NewAssociations

NEWS, ANALYSIS, OPINION FOR THE PSYCHOANALYTIC COMMUNITY | **ISSUE** 14 **SPRING** 2014

BRITISH PSYCHOANALYTIC COUNCIL

Mental illness and its treatment today

By David Bell

AT SOME POINT in their life, one in four adults in Britain suffers from some kind of mental illness. At any given time one adult in six is suffering from at least one mental illness.[1] Most suffer from the 'common' psychiatric disorders, typically depression and/or anxiety, which may be relatively mild and short-lived but which can also take a severely disabling form.[2] And in England in 2012, 150,000 people were suffering from psychotic illness – the more severe form of mental disorder where a person's relation to reality is disturbed, leaving them unable to live an ordinary life.[3]

It is often thought that those with mental illness suffer less than those with physical illness. But anyone with experience of mental illness, whether their own or that of someone close to them, knows that the suffering is great, and is often even greater than is the case with physical illness or injury.[4] Mentally ill people are also three times more likely to die than the general population; those aged 30 to 39 are five times more likely to die.[5] In addition people suffering from psychiatric disorders have to live with the stigma that attaches to mental illness.

The neoliberal context

Since the turn of the century, and particularly in the last three years, mentally ill people in England have been deeply affected by two main kinds of change: on the one hand, changes in the structure and scale of the health services available to them, and on the other, a profound change in the cultural context in which they live. The second of these changes interacts with the first. The rise of neoliberal values, now espoused by all the major political parties and accelerated and intensified by 'austerity', has produced a deep shift in the prevailing 'structure of feeling' (to use Raymond Williams' expression) as regards our sense of community, our obligations to and for each other.

In this new worldview welfare provision is no longer seen as something that provides people with the basic necessities of life, as part of the duty of the state, but as a mechanism by which people are disempowered, creating in them a helpless state of invalidism. Instead of 'getting on their bike' and competing in the marketplace, people are seen as staying at home and 'whingeing' for the 'nanny state' to do something for them. Or to put it another way, to have one's basic needs met by the state is represented as being in a state of infantile dependence, dominated by the delusion of an inexhaustible supply of provision. People on welfare become 'scroungers'. Worse still, many who are legitimately entitled to benefit identify with this ideology. They see themselves as having failed, as being parasites on society and undeserving, and collapse into despair.[6]

This kind of primitive thinking has long been the staple fare of some tabloid papers; the fact that it has now been adopted by political leaders lends it a new power. The previously unthinkable becomes quotidian, dramatically illustrated by the way the imposition of a cap on housing benefits is forcing families to vacate their homes, fuelling the sense that they do not deserve to live here. And changes driven by this thinking are taking place at such breathtaking speed that it is difficult to remain aware of their massive impact on vulnerable people, and of the erosion of our ordinary sense of responsibility for others.

People who are mentally ill are peculiarly vulnerable to these broader sociocultural changes. There is a default position in relation to the mentally ill which requires continuous work to resist, namely that they are responsible for their illness; a position that of course easily fits into the characteristic self-righteousness of the mindset just described. Baroness Hollis captured it well when she said that 'Until recently, when we introduced a bill like this [the Welfare Reform Bill] it would not have been a welfare reform bill, it would have been a social security bill.'[7]

'People who are mentally ill are vulnerable to broader sociocultural changes.'

The dramatic material changes in the socioeconomic landscape caused by the financial crisis similarly affect people who are mentally ill in a variety of different ways which reinforce each other. Unemployment, widening inequality, loss of job security and economic hardship all cause increased psychological morbidity in the population, and those who are already mentally ill are particularly affected. Aspects of care that for generations have been regarded as essential – for example having a Community Psychiatric Nurse to provide consistency and continuity of care over an appropriate period of time – have transformed magically into luxuries that can be easily dispensed with. There has also been a crucial deskilling of the workforce: tasks formerly done by skilled personnel are now carried out by individuals with little or no appropriate training or clinical experience.

These changes have a profound effect on the morale of the workforce too – something which is, however, never mentioned in policy documents. Documents focus on various 'skills' or 'skill mixes', but never on the people themselves. Staff manning wards and services without adequate resources, forced to reapply for their own posts, which have sometimes also been downgraded, as bed numbers, and the staff complements that go with them, are cut (see Box 2 below), are hardly in a position to maintain the 'containment' – the capacity to manage the intense and disturbing interactions involved in the care of these patients , to withstand pressures to act precipitately, to maintain the capacity to think – that is one of the most vital aspects of the care of the mentally ill.

Work Capability Assessments

The work capability assessment process, WCA, run by the French IT company ATOS, expresses very clearly the transformation in attitudes which has such a disproportionate effect upon the mentally ill. The brutal way in which it has been managed, the lack of skill of those carrying out the task and the profoundly traumatic effects it has, even for those who have the wherewithal to appeal and get an adverse decision reversed, have been well documented.[8]

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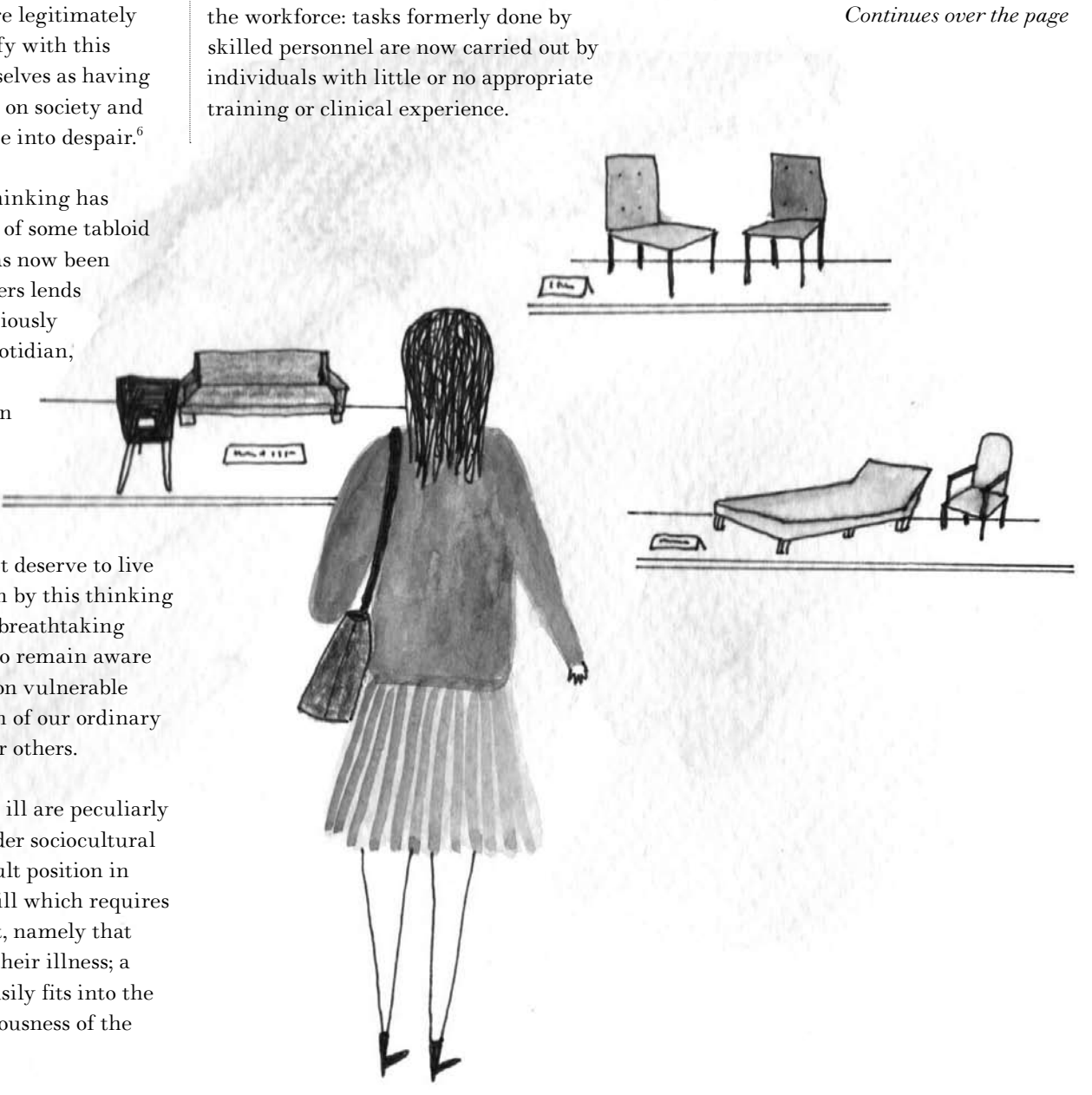

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The mentally ill are particularly disadvantaged here, as few of those carrying out the assessments have any knowledge of mental illness or any understanding of how the process of assessment so regularly traumatises mentally ill people. I have known a number of patients suffering from enduring mental illness, who feel so persecuted by the WCA process that terror of it comes to dominate their mental state. It needs to be understood that many people who are mentally ill are already, internally, persecuted by a terrible kind of inner self-judgement that relentlessly tells them they are worthless, filling them with humiliation and shame.[9] In this situation, they need to find reassurance in external reality that provides some degree of protection/insulation against this inner persecution. But the WCA process itself, and in particular the assumptions which it has come to embody – that those on benefits are trying to get away with something, the whole atmosphere of distrust of claimants – creates an external reality that, far from providing reassurance, reinforces these menacing internal processes.

I have known patients with enduring serious mental illness who inform the panel that they are 'feeling much better and are ready to work.' This is of course not based on any real assessment of their own capacities, but arises from a wish to prove themselves worthy, while the panel are quick to accept such statements as it is not in the nature of the exercise to question their veracity, or to discuss them with the mental health professionals who know the patient. Other patients have not even attended the assessment because they are so scared of it. There are cases of people dying not long after ATOS has considered them fit for work, including cases of suicide.

A GP who has given a very disturbing account of the WCA experiences of patients with mental illness concludes:

> I am fearful that more of my patients will be put at risk of homelessness and suicide by this brutal new system. From my perspective, the most disadvantaged in our society are being punished. Work is good for all of us, if we are lucky enough to be in employment. But not all of us have the skills to work and some of us are so unwell or damaged by past experiences that they cannot do a job. We should accept that some people, for many different reasons, need supporting.[10]

A case in point: F was a woman in her 50s who suffered from chronic severe depression and drug addiction, with multiple serious physical complications. She was malnourished and could barely walk as a result of physical difficulties arising from her drug addiction. The only time she left home was to attend sessions at a psychotherapy centre and to see her GP to get her prescription for Methadone. Slowly she was trying to think about herself and make the first moves towards life. She lived in dread of her housing benefit being taken away if she 'failed' at the WCA panel. In the end, having suffered months of terror, she was deemed incapable of work, but only for one year, after which she would have to go through the same thing again. For such patients a further assessment in a year's time is not experienced as something in the future but as a continuous hovering presence that acts to interfere with the prospect of recovering some function. A brief conversation with any of those directly involved in her care would have quickly clarified the medical and psychological realities of her life and would have spared her this whole process which has so traumatised her, and continues to do so.

Changes in the care of patients with serious mental illness

The deterioration in the care of the mentally ill has a long history but not one that is easy to chart. Although closure of the large mental hospitals embodied a potentially beneficial change in attitude to psychiatric care, there has never been adequate investment in properly organised, integrated, community care. Serious neglect and institutionalisation were endemic in the asylum era, and the wish to care for patients in the community was a laudable aim, but this vision was always a hostage to fortune. Real care in the community would have required a very significant injection of resources but as the years rolled by serious lack of provision and neglect became a familiar story, which has turned into an accelerated decline in care over the last five years.

As regards in-patient care I can best use some of my own experiences to show the contrast between how it was, say, twenty years ago, and how it is now (I have discussed this with numerous consultant colleagues who have had similar experiences). Twenty years ago occupancy rates on in-patient wards were about 80%, which is generally agreed to be about right. It means that on a twenty-bed ward, 16-17 beds would be occupied at any one time. This allowed nurses to have more time with patients, and time for teaching or discussion of difficult issues. The wards I worked on would have perhaps less than a quarter of the patients held on section (that is, detained compulsorily). Some of the voluntary patients would originally have been compulsorily detained, but almost always stayed on the ward after they had been released from their section. This was a crucial period for establishing the vital therapeutic relationships with the staff, as it is obviously very difficult to establish such trusting relationships when patients are being held against their will. Patients would stay for a number of weeks or months. They would prepare for discharge by going home for a trial period and then would return to the ward to report to their keyworkers on how they had got on. And even after complete discharge these patients would return to the ward to meet informally with the staff. A patient would be seen in the outpatient clinic by the same team that had admitted him or her as an in-patient – as it was understood that continuity of care is of central importance because patients feel safer with those who have known them at their worst and share with them a knowledge of their history.

'As the years rolled by serious lack of provision and neglect became a familiar story.'

Now the current situation. Bed occupancy rates are very often over 100%.[11] This means that wards are overcrowded and that the beds of patients on leave (even for one or two days) are immediately taken by other patients, regardless of the impact on the returning patients, who then have to be moved to other vacant beds. Acutely psychotic patients are sometimes admitted to wards where there are no beds and given mattresses on the floor.[12] Patients are discharged well before they are ready (partly because of the pressure on beds), and the result is often early readmission.

And instead of only a minority of patients being held compulsorily, the majority of patients on the ward are now in this category. Not only must the few available beds be given to the most acutely ill, but there is even some evidence of patients being held on a section simply to ensure they will be given a bed.[13] And as soon as these patients move to voluntary status the pressures to discharge them, to free up beds, are impossible to resist, so that patients are regularly discharged before they can really manage in the community.

Box 1: Work Capability Assessments

Before 2009, those with disabilities received Incapacity Benefit (IB). After 2010 IB was replaced with Employment Support Allowance (ESA). New claimants are assessed, and those who were recipients of IB are re-assessed, as either as Fit For Work and moved onto the much lower Job Seekers Allowance, or as in need of ESA. People placed on ESA are assigned to one of two groups: the Work Related Assistance Group, through which they receive help to enable them to become Fit For Work, or the Support Group. Recipients of ESA in the Support Group receive financial support similar to Incapacity Benefit, but are regularly re-assessed, at intervals up to a maximum of 24 months.

From the start of the WCA programme until November 2012, 887,500 people who were formerly on IB have been re-assessed. Of these 23% have been judged Fit For Work, 36% have been placed in the ESA Work Related Assistance Group, and 46% in the Support Group. The proportion of those who were formerly on IB on account of mental illness is unknown.

The increased rate of bed occupancy, and the fact that most patients are now held compulsorily, both have very powerful negative effects on the ward atmosphere: wards are overcrowded with acutely psychotic patients. No wonder that patients and psychiatrists try to avoid admissions to this very disturbing environment. The high intensity of the atmosphere on wards, coupled with the declining capacity to contain it, combine to create a toxic environment that of course impacts upon the mental states of the patients.[14] However this deterioration is most unlikely to be thought of as brought about by these environmental and systemic causes. Instead it will be recorded in terms only of the individual factors in the patient, and is then seen as indicating a need not for a more containing environment, but for increased medication.

Overcrowding and high turnover of patients also have, inevitably, a massive impact on the nursing staff. The labour process is intensified, and the space for reflection and carrying out the 'emotional labour' which is a crucial part of nursing is compromised, resulting, again, in a lowering of morale and, in many cases, burnout.

The transformation of day hospitals

A further major deterioration in services arises from the reorganisation of day hospitals. Until recently patients with enduring mental illness have been well managed in day hospitals, which provided a non-toxic environment where they could gradually develop interpersonal skills and receive emotional support in a structured environment, this often requiring many months and often more than a year. However, these centres have been re-designated as 'recovery centres'. The implication here is that in a quite limited amount of time, measured in weeks, these patients can recover from years of mental illness and return to ordinary living. This conception not only bears no relation to the nature of most of these patients' difficulties, but also creates a kind of tyranny for the staff. Patients are now supposed to recover, and there are performance targets against which this will be judged: if they don't recover the conclusion drawn is that the staff have failed.

A local policy statement (from Camden in London) illustrates the new thinking:

> Since the Day Hospitals opened in 1992, there have been changes to the way mental health services are provided… Research shows that people do better if there is a strong and persistent emphasis by services on rehabilitation and recovery. We need to adapt all the services that we provide to ensure that they are as effective as possible at helping older people to avoid admission to mental health in-patient wards, and to be able to support older people returning to their own home as quickly as possible.[15]

Box 2: Mental health bed closures

Freedom of Information requests were sent to 53 of England's 58 mental health trusts by BBC News and Community Care, and 46 trusts replied. The figures show that a minimum of 1,711 mental health beds have been closed since April 2011, including 277 between April and August 2013. This represents a 9% reduction in the total number of mental health beds – 18,924 – available in 2011/12. Three quarters of the bed closures were in acute adult wards, older people's wards and psychiatric intensive care units. Average occupancy levels in acute adult and psychiatric beds are running at 100% according to the FOI figures from 28 trusts. Half of these trusts had levels of more than 100%; all of them had occupancy rates above the 85% recommended by the Royal College of Psychiatrists. The problems of running at capacity are highlighted by the tragic case of Mandy Peck. The 39-year-old told psychiatric staff she was feeling suicidal but her local mental health service centre said they had no beds available. A day later she jumped to her death from a multi-storey car park. A subsequent investigation found that a bed had actually been available. (Source: BBC News and *Community Care Magazine* 16 October 2013)

'We are witnessing an accelerating commodification of mental suffering.'

In my view this statement makes an unsubstantiated global claim whose real function is to justify cuts.[16] What is missing here is any recognition that a great deal of the care of those with enduring mental illness is more to do with damage limitation and providing forms of support and care, skills which are now much less valued. And as so often in discussing mental illness, the word 'community' conjures a picture of a caring, cosy hearth; but the reality of life in the community for those with psychiatric disorders is very different, all too often friendless and even homeless. The recognition that patients are damaged by institutionalisation is twisted into a justification for not providing services they can depend upon.[17]

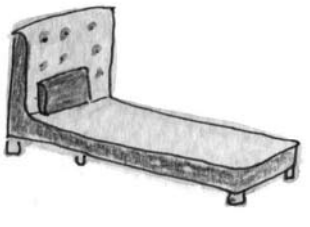
Moreover day hospitals were staffed by teams, often established over many years and composed of individuals with high levels of skill. But the de-skilling process, driven by financial pressures, results in patients being looked after by well-intentioned individuals who have virtually no experience of working with the mentally ill. The parallel with the reduction of the skill mix already familiar in social care, and now taking place in NHS hospitals, is obvious.[18] The sweeping changes in NHS mental health services have resulted in a perversion of care where the realities of suffering, dependence and vulnerability are now being disavowed.[19] Since the focus is on quick outcomes that behavioural therapies are alleged to provide, the complexities of managing those in psychological distress are systematically evaded. The NHS 'market for care' turns a blind eye to the emotional realities of suffering, instead constructing what has been identified as a 'virtual reality' where attention to targets, outcomes, protocols and policies is privileged over attention to the patient's psychological needs.[20]

In a perverse logic some of these changes in health care are presented as providing the patient with more freedom to choose the services they want. But patients can't choose a service that has been closed. A colleague reports that when a day hospital in Nottingham was recently closed the budget was transformed into personal budgets given to individual patients who were then asked how they would like to use them. The patients replied that what they wanted was their day hospital back. In general, the 'choice agenda' serves to make people feel they have more freedom and to mask the fact that they have less.

Marketising the care of the mentally ill

As NHS care is increasingly converted into a healthcare market there is pressure to divide care up into marketable packages for which contracts can be put out to tender to be competed for by rival bidders. While this may be possible for some standard medical treatments such as hip replacements, it is totally inappropriate for long term chronic disorders, and it is in this latter category that much of the care of the mentally ill belongs.

In the case of mental illness it now means trying to fit every patient into one of twenty diagnostic 'clusters', each with a prescribed package of care, with a price attached.[21] Not surprisingly it is difficult and often impossible to categorise mentally ill patients in this way. Although the policy was introduced in 2005, the following extract from the Department of Health's *Guidance on Payment by Results for mental health in 2013-14* shows that it is still not working as its advocates wish: 'Diagnosis is an area… where there is currently great variability between the percentage recorded by providers. It is important that wherever possible, diagnosis is captured.' The mental health clustering booklet sets out how this should be done. Currently not all clinicians are recording every item in Health of the Nation Outcome Scales (HoNOS). It is very important that they do, as this data will be used when looking at whether particular outcomes have been achieved.[22]



In other words, the care of mentally ill patients must be forced into a market model in which outcomes can be measured and paid for accordingly, regardless of whether it makes sense.[23] What we are witnessing is an accelerating commodification and instrumentalisation of mental suffering.

In addition, integration across services is vital for the needs of the mentally ill just as much as it is between health and social care services for patients with physical illnesses, if not more so. But this becomes impossible when services are marketised. For example it is characteristic of mentally ill patients that because of their difficulties they often move from one place to another; yet when they move from one purchasing area to another the commissioners in the new area may not feel under any obligation to pay for their care, and thus the service provider has to stop their treatment.

Marketisation also involves serious costs in terms of staff resources. Many consultants spend a significant part of their time discussing not patients but the contracts their unit or department has with a range of different commissioners, and responding to pressure to treat patients more rapidly if a contract is 'underperforming' (or where there is even a threat that it may not be renewed, with potentially catastrophic consequences for the department's ability to function). Where contracts are 'over-performing' – i.e. the service, perhaps because local GPs are satisfied with it, is treating more patients than are provided for in the contract – there are very powerful pressures to discharge patients from care.

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Editorial

Feeling more confident

By Gary Fereday

THIS EDITION of *New Associations* takes a look at the state of mental health care in Britain today, thinking of the provision of psychoanalytic psychotherapy and psychoanalysis both in the public sector and in private practice.

David Bell's excellent analysis paints a picture of NHS services being deprived of adequate resources in a society that increasingly views people suffering from mental illness as being delinquent. Following up the theme, Phillip Stokoe and Andrew Soutter develop their arguments as to the role that psychoanalytic psychotherapy can offer a progressive health service. Sally Beeken takes a slightly different route, describing her experience of leaving the NHS with a view to providing services through the 'Any Qualified Provider' pathway. And Amita Sehgal highlights the important role of couple psychotherapy, a modality where there seems to have been some growth in funding in recent years.

We seem to have a long way to go and, in the current climate, care funded by public resources or charitable funding has to demonstrate its effectiveness. Whilst there is evidence for the efficacy of psychoanalytic psychotherapy, it somehow seems misunderstood, scattered and not easily accessible. There is an urgent need to gather together the available research and to effectively communicate it in a way that policy makers and commissioners understand, and that clinicians can communicate. The BPC has started to undertake this vital task through our clinical research and evidence base task group.

To ensure psychoanalytic psychotherapy remains available as a service in the NHS, we urgently need to create a much better narrative of what it is we do and how we add value in today's world, with its attendant language of cost effectiveness. Another BPC task group is working on this, looking at how psychoanalytic psychotherapy can be integrated into wider NHS mental health services and other areas of the public sector.

Of course, whilst some psychotherapists work in the NHS, many others work solely in the private sector. The series of short articles, looking at what it's really like out in private practice around the UK, provides a fascinating snapshot of life for many of our registrants.

Whilst a large number of them live and work in parts of the country outside the capital and the south east, our profession still remains London-centric. Yet another BPC task group is looking at potentially how we can support and develop psychoanalytic training and clinical practice throughout the whole of the country.

'It is starting to feel like the profession is mobilising.'

It remains a concern of mine that the profession does not reflect the cultural and ethnic diversity of modern Britain. We must rethink the way we see ourselves and others. Smita Rajput Kamble in her article talks of her complete disorientation and fear of losing her culture when she came to Britain, training as a psychotherapist. Our ethnicity, culture and racism task group is looking at what we need to change in ourselves, and in our organisations, in order to become a profession that is inclusive for members, trainees and patients from all cultural and ethnic groups.

Equally important is the work that needs to be done to implement changes in training so that we can make the profession more accessible to gay and lesbian people. This work is being tackled by the BPC homosexuality task group, helping us develop policy on making the profession more accessible to people with different sexual orientations.

Yes, there are challenges ahead, but it is starting to feel like the profession is mobilising to tackle both the external challenges and some of our own internal issues. I'm starting to feel more confident about the future.

Gary Fereday is Chief Executive of the BPC.

Mental illness and its treatment today

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Conclusion

We have taken an extraordinary step backwards in our attitude towards people with mental illnesses. The several hundred thousand people disabled by depression and anxiety, and the 150,000 with psychotic illnesses, unable to cope with normal life, are once again being represented as closer to being delinquents than being ill. Instead of being cared for they are increasingly being deprived of adequate services and pushed out to fail and suffer again. A century and a half of advance in our understanding of mental illness, and in our sympathy for its victims, is being brusquely jettisoned. To marginalise and neglect the needs of sick people in this way would be judged intolerable if applied to the physically ill. And it is not even clear that what is happening will save money.

If we are serious about caring for people who are mentally ill some basic principles must be reasserted. Resources for these most vulnerable members of the population must be restored. Bed occupancy rates for in-patients need to get down to 80% and patients need to be able to remain voluntarily in hospital long enough to establish therapeutic relationships with staff. Continuity of care must be restored, so that those looking after patients as in-patients continue to look after them in the community. Day hospitals must be restored to their original mission of caring for people on a long-term basis, accepting that most of them will need permanent help. Work Capability Assessments of mentally ill patients must be based on recommendations by professionals who have knowledge of psychiatric illness and who know the patients. The myth that everyone can and must recover – and in short order – must be dropped. We have to recognise that much of the care of the mentally centres upon damage limitation and rehabilitation, but not on cure ■

Dr David Bell is a consultant psychiatrist at the Tavistock and Portman NHS Foundation Trust in London where he is the Director of the Fitzjohns Unit. He is a past President of the British Psychoanalytic Society, and a recent Professorial Fellow at Birkbeck College, University of London.

Originally published by the Centre for Public Health and Interest, December 2013. Reproduced with permission. http://chpi.org.uk

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2. The Office for National Statistics. *Psychiatric Morbidity report, 2001.*

3. Mental Health Bulletin. *Annual report from MHMDS returns – England 2011-12, initial national figures* (2013)

4. It is also estimated that 10% of the cost of treating patients' physical symptoms is due to symptoms caused or exacerbated by mental illness. www.iapt.nhs.uk/silo/files/medically-unexplained-symptoms-positive-practice-guide.pdf

5. Mental Health Bulletin. *Sixth report from Mental Health Minimum Dataset returns – England 2011/12*, initial national figures, p. 5. Nearly 6% of mentally ill patients who die aged 19-74 have committed suicide. Mental Health Bulletin. A*nnual report from MHMDS returns – England 2011-12* (2013)

6. The catch-word 'nanny state' perfectly expresses this perverse logic and hatred of vulnerability. Some of the issues touched upon here and elsewhere in this paper are explored in more depth in David Bell (1996) 'Primitive Mind of State', available at www.tandfonline.com/doi/abs/10.1080/02668739600700061

7. HL Hansard, 4 October 2011, cols GC 331–332

8. Notably by Dr Greg Wood who worked as a WCA assessor; see www.theguardian.com/society/2013/may/16/atos-doctor-claimants-biased-medical-assessments; see also www.theguardian.com/commentisfree/2013/jul/23/work-assessments-atos-dwp-test

9. In technical language one would say that a very harsh persecuting superego is a very common feature of mental illness.

10. www.guardian.co.uk/commentisfree/2013/jan/04/gp-atos-work-capability-assessment.

11. www.guardian.co.uk/society/2011/jun/20/mental-health-services-in-crisis-over-staff-shortages

12. E.g. www.mirror.co.uk/news/uk-news/vulnerable-mental-health-patients-forced-2343568

13. House of Commons Health Committee Post-legislative scrutiny of the Mental Health Act 2007 *First Report of Session 2013–14*

14. There is vast amount of evidence that psychotic patients are highly sensitive to the emotional intensity of their environment.

15. www.candi.nhs.uk/_uploads/documents/corporate/camden-mews-piercy-consultation-document.pdfm

16. Although it is stated that 'research has shown' no information is given about this research, so this is in effect just an *ex cathedra* statement .

17. The Care Quality Commission's 2011 Mental Health Survey in the community found that 31% of respondents who needed support from someone in NHS mental health services with their physical health needs said that they had not received support but would have liked it. 42% of respondents received care under a Care Programme Approach – an approach which should include support on housing, employment and financial advice. However, the survey found that 35% had not received any help with finding or keeping work; 27% had not received any help with finding or keeping accommodation; 27% had not been given any help with financial advice or benefits. Mental Health Network/NHS Confederation Factsheet November 2011.

18. The Centre for Health and the Public Interest, *The Future of the NHS: lessons from Social Care*, October 2013, para 35.

19. Rizq, R. 'The perversion of care: Psychological therapies in a time of IAPT'. *Psychodynamic Practice*, 2012, 18, 1, 7-24.

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21. Lee, SW, Morley, M., Taylor, RR., Kielhofner, G., Garnham, M., Heasman, D., Forsyth, K. (2011) 'The development of care pathways and packages in mental health based on the Model of Human Occupation Screening Tool', *The British Journal of Occupational Therapy*. June 2011, 73(6): 284-294

22. Department of Health, Mental Health Payment by Results Guidance for 2013-14, p.6. www.gov.uk/government/uploads/system/uploads/attachment_data/file/232162/Mental_Health_PbR_Guidance_for_2013-14.pdf. Monitor has recently stopped talking about 'payment by results' and instead talks of 'payment and pricing systems'.

23. There are eight non-psychotic clusters, eight psychosis clusters, and four cognitive impairment clusters. Individuals can be allocated to a different cluster if their care plans need to be changed, but this does not overcome the problems of the poor inter-rater reliability of clustering; clusters becoming tariffs, with the cluster numbers becoming "gateways to particular services". See Kearney, T., Dye, S., Sethi, F. (2013) 'Patient journeys within psychiatric intensive care: Payment by results versus lean pathways development', *Journal of Psychiatric Intensive Care* 9(1): 4-11. The model has also been criticised as being of questionable efficiency, but if it were efficient it would be an efficient perversion of mental health care.

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NHS Special

Selling psychoanalysis to the NHS

By Philip Stokoe

How can we maintain a psychoanalytic presence in the turbulent NHS?

MY AIM IN this article is to offer some thoughts about how to maintain a psychoanalytic presence in the NHS. To save time and space I should like to refer the reader to Harvey Taylor's excellent briefing paper (June 2013) in which he argued that the enterprise of psychoanalysis '…to date has been heavily individualistic in both institutional forms and clinical practice. This has resulted in an enormous creativity in both theory and practice, *but not ultimately in institutional adaptations to a changing external environment, and therefore in growth*' (my italics). He shows how attitudes that developed within British psychoanalysis have in fact stood in the way of development and change and I shall take this as a starting point. I therefore refer only briefly to the resistance to change that is such a feature of our psychoanalytic institutions.

Psychoanalytic presence: what it is and what it isn't

By psychoanalytic presence I mean a combination of thoughtful enquiry that depends upon an ability to maintain a depressive position capacity in the face of any human question, and a model of human nature that holds unconscious functioning at the centre. This would be experienced as a mind capable of listening to and understanding another human being's emotional and psychological experience without judgement. All of this is the expression of genuine, compassionate *interest*. But the thing that makes it psychoanalytic is a particular understanding of the development of the human mind; how the conscious mind grows out of the unconscious and how the two interact with each other. This model means that we cannot rest with a purely superficial description of a process; instead we must always look at the deeper interaction.

The capacity to think in this way depends upon a combination of a good training, to provide a clear theoretical structure, and a good enough enquiry into our own minds (our own analysis), so that we are sufficiently familiar with our own unconscious tendencies, vulnerabilities and valencies that we can recognise the signs that we are becoming drawn into something that is interfering with a truly objective thinking process. The experience of analysing a patient four or five times a week over several years is the ultimate form of learning about the human mind and about our own capacity to enquire into it. But there are other contexts (not least of which the study of organisations) that are essential for the body of knowledge that we might call the psychoanalytic model.

Defining psychoanalysis as essentially a combination of a model of the mind and a particular approach to studying human nature, it follows that all treatments or interventions are 'applications', including four or five times weekly psychoanalysis; it may *symbolise* psychoanalysis but it is not the thing itself.

The NHS today

Health care cannot be provided within a financial marketplace model. A true marketplace is one in which I buy your product with my money and you will sell more products if you can convince more people to buy them. In the NHS a commissioner is buying my health care on my behalf without asking me about it, and the criteria that he uses are dictated to him by government. This is the same government that has given him the money to buy health care on my behalf, and this government produces stringent rules about how to spend its money!

Andrew Lansley's plan for the reform of the NHS was one of the most flawed documents I have ever been forced to read. However, one of its central beliefs seems to me to be true: namely that commissioners cannot buy health care without the guidance of trained clinicians. Given that his expressed purpose was to close down PCTs, tragically this terrible legislation was brought in at exactly the point that most primary care trusts had realised the centrality of the clinical view and had begun to reorganise themselves around that.

When we are anxious, we collapse into our default state of mind, the paranoid schizoid state. In this state of mind our thinking is replaced by 'knowing'; in other words by certainties. Thus people responsible for spending money on healthcare will be moved towards those who can reassure them with concrete certainties or with dazzling displays that appear to be certain.

The best example of this in recent times was the double act of Lord Richard Layard and Professor David M. Clark, who managed to give the impression that CBT would cure 50% of people with mild to moderate depression or anxiety whose mental state meant that they were drawing very large amounts of benefit from the state. Layard argued that the saving to the Treasury when these people went back to work as a result of being cured by CBT would pay for the training of those CBT practitioners needed to carry out this work. The dazzling display that I referred to earlier was the impression that Clark gave that CBT had been evaluated and shown to be as effective as he claimed it was.

The other part of the NHS that we need to think about is the provider side. The changes in the NHS initiated during Tony Blair's government and developed subsequently have led to the current position where any qualified provider can tender to deliver healthcare. This means that the NHS is no longer the only provider of healthcare bought by 'the NHS'!

Selling to the NHS

Given this background, one might be forgiven for thinking that it would be impossible to sell services organised in a psychoanalytic way. In fact this does not have to be the case. I want to describe the thinking behind the development of a model that has been sold to City and Hackney by the Tavistock and Portman NHS Foundation Trust, where it operates as the 'City & Hackney Primary Care Psychotherapy Consultation Service', or PCPCS for short. This is the service that won the innovation award from the BPC.

In 2007, as a result of the work of Layard and Clark, the government agreed to fund the project called Improving Access to Psychological Therapies (IAPT) which, for the first time in my professional memory, had attracted significant funding into the mental health side of the NHS. I had just been appointed director of the Adult Department at the Tavistock. It seemed to me that there were two fundamental problems with the IAPT plan: the first was that assessments of patients would be carried out by CBT therapists with the lowest level of training and experience and, secondly, there was no clear connection between the high intensity intervention (called step three) and specialist provision like outpatient therapy (called step four). Additionally it seemed to me unlikely that there would be very many patients presenting with simply mild-to-moderate depression or mild-to-moderate anxiety; in my experience most patients had much more complex presentations. On the other hand it did seem very clear that the move within the NHS was towards community and primary care treatments, and away from specialist or secondary care.

I set about designing a service that could be run in primary care settings but aimed at more complex and more difficult patients. Conversations with GPs showed that they struggled with patients who were frequent attenders but who showed very little sign of improving. These patients tended to be of three particular types: long term mentally ill who were currently not crossing the threshold to be admitted into hospital, patients with medically unexplained symptoms, and a range of patients who could be described as suffering from personality disorders. It seemed to me possible to design interventions that could help GPs to manage these sorts of patients. One of the first things that needed to be recognised was that we were talking about improving *quality*, not providing a *cure*. I think this is a really important point that commissioners very often do not take on board, namely that the most demanding patients within this sector are also those for whom cure is very unlikely.

Continues over the page

In brief, the important ingredients were the provision of well qualified therapists who could work alongside the GPs in their practices and provide some brief therapy (of which psychodynamic therapy was only one amongst many), joint consultation with the GPs, training primary care staff, working to repair and support the network surrounding a particular patient and, finally, offering consultation to the GP about his work with a particular patient. We felt that it would be essential to evaluate the effectiveness of our interventions, and so this was part of the design. My colleagues in the Adult Department helped me to turn this into an effective programme, and this coincided with City and Hackney PCT inviting tenders to run a primary care service. Ours was the only service requiring such a high level of qualification for the therapists; the others offered something that was much closer to the IAPT model. To my great relief we won, and subsequent evaluations have demonstrated that this is a very effective service. Key to the design was the appointment of psychoanalytically trained therapists and particularly a clinical psychologist and a psychiatrist with good psychoanalytic qualifications to run the service. The reason for that was my conviction that only by thinking psychoanalytically about the clients being sent to the service would it be possible to run an effective intervention. It is my view that these patients become very difficult *because of the unconscious impact they have on the workers*, therefore attention to these unconscious processes would be the key to having a positive outcome.

'We have to learn how to become successful businesses.'

When it came to selling this service, it was really important to draw out from the commissioners what caused them most anxiety. By genuinely showing interest in the experience of the Commissioner, particularly what is making them most anxious, it becomes possible to reduce that anxiety in the room by engaging with it and showing how a psychoanalytic approach can address the problem more generally. I have found this to be true in both sides of the NHS (physical health as well as mental health). It is a serious mistake to think that the way to sell something is simply to assert that it is the best system.

This brings me to my final point, although it is also my central point. In the same way that Harvey Taylor has argued that psychoanalysis has to adapt and change in a new world with new demands, so I think the psychoanalytic community within the NHS has to change in reflection of the truth about this modern health service. We have to learn how to become successful businesses. I don't think there is any shame in that; indeed my work as an organisational consultant has shown me that the psychoanalytic approach to understanding organisations also provides a model for good business. Businesses survive and prosper entirely in proportion to their ability to face reality and the truth about the environment in which they are living. If we try to sell psychoanalytic therapy in a marketplace that is looking for cures, we shall fail quite simply because other forms of therapy have developed a much better case (in the form of an evidence base). On the other hand, amongst the population of patients who are unlikely to be cured but can be significantly helped to improve their quality-of-life, no therapeutic intervention can stand against the argument for psychoanalytic therapy.

Like many other psychoanalytic departments, the Adult Department of the Tavistock, over many years, has provided consultation to frontline services (like wards in mental health trusts, hostels for forensic patients and so on) that has dramatically improved the quality of service for those teams and has transformed the individuals from an attitude of denigration of psychoanalytic ideas to an attitude of appreciation. This attitude continues as these individuals move up the system, and there are many examples of such individuals calling upon psychoanalytic establishments to help them with their work later on. This is true of frontline services in the physical health sector as well as the mental health sector, and it is particularly relevant now because of the concern in the public mind about the level of compassion amongst nurses. It seems to me that a psychoanalytic presence in this context can provide *measurable* improvement in compassion and quality of practice.

I have no doubt that the current collapse of the NHS provides one of the best opportunities for psychoanalytic practitioners to offer a psychoanalytic mind to help our colleagues who are struggling to keep the system going against all the odds. I believe that these sorts of interventions will be welcomed. It is simply a matter of thinking in a business-like way about opportunities as they occur, and also being able to move very quickly to seize them ■

Philip Stokoe is a psychoanalyst and organisational consultant. He is Honorary Visiting Professor at City University and past Director of the Adult Department of the Tavistock and Portman NHS Foundation Trust.

Case study
Devon Specialist Personality Disorder Service

The Devon Personality Disorder Service funds psychological therapies from cost savings made elsewhere in the local health and social care economy. The service addresses the therapeutic needs of people with severe and complex personality disorders who would otherwise be placed in locked units out of county due to their high risk of suicide. In Devon, as in other counties, many millions of pounds are spent on such placements each year. In these units people receive intensive input, usually Dialectical Behaviour Therapy (DBT), but local psychotherapy services remain under-resourced so there is little ongoing therapy to step down to or return to.

To address the complex needs of these people, the service has adapted the best of evidence based practice from personality disorder national treatment centres. These innovative adaptations include working therapeutically with people who are detained under the Mental Health Act; people with personality disorder and eating disorder; people with personality disorder and severe somatisation; and people with personality disorder and substance misuse

People attending the service may be offered:

- Seven months of intensive day treatment with twice weekly individual psychodynamic therapy, group analysis, family therapy and psychosocial practice, followed by two and a half years of an outpatient psychodynamic therapy programme.
- Mentalization Based Therapy (MBT)
- Cognitive Analytic Therapy (CAT) for personality disorder
- Family therapy
- Psycho-education groups

Furthermore, the Specialist Personality Disorder service staff offer Knowledge and Understanding Framework (KUF) training to other mental health professionals, as well as consultation supervision and training in work with personality disorder. Supervision consultation and training is also offered to local GPs.

The service has been open for two years, and is measuring outcomes as well as developing a research collaboration with Exeter University to develop and test the model. Early results show 80% of patients have been successfully returned from placements out-of-county or have been diverted from being sent on placements. Such placements cost on average around £200,000 per patient per annum. The service costs considerably less than this. So for less money patients can receive more effective treatment closer to home, and the service provides training, supervision and support for work with PD for professionals across the mental health trust and other agencies.

Case study
City and Hackney Primary Care Psychotherapy Consultation Service

The PCPCS is a well established, innovative service that delivers a clinical and consultation service to GPs and their patients throughout the London boroughs of Hackney and the City.

The service provides primary care interventions, including psychoanalytically informed modalities, for a range of complex chronic patient s who otherwise would fall into the gaps due to a lack of specialist care for more complex patients, including those with medically unexplained symptoms (MUS); with personality difficulties/disorder (PD) but not managed by local PD services; and with psychiatric morbidity but not managed by, or recently discharged from, psychiatric services.

The service model is innovative in four key respects:
1. The service caters for patients with complex conditions characterised by co-morbidity and risk in a primary care setting, thereby offering an adjunct to IAPT provision and, where appropriate, a bridge to secondary care.
2. The service provides a collaborative care model for patients with physical and emotional difficulties, specifically for people with MUS and Long Term Conditions (LTC).
3. The service is embedded in local GP services, and delivers support to GPs through consultation and training beyond a direct clinical service to patients.
4. Partnership working with other providers in health and social sectors.

Treatment is based on a multi-model approach, consistent with NICE guidelines and evidence-based practice, working with individuals, families and groups, utilising:

- Brief dynamic approaches, including Dynamic Interpersonal Therapy (DIT) and Mentalization Based Therapy (MBT)
- CBT and CBT-informed approaches, such as Mindfulness
- Group approaches, including psycho-education and mentalization groups
- Family and couple therapy.

GP satisfaction is high, with 92% stating the service they received helped them deal more effectively with their patients. Questionnaires posted to patients one month after discharge also found a high level of satisfaction, with 73% reporting being satisfied with the service either 'most of the time' or 'at all times'. Clinical outcomes are very encouraging with significant changes in functioning reported on GAD7 and PHQ9.

The Centre for Mental Health assessment of the service (October 2013) found that the service improves health outcomes and leads to reduction in health service use in both primary and secondary care settings. The assessment concluded that the financial savings from reduced service use are equivalent to about a third of PCPCS treatment costs: a significant offset.

NHS Special

The NHS challenge: a way forward

By Andy Soutter

THE GREATEST challenge to psychoanalytic psychotherapy in the NHS at the present time is survival – to survive amidst the structural upheaval in the NHS, with constant reorganisation of mental health services changing the provision of psychological therapy services. Recent years have seen some psychotherapy services disappear and others change radically, usually with a loss of senior clinicians. In many cases the services have had to move from providing psychoanalytic psychotherapy tailored to the individual, to services designed for clusters of patients, e.g. mentalization based programs for those with borderline personality disorder. Whilst there has always been change in the NHS, the political demand to shape it into a business within a marketplace has become more radical in the present economic climate. In recent times, amid all this austerity, mental health services have faced further financial cuts which have led to a further slimming down of services.

Changes ushered in by myriad consultation exercises see clinical and management hierarchies becoming more pyramidal in shape. The higher banded clinicians and managers are weeded out in the process, and many have faced a downgrading of their posts. Those who have retained their grades have had to incorporate greater management functions into their time. So there are fewer teams of experienced, clinically focused psychoanalytic psychotherapists working together, and this can bring the challenge of relative isolation. There has also been a reduction in the NHS of posts that those qualified in psychoanalytic psychotherapy can apply for, lengthening the gap between undertaking a psychoanalytic training and starting work in the NHS. There is work to be done to bridge this gap through the recognition and accreditation of a wider range of steps towards developing psychoanalytic competencies, especially those that will be recognised within the NHS.

Like their physical health counterparts, mental health services are gearing up for a system of payment by results. Easier to comprehend in physical health in terms of elective surgery: for example, a hip operation completed. Often in mental health, as David Bell's article notes, there are no clear outcomes or end points to achieve. So our challenge is to articulate to our managers and commissioners the shape and function of realistic services that can both contain and help some patients to develop, and the value of the psychoanalytic approach within them.

'The challenge is to market psychoanalytic psychotherapy more effectively.'

But what is a result? Well, at the moment it is by demonstrating that a person is a patient in the service and they are clustered (categorised by symptom profile and problems). The cluster determines the cost of the care pathway they are using, but at the moment it is not able to distinguish between patients receiving treatment and those on a waiting list. Accurate accounting is the 'result' paid for, with the 'paperwork' devolved to the clinician. Except it's not paperwork – it's an electronic recording system that requires training to use. I flag up, in passing, issues of time and confidentiality.

Despite this lack of sophistication in the system, psychological therapies in particular are under pressure to demonstrate evidence-based practice. Psychological therapists are set to compete amongst each other to demonstrate they have the best evidence for what they do and that their therapy is best. Guidelines of the NICE variety quickly become a dogmatic blueprint, wielded by colleagues and mangers alike, often by way of expressing ambivalence and in an attempt to relieve anxiety stemming from uncertainty. In contrast, the psychoanalytic approach embraces doubt and encourages uncertainty but does not find research on the whole very palatable. So it is a challenge to work together and find a common language that speaks to common goals whilst conveying the value of our psychoanalytic principles. In fact, psychological therapies do have a rich evidence base compared to many other components of the mental health services, consistently demonstrating that what we do works. The challenge is to market psychoanalytic psychotherapy more effectively, and recognise that the greatest marketplace currently remains the NHS. If psychoanalytic psychotherapy through its ongoing provision, applications and derivatives does not survive in the NHS in a recognisable form, then there is a danger it will be consigned to the periphery of the national psyche. The NHS is a powerful kite mark.

My own experience, and that of my colleagues, is that the most recent demands to change have been unlike many before and have succeeded where previously they had been resisted. They seem to have been much more consistent and coordinated across the NHS, with a blueprint that includes expectations of evidence-based practice, rather narrowly defined, that demonstrates equality and consistency across clearly mapped care pathways, and delivers in the short term. All very well; but existing long established psychotherapy services become caricatured as greedy resources unfairly distributed with a lack of equity to the community. The realities of the complexity and long-standing nature of the problems of the people who inhabit the non-psychotic clusters are not easily conveyed, and the provision of such things as a year of weekly psychotherapy and longer term groups is not easily matched to the demand and the available resources. So it can be a huge challenge trying to navigate a service through change being imposed upon it. How much to adapt to survive? Or adapt and die in terms of psychoanalytic work?

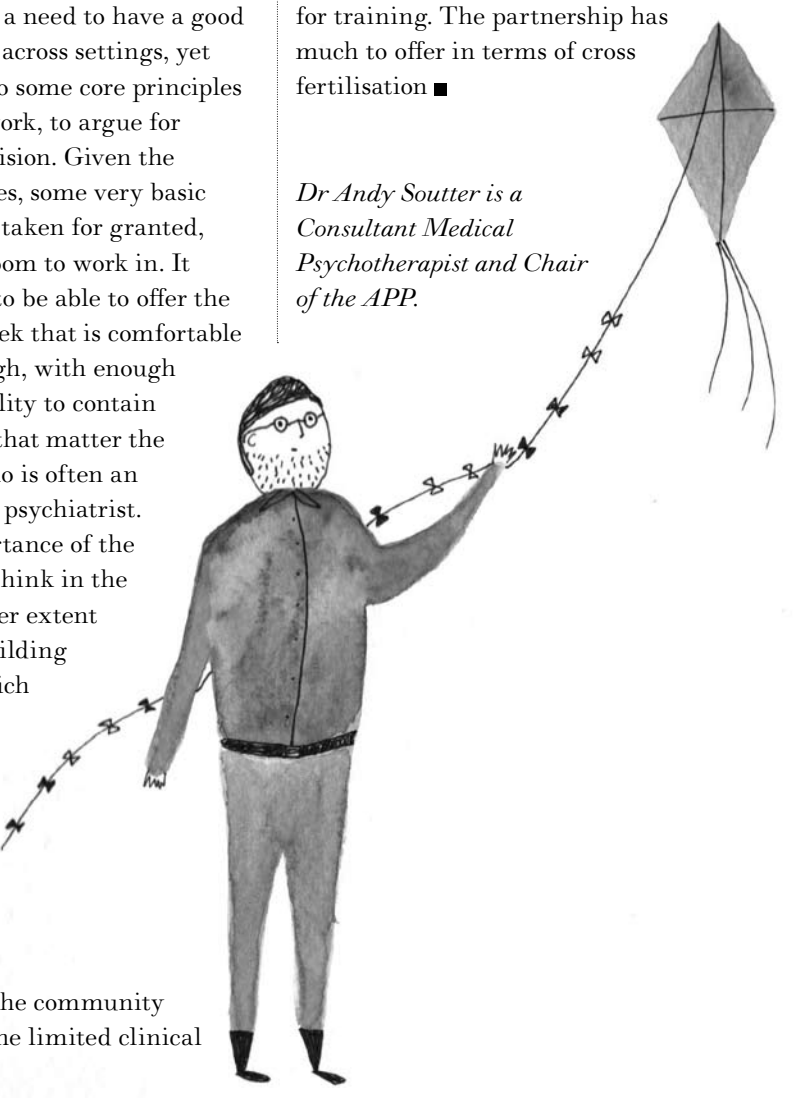
In my view there is a need to have a good deal of adaptability across settings, yet manage to hold onto some core principles of psychoanalytic work, to argue for a good enough provision. Given the pressure on resources, some very basic elements cannot be taken for granted, such as a suitable room to work in. It can be a challenge to be able to offer the same room each week that is comfortable enough, quiet enough, with enough sense of confidentiality to contain the patient and for that matter the psychotherapist, who is often an honorary or trainee psychiatrist. We know the importance of the transference, but I think in the NHS this to a greater extent encompasses the building and the service, which includes a need to have a competent reception and administrative function that can help hold patients' anxieties.

Teams working in the community are challenged by the limited clinical space, and sometimes challenged by what space they do have. For instance, the demands of infection control can leave new developments cold and sterile with plastic floors and chairs. Clinicians then have to work hard to re-humanise the setting. It is a challenge in the NHS to look outwards for all these things and retain enough mental space to be able to look inwards psychoanalytically to the work with patients. It is a challenge for clinicians to maintain a space for thinking whilst there is increasingly less structure to contain them.

We need to find a common language that conveys clearly what the psychoanalytic psychotherapies have to offer, and how the focus is different to other therapies but can be part of a complementary team. I think this would be by stressing our interest in understanding the difficulties people have in relating and with feelings, the interpersonal and affective focus as opposed to the cognitive and behavioural. We carve out our niche, set out our stall in the market. We speak the economic and evidenced-based language with more confidence, and voice the clinical issues about patient choice and dealing with complexity.

In my experience there remains a great deal of interest among staff for a psychoanalytic understanding of patients in the NHS, and we need to tap into this and provide a framework to support this interest, and provide appropriate validated training at as many levels as possible. To this end the APP and BPC are working to forge a stronger and much more definite partnership. The APP has directed much of its energies recently to developing as an organisation that can draw in and offer a broad as possible membership; and the BPC is working hard to become a central accrediting body for training. The partnership has much to offer in terms of cross fertilisation ■

Dr Andy Soutter is a Consultant Medical Psychotherapist and Chair of the APP.



Private Practice

What's it really like out there?

The BPC is piecing together a national picture of private practice to better understand the challenges our profession faces. From the newly-qualified to the seasoned practitioner, we asked BPC registrants to give us their account of what it's really like today to practice privately.

The initial response has been positive, and you can read here some illuminating vignettes from colleagues across the UK. We are not able to print all the pieces we received, but these and more stories are available on the BPC website. This is an ongoing project and submissions, ideas and feedback are welcome. Please email Leanne Stelmaszczyk, BPC Development Officer, at leanne@psychoanalytic-council.org

On working collaboratively

I work in full time private practice in Plymouth. I moved here from London at the end of 1996, having trained at the London Centre for Psychotherapy, and began to build a practice locally in 1997, after a period of major re-adjustment and acclimatisation.

Until 2012 I combined a small private practice with work in NHS psychotherapy departments and a young people's charity. Currently I have a practice that is two-thirds individual work with patients; the rest is individual and group supervision for agencies and individual supervision for therapists and counsellors. I run my own small EAP for local educational staff and enjoy the contrast, getting to use my business as well as clinical skills. I also teach psychotherapists and trainee psychologists in Exeter and Plymouth.

Most of my referrals are from other therapists, GPs or psychiatrists but some people self refer, having got my name from their contacts or from the BPC register. On occasion colleagues from London kindly make referrals, or pass on my details to patients moving west, or seeking contacts for friends or family members. Their sense of geography can be shaky at times; more than once I received referrals that lived in Portsmouth and Bournemouth… and this highlights a preoccupation which has now faded, my distance from the mother ship.

I belong to two supportive networks of practitioners from different orientations in Plymouth and an analytic supervision group in Exeter. There are at least six professional meetings held within fifty miles each year and so I am lucky to be able to maintain my professional development in an enjoyable and collegial way. But I did have to confront my fears and learn to drive in order to network and make links.

My professional life feels much more stable now that I work full time in private practice. I have no shortage of referrals, but I sadly regret the cuts that are happening to psychotherapy in the public sector, and often patients referred to me are in despair after years of trying to get help. I think that my work in the NHS is of more use to my reputation in Plymouth than is my psychoanalytic training, but registration with the BPC has also helped.

'Often patients are in despair after years of trying to get help.'

Most of my patients come once weekly, and I wonder about the lack of attention that is given to effective analytic work with this most common frequency. Yes, I enjoy and hope I do good work with the patients who come twice or, less often still, thrice weekly, but I think that once-weekly work is neglected in our theorising and weakens our arguments in the face of other therapies.

Fees are a shared preoccupation. What should one charge in a poor city? How much are they charging in London these days? I set a standard fee, and hold two spaces for patients who can only afford a lower amount. I am curious to see how my experiences compare to colleagues across the country.

Lily McConville, Psychoanalytic Psychotherapist, South West England

On health insurance

In spite of, or because of, the NHS, many individuals take out private health insurance policies, and often companies provide such cover for their employees and sometimes for their families. About 8% of the UK population are covered (i.e. about two million people). Many BPC members, perhaps the majority, work in private practice. Having recently retired from the NHS and started in private practice, I have found myself lacking in any kind of guidance as to which (if any) insurance companies know about our field, whether any of them recognise the conditions for which psychoanalytic therapy is indicated, and especially whether there is any appreciation that for some patients an intensive therapy is the treatment of choice.

Working as a psychiatrist and psychoanalytic psychotherapist I get referrals from GPs and self referrals through my work in a private hospital outpatient setting. More than half are insurance-backed and I find that most have no knowledge of psychotherapy, yet the majority are well suited to starting off in a psychoanalytically informed conversational model that gradually moves into a more formal psychoanalytic therapy.

I have no difficulty in getting insurance companies to support a weekly therapy that is clearly going to achieve solid results in twenty or thirty sessions, and this is highly appropriate for certain groups of patients. Where it gets more complicated is with patients where it is clear from the assessment that the person will need more than once a week therapy and for longer than about six months. Here I find the insurance companies most reluctant, in spite of them being informed that the patients have previously failed to sustain a response on several occasions to medication or CBT. I make it clear that the problems have a long history and have been present for years.

Although insurance companies have 'Psychiatric Case Managers' who liaise with the patient and the practitioner about therapy, these PCMs have no knowledge of our approach and its potential benefits. This seems to contrast with other countries such as Germany and Finland, where insurers readily provide longer-term more intensive therapy because it is known to be cost effective *for the insurers* for certain groups of patients.

So far, I have not managed to negotiate the extension of twice a week therapy for more than three months at a time; in spite of my fees for these patients being half what a routine outpatient fee would be for half an hour. I am also under pressure to provide some external criteria of rapid benefit, such as return to work. Of course, these kinds of criteria are important, but too early a focus on such issues can sometimes interfere with work on the foundations that would lead to a more solid return to work. It needs to be remembered that these patients or their employees are paying for insurance cover, in the same way we all pay for the NHS. Furthermore some patients are prepared and able to pay extra if they sense that three times a week therapy is likely to be additionally beneficial.

The good news for BPC members is that there is absolutely no shortage of really interesting and rewarding work if one is in the right position to receive it. However, it seems that as a profession we have as much work to do in the private health sector to earn our place in the market as we do in the NHS.

Brian Martindale, Psychiatrist and Psychoanalyst, North East England

On increasing containment

My private practice in East London is busy but with relatively few patients wanting, or being able to afford, more than weekly sessions. Some wish to have a therapeutic input but at less regular intervals than this. It means holding a large number of patients or clients in mind, and is demanding because of this.

I have seen an increase in younger people coming for help privately, most recently a young person making the transition from school to Sixth Form College. This young person had complex needs recognised in a statement of educational needs, and the transition was likely to be a difficult one. Lack of preparation or thinking about what these difficulties might mean for the student has led to a difficult start to this new phase. It is apparent that the structures necessary to support complex student needs are not present within the college or, if present, are not robust enough. This is in an area of London where Tier 2 adolescent mental health services have been effectively eradicated, leaving parents floundering to find adequate help for their teenagers.

It seems to me that more complex adult patients are coming into the private sphere, perhaps as a result of the decrease in provision for longer-term therapy in the NHS. In these cases there is a need to connect with other services involved with a patient, in order to ensure a safe container for the work. I have found there is a noticeable lack of someone in an overseeing role, except perhaps in the most severe cases. There is pressure on organisations to tend their own patch so that they are not able to give time to thinking systemically about how a patient might best be supported. Thinking, it sometimes seems, simply comes with too high a price tag.

A lot of work is currently coming through employment assistance programmes, reflecting the impact of constant changes in the public and private sectors and the pressures these bring. Work is interesting and varied on one hand, but there is pressure on EAPs to keep fees low. More administration is expected of Network Counsellors than previously, with no increase in fees.

Support for Network EAP Counsellors in the service I work for has decreased substantially in the last ten years, from two supervision sessions per six-week case provided by the organisation, to telephone case management (approximately 10 to 15 minutes) for cases only where there are risk factors present. Once again, for the private psychotherapist this means holding more anxiety not only for the individual that we meet for therapy, but also for the organisations to whom we provide our services.

Michelle Golding,Psychoanalytic Psychotherapist, London

On working flexibly

Here in the leafy south of London, away from the traditional psychoanalytic home hub, the perception may be that we are the poor relations who might struggle to find patients. This has never been my experience, partly perhaps because of the density of population in our metropolis. However, there have been significant changes in private practice since I began practising nearly 25 years ago, especially in the last five years.

‘It seems more complex patients are coming into the private sphere.’

These are the trends I observe:

- More once or twice-weekly patients are working in an intensive style by using the couch, engaging in transference, freely associating and delving deep into their unconscious – and increase to three or four times weekly if, as and when they need to.
- People looking for a therapist are ‘shopping around’ before committing.
- The informality, accessibility and speed of digital technology are creating a culture that is less formal. (And Google can throw up some pretty random information about a therapist!) Email communication can be challenging, but I have found that Skype (with/without visuals) has opened up enormous possibilities for working at a distance. Not the same, but not without value either.
- A trickle of enquiries about therapy from websites began as soon as the information was available online. Those coming out of the blue via email don’t often come to anything but some enquiries via telephone, having studied websites, can lead somewhere – even when the enquiry is about a course.
- Referrals from my organisation’s Clinical Services have plummeted, but those from GPs, counsellors and colleagues have not. Perhaps being a training therapist for a few organisations helps a little, but trainees’ finances seem to be more stretched these days.

I’ve always been intrigued by the pattern and flow of people coming and going through my consulting room; fascinated by the tension between the external realities of individuals’ circumstances and the capacity and availability of my own internal world. How is it that that so many come without consciously knowing that their issues fit my interest and experience? The collective unconscious certainly moves in a mysterious way. Whatever the mechanism, the demographic and size of my patient population has been a constant.

In the wider world, however, much has changed: finances are tight, time is short, employment is less secure. House prices have soared away from wages; more people need to work full time and fewer can afford a full fee for multiple weekly sessions.

In spite of all of this, there are still individuals who seek a Jungian analysis to change unhappy states of mind, body and soul.

Marilyn Mathew, London

On embracing technology

I thoroughly enjoy working in private practice. Especially now it is well established, with streamlined days and times, economy of time, a very suitable setting from which to operate, a well oiled administrative system to support the work, a varied caseload of children and adults coming for intensive and less intensive treatments, a sprinkling of family or couple work, and some supervisees and people coming to ask about careers or training in the psychotherapies.

The patients who come through the door, from under-fives to over-eighties, have mainly come through word of mouth. Starting thirteen years ago with one patient at 8am and the next at 5pm, I now have a steady caseload, from 8am to 3pm or later each day, Tuesday to Thursday inclusive. Children sometimes come after school, so 4 or 5pm. Adults sometimes need to come before work, so 7 or 8am. Intensive cases (currently four) have settled into regular days and times over five, six, seven, eight years. With low wage earners paying £40, some people £50, and the full fee £60, the pay scale is roughly equivalent to a Band 8 NHS grade. However, if you have a cup of tea, go to the loo, are off sick, or take a holiday, no-one pays you, and so there’s a real feeling of working hard, and really having to earn the pay! I rarely take a holiday and am never off sick, but I do drink tea and go to the loo!

I keep Monday for Skype supervisions for myself (with two psychoanalysts in London) and for administrative tasks, note taking, CPD activities and catching up at home. And on a Friday during term times, I do five hours’ work in a Special School. The school doesn’t employ me, but rather buys five hours of my time in the same way that my patients do.

Thanks to e-learning, teleconferencing, Skype etc, being geographically isolated isn’t as big a problem as it might have been before. However, supervision and CPD costs me a lot. As far as I am aware, there isn’t another dually-qualified psychotherapist in Scotland, or indeed even close by in the North of England, and so to access my preference for a dual qualification/experience in a supervisor means linking up with someone in London, and costs and prices of things there are higher than here. However, I consider this very worthwhile and benefit greatly from being able to do this. People are fortunate, though, who have paid supervision and CPD opportunities through the NHS, although I gather this is becoming more sparse due to the cutbacks. Also, to attend a conference in London incurs significant travel and accommodation costs as well as a conference fee.

I love working in private practice. It is what one makes it. It’s very hard work. One is responsible for providing and maintaining a setting in which the work can take place. One has to be at the buzzer every time a patient rings it. If a four year old scatters toys all over the room minutes before an adult is due to come in and lie on the couch, these are all things that have to be managed and thought through. It’s infinitely rewarding, beautifully creative, often a challenge, always interesting, and, by me at least, never regretted!

Janette Montague,
Psychoanalytic Psychotherapist, Scotland

On new ventures

I began full-time in private practice in March 2011, after being required to leave the NHS after nearly thirty years as a consultant to the Family Unit, Cassel Hospital, which closed soon afterwards. I had been in part-time private practice as a psychoanalyst since 1981, and also did a small amount of private expert witness work for the family courts, as well as some private child psychiatry with families for some twenty years.

I had been given seven months’ notice to quit, so was able to prepare the shift over to full-time private work. That meant rapidly building up links with family lawyers, to let them now I was more available for expert witness work. Simultaneously I was fortunate to be able to join two private organisations – The Child and Family Practice, originally in Wimpole Street and now in its own building in Ridgmount Street, London, and Ashwood Associates at Woking; the latter is essentially a small private Child and Adolescent Mental Health (CAMHS) service. I also consult once a month to a specialist therapeutic fostering agency in Kent – Kaleidoscope.

Since then I have been busy with a combination of analytic work with adults, expert witness work, private child and family work, and occasional teaching. Life in private practice is much less stressful institutionally, with a minimum of bureaucracy. It is, however, a business and needs to be run on business lines, with

Continues over the page

detailed attention to accounts, and, with court work only, VAT. I now have my own company, which is a more efficient way of managing all this.

The Child and Family Practice is a unique organisation consisting of a number of mainly experienced practitioners. Our service includes several consultant child and adolescent psychiatrists, a senior consultant paediatrician from Great Ormond Street Hospital, family, marital, couple, child and adult psychologists and psychotherapists. In addition, we have the possibility of calling on a number of other professionals who are part of the practice, including a family mediator, physiotherapists, occupational therapists, speech and language therapists, educational advisors, an audiologist, our Eating Disorder Service, specialist paediatricians, our Multi-Disciplinary Assessment Team for children with complex problems, and the Social and Communication Disorders Team. There is also a smaller Adult Service. I myself also see some adults, for psychiatric help for analytic colleagues, and for compensation cases, for example for survivors of sexual abuse.

It was initially anxiety provoking to no longer have my NHS salary there as a constant, though of course I was helped by having my NHS pension as a cushion. And the first months were a bit hair-raising because of cash flow issues – some lawyers are notoriously bad at making payments on time. But life is frankly a lot less stressful overall and it is rather invigorating taking up new challenges at my relatively mature stage of life.

Roger Kennedy

On marketing a practice

I have been in private practice as a psychodynamic psychotherapist for the past five years. My practice is based in Central London and I moved from renting a consulting room on a sessional basis to my own room four years ago as I wanted to have the flexibility to expand my practice.

It was initially a slow start and relatively difficult to find new clients. However, I then gave much more thought to my marketing strategy, and this paid off in terms of the direct correlation between the effort I have invested in marketing and the number of clients I have. Nevertheless it has taken a lot of perseverance and many unanswered letters, calls and emails from potential referral sources!

Currently, I am fortunate enough to have a broad range of clients for open ended and for time limited therapy. My clients come from a variety of sources including online directories, my website, and referrals from colleagues as well as the graduate association of my training organisation. A number of clients have come to me specifically because of my psychodynamic orientation. That said, an equal number have come to me not because they are familiar with the psychodynamic approach, but because of a number of other factors including my location, my availability, my online directory entries and website. Often, clients do not know about the various therapy orientations but just know that they want some help. Interestingly, however, a number of clients have either had CBT or are broadly familiar with it.

The competition in private practice in Central London feels pretty fierce at times, with therapists of all persuasions competing for clients. However, I nevertheless feel that with a lot of thought, effort and some luck it is possible to run a viable practice.

There is, no doubt, still scope for us all as members of the psychodynamic community to continue to promote awareness of our approach amongst the public so that a psychodynamic practitioner could become the practitioner of choice, rather than at times a practitioner chosen by default.

Anonymous

‘With a lot of thought, effort and some luck it is possible to run a viable practice.’

On active collaboration

I have been in private practice for nearly 25 years. I trained originally as a psychodynamic counsellor then as a psychoanalytic psychotherapist. I followed this up with training as a supervisor.

I am actively in contact with psychoanalytic colleagues from my own organisation and others, so there is good cross-fertilisation (supervision groups, reading groups, conferences, workshops, committees, etc.). Over the years there has been a slight change from when I first started as a qualified counsellor, when I could only work during school hours for family reasons. A negative change is that it is perhaps harder now to find patients who can come for more intensive therapy, once-weekly work being the norm for me. I think that the types of issue that patients bring have remained consistent, though more of them know more about psychotherapy now, and there is an increase in some problems, for example around internet pornography.

The origin of referrals has come consistently from the same network:

- from GPs
- from colleagues
- from my training organisation’s Referral Out network, though rare
- from an organisation that I belong to, consisting of about twenty psychoanalytic therapists, that has operated for about many years.
- from my own training institution, for which I am a Training Therapist. I usually have one new patient a year and these candidates often need to have more than once a week therapy, in one case up to three or more times a week.

My clinical days of work are Monday to Thursday. I usually have about 12 to 14 patients who come once a week, about three come twice a week, one three times a week, and one four. I do about 25 hours of clinical work per week.

For my own supervision, I have always consulted with a psychoanalyst or psychoanalytic therapist on a weekly or fortnightly basis. I have for 12 years plus been a member of a peer supervision group.

As a supervisor I have supervised groups in two training institutions for four years each. I offer supervision in private practice – at the moment I have about five supervisees. One of them is in psychoanalytic training and I supervise their work with a training patient. I taught for two years in my own training institution, but was not so interested in teaching as in supervising.

I have not felt the need to diversify; my interest is in long term intensive therapy in general practice. Perhaps if I wanted to cut down in years to come, I would take a training in short term work ■

Anonymous

Jumping the NHS ship

By Sally Beeken

Swapping an NHS job for the 'Any Qualified Provider' scheme can be bewildering and anxiety-provoking. Sally Beeken steers a passage through unfriendly seas of contracting, procurement and risk.

I HAVE BEEN TRYING to remember the event that precipitated my decision to jump the NHS ship into the sea of 'Qualified Provision'. I recall that at the beginning of the dissolution of our Primary Care Trust and the takeover by a large Foundation Trust there was an unannounced visit from the Information Governance team. The people who came to our team base searched drawers and cupboards for evidence that we were, or were not, following policies and procedures that we had not yet seen. Later it was described by a colleague as an 'invasion'. For me, this visit that came without warning was to herald the change of culture to come. This, along with a growing sense of an organisation bereft of true authority and reliant on a 'do it or else' style of management, induced in me a growing and crippling anxiety. Yet it wasn't this or the at times alarming disregard for the centrality of patient care that prompted my decision. Or, when I think about it, the deprofessionalisation of clinicians or the commodification of patients.

There was, it felt to me, an absolute terror in the organisation when thinking broke out. Fear of reprisal for the expression of any dissent started to grind me down, but overcoming the fear and speaking out resulted in becoming the object of hostility. It began to feel unsafe, not just to express an alternative view but also to hold an alternative view. I felt pulled into a process I jokingly called Stepford Wife-sation.

In this context the final straw came with the introduction of compulsory risk assessments, hitherto regarded with a healthy scepticism and questioned as to their value in the work where assessment of risk, in all its facets, is integral and carefully considered. In addition, levels of paranoia within the staff in the organisation were high, with rumours of restructuring, redundancies and disciplinary procedures to try to tackle unmet targets. As regards the risk assessment I felt damned if I completed one and damned if I didn't. During this period of my own internal conflict I asked a well-known patient, a child, if she had had thoughts of self harm or suicide since I had seen her last. Prior to the requirement to tick the box I had never before felt the need to ask her this. What was fired back at me was a look of puzzlement bordering on fear, perhaps a fear that I was a madwoman, and saying 'no' in that indignant voice so well practiced by children; a look of calm settled on her face. The madness had been successfully located back into me and I, in turn, located it back in the organisation. Safely residing there I was able to think through my position and shortly afterwards announced my resignation.

'The NHS nevertheless provided a physical space in which to work and people with whom to share it.'

I felt a huge relief to have jumped ship. It was as if the vessel I was in was managing existential anxieties by the use of Titanic defences: denial, omnipotence and contempt. My experience was that the NHS world was topsy-turvy. Rather than the organisation being there to support the work, the work was being corrupted to support the organisation. Of course, some might say that it is easy for me because I am fortunate to be able to exercise choice. However, I am not alone: psychotherapists are leaving the NHS, some like me have jumped or taken early retirement or redundancy, others are waiting to board a different ship. No sign yet of a mutiny; however, there is always the hope of change on the horizon.

It took a while for me to escape the internalised totalitarian mental state I felt myself to be in. I was lacking in confidence and full of self-doubt, perhaps something akin to learned helplessness. I was aware that despite the NHS structure having become distorted it was nevertheless a structure that, if nothing else, provided a physical space in which to work and people with whom to share the work. It seemed to me that one of the things that had been lost was the centrality of our relationship with the patient. It is this relationship, in my view, that contains risk and it is this that needs the support of the organisation. Whilst this loss may have been an inevitable result of financial constraints it is antithetical to psychoanalytic work. The question facing me now is how to create a new working structure in the independent sector where relationship is the priority and recognised as such by external agencies looking to purchase care.

Part of the answer that I have arrived at so far has involved an exploration of quality assurance, or at least what it means to me, and how I might define it. How can quality be defined for the work we do, and measured in such a way that the integrity of the work itself is preserved? It is paramount that the public is protected, but isn't there also an issue about how the work can be protected in the process? In addition, there is the ever increasingly competitive world of contracts, procurement and tendering, and the inevitable tension between clinical and commercial ethics. A landscape where what may develop is the paranoia born out of competition and envy. What may, I think, facilitate meaningful quality assurance is a meaningful relationship with the assessors.

The Care Quality Commission has a hard task that it seems still to be working out how to achieve. I have never encountered the CQC but have been faced with the threat of a visit from them at any time and the need to prepare evidence that did not necessarily reflect the quality of the clinical encounter. My thoughts are still at an early stage about how the quality of care delivered by psychotherapists can be assured. It could be that verifying the claim to be 'Any Qualified Provider' is straightforward enough on the surface, but what of a profession that is not just about the surface but about meaning and that which is underneath? Before engaging with the process I've been pondering what I would feel comfortable with and confident in, and how much compromise would need to be made. What I have arrived at is my recollection of the application process for my psychoanalytic psychotherapy training.

First, there was a detailed application form to complete, and then a presentation of my work before a panel of experienced psychotherapists. If successful, there then followed two interviews with psychoanalysts, both searching in their own way and leaving me with a feeling that, whatever the outcome, at least I had been thoroughly and thoughtfully examined and that I could trust the process because I was listened to. Ten years on from the experience I realise that the examination of mind is a liberating process, and that the capacity to think independently is critical to mental health work of all kinds. Perhaps it was the compromising of the examination of mind and relationship, and the loss of the value of autonomous thought, that meant that to jump ship was to preserve my own mind and capacity to think ■

Sally Beeken trained as an Adult Psychoanalytic Psychotherapist whilst working as a Consultant Child Psychiatrist. In 2012 she resigned from her consultant post and is currently working part time as a specialty doctor in order to develop an independent psychoanalytic psychotherapy practice for children and adults.

News

Public Affairs Update

As we near spring, things are hotting up for us at Westminster. At the start of February we had a letter published in *Health Service Journal*,[1] calling attention to recent Health and Social Care Information Centre figures, which highlighted that a great many people drop out of treatment on the NHS's psychological therapies programme. Our letter called for greater choice of therapies on the NHS, emphasised the need in particular for psychotherapeutic provision for people with complex mental health needs, and raised the mental health issue *du jour*, 'parity of esteem' – suggesting that it is unlikely patients would have to suffer such a paucity of choice should they be requiring treatment for physical health problems.

Greg Mulholland MP has also tabled an Early Day Motion (EDM) at Parliament,[2] which includes calling for a full range of psychological therapies on the NHS to be available for people who need them within 28 days of requesting a referral and sooner if they are in a crisis. This EDM is an excellent way of raising the profile of the issue. We have created a pro forma letter template for registrants and trainees to use to write to their MP, requesting them to sign the EDM. This may be found on the BPC website, at www.psychoanalytic-council.org/resources/early-day-motion-1063. It would also be best if the letter could be personalised and signed as a constituent. MPs receive lots of campaign letters from organisations and are more likely to pay attention to a personalised letter from a constituent.

More recently, at the request of the Department of Health, we have worked with UKCP, Stonewall and other organisations to produce a joint statement against gay conversion therapy.[3] We also responded to an article in *The Guardian* which made some ill-thought comments about the 'dangers of unregulated psychotherapists and counsellors'.[4]

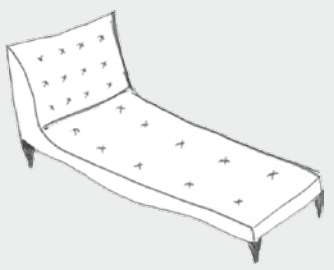
References

1. www.hsj.co.uk/comment/readers-letters-7-february-2014/5067736.article
See also: www.psychoanalytic-council.org/news/call-greater-choice-psychological-therapies-nhs

2. www.parliament.uk/edm/2013-14/1063

3. www.psychoanalytic-council.org/news/gay-conversion-therapy

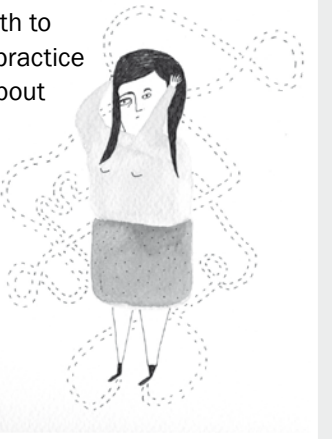
4. www.psychoanalytic-council.org/news/reply-patrick-strudwick-article-unregulated-therapists



BPC Seminar: Private Practice Realities

British Psychoanalytic Council

Saturday 10 May 2014



Private Practice Realities will be of interest both to those just embarking on setting up their own practice and those wanting to develop or learn more about the business side of therapy.

Our panel of speakers will be offering their experience from the field, sharing stories and best practice of developing a private practice and working with and alongside institutions and the private sector.

Provisional Programme

Julian Lousada: Chair
David Riley: Ethical considerations of setting up a private practice
Laurence Spurling and Judith Trowell: Experience from the field
Sally Beeken: Developing a service: working with others
Steve Martyn: Marketing your practice
FAQs and how to's with Pauline Hodson (author of *The Business of Therapy)*
Closing panel: questions from the floor

Venue: BPF Kilburn, London NW2
Ticket price: BPC Registrants: £55; BPC Trainees: £45; Non-BPC: £65
Contact: 020 7561 9240 or leanne@psychoanalytic-council.org

New Associations is published by the British Psychoanalytic Council, Suite 7, 19-23 Wedmore Street, London N19 4RU
Tel. 020 7561 9240
Fax 020 7561 9005
www.psychoanalytic-council.org
mail@psychoanalytic-council.org

Three issues of *New Associations* are published each year in March, July, and October.

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

For insertion of advertising materials contact
Leanne Stelmaszczyk,
leanne@psychoanalytic-council.org

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Production and editorial
Janice Cormie and
Leanne Stelmaszczyk
Illustrations Leanne Stelmaszczyk
Printer Advent Colour

Contribute to New Associations
We welcome your ideas for articles, reviews, and letters to the editor. In particular we are looking for reviews of cultural events, books and films with psychoanalytic interest. If you would like to propose a topic for a longer article (up to 1200 words) please contact Janice Cormie: janice@psychoanalytic-council.org

Deadlines: The next issue of *New Associations* will be published in June 2014. The deadline for article proposals is 25 April 2014. Contributions and letters to the Editor should reach us no later than 23 May 2014.

ISSN 2042-9096

What is psychoanalytic couple therapy?

By Amita Sehgal

PSYCHOANALYTIC psychotherapists generally accept that the unconscious is revealed in, and shaped through, relationships. Psychoanalytically-informed couple psychotherapists regard the intimate couple relationship as being the locus at which the intra-psychic and interpersonal realities converge within an external setting. Couple psychotherapy, then, 'is the process of attending to the experience created by [these] three interacting variables with the purpose of achieving change' (Clulow, 2011, p.3). The therapeutic process of identifying and understanding the function of the unconscious processes operating within the relationship gradually leads to a change in the quality of interaction between the partners.

So how is couple psychotherapy different to psychotherapy with individuals? Are psychotherapists who have completed a psychoanalytic training to work with individuals equipped to see couples? One significant difference lies in the setting. During couple psychotherapy sessions partners sit on chairs or sofas positioned to face the therapist. They do not lie on a couch facing away. Secondly, there are three people in the room. Uniquely, not only are both individuals forming the partnership present, but there is an existing, pre-established level of intimacy between the two. Generally speaking, at the point at which partners present for therapy each partner is looking for relief from, and help for, their own often painfully-felt experiences within the partnership. They also express how the relationship itself is no longer working for either of them, often illustrating this feeling by describing incidents where contact with the other has left each feeling unloved, uncared for, and emotionally depleted. Oedipal anxieties can get stirred up as couple therapists, such as myself, are invited to observe and unconsciously participate in the couple's relational dynamics. Our therapeutic skill, one that is acquired during our specialised intensive training, lies in the delicate and sensitive management of each partner's distress in the presence of the other whilst remaining alert to the nature of the relationship that the partners have co-created. Theoretically we pay attention to each partner's parental couple as an internal object, and our attention is focused on the shared internal objects within the partnership. At all times we remain aware that the dynamics of the couple's relationship can get readily and unpredictably re-ignited and enacted within the clinical setting and that we can become unconsciously drawn to participate in it.

In order to assist partners with problems that are central to being a couple, namely those of intimacy, separateness, and sexuality, we couple therapists must be able to tolerate anxieties related to primal scene phantasies associated with intruding into the private lives of others. Our clinical effectiveness rests upon the internal couples that we as clinicians mobilise personally and professionally to assist us in this work.

My interest in the specialist field of couple psychotherapy developed through my experiences as a geneticist working at the Institute of Child Health, London. During the early 1990s I was part of a team of scientists involved in developing gene therapy as a cure for a genetically inherited immunological disorder in children. Almost all of the children afflicted by this particular disease die by age 13. Being based in Great Ormond Street Hospital for Sick Children in London I was regularly confronted with distressed parents attending to their sick and often dying children. I saw the effects of sustained emotional strain on each partner and on their relationship. I observed how the quality of their relationship held the potential to influence each partner's mental and physical wellbeing and, in varying degrees, that of others around them. I began to view the couple relationship as the nucleus of micro-communities, the foundation of societies. The importance of emotional wellness in couple relationships now took on new meaning for me.

In the years that followed, my search for an in-depth, comprehensive and thorough training that would adequately prepare me to work with couples led me to apply to train at the Tavistock Centre for Couple Relationships (TCCR), the UK's leading training institution with a global reputation for psychoanalytic couple psychotherapy and counselling. I was delighted to be accepted onto TCCR's disciplined and rigorous training, which is grounded in psychoanalytic theory and practice. Psychoanalytic couple psychotherapists like myself who have graduated from TCCR are registered with the BPC through our professional body, the British Society of Couple Psychotherapists and Counsellors (BSCPC). We have an international journal, *Couple and Family Psychoanalysis*, dedicated to promoting the theory and practice of working with couple and family relationships from a psychoanalytic perspective. Our journal also seeks to provide a forum for disseminating current ideas and research and for developing clinical practice, and offers a wealth of contributions from our colleagues around the world.

It is encouraging to see that the interest in the field of couple psychotherapy is growing, and that the awareness amongst professionals that 'thinking couple' is a skilled specialism is increasing. In recent years, the Couples Unit in the Adult Department of the Tavistock Clinic has begun to offer a course in psychodynamic psychotherapy with couples. This course is aimed at clinicians interested in developing their practice to working with couples, and is also accredited by the BPC.

In defining psychoanalysis as being 'the science of unconscious mental processes', Freud (1925) integrated the 'art' of therapeutic practice with scientific diligence. Freud's vision remains pertinent in today's evidence-based culture: if we are to take couple psychoanalysis seriously, it seems essential that we are able to link its practice with research-based evidence of its effectiveness.

How Couple Relationships Shape Our World: Clinical Practice, Research, and Policy Perspectives is a book produced as a joint venture between the BSCPC and TCCR. It offers clear evidence of how the quality of our most intimate relationship – the adult couple relationship – profoundly affects not only the 'emotional, cognitive, and physical development of our children', but also impacts upon 'the likelihood of hospitalization, the rate of progression of disease in dementia, and even mortality rates' (p. xxix). It provides data verifying what we already know, that unhappy couples are exposed to a greater risk of cardiovascular disease, obesity, diabetes and other health concerns (Meier, 2011); that relationship breakdown comes at a great cost to the individual and to the State and can lead to an increased risk of anxiety disorders, alcoholism, depression and even suicide. Clinical studies conducted on the importance of involving the partner in treating depression in adult patients demonstrate 'the superiority of couple therapy over an approved antidepressant regime both in reducing the symptoms of depression and in maintaining the improvement… couple therapy was not more expensive than pharmacotherapy' (p. 181). A clinician's guide to couple therapy for depression is currently in the process of being published (Hewison, Clulow and Drake, in press). It incorporates analytic approaches with behavioural and systemic ones in describing an integrated approach to treating depression through couple therapy.

Psychoanalytic couple psychotherapy works well alongside other modes of psychoanalytic psychotherapy. It is a specialist, highly skilled approach to providing relief, support, and treatment for intimate couple relationships that have become problematic, and one that is compatible with ongoing individual therapy. Psychoanalytic couple therapy is an effective application of psychoanalysis, and an exciting development in its long and prestigious history ■

Amita Sehgal, MA, PhD, is a psychoanalytic couple psychotherapist. She is a Visiting Clinician and Lecturer at the Tavistock Centre for Couple Relationships, and maintains a private practice in Bloomsbury. She is a Collaborative Practitioner registered with Resolution.

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Diary

MARCH

22 March 2014

TCCR PSYCHOSEXUAL CONFERENCE: THE POWER OF SEX

Speakers: Stephen Levine, Woet Gianotten
70 Warren Street, London W1
http://tccr.ac.uk

22 March 2014

THE RIGHT BRAIN, LEFT BRAIN DIVIDE: WHAT IS ITS RELEVANCE TO THE TASK OF PSYCHOTHERAPY?

Speaker: Iain McGilchrist
SHSC, Crewe Road South, Edinburgh
www.confer.uk.com

22 March 2014

THE GOD OF THE LEFT HEMISPHERE: BLAKE, BOLTE TAYLOR AND THE MYTH OF CREATION

Speakers: Roderick Tweedy, Robert Snell
BPF Kentish Town, 32 Leighton Road, London NW5
www.britishpsychotherapyfoundation.org.uk/Newsitem1/god-of-the-left-hemisphere

22 March 2014

LOVE IN THE AGE OF THE INTERNET: FACE-TO-FACE/BOOK

Speakers: Linda Cundy, Emerald Davis
1 Highbury Crescent, London N5
carol.tobin@thebowlbycentre.org.uk

24 March 2014

BOUNDARIES IN ETHICAL AND SUSTAINABLE PRACTICE

Speaker: Valerie Sinason
Tavistock, 120 Belsize Lane, London NW3
www.confer.uk.com

25 March 2014

BIGGER ON THE INSIDE: AN EXPLORATION OF THE EMOTIONAL DEPTHS OF THE DOCTOR WHO TELEVISION SERIES

Speakers: Michael Rustin, Iain MacRury, Paul Jenkins
Tavistock, 120 Belsize Lane, London NW3
www.tavistockandportman.ac.uk/TCF

27 March 2014

ARTICULATING THE UNSPEAKABLE

Speakers: Marian Partington and Gwen Adshead
Friends' Meeting House, 42 St Giles, Oxford OX1
Contact: Oxboffice 0845 680 1926

31 March 2014

REACHING THE LIMIT: ETHICAL NEGOTIATION OF UNENDURABLE WORK

Speaker: Annie Power
Tavistock, 120 Belsize Lane, London NW3
www.confer.uk.com

APRIL

4 April 2014

OBSERVATION AND TRANSFORMATION: HOW DOES EXPERIENCE INFORM OUR CREATIVITY?

Speakers: Stuart Brisley, Judith Edwards, John Crossley, Fergus Hare, Sandy Layton
Tavistock, 120 Belsize Lane, London NW3
www.tavistockandportman.ac.uk/m16conference

5 April 2014

WHEN THE THERAPIST GETS IT WRONG: SURVIVING AND LEARNING FROM MISTAKES IN COUPLE AND INDIVIDUAL THERAPY

Speakers: Patrick Casement, Chris Vincent, Susanna Abse, Molly Ludlam
70 Warren Street, London W1
http://tccr.ac.uk

5 April 2014

UNDERSTANDING AND WORKING WITH DREAMS

Speaker: Marcus West
SAP, 1 Daleham Gardens, London NW3
publicevents@thesap.org.uk

6 April 2014

SHAKESPEARE ON THE SCREEN: THRONE OF BLOOD

Speakers: Michael Brearley, Ian Rickson
ICA, The Mall, London SW1
www.couchandscreen.org/the-stuff-of-dreams

7 April 2014

CONFIDENTIALITY AND ETHICS

Speaker: Karl Figlio
Tavistock, 120 Belsize Lane, London NW3
www.confer.uk.com

9 April 2014

FREUD'S CANCER AND ITS INFLUENCE ON HIS THEORIES

Speaker: Martin Schmidt
Freud Museum, 20 Maresfield Gardens, London NW3
www.freud.org.uk/events/

12 April 2014

IN MY OWN IMAGE - ILL FIT

Jane McAdam Freud in conversation with Robert Snell
BPF Kilburn, 37 Mapesbury Road, London NW2
www.britishpsychotherapyfoundation.org.uk/Newsitem1/in-my-own-image

MAY

2 May 2014

SPEAKING WITH THE BODY: YOUNG PEOPLE AND SELF-HARM

Speakers: Steve Briggs, Alessandra Lemma, Jeanne Magagna, Anna Motz, Marcus Evans
Tavistock, 120 Belsize Lane, London NW3
www.tavistockandportman.ac.uk/selfharm

10 May 2014

PRIVATE PRACTICE REALITIES

Speakers: Sally Beeken, Pauline Hodson, Julian Lousada (Chair), Steve Martyn, David Riley, Laurence Spurling, Judith Trowell
BPF Kilburn, 37 Mapesbury Road, London NW2
Contact: Leanne at 020 7561 9240 or leanne@psychoanalytic-council.org

10 May 2014

UNDER THE DEVIL'S SPELL: STOCKHOLM SYNDROME AND THE STRUGGLE TO EXIST

Speaker: Coline Covington
Quaker Meeting House, 40 Bull Street, Birmingham
Contact: Sue Harford, 08444 631 341 or jtc@wmip.org

10 May 2014

SELF MUTILATION: WHO FEELS THE PAIN?

Speaker: Rob Hale
Freud Museum, 20 Maresfield Gardens, London NW3
Contact: fortilaura@hotmail.com

12 May 2014

VAL MCDERMID IN CONVERSATION WITH SUE EINHORN

Kings Place, 90 York Way, London N1
www.connectingconversations.org

12 May 2014

THE PSYCHIC HOME: PSYCHOANALYSIS, CONSCIOUSNESS AND THE HUMAN SOUL

Speakers: Roger Kennedy, Josh Cohen
Freud Museum, 20 Maresfield Gardens, London NW3
www.freud.org.uk/events/

16 May 2014

SEXUALITIES IN PSYCHOANALYSIS

Speakers: Alessandra Lemma, Leezah Hertzmann, Ann Horne, Mary Target
Pearson Building, UCL, London WC1
Contact: christine.jackson@ucl.ac.uk

16 May 2014

THE PAST AS A FOREIGN COUNTRY: ACTS OF REMEMBERING IN HAROLD PINTER'S WRITING

Speaker: Mark Taylor-Batty
Institute of Psychoanalysis, 112A Shirland Road, London W9
www.beyondthecouch.org.uk

18 May 2014

SHAKESPEARE ON THE SCREEN: KING LEAR

Speakers: David Bell, Max Stafford-Clark
ICA, The Mall, London SW1
www.beyondthecouch.org.uk

18 May 2014

PURGATORY AND PSYCHOTHERAPY:

Speakers: Kalu Singh, Miri Rubin, Andrew Ekpenyong, Richard Carvalho, Hattie Myers, David Morgan, Rodney Bomford
Freud Museum, 20 Maresfield Gardens, London NW3
www.freud.org.uk/events/

24 May 2014

THE CLINICIAN AS RESEARCHER

Speakers: Karl Figlio, Robert Hinshelwood, Jeremy Holmes, Sue Kegerreis, Jean Knox, Gillian Miles, Judith Trowell
BPF Kilburn, 37 Mapesbury Road, London NW2
www.britishpsychotherapyfoundation.org.uk/Newsitem1/the-clinician-as-researcher

31 May 2014

THE PULSE AT THE CENTRE OF BEING

Speaker: Sally Jakobi
SAP, 1 Daleham Gardens, NW3
publicevents@thesap.org.uk

JUNE

7 June 2014

TRANSFORMATION: JUNG'S LEGACY AND CLINICAL WORK TODAY

Speaker: Richard Carvalho
BPF Kilburn, 37 Mapesbury Road, London NW2
membership@bpf-psychotherapy.org.uk

7 June 2014

WHAT MADE THE MONSTER MONSTROUS? ON MARY SHELLEY'S FRANKENSTEIN

Speaker: Ron Britton
Quaker Meeting House, 40 Bull Street, Birmingham
Contact: 08444 631 341 or @wmip.org

7-8 June 2014

ON THE ROAD TO THE UNCONSCIOUS

Speakers: Ross Crowther-Green, Alexandra Pokorny, Gavin Farrell
Nuffield Orthopaedic Centre, Windmill Road, Headington, Oxford OX3
www.istdp.org.uk

8 June 2014

SHAKESPEARE ON THE SCREEN: THE TEMPEST

Speakers: David Bell, discussant tbc
ICA, The Mall, London SW1
www.beyondthecouch.org.uk

12-13 June 2014

A STRANGER IN MY OWN BODY: GENDER DYSPHORIA IN CHILDREN

Speakers: Peggy Cohen-Kettenis, Katrina Roen, Stephen Whittle, Alessandra Lemma, Riittakerttu Kaltiala-Heino
Tavistock, 120 Belsize Lane, London NW3
www.tavistockandportman.ac.uk/gids

14 June 2014

ART THERAPY AND ANALYSIS

Speaker: Frances O'Brien
SAP, 1 Daleham Gardens, NW3
publicevents@thesap.org.uk

14 June 2014

SOMATIC CONTERTRANSFERENCE AND THE SOMAPSYCHE, THE PSYCHOID AND THE PSYCHOLOGY OF THE TRANSFERENCE

Speaker: Richard Carvalho
Friends Meeting House, 91-93 Hartington Grove, Cambridge, CB1
publicevents@thesap.org.uk

21 June 2014

TRANSGENERATIONAL TRANSMISSION OF INDIGESTIBLE FACTS

Speaker: Alessandra Cavalli
Friends Meeting House, 43 St. Giles, Oxford, OX1
publicevents@thesap.org.uk

22 June 2014

SHAKESPEARE ON THE SCREEN: TWELFTH NIGHT

Speakers: David Bell, Michael Pennington
ICA, The Mall, London SW1
www.beyondthecouch.org.uk

JULY

6 July 2014

SHAKESPEARE ON THE SCREEN: RICHARD III

Speakers: David Bell, Margaret Rustin, Michael Rustin
ICA, The Mall, London SW1
www.beyondthecouch.org.uk

12 July 2014

DESTROYING THE NEED FOR LOVE IN PSYCHOTIC & PERVERSE STATES OF MIND

Speakers: David Morgan, Aleksandra Novakovic
70 Warren Street, London W1
http://tccr.ac.uk

Training

Getting it ‘right’

By Smita Rajput Kamble

Afterthoughts on completing a psychoanalytic training, with a comparison between Indian classical training and a psychoanalytic one

A LONG TIME AGO, during my psychodynamic counselling training at Rewley House, Oxford, a visiting lecturer suddenly exclaimed in the middle of her presentation (she was not English), about transference and countertransference, ‘Your training is only two or three or five years old; you have lived much longer than that and brought all that with you!’

Like any classical training, psychoanalytic training is long and arduous and renegotiates ‘all that you have brought with you’. Any training can be long and arduous but the psychoanalytic one becomes more so, maybe because it does not have the assured ‘pot of gold’ at the end, an assured job or income, and tests one’s limits of mental endurance like few other trainings can.

It reminds me of the other classical trainings where one has to spend more time to just set the first note right with no assurance of income, knowing well that you may perform to a small, critical and select audience while the rest go off and listen to something short and popular; a bit like the shorter approaches to therapy which lead to immediate gratification, what we call ‘flight into health’.

In Indian classical music, students undergo a tremendous amount of training to set the first note ‘*sa*’. This takes precedence over everything because if the first note is not right, the rest of the rendition will fall apart. It is a bit like the first position in Tai chi where you spend time trying to hold a space between your hands but cannot get the tension right. And like the psychoanalytic session, where if you don’t hold the tension and think before saying something, the session will fall apart.

Indian classical music has its origins traced to 1500–1000 BCE, in the sacred Hindu scripts called ‘*Vedas*’. The student lives at his chosen guru’s home and performs household duties, like cleaning and cooking, to learn the art form. To reach its highest accolade, which is to be considered a *Pundit* (for Hindus) or *Ustad* (for Muslims) in India, you must have practised for many years and shown what we call ‘*lagan*’ or devotion to your art form. The performer will prove how he has learned the classics – the ‘*raagas*’ – which manifests in a 45 to 60 minute performance, and possibly made his/her own improvisation as well as how or what he/she did to spread the art form in the world. Indian classical music or dance is not an assured source of income, and it is understood that its continuity depends on individual achievement and marketing which will inspire others to follow and therefore keep it alive.

These days, in an Indian post-modern world, students continue with normal school while they live at the guru’s house. Recently, a famous Indian vocal performer, who happened to be my guest before her performance in London, told me how she scolded her students when they got caught up in schoolwork and did not practice, with: ‘Do you forget to breathe? No? Then don’t forget to sing!’ How else can an art form, which does not bring income like other lucrative professions, survive without a bit of attitude from the guru? It is probably this kind of ‘native conditioning’ which has seen me through the various ‘attitudes’ of supervisors and therapists during my psychoanalytic training.

‘Psychoanalytic training is long and arduous and renegotiates “all that you have brought with you”.’

During a public performance, the Indian classical performer does not rush into his performance. The audience is treated to a pre-performance act where the artistes, while sitting in front of their audience, tune their instruments quietly or engage with each other sporadically, creating a mood, a concentration and tension which forms the preamble to the performance. These are just a few of the details of Indian classical art life.

Before coming to the UK, this is what I knew to be a good and ancient training. Being one of the few Indians born and brought up in India and training to be psychoanalytic here, I had my moments of complete disorientation and the dreaded feeling that I was ‘losing my culture’. This coincided with the fact that I had actually lost my physical environment completely and, at such times, trips to Southall help only marginally. In India, you can have the option of walking down a street where culture can waft out of windows and pervade your consciousness. You may be fortunate enough to live next to classical performers or have one in your family. I have been fortunate.

To reassure myself in my training years, I thought of drawing parallels from similar Indian traditions like Indian classical music. I compared increased frequency of sessions in therapy and supervision to living in a psychoanalytic ‘home’ made up of therapist, supervisors, training institute and training patients so that I could try to ‘internalise’ a tradition without too much resistance – breathe it, digest it, internalise it, till it was as natural as breathing itself – like the Indian singer expected her students to do.

It is only when the Indian performer has got his note right will he/she perform, and then there will be a thunderous applause and personal satisfaction. The waiting and tuning creates the tension needed to sink into something deeper, more unconscious and infinitely more satisfying. As a trainee, one loses one’s ‘notes’, including one’s beliefs, flails helplessly on the surface and cannot sink into a deeper connection. At such times, in my anxiety to perform, I have said things which were not personally satisfying and received a thunderous criticism from my supervisor, greeted in various ‘notes’ – from silence to censure and sarcasm, and then the rare compliment when I got it right again. How much more welcome it is then!

Now that my training is behind me, I find myself more quiet, less pressurised and less concerned with my client’s immediate demands. Like the audience members at a performance who come into the auditorium from various settings with things on their mind, clients come in from the outside world under tremendous pressure at times, but it is I, their therapist, who must tune into a psychoanalytic environment, sink into the inner world and set the mood ‘right’, either with my silence or my words.

Going back to the length of time it takes to establish the first note and the atmosphere for rendering it, I value this first moment and the setting up of the session more than anything that follows afterwards. Only in psychoanalytic therapy have I experienced that special moment when one anticipates one’s session and the therapist ushers you into this empty live space which is different from the outside world because it makes no social demands – you can be quiet if you want, not say ‘good morning’… whatever… It welcomes you to shut out the outside world and develop an inner meditative stillness, a little like the Indian performer who tunes himself in front of his audience and silently invites them to slow down and wait; or like Tai chi, where you learn to hold an imaginary space between your hands. It is a very special space and it takes a long training to hold it and get it right. And I think it would not be the same if there was an assured ‘pot of gold’ at the end ■

Smita Rajput Kamble is a psychoanalytic psychotherapist in private practice in Milton Keynes.