They will commission services if they have demonstrated they can both improve care and reduce costs. They will be more likely to do so if they are clear about the workforce required and where training is available in areas were recruitment is difficult. To this end the Task Force is setting up workforce development and training work streams.

We are focussing our attention on those psychological disorders where the case can most clearly be made for cost savings and investment, and where the gaps in services are most noticeable. These include Primary Care, Personality Disorder, Historic Childhood Sexual Abuse, Medically Unexplained Symptoms, Tier 2 psychotherapy services, and Reflective Practice. Clinical working groups hosted by the Psychotherapy Faculty RCPsych have been set up in these areas. Expressions of interest are being sought for membership of those groups from members of the task force organisations with expertise in these areas of work.

This is an ambitious project; we are being strategic in our thinking about where to invest our resources. We continue to attract considerable political interest in the work, and hope to have the initial health economic report within the next six months. If you are interested in being involved in the clinical working groups please contact Gary Fereday at gary@bpc.org.uk ■

Susan Mizen is Chair of the Talking Therapies Task Force.

Review

Fourteen hours with R.D. Laing

By Brett Kahr

I MET THE LATE Dr R.D. Laing only once.

But we spent fourteen consecutive hours together.

And I can promise you that he made a lifelong impression.

Back in 1983, I organised a series of lectures on psychoanalysis at my university, and I had the privilege of hosting visits by such luminaries as Dr John Bowlby, Dr Hanna Segal, Dr Robin Skynner, and many others, including the great American psychoanalyst Dr Muriel Gardiner who, *inter alia*, had the task of caring for Sigmund Freud's patient 'Der Wolfsmann' in later years.

At that time, I worked in a rather decrepit regional psychiatric hospital which offered no psychotherapy at all. The doctors and nurses spent the vast portion of their days actively neglecting all the patients, and I found this quite horrifying.

For solace, I read R.D. Laing's classic book *The Divided Self: A Study of Sanity and Madness*, and I found it to be a humane, life-affirming, and refreshing antidote to the highly pharmacologically orientated psychiatry of that period. I must confess that I became quite a fan of Laing's published writings; and so, when I began to organise my programme of visiting speakers, I wrote to Laing, extending an invitation.

Virtually all of the other distinguished men and women whom I had approached answered their letters personally; but Laing employed a private secretary who responded on his behalf. None of the other speakers asked for any remuneration – I had of course offered to pay for travel expenses – but Laing's secretary explained that he would be obliged to charge a fee of £1,000. I imagine that an honorarium of £1,000 in 1983 would be equivalent to a figure many times that amount in contemporary terms. I explained, politely, that my student organisation could certainly not afford such a figure, and I offered to pay £200 instead. The secretary graciously accepted this reduced amount. As per university custom during that period, no one ever charged for academic lectures; but in order to raise the £200 for Dr Laing, I had to sell many tickets for £1 each!

At that time, I had already begun to undertake some research into the history of psychoanalysis, and through my interviews I had come to meet Mary Barnes, one of the former residents at Kingsley Hall: Laing's famous psychiatric halfway house in East London. When I told her that I had invited 'Ronnie' to participate in my series of talks, she warned me that, in all likelihood, he would not appear on the day, in spite of having agreed to do so. Incredulous, I asked for clarification, whereupon Miss Barnes explained, 'If you want him to show up on the day, you will have to drive to London, pick him up yourself, put him in a car, and then take him to the lecture directly – otherwise, you won't see him!'

Having already sold hundreds of tickets – just enough to pay the £200 fee, plus petrol costs – I did not wish to disappoint the audience, and so I enticed a friend with a car to accompany me into London, and to help me fetch Dr Laing from his home.

On the appointed day, we arrived at Laing's spacious residence in Chalk Farm, in North London, round about midday. And within moments of meeting him, I soon learned everything that I have ever needed to know about disillusionment.

He answered the doorbell quite drunk. My anxiety rose and my heart sank, wondering how on earth such an inebriated man could possibly manage to give a lecture later that afternoon.

Somehow, we convinced Dr Laing to get into the car – not an easy task, as he had decided to demonstrate his rather clumsy piano-playing skills – but we eventually succeeded, and then we began the hour-long drive to Oxford. Within minutes, he reached into his coat pocket and produced a 'spliff' of what he described as specially imported Lebanese marijuana, and he began to smoke. Courteously, he offered me a 'drag' on his spliff, and I refused politely. I then opened the windows as far as I could on that cold November day, and wondered how on earth I would navigate what I suspected would soon turn into a disaster.

Fortunately, we managed to arrive in time, and to escort Laing to the absolutely packed lecture theatre in the university's Department of Experimental Psychology, and I then had the privilege of introducing him to thunderous applause.

Although I knew very little about Laing's personal or professional history at that time, I did know that he had somehow become *persona non grata* in the psychoanalytical world; and yet this baffled me, as his books seemed to epitomise the very best of Freudianism, namely, that madness makes sense! And so, when Laing's secretary and I had discussed the topic for his lecture, we agreed that he would speak about his views on British psychoanalysis. His secretary confirmed that Dr Laing would be happy to pontificate on the subject of 'Theoretical Influences from Klein to Bion'.

After the introduction, I sat down, and eagerly anticipated Dr Laing's talk, desperately hoping that his booze-filled, marijuana-laced morning would not interfere with his capacity to speak. Laing set about his task with gusto, but within minutes, he began by insulting Melanie Klein and Wilfred Bion, both of whom he had known personally, reviling each one publicly in a highly unprofessional manner.

Then, after about fifteen minutes of ridiculing the Kleinians, Laing put his fingers into his mouth and began to jiggle one of his teeth. This surprised me greatly, though in retrospect it should not have done. After several moments of fiddling with this tooth, he removed it from his mouth and held it up to the audience! He then stood in stony silence, staring at what he had just extracted from

his mouth. He became almost catatonic. After a few moments of intense and uncomfortable silence, I approached Dr Laing and asked him whether I could offer him some water. He looked at me forlornly and croaked, 'Get me out of here. Now!'

'She warned me that, in all likelihood, he would not appear on the day…'

Mobilising my best diplomatic skills, I turned to the large audience and expressed my regret that Dr Laing had become unwell and that, therefore, we would have to end the lecture (after only twenty minutes). I explained that I would be happy to offer a refund to anyone who wished to reclaim his or her £1 note. Although I feared that the audience might begin to moan or curse, no one uttered a sound of complaint, and no one asked for any reimbursement. I suspect that everyone had come to see the 'great man' live, and so, perhaps they felt that they had already received their money's worth, having caught a glimpse of the world's most famous psychiatrist pulling a tooth out of his mouth!

My anxiety level burst through the roof, and I felt deeply ashamed by my naïveté. But of course, as none of the previous speakers had behaved in such a way, I had no preparation that such a distinguished mental health professional could possibly comport himself in this sort of manner. We left the lecture theatre, and I asked Dr Laing whether he might wish to return to London. But he knew that we had already organised a post-talk supper for him at the home of a gracious friend; and, relieved to have left the lecture theatre, Laing chirped in a more energised fashion, 'Don't be silly. Let's eat!'

I shall not attempt to summarise our supper, which lasted until the small hours of the morning, but needless to say, Laing outdid himself in terms of outrageousness: drinking, smoking, and, at one point, chanting the entire Book of Jonah, after having requested a copy of the Bible from our bewildered hostess. At one point, I remember asking Laing why, in view of his loathing of pharmacological interventions, he had trained as a physician. He replied with a straight face, 'My God, being a doctor is amazing. You can do anything you want to a patient. You can even remove someone's brain if you like.'

As a very young man at that time, I felt that I had no option but to sit out this increasingly painful evening meal and to discharge my role as host as best I could. But throughout I felt intensely uncomfortable and extremely despondent that my great hero had revealed himself as such a tragic figure.

Years later, while conversing with one of Laing's colleagues at a conference, I learned more about why his tooth had fallen out at his Oxford lecture in 1983. This gentleman – who knew all about the tooth incident – explained that, the night before the talk, Laing had got embroiled in a fistfight, and his opponent had socked him in the mouth, thus loosening the soon-to-be infamous tooth in the process!

In spite of this extraordinary day with R.D. Laing, and in spite of my sense of horror and distress that a well-trained and fully psychoanalysed physician could have deteriorated to such a degree, I still maintained a lifelong appreciation for his published works and for his bravery in attacking the more primitive and sadistic aspects of British psychiatry which, as a young student, I had witnessed first-hand in some truly ramshackle institutions.

As the years unfolded, I met many people who had known Laing in the early days, and who reminisced about him in a most affectionate manner. Marion Milner – Laing's one-time clinical supervisor – spoke of him with great fondness as a kind, sweet, thoughtful, and intelligent young man. And Brendan MacCarthy – a model of sobriety and sanity – told me that Laing had endeared himself to many fellow trainees at the Institute of Psycho-Analysis by offering them frank and helpful assessments of which supervisors should be embraced and which should be avoided! I even found some unpublished letters that Donald Winnicott had written to Laing back in the 1950s, praising him for his pioneering work.

Clearly, I had had the misfortune of seeing the worst of Laing, rather than the best.

But whatever one makes of Laing as a man, his written work still retains an independence and, I would argue, a genius.

Perhaps more than anyone else, Laing explored, and then exposed, the madness which lurks within the families of those individuals who become schizophrenic in later life. Laing undertook pioneering work at the Tavistock Clinic in the 1960s, tape-recording sessions with families struggling with a schizophrenic member. Previously, no British mental health professional had ever dared to study these families quite so closely or to conclude that families, not genes, might drive people crazy.

Of course, over the years, many people have doubted the authenticity of Laing's research and have wondered whether he had, in fact, fabricated these seemingly mad families for dramatic purposes. In response, I can but repeat the words of Janice Uphill, Laing's former secretary at the Tavistock Clinic, whom I came to know during the early 1990s, and who revealed to me, 'I typed up every single one of the tapes with those families. And I can tell you, they are absolutely authentic. Every single word of them. Dr Laing did not make up his data.'

Since his death in 1989, several biographies of Laing have appeared, including a very engaging memoir written by Adrian Laing, his son. These works have brought much compassion and insight to our understanding of the personal traumata that Laing endured in boyhood and the consequent private demons that haunted him throughout his adult life.

Nevertheless, Laing's reputation has suffered irretrievably and many now remember him as an alcoholic, as a drug addict, as a womaniser, as a physically violent man, and, moreover, as an irresponsible physician, psychiatrist, and psychoanalyst. In view of the fact that Laing underwent a full five-times-weekly training analysis, one cannot help but wonder to what extent his outrageous acting-out has damaged the probity of the psychoanalytical profession.

And yet, Laing's books still bristle with brilliance; and he, unlike any of his more softly spoken colleagues, did have the courage to challenge the grotesque and primitive leucotomies and crude bilaterally-administered electroconvulsive treatments which deprived so many patients of basic cognitive functioning.

'Whatever one makes of Laing, his written work retains an independence and a genius.'

What, therefore, might we make of Laing's legacy?

Unsurprisingly, this psychiatrist – part genius, part madman, part guru, part rock star, and part forensic patient – has become an iconic figure. And now, nearly thirty years after his decease, the film industry has immortalised him in a feature-length movie entitled *Mad to Be Normal*, featuring his fellow Scot, David Tennant, in the starring role.

Robert Mullan, the director of this new film, has already published no fewer than three books about the great anti-psychiatrist: two solo-authored texts, *Mad to Be Normal: Conversations with R.D. Laing*, which appeared in 1995 – whose title has now become enshrined in film – followed by *R.D. Laing: A Personal View*, published in 1999, as well as an edited volume of reminiscences, the cunningly entitled *R.D. Laing: Creative Destroyer*, released in 1997. And now Mullan, a film-maker of long standing, has transformed his books into an outstanding work of cinema: slick and stylish, historically convincing, and magnificently presented and performed by an outstanding cast whose members include not only David Tennant, but also the actors Gabriel Byrne and Sir Michael Gambon.

Set in the 1960s, the film treats us to various snapshots of Laing's life and work. Over the course of one hour and forty-six minutes, the movie introduces us to Laing as anti-psychiatrist, as sex symbol to mini-skirted women, as lecturer, as radio and television personality, as political agitator, and as family man (both as father to many children and as a son to a very chilling mother). David Tennant has embraced the title role with gusto; indeed, both vocally and facially, he bears such a striking resemblance to the real R.D. Laing that one quickly forgets that Mr Tennant had burst to fame as the English-accented Doctor Who. Indeed, Tennant has delivered an Oscar-worthy performance which provides tremendous continuity to the entire film. It may not be widely known, but in real life, Tennant has married the British-born granddaughter of none other than the American psychoanalyst Dr Harold Searles; so, perhaps Mr Tennant has absorbed something of psychoanalytical culture through his wife's family!

Those familiar with Laing's life and work will recognise many of the set pieces, including the famous and much-discussed episode in which Laing interviews in a padded cell a young woman, diagnosed as suffering from catatonic schizophrenia, who refuses to speak. Although the other psychiatrists had given up on this patient, Laing decided to persevere; and when the young woman removed some of her clothing, so, too, did Laing, in an effort to make her feel somewhat less exposed. He then ordered a pizza, suspecting that this patient might be hungry. And before long, the woman became verbal once again, while Laing then had to endure the calumnies of the attending psychiatrist who accused him of unethical behaviour. Although I know of not a single colleague who would, or should, ever undress in front of a patient, this scene poses many questions about how one might intervene with a seemingly hopeless and ostensibly irretrievable patient. And if ordering a pizza might help, then so be it!

However, in spite of providing us with glimpses into some of the more creative and inspiring aspects of Laing, and of his wish to protect his patients from the grim psychiatric institutions of the 1960s, the film portrays far more of Laing the alcoholic and the Laing the madman. Consequently, the balance tips in favour of his antipathists rather than towards his sympathists. We encounter much more of Laing administering LSD to his fellow residents at Kingsley Hall than we see of him lecturing about the evils of psychiatric neurosurgery.

Although brilliantly made, I cannot describe this film as a jolly good night out! In fact, I found *Mad to Be Normal* intensely painful to watch, as it overflows with scenes of Laing in punch-ups; of Laing making love to his girlfriend at Kingsley Hall while a psychiatric

Continues overleaf

R.D. Laing

continued from previous page

patient watches; of another patient undergoing electroconvulsive treatment in hospital, drooling at the mouth; of Laing's mother treating him with icy silence; of Laing's own daughter dying from a terminal disease; and so on. A group of cinema patrons who sat nearby laughed uncomfortably throughout much of the film; while others dozed off from time to time: no doubt defences against the emotionally excruciating material portrayed herein.

But the film does succeed greatly in terms of accuracy, not only in David Tennant's magnificent reincarnation of Ronald Laing, but also in the vivid way in which the director has recreated the ancient psychiatric wards, which many of us will still remember only too vividly.

'Although brilliantly made, I cannot describe Mad to Be Normal as a jolly good night out.'

I left the cinema exhausted but also hopeful that good, solid psychotherapy – quite a rarity in the 1960s – has since become increasingly standard.

Laing has now become an historical figure, and research students have begun to produce a welter of academic dissertations about both Laing the man and about the anti-psychiatric movement. I suspect that, in upcoming years, we shall learn much more about Ronald Laing as a tormented genius and about the impact of his arguably necessary sledgehammer-like attack on traditional psychiatric provision. Robert Mullan's film will help to educate us, and to introduce the best of Laing's work to the newer generation who missed out on reading him first time round.

Since my only meeting with Laing, back in 1983, I have, of course, met many colleagues who had their own complex accounts of this unforgettable Glaswegian. In retrospect, I seem to have escaped quite lightly. One of my colleagues underwent analysis with Laing back in the 1960s, and this woman – a great beauty indeed – told me that Laing worked hard in the analysis to convince her to leave her boyfriend, as he rather fancied her himself. Another colleague shared with me the horrific details of a dinner party with R.D. Laing in which he ran into the kitchen, picked up a sharp knife, and threatened one of the other guests.

Although one cannot condone any of Laing's outrageous behaviours, one can sympathise with his private struggles, portrayed so evocatively in *Mad to Be Normal*. In one scene, Laing finds himself being interviewed on American radio, having to answer some extremely insipid questions. By this point, he had become not a *person* in the mind of the general public but, rather, an *object* to be used. I realise that when I had introduced Laing to the Oxford audience back in 1983, he might have felt rather like a show-dog being trotted out, yet again, on parade; and although he might have welcomed the £200 fee, he had probably given so many talks by that point that I suspect he simply wanted to disappear. Naively, I had thought that by having invited him to speak about his relationship to psychoanalysis, he might have found that more engaging than delivering yet another rant against cruel psychiatry. But Laing failed, alas, to offer a coherent account of why he came to hate the psychoanalysts, many of whom held similar ideological positions in relation to somatic treatments.

Laing trained in the 1950s, and he 'practised' in the 1960s and 1970s and 1980s, long before the creation of regulatory organisations such as the British Psychoanalytic Council. It may be sobering to realise that had Laing lived past 1989, he might well have become a registrant of the BPC, though one cannot imagine him actually filling out his Continuing Professional Development forms. As the film unfolded, I kept thinking that if Laing had become a BPC registrant, he would, in all likelihood, have kept our Ethics Committee working overtime.

So, do we embrace Ronald David Laing as one of our own? Do we regard him as someone who had the potential to be one of us, but who fell badly by the wayside? Or do we drop him completely from our radar and pretend that we have no relation to him whatsoever? Psychoanalysed by Dr Charles Rycroft, supervised by Marion Milner, and educated in seminars conducted by Melanie Klein, Laing had access to the best minds in British psychoanalysis. Rather like Masud Khan, another 'genius' who fell from grace – and quite spectacularly so – exceptions such as R.D. Laing raise some chilling questions: How did these well-analysed men become so troubled? What, if anything, did senior colleagues do to intervene? And what shall we do with their legacy of publications?

I recommend Robert Mullan's film *Mad to Be Normal*, and I hope that the film will stimulate some powerful engagement with these complex and troubling and, from time to time, inspiring issues ■

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Editor's farewell

'If someone speaks, it gets lighter,' as put forward in Freud's *Introductory Lecture XXV*, seems to be a good place from which to kick off this goodbye.

Bar the odd interview here and there, my words have never graced this fabulous (if I do say so myself) magazine, and I have been racking my brain as to what to write. Oh the pressure. So, I'm drawing on the wise words of the big fella himself to help me formulate this short goodbye.

I joined the BPC in early 2009, and part of my role, over the last eight years, has been to support the development of the organisation's promotional and advocacy work. I am immensely proud of what I, and colleagues, have achieved in two areas in particular: the PP NOW conference and lectures, and this publication.

PP NOW as a concept has gone from strength to strength, and is such a positive showcase of our profession's reach, not only within the world of mental health practice, but in its ability to shed light and frame understanding of some of society's trickiest issues. I cannot wait to attend this year's event as a delegate, and the team behind this year's programme – well what can I say? OMG, how exciting!

New Associations set out to be a unique publication which would collate and publish the 'news, analysis and opinion for the psychoanalytic community'. What a challenge. How could our in-house publication wrestle for readers alongside some of these esteemed and well established publications? How will we get people to contribute? What should we write about each issue? Well, as it would turn out, we readily developed a style, and getting people to write wasn't the quite the daunting task we thought it might be. Members from our analytic community had a lot to say about a huge swathe of subjects, and not just confined to ideas pertaining to analytic practice, but in a seemingly endless choice of modalities. It was clear that we had created a platform upon which many wanted to use their voice. How fantastic it has been to nurture and support that idea.

The analytic profession seems always to be under fresh attack from some faction of society, and it is my hope that, in giving our community an outlet to vent their thoughts, ideas, anger, frustration, joy and successes, we have helped, just a little, to chip away at the relentlessness of being scrutinised and judged; to support the 'lightening'.

And at the very least, we have shown that, with close to 200 thought-provoking articles, the influence of analytic thinking *isn't going away*.

It's been such a privilege to edit the publication, and I can't express the gratitude I feel towards the contributors who have offered their pieces under my tenure. I sometimes feel like such a fraud (ha! I just had to re-type that as I'd written Freud – interpret that!) – It's the words of the writers who have done all the hard work each issue! I have, though, learnt so much, and made some great friends.

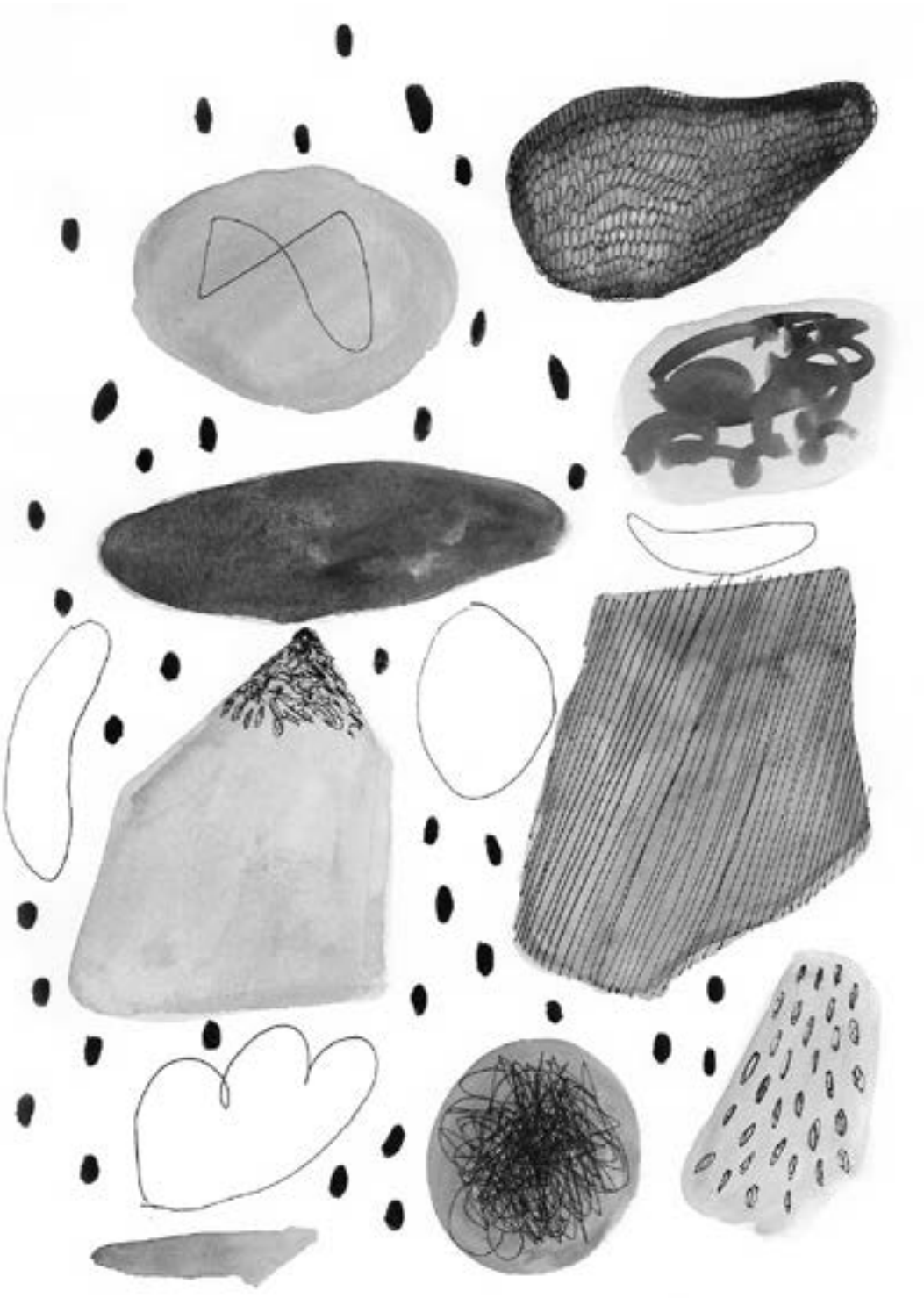
I joined the BPC from arts publishing with only – let's say for politeness – a slight interest in psychoanalysis; but I leave it now, on a path to training as a child psychotherapist. How deliciously surprising life can be ■

Leanne Stelmaszczyk was editor of New Associations – *this is her final edition.*

Practice

Art therapy and psychotic states of mind

By Katherine Killick



PSYCHOSIS, whether transitory or enduring, is a state of mind in which symbolic communication and interpersonal relatedness are problematic. Psychoanalytic understanding of the plight of the person in a psychotic state has enabled specialised psychotherapeutic approaches to people with psychiatric diagnoses of psychosis to develop, and several chapters within the book *Psychotherapeutic Approaches to Schizophrenic Psychoses* (Alanen et al 2009) present these. The chapter by Murray Jackson (Chapter 8) summarises the psychoanalytic concepts that had at that time proved most relevant to work with psychosis in mental health settings in the UK and the USA.

Within the UK, some psychoanalysts have developed psychoanalytically informed settings that worked with people diagnosed with psychosis in collaboration with conventional psychiatry. One of these settings was the inpatient unit at the Maudsley Hospital that was dedicated to the application of psychoanalytic principles to people with psychiatric diagnoses. This unit was run by Murray Jackson for 11 years, having been inaugurated by John Steiner in 1972, and people with psychotic and borderline diagnoses formed the majority of its intake. Other UK psychoanalysts who have brought psychoanalytic understanding to bear on psychiatric settings working with psychosis include Michael Conran, Richard Lucas, and Brian Martindale. These pioneering psychoanalysts also introduced psychoanalytic understanding to other professions working in their multidisciplinary teams, which often included art therapists. In my opinion, the supervision and teaching offered by these psychoanalysts, and those trained by them, has enabled specialised forms of art therapy for psychosis to develop in the UK.

In psychotherapeutic work with psychotic states of mind in art therapy, art making, art objects, and transactions surrounding art making and art objects can become a medium for engaging and holding the psychotic defensive organisation while exerting persistent challenges to its requirements. The experience of holding and containment over time can facilitate development and restoration of the ego. Art making, and transactions surrounding images in the therapeutic setting, constitute a field of activity that in itself exerts a gentle but effective challenge to the prevailing tyranny within the psyche. The therapist's understanding and acceptance of the nature of psychotic anxiety and psychotic defences enable a particular form of primitive therapeutic alliance to develop. This exerts no pressure on the patient to engage prematurely in symbolic ways of relating, but maintains a constant invitation to do so if and when she or he is able and willing. Accordingly the potential for learning from experience and individuation can be established in a lasting way.

'Art making exerts a gentle but effective challenge to the prevailing tyranny within the psyche.'

The profession of art therapy is now established as a psychotherapeutic modality both in the UK and internationally. The development of the profession in the UK has been described by Diane Waller (1991), where art therapy began in dedicated art rooms within Victorian asylum-style psychiatric hospitals. These hospitals served people with psychosis prior to the changes to NHS mental health service delivery that were initiated by The National Health Service and Community Care Act (1990). Two of the pioneers of the profession in the UK, who have written about their work in psychiatric settings, were Edward Adamson (1984), and E.M. Lyddiatt (1971).

In 1997 the book *Art, Psychotherapy and Psychosis*, edited by Joy Schaverien and myself, gathered the body of thinking and specialised approaches to psychosis that had evolved within the profession in the UK. At that time this was primarily influenced by psychoanalytic understandings both of psychosis and of psychotherapeutic approach to psychosis.

The recently published book *Art Therapy for Psychosis: Theory and Practice* (Routledge 2017) that I edited for the International Society for Psychological and Social Approaches to the Psychoses takes a further step in defining the specific value of art therapy as a psychotherapeutic approach to psychosis by gathering expertise that has developed internationally. It presents a collection of papers from art psychotherapists, and psychoanalysts and psychiatrists trained in art therapy, from the UK, the USA, Italy and Scandinavia, which share specialised expertise in using art making, and transactions involving art objects, in psychotherapeutic approaches to psychosis. These include perspectives derived from neurophysiology, phenomenology, ontology and cognitive analytic theory, as well as those derived from different psychoanalytic traditions, including Lacanian psychoanalysis. They explore common experiences of the particular appropriateness of art therapy as a psychotherapeutic approach to psychosis. Both individual and group treatment settings are considered.

The specific value of art therapy for psychosis, as presented in this book, lies in its capacity to offer structured psychotherapeutic approaches that minimise the requirement for forms of interpersonal relating that are to a greater or lesser extent problematic in psychotic states. The various approaches presented reveal ways in which art-making in itself can become a healing agent, and in which the interpersonal context within which this happens can become another. The presence of art materials and art objects in the setting, and transactions surrounding the making of images and their actual presence, can be employed by the therapist to form a therapeutic alliance with a person in a psychotic state, and to undertake work by means of which fundamental change is possible. Common understandings of the profound anxieties pervading these states of mind, and of their role in psychotic states, form a basis for appreciating the traumatic threat that the relationship with the therapist presents, and accordingly for this to be taken into account in the therapist's approach.

In art therapy, the frame of the psychotherapeutic relationship

Continues on page 13

Review

Balint Matters: Psychosomatics and the Art of Assessment

by Jonathan Sklar
Karnac Books, 2017
Review by Helen Johnston

A famous professor of psychiatry once asked me – how many patients do you have in your practice – three? The implication was that while he was helping thousands of patients, as a psychoanalyst I was self-indulgently dedicating myself to a select few. Jonathan Sklar's book shows just how mistaken that attitude is. He demonstrates that psychoanalytic ideas can make a radical difference to the way we practise medicine, psychiatry or psychotherapy, enabling us to have a very different impact on our patients' lives.

Balint's idea of whole-person-centred medicine is fundamental to Sklar's approach. We are invited to appreciate the value of listening to the complex rhythms of the psyche-soma and of taking into account the unconscious processes that take place within the minds of our patients and within the minds of those who treat them. He sees no point in 'listening to the surface presentation of the patient as a collection of symptoms without linking the material to unconscious processes'; as there is no point in telling the patient simply to 'cease their negative ruminations and to follow a positive course towards life changes.'

Reading this book, I wished that I had read it many years ago when, as part of my psychiatric training, I embarked on treating patients in psychodynamic psychotherapy, taking part in and later leading Balint groups, conducting psychoanalytic assessments and supervising junior doctors for their first psychoanalytic case. The book is clearly written by a psychoanalyst who is also a psychiatrist. It answers many questions and offers solutions to dilemmas and conflicts that we invariably face during our psychiatric and psychoanalytic training and continue to experience after our training is complete. It is a great gift to those who are in training and to those who train them.

Take Sklar's ideas on psychoanalytic assessment: it is well known that assessment is a complex task when one needs to learn a great multitude of facts, variables, and an often complicated history. As doctors we are trained to collect the necessary information about patients through a structured interview. This technique is not suitable for psychoanalytic assessment. Quoting Balint, Sklar reminds us that 'if you ask questions, you will only receive answers.'

In explaining how things can be done differently, Sklar divides the process of assessment into the beginning, the middle and the end stages. He invites the reader to think carefully about the impact making contact has on both the patient and the practitioner. 'The more difficult task,' Sklar notes, 'is for the consultant to let the process unfold, and to let the patient relate to them in their usual manner.' But how can we actually do this in practice? Sklar describes the way he does it and why he does what he does. For him, creating the right setting and allowing the patient to make use of the space, which is explicitly treated as belonging to the patient, is essential. His approach is non-intrusive and facilitating – it's about allowing the patient freedom to use the space of consultation, but at the same time not leaving the patient to their own devices. He gives generous advice and explanations of his technique. 'Some sort of understanding of fragments of clarity needs to emerge for a beginning to be made,' so the patient can 'feel a little contained or even held – in the primitive sense of parent holding a baby, rather than leaving a baby to look after itself.'

'The book is a great gift to those in training and those who train them.'

Sklar's account reminded me of Winnicott's paper (1941), 'The observations of infants in a set situation'. The paper describes Winnicott's observation of infants who are attending consultation in his paediatric clinic with their mothers. Winnicott puts a spatula on the table and observes how the infant reacts to the attractive shiny object. This is how Winnicott describes his observation: 'the baby puts his hands to the spatula, but at this moment discovers unexpectedly that the situation must be given thought. He is in a fix. Either with his hand resting on the spatula and his body quite still he looks at me and his mother with big eyes, and watches and waits, or, in certain cases he withdraws interest completely and buries his face in the front of his mother's blouse. It is usually possible to manage the situation so that active reassurance is not given, and it is very interesting to watch the gradual and spontaneous return of the child's interest in the spatula.'

There is a particular quality that is present in Winnicott's way of being with an infant that is also present in Sklar's way of being with his patients. This particular quality is described by Michael Parsons (2015) as 'a feeling of being attended to, with a kind of relaxed intensity at a very deep level.' This bears similarity to the attitude of an analyst who observes in a non-intrusive way, allowing the emergence of the patient's own way of managing a new situation in an environment which is supportively responsive to the patient's needs.

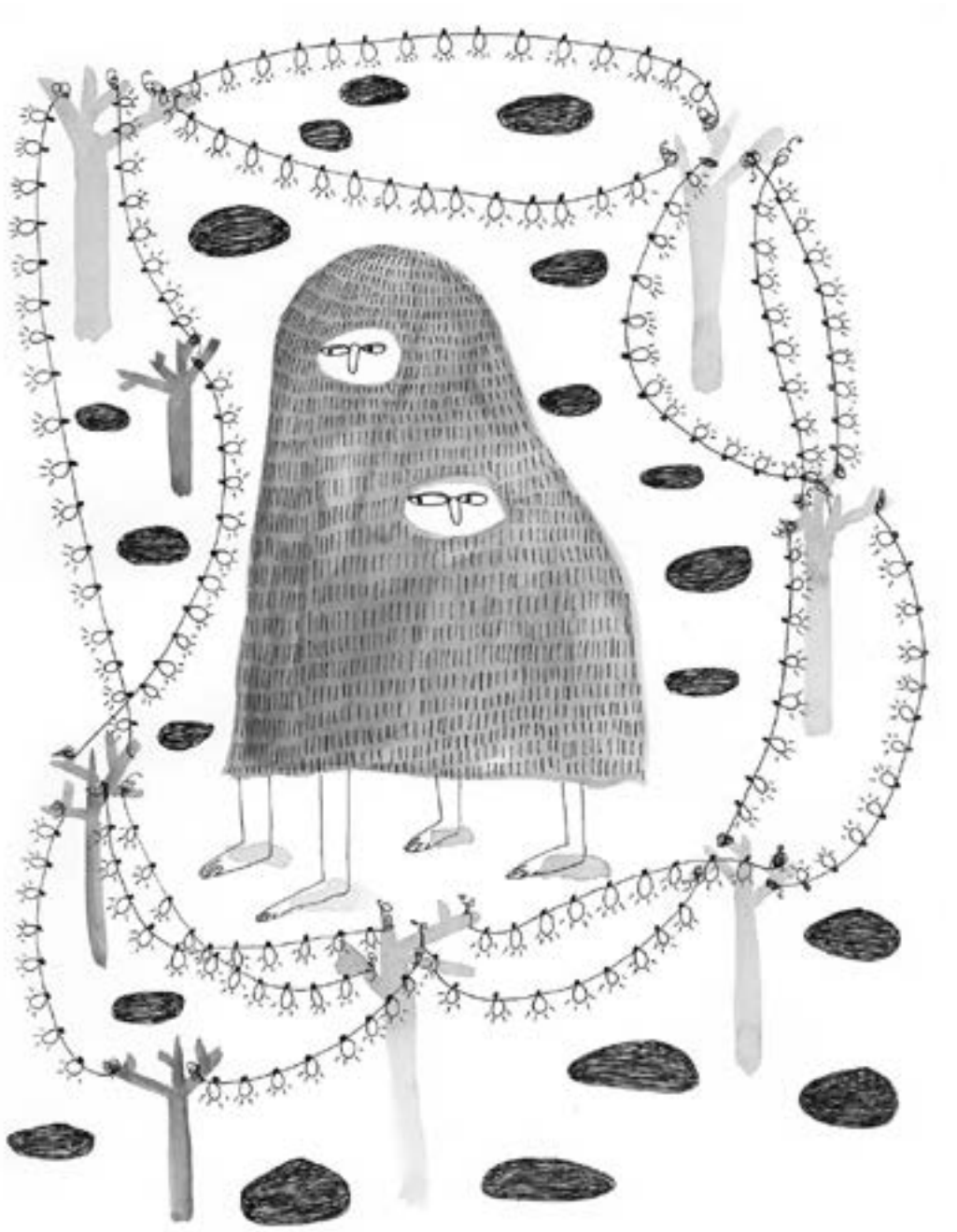
In the second stage of assessment Sklar gives us a map of how to think about the highly complex material that comes to light during assessment. His advice is to explore specific elements of the assessment – an early memory, a dream, a sexual fantasy, and the transference-countertransference dynamic in the room. Clinical vignettes provide fascinating reading and allow the reader to follow the analyst's mind at work. We are invited to observe the moment to moment interaction of patient and analyst, and see how the complex interplay of unconscious processes is decoded and understood by the analyst. What particularly impressed me was Sklar's light touch and his way of exploring the patient's feelings in as non-traumatic a way as possible. Ultimately it becomes clear that this approach can elicit far more than the technique of asking questions ever could realise.

The third part of the assessment is crucial, bringing the process to an end and deciding how to help the patient and take the consultation forward. Sklar's attitude is thoughtful and again non-intrusive. He writes: 'Following the work of assessment, the patient may be aware of having a choice. There is no demand from the consultant that they undergo the rigour of treatment. Knowing that there is a potential may suffice for some. Or a patient may feel that the treatment is not appropriate now but that it might be possible in the future. There is nothing wrong with such an outcome.' Nothing is imposed. The analyst is ready to help if the patient is ready to receive help.

The process of assessment with its beginning, middle and end constitutes a full therapeutic experience, and for many patients it provides a different type of experience to the previous events in their life. Reading Sklar I am again reminded of Winnicott (1955-56), who writes, 'The behaviour of the analyst, represented by what I have called the setting, by being good enough in the matter of adaptation to need, is gradually perceived by the patient as something that raises hope that the true self may at last be able to take the risks involved in its starting to experience living.'

Sklar's non-intrusive and facilitating approach reflects his appreciation of the work of Michael Balint, and his book explores the theories and life of Michael and Enid Balint as well as their unique contribution to psychoanalysis and medicine. Their main theoretical concepts of 'basic fault', 'benign and malignant regression' and 'new beginnings' form an important part of the Independent Group's theory and practice today.

One of Balint's greatest contributions to the world of general practice, psychiatry and psychoanalysis was his creation of Balint groups. The work in a Balint group is about understanding the unconscious relationship between the doctor and the patient from the point of view of the doctor's countertransference. The profound difference that this understanding brings to clinical practice, to patients' care and to doctors' experience



is demonstrated through multiple clinical examples. It was interesting to me, having had experience as a member of both excellent and poorly run Balint groups and having led Balint groups myself, to reflect on the best way to conduct them. Sklar is very clear that a Balint group is not about clinical supervision or discussion of clinical work, nor about personal analysis. It is about something very different. Sklar writes: 'A patient's illness or "stuckness" can be better examined, and have its grips more easily loosened, by the doctor who can find change in themselves.' Learning in a Balint group is non-hierarchical and is a two-way process. The role of the leader is to listen to the doctor-patient interaction and to the associations coming from the members of the group. The leader facilitates the process of emerging understanding among group members and intervenes only if the group ignores something important, thus deepening the thinking and associative process in the group.

Sklar describes the process that takes place in the doctor: 'The doctor stuck with the heart-sink patient will often need to find new emotional resources within themselves in order to become available in a new way with their patient. This is very different from being given a prescription from the group, in a way that a patient often expects to receive a prescription from their doctor in place of something more tangibly complex.' Sklar's descriptions of Balint groups are part of a wider argument for the value of whole-person centred medicine and the way this approach can humanise medicine and enable doctors to practise it in an authentic way.

Sklar writes very thoughtfully about processes of training and supervision. For Sklar a good supervision is not about a candidate learning the supervisor's particular model, but about enabling a person in supervision to find their own freedom in their clinical work. This is a precondition for a candidate developing love for their psychoanalytic work and their ability to tolerate the psychic pain and uncertainty that our work inevitably brings.

Sklar's love for his work is evident in his writings. His style is authentic and alive with conviction. He writes 'there is a great psychological difference between being told how to do something and finding it out for oneself in the presence of the other'. The book is stimulating in allowing the process of 'finding out for oneself' to be generated. It brought memories of many encounters with my patients and the new understandings and reflections that emerged. That is what a good read is – it is akin to a 'good feed', to use Winnicott's metaphor ■

Dr Helen Johnston is a Psychiatrist and Psychoanalyst.

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Art therapy

continued from page 11

incorporates interactions with objects, both found and made, substances, and art making activity. These aspects of the frame assume a particular significance in art therapy for psychosis. Art-making, transactions surrounding the making of images, and the presence of art objects establish interactive fields within the therapeutic relationship that enable that which cannot yet be thought to be held within the setting until it becomes available to thinking. In my view, Wilfred Bion's (1962) concept of 'nameless dread' is crucial to understanding psychosis in the context of the trauma of uncontained infantile anxiety. Until a containing object is established, any experience that mediates the reality of separateness, and accordingly the potential for frustration, resonates with the trauma of failed containment, and is efficiently evacuated by means of projective identification in its defensive, rather than its communicative, mode (Bion 1962, Meltzer et al 1986). The presence of the absence of a containing object is in my view crucial to understanding the meaning – or meaninglessness – of art produced by a patient in this state of mind.

Michael Eigen (1985) writes of a patient described by Bion: 'As Bion puts it, this person utters actual objects, not simply phrases. On the one hand the chaos of his utterances reflects a de- or un- forming and utterly obliterating catastrophic state approaching an entropy of sense. However, this patient also has the possibility of learning about himself by observing the objects he speaks. He has the possibility of meaning something by noting the nothing he tries to create.' This formulation, of 'noting the nothing he tries to create', seems to me to identify the starting point of the psychotherapeutic work that is possible with people in states of acute psychosis. It also defines a significant potential of the role of the interactive field established by the presence of art making activity and art objects in art therapy for psychosis. Within this field the therapist is able to assist the patient in discovering ways of using the setting as a holding environment by assisting the patient to evacuate mental contents into art objects, which can be related to in such a way as to enable the patient to 'note the nothing' that he or she has created.

The psychotic patient's use of imagery, and of the art therapy setting, can often be understood to present a desperate defensive endeavour, even though the art work can appear alluringly rich in symbolic meaning to others. When this is the case, art making is being employed as a means of 'evasion by evacuation' (Bion 1962) and the setting can be deployed to hold that which has been evacuated until such time as the patient is ready to reclaim it. For example, the therapist can cooperate with the patient in finding mutually acceptable ways of placing, hiding, and otherwise lodging objects that have been invested with unbearable meaning, without engaging in any discussion of meaning or content. Paradoxically, this activity in itself signals understanding and acceptance of the patient's state of mind. Within the frame of the psychotherapeutic relationship enabled by the art therapy setting, evacuated material can be held in its evacuated form until the presence of a containing object has become established. At that point 'realistic' projective identification (Boon 1962), which seeks containment, becomes possible, and projected material can become more thinkable, potentially reclaimable, and available to symbolisation, by the patient. If the therapist responds to the art made by the patient as if it is a symbolic communication before it has acquired that potential for the patient, he or she will repeat the trauma of failed containment for the patient, and accordingly exacerbate the necessity for defensive activity.

As the case studies in *Art Therapy for Psychosis* show, a psychotic patient's sense of self can gradually strengthen through repeated experience of the specialised art therapy setting, to the point where he or she may dare to risk engaging affectively with the therapist, and with the art work. At this point the images can begin to serve communicative purposes, and accordingly, to develop the potential to be used as symbols. The different approaches presented in the book make use of the potentials of the art therapy setting to protect the patient's fragile sense of self while the unintrusive, yet consistent, presence and attitude of the therapist maintains the possibility of engaging in an interpersonal relationship. They also present arguments for the potential for the activity of art making to be healing in itself once it has begun to serve symbolising purposes. At this stage, patient and therapist can begin to engage in reflective discussion in relation to images that have acquired symbolic meaning within the relationship. The patient can at this stage potentially engage in forms of art psychotherapy, and other psychotherapies, that rely on the capacity to use words as symbols.

In 2007, Brooker et al. published the outcome of years of painstaking research into the specialised field of art therapy for psychosis. This work distilled understandings gleaned from all published material on the subject, service user experiences, and expert practitioners to develop a 'Clinical Practice Guideline' for art therapists to refer to when working with people in, or prone to, psychotic states. As yet, there have been no clinical trials of art therapy for psychosis using this document as a basis for establishing research protocols, and accordingly the effectiveness of art therapy as a treatment approach to psychosis remains a matter of opinion ■

Katherine Killick is a Training Analyst of the Society of Analytical Psychology working in private practice, who previously trained as an art therapist.

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Diary

See also event listings on the BPC website: www.bpc.org.uk/events-calendar

SEPTEMBER

30 August – 3 September 2017
MAKING REAL CHANGE HAPPEN
International Society for Psychological and Social Approaches to Psychosis Congress
University of Liverpool
www.isps2017uk.org

9 September 2017
AN ENGLISH GUIDE TO BIRDWATCHING: ON PSYCHOANALYSIS AND LITERATURE
Adam Phillips in conversation with Nicholas Royle
Freud Museum, 20 Maresfield Gardens, London NW3
www.freud.org.uk

9 September 2017
PROJECTIONS: CINEMATIC REPRESENTATIONS OF MENTAL ILLNESS
Freud Museum, 20 Maresfield Gardens, London NW3
www.freud.org.uk

16 September 2017
FREUD, JUNG AND THE MODERN WORLD
Ken Robinson, Marcus West, Ray Brown, Tom Camps
7 Cannon Street, Birmingham B2
www.wmip.org/conference.html

16 September 2017
ANXIETY AND FEAR
Smita Rajput Kamble
WPF Therapy, 23 Magdalen Street, London SE1
wpf.org.uk

23 September 2017
LOVE, DESIRE AND DEMAND IN AND OUT OF THE CLINIC
Philip Hill
WPF Therapy, 23 Magdalen Street, London SE1
wpf.org.uk

23 September 2017
MEN ON THE COUCH
Rotimi Akinsete, Paul Atkinson, Andy Metcalf, Eyal Rozmarin, Andrew Samuels
Foyles Bookshop, 107 Charing Cross Road, London WC2
www.confer.uk.com/men.html

26 September 2017
FREUD: IN HIS TIME AND OURS
Dany Nobus in conversation with Élisabeth Roudinesco
Freud Museum, 20 Maresfield Gardens, London NW3
www.freud.org.uk/events/76952/freud-in-his-time-and-ours

30 September 2017
WORKING WITH CHEMSEX
Jamie Willis
WPF Therapy, 23 Magdalen Street, London SE1
wpf.org.uk

30 September 2017
ETERNAL RECURRENCE AND THE UNCONSCIOUS: THE QUESTION OF FATE IN PSYCHOANALYSIS
Anna Freud Centre, 12 Maresfield Gardens, London NW3
www.freud.org.uk

30 September 2017
THE SELF-DISCLOSURE DILEMMA
Sue Cowan-Jenssen, John O'Connor, Marcus West
Marine Hotel, 13 Sutton Cross, Burrow, Sutton, Co. Dublin, Ireland
www.confer.uk.com/ire-dilemma.html

30 September 2017
AUDIENCES WITH AUTHORS: SHATTERED BUT UNBROKEN
Valerie Sinason
BPF, 37 Mapesbury Road, London NW2
www.britishpsychotherapyfoundation.org.uk/Events/AWAVS

OCTOBER

1 October 2017
SCREENING: WILFRED BION, A MEMOIR FOR OUR TIME
Discussion led by Meg Harris Williams
BPF, 37 Mapesbury Road, London NW2
www.britishpsychotherapyfoundation.org.uk/Events/WBMEM

1 October 2017
LACAN AND KAFKA: KNOWLEDGE, ENJOYMENT AND THE BIG OTHER
Freud Museum, 20 Maresfield Gardens, London NW3
www.freud.org.uk

14 October 2017
ON BEING ALIVE TO DEATH
The Harbour 25th Anniversary Conference
University of Bristol, Clifton, Bristol BS8
www.the-harbour.org.uk/about-us/conference

14 October 2017
BOY MEETS GIRL: CONSIDERING GENDER NON-CONFORMING AND GENDER DYSPHORIA THROUGH POPULAR CULTURE
Sue Lee
WPF Therapy, 23 Magdalen Street, London SE1
wpf.org.uk

14 October 2017
THERAPY WITH ELDERS: CHALLENGES OF AGEING
Paul Terry
WPF Therapy, 23 Magdalen Street, London SE1
wpf.org.uk

17 October 2017
'ACTION NOT WORDS?' WORKING ON THE FRONTLINE
Çaglar Tahiroglu, David Morgan
Institute of Psychoanalysis, 112a Shirland Road, London W9
psychoanalysis.org.uk

20-22 October 2017
GROUP RELATIONS CONFERENCE
BPF, 37 Mapesbury Road, London NW2
www.britishpsychotherapyfoundation.org.uk/Events/GRC

21 October 2017
WORKING WITH SUICIDE
Kirstie Adamson
WPF Therapy, 23 Magdalen Street, London SE1
wpf.org.uk

21 October 2017
WHY DO YOU THINK YOU'RE SO SPECIAL? WHAT HAS ANALYSIS REALLY GOT TO OFFER?
Richard Mizen
SAP, 1 Daleham Gardens, London NW3
www.thesap.org.uk/events/3410/

21 October 2017
THE ROLE OF EMOTION IN THINKING, NEGLECT AND DEFICIT IN THE INTERNAL OBJECT
Anne Alvarez
Friends Meeting House, 91 Hartington Grove, Cambridge CB1
www.thesap.org.uk/events/role-emotion-thinking-neglect-deficit-internal-object

27-28 October 2017
ADOLESCENT PSYCHOANALYSIS TODAY: EXPERIENCE AND INNOVATION
Brent Centre 50th Anniversary Conference
Royal College of Physicians, London
www.brentcentre.org.uk/conference-2017/the-conference

28 October 2017
BORDERLINE PERSONALITY DISORDER: THE THERAPIST'S EXPERIENCE OF THE PATIENT
Duncan Keggereis
WPF Therapy, 23 Magdalen Street, London SE1
wpf.org.uk

NOVEMBER

3 November 2017
PP NOW LECTURE: DEVELOPING A DEMOCRATIC PSYCHOLOGY
Jessica Benjamin, Gabrielle Rifkind
Imperial College London
(Waiting list only)
www.bpc.org.uk/PP-NOW-2017

4 November 2017
PSYCHOANALYTIC PSYCHOTHERAPY NOW: THE INNER WORLD AND REBUILDING THE STATE WE'RE IN
Imperial College London
(Waiting list only)
www.bpc.org.uk/PP-NOW-2017

3-5 November 2017
EPFF9: INTERIORS / EXTERIORS
Ninth European Psychoanalytic Film Festival
BAFTA, London
psychoanalysis.org.uk/civicrm/event/info?id=551

11 November 2017
'AND THEREBY HANGS A TALE': NARRATIVE IDENTITY, CHANGE AND THERAPY
Martin Weegmann
WPF Therapy, 23 Magdalen Street, London SE1
wpf.org.uk

11 November 2017
WINNICOTT AND THE COUPLE
Tavistock Relationships Autumn Conference
Brett Kahr, Angela Joyce, David Hewison
70 Warren Street, London W1
www.tavistockrelationships.ac.uk/forthcoming-events/1048-winnicott-and-the-couple

11 November 2017
WHO IS MY JUNG? CELEBRATING 40 YEARS OF THE AJA
British Library, 96 Euston Rd, London
www.jungiananalysts.org.uk/events/who-is-my-jung

17 November 2017
OBSESSIONS: BETWEEN THINKING DISORDER AND DEPRESSION
Francesco Bisagni, Anne Alvarez
SAP, 1 Daleham Gardens, London NW3
www.thesap.org.uk/events/obsessions-thinking-disorder-depression-francesco-bisagni

24-25 November 2017
BEFORE AND BEYOND WORDS: EXPLORING MELANIE KLEIN'S WORK AND INFLUENCE
Andrew Dawson, Debbie Hindle, Kristin MacDonald, Margaret Rustin, John Shemilt, Margot Waddell
Festival Theatre, Pitlochry, Scotland
Contact Susan.Richardson@rcpsych.ac.uk or cripwellclaire@gmail.com

25 November 2017
MADELEINE DAVIS LECTURE
Gregorio Kohon
squiggle-foundation.org/events/26/preliminary-announcement-madeleine-davis-lecture-2017

25 November 2017
SIP 26TH ANNUAL PUBLIC LECTURE
Alessandra Lemma
Watershed, 1 Canons Road, Harbourside, Bristol, BS1
www.sipsychotherapy.org/news-and-events

25 November 2017
TECHNOLOGY, SOCIAL MEDIA, AND THE SELF
Aaron Balick
SAP, 1 Daleham Gardens, London NW3
www.thesap.org.uk/events/technology-social-media-self-addressing-psychological-emotional-challenges-opportunities-today-aaron-balick

FURTHER AHEAD

1-3 December 2017
ANXIETY, DREAD AND FEAR
Speakers include Rosine Jozef Perelberg, Vic Sedlak, Gigliola Fornari Spoto
University College London
Contact: events.psychoanalysis@ucl.ac.uk

News

NICE draft guidance for depression in adults

The National Institute for Health and Care Excellence (NICE) has published its consultation on new draft guidance for depression in adults. This is a significant consultation that will set the parameters for psychological services commissioned in the NHS. The BPC believes that this will not only affect clinicians working in the NHS but is likely to have a knock-on effect for private work, as the availability of services in the NHS often gives additional legitimacy for services provided privately. It is also likely to have an effect on training providers as potential trainees may be looking to see what careers are available in the NHS once they qualify.

The consultation is available on the NICE website at https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0725/consultation/html-content

The BPC is pleased that the NICE draft guidance on adult depression includes recommendations for short-term psychodynamic psychotherapy, couples therapy, and counselling. This maintains a degree of patient choice. However, it is crucial that patient choice is not just about maintained, but that it is expanded. This is essential if users are to receive the right treatment for them and for their conditions. The draft guidance recommends cognitive behavioural therapy as a default, first line approach for nearly all. CBT is the right kind of psychological therapy for some, but not for all. Talking treatments based on psychoanalytic theories, such as dynamic interpersonal therapy (DIT) for example, and longer-term psychoanalytic therapies as well, are needed if services on offer are to become more responsive and more effective.

The consultation runs from 18 July 2017 with a deadline for comments of 12 September 2017. It's expected that the final guideline will be published in January 2018.

Anyone can respond to the consultation; however, NICE will only acknowledge responses from stakeholders registered for the specific guideline. Registration is only open to organisations, not individuals. The BPC is a registered stakeholder and will be providing sound evidence-based representations to NICE in support of improving what is recommended to patients suffering with depression.

The BPC has a number of registrants with substantial experience and expertise in research and research methodology who are supporting the BPC in preparing its response to the consultation. If you have expertise in this area and would like to support this initiative please contact mail@bpc.org.uk ■

PSYCHOANALYTIC PSYCHOTHERAPY NOW 2017

With the rise of the 'strong leader', politics seems more confrontational, less understanding and less inclusive. Expression of racist and sexist views seem to be increasingly legitimised.

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Evening public lecture

Developing a Democratic Psychology:
The Ethos of 'More than One can Live' versus the Neo-Liberal imaginary of 'Only One can Live'

Jessica Benjamin
Internationally renowned American psychoanalyst, author, feminist and political activist

Gabrielle Rifkind
Political entrepreneur, senior consultant to the Middle East programme at the Oxford Research Group, group analyst, psychotherapist, and specialist in conflict resolution

Saturday 4 November

Psychoanalytic Psychotherapy NOW
Keynote speaker
Daniel Pick
Psychoanalyst and historian

Free Associations? Psychoanalytic History, Democracy, and the State we are In

Afternoon Plenary with
Jessica Benjamin and Susie Orbach
Women on the Verge of a Post-Liberal World

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