NewAssociations

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BRITISH PSYCHOANALYTIC COUNCIL

Whose problem is it anyway?

By Helen Morgan

RECENTLY I and a colleague were discussing the concerns she had about the work of a particular member of the clinical seminar group she runs for trainees. As we talked it emerged that this trainee was black and the rest of the group, including the seminar leader, were white. However, this difference had never been raised or discussed in any way. My colleague acknowledged that this may well be affecting the trainee, the group and herself, but noted that she was finding it impossible to open up the subject. In her mind she should treat everyone the same, which somehow meant not noticing where there was difference. The business of training concerned the internal world and racism was an external world phenomenon, wasn't it? It was as if pointing out the fact of difference would be rude. This contains the implication that to be black was some sort of handicap it was impolite to notice. Besides, the black trainee hadn't mentioned it, so perhaps it wasn't an issue for her. Perhaps she hadn't actually noticed herself…

As she talked about it further my colleague recognised that she felt at a loss; she feared that she would get it wrong, say the incorrect thing, and that something would be exposed. She was in the position of authority, the one who 'knew'. How could she admit her unknowing in this particular area? The unspoken difficulty the group was left with, however, was that difference and diversity could not be noticed as just another factor within the group to be thought and talked about in an ordinary way. The black trainee was left vulnerable to carrying projections of inadequacy and of failure for the other trainees as well as for the tutor.

This inability to own, explore and engage in ordinary conversations about our racism is, it seems to me, at the heart of why this profession remains so stubbornly white. I notice that in discussions with other white therapists who are also deeply troubled about this matter we seem to find it hard to stay with what *we* are doing and feeling. The blame gets laid at the door of other colleagues who form a vague, nameless, conservative group of 'others' who have a problem. Or we move to practicalities such as the suggestion that it's the cost of training that is prohibitive, which somehow manages to shift the problem onto 'them' and away from 'us'.

'Institutional racism seems to be clinging on tight.'

A while back I presented a paper on racism in supervision to a group, all members of which were white. The ensuing discussion took a familiar form where we seemed unable to open up an enquiry into our own experience, and the discussion was fragmented, defensive and superficial. Then a previously silent participant said she had been thinking about an incident that morning where she had pulled up at a junction and saw that at the wheel of the car next to her was a woman in full burqa. Into her mind came the thought: 'So they can drive, can they?' Was this, she wondered, how racism works? Subtly and quietly, 'us' and 'them', poles of superiority and inferiority infusing all relationships where there is difference. Then, for the liberal individual, the shame and anxiety that follows if the feeling is acknowledged and owned. For, she said, she hated the thought and wanted to be rid of it. At this point the atmosphere in the room shifted, dropping into something more thoughtful, more curious. Was it a racist thought? What does that mean? Where did it come from and how was it formed? What was its purpose and why the rush to deny it? At last we were thinking.

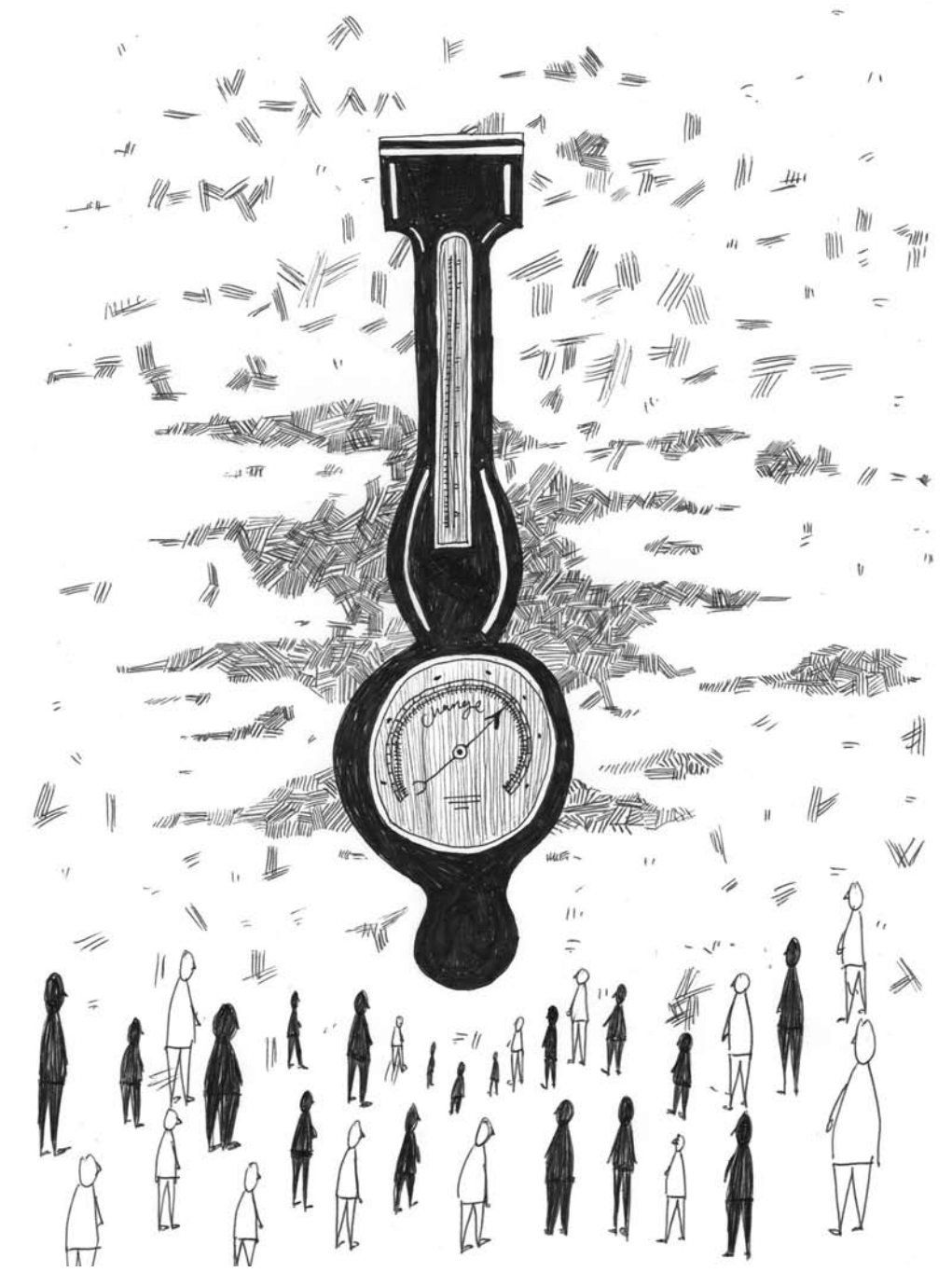
I don't know if there is a particular problem for our profession, but the institutional racism within it seems to be clinging on tight. Why are we so colour blind? What is this silence? Why such a lack of curiosity about the 'other' and about ourselves? Perhaps our division of the world into 'inner' and 'outer' is problematic – in which case an exploration of the psychology of racism might prove creatively challenging. Maybe we hold too tight to the myth of the 'good' analysis where such matters should have been 'sorted' long ago. Yet I wonder how often racist thoughts and feelings are discussed, or any racist structure within the psyche examined, when a white analyst and a white analysand are working together. It certainly didn't happen in my analysis.

I know of no other topic where the raw, primitive emotions of fear, anxiety, anger and blame can erupt so easily into a group, raising the temperature and paralysing minds. The authors who have written the articles that follow on the subject of racism within our profession have generously offered their accounts, however painful, that we may learn something of the experience of those from minority ethnic groups who try to engage with and join this profession. We need to be open and undefended to hear the pain of the experiences of those who have been on the receiving end of the hidden racism in ourselves and in our institutions, such as those described by Onel Brooks or Fakhry Davids, or as shown by the research described by Karen Ciclitira and Nena Foster. We also need, as Frank Lowe describes, safe places, thinking spaces, in which we can explore together. We need to wonder about our theory and technique; whether, as Agnes Bryan describes, it is too narrow and excluding of those from backgrounds other than white European.

And we need to consider how we might embed the complexities of difference within our trainings, such as that being developed in the Tavistock D59 course as described by Gail Lewis, rather than just adding on a few extra seminars on the subject.

This rethinking of how we see ourselves and others is essential if we are to become a profession that is inclusive and relevant for a twenty-first century world that is rich in cultural and ethnic diversity. In order to progress the work of such an exploration and to bring about real change the BPC is setting up a Task Group, and we invite anyone who wishes to contribute to the work of this group to contact either myself at helenmorgan@phonecoop.coop or Gary Fereday at gary@psychoanalytic-council.org ■

Helen Morgan is a Jungian Analyst and chair of the BPC Future Strategy Working Group and of the BPC Executive sub-committee responsible for the support and promotion of the profession. Her publications on this subject include 'Issues of "Race" in Psychoanalytic Psychotherapy: whose problem is it anyway?' in the BJP, *Vol 24, No 1. 2008.*



Editorial

The best of times, the worst of times

By Gary Fereday

I WAS REMINDED the other day of the famous line that opens the Charles Dickens novel, *A Tale of Two Cities*: 'It was the best of times, it was the worst of times.' I often think that that this line could also be used to describe the state of psychological therapies in Britain today.

It is the 'best of times', as the Government has increased investment into NHS psychological services, new staff have been trained, and over a million people are claimed to have received some form of treatment through the IAPT programme. We have had a number of high profile politicians and celebrities coming out and publicly speaking about their depression and emotional distress, and how psychotherapy helped them. In private practice, we have registrants in some parts of the country telling us that demand has never been greater, and training institutions telling us that interest at open days has never been higher.

But the 'worst of times'? Well, whilst CBT has enjoyed real growth in the public sector, psychoanalytically informed services are coming under serious pressure. The focus on a manualised CBT approach with its emphasis on 'cure', whilst bringing real improvement to some people, has left many others in psychological distress. It's really not clear what is going to happen when those in serious difficulties, those chronic and disturbed patients, the personality disordered and the perverse, fail to be 'cured'. It's this emphasis on the short term that underlies the challenge that faces psychoanalytic psychotherapy. In private practice there is a concentration of psychoanalytic psychotherapists in London and the south east, with some registrants telling us that maintaining a full time practice is difficult. Trainees meanwhile are telling us of the difficulties of finding suitable training patients.

We need to articulate better what we do, be clear about the evidence base for our work, and articulate the unique contribution that psychoanalytic work brings, and, crucially, how we can support and work with other modalities and professions. We must ensure we are relevant to, and reflect, the contemporary multi-cultural society we live in. Our profession had a reputation as being a bit elitist, somewhat separate from the coal face, with psychoanalysis revered as the pinnacle and everything else being a slightly inferior psychological intervention. Thankfully that's changing, and the BPC is increasingly working with other organisations and accrediting a wider range of trainings that includes psychodynamic and couple work.

BPC registrants and trainees will have recently received emails about a number of significant developments in the organisation. They include increased lay involvement in our work and the creation of a series of Task Groups that will consider the key challenges we must address. Registrants and trainees are urged to think how they can contribute to this important work, whether by becoming a member of a group or responding to calls for information or commenting on the work. Crucially the groups will be task focused, time limited, and charged with delivering tangible outputs. The profession has no time left for meandering discussions masquerading as psychoanalytic reflection!

We need to engage with others around us; colleagues working in different modalities, in psychology and in psychiatry. We need to articulate how psychoanalytic work can be better integrated into NHS services, how it can support other front line staff and other public services, and raise awareness in the wider public as to how psychoanalytic psychotherapy could help them. We need to find better ways of presenting the evidence base and work to widen the recognition of psychotherapy in NICE guidance.

We need also to reflect on our own shortcomings as a profession. Why are we so white, middle class, and so often based in London? How are we dealing with the legacy of historical psychoanalytic views of homosexuality? These are all tough issues that we need to honestly debate. This edition of *New Associations* focuses on one of them: that of race and ethnic diversity in the profession. The articles are unashamedly challenging as they were commissioned to generate that debate.

Finally, to return to Charles Dickens' *A Tale of Two Cities*: those familiar with the novel will know it depicts the plight of the French peasantry demoralised by the aristocracy in the years leading up to the French revolution, and then the corresponding brutality demonstrated by the revolutionaries toward the former aristocrats in the early years of the revolution.

Sadly such rivalries may sound a familiar tale to anyone in our profession. In debating our future we must avoid the situation where different psychological therapies battle against each other. We must avoid a debate that unnecessarily sets cognitive and other modalities against psychoanalytic ones, and we need to avoid sterile debates about the hierarchy, the frequency, and whether psychodynamic is as good as psychoanalytic; all those old debates that our profession has been so fond of. So whether you regard yourself as a peasant or an aristocrat, please get involved ■

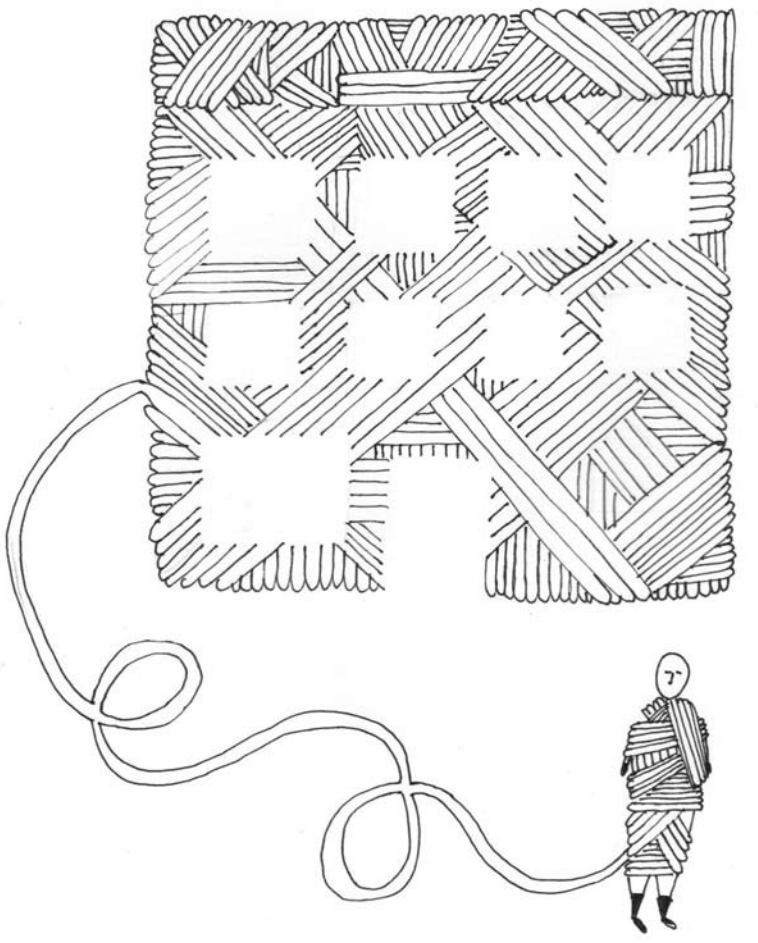
Gary Fereday is the BPC's chief executive. Details of the task groups are available at www.psychoanalytic-council.org/task-groups

Race and Ethnicity

‘Why so white?’

By M. Fakhry Davids

M. Fakhry Davids asks why, while the ethnic complexion of the professions around us has changed over the last thirty years, the psychoanalytic profession remains overwhelmingly and stubbornly white.



A PATIENT ARRIVED deeply distressed. It was Monday, and she had just come from a meeting at a psychoanalytic institution, where she was the second to arrive. The first, a black[1] man, was already seated at the end of the front row and she decided to sit down in the middle of the second, behind him. A central aisle divided the room, and three white colleagues who arrived next sat down on the other side of the aisle; an Asian woman arrived and took a seat at the end of the row behind my patient. The first three rows on their side of the room now each had a minority group member in it.

Just before the meeting began my patient noticed that every seat had been taken except those immediately next to the three minority group members. At the most basic level, she felt, one might make an observation that the white members seem to stick together and avoid blacks – a possible manifestation, to the man-in-the-street, of an unconsciously racist attitude towards them. She herself was British-born of a minority background, and had studied at three UK universities. There she found that such occurrences were noticed and spoken of. Here, however, no one seemed to notice and not a word was spoken; there was a collective silence. Why should a profession, whose very mission lay in bringing into the open what is ordinarily hidden, steadfastly refuse to notice what was, in one way, so obvious?

My patient was an intelligent and gifted professional woman who was considering a BPC training. It was on an introductory course that she first noticed how prone our profession is to turning a blind eye to race. Elsewhere, though it might be awkward, people noticed – and it made a difference. They tried harder, for instance by making a conscious effort to get to know black colleagues, to walk to the tube with you, to strike up a conversation whilst waiting for a lecture to begin, etc. Why is it so different here? Why is this profession so *white*? Why so blind to how blacks might feel? Is it because it has so few black members, or is this why it has so few?

As her analyst I worked with the deeper personal resonances behind her pain at being shunned. However, the incident decided her against training. Interested as she was in the psychoanalytic approach, she knew the territory of unacknowledged unconscious racism well and was sure that, whether taken up or ignored by others, black members could not turn a blind eye to it. Yet, to get involved would be intensely painful and difficult. As a young student, she opened all of this up and came to see how others recruit one into their hidden racism, and what an enormous effort it took to disentangle from this one’s own involvement in it. The incident (it was not the only one) made it clear that she could not get the training she wanted without this pain being stirred up all over again. She was older now and no longer had the stomach to revisit this – why should she open up her personal pain to help a profession unaware of its own racism to recognise it and become less so? I felt acutely the loss of what would have been a very able member of our profession.

The defensiveness of our profession on matters racial, which my patient speaks of, came home to me when I addressed a group of black colleagues. Over the years I have often spoken to colleagues on the psychology of racism, but I was surprised at how different the atmosphere of this meeting was. I realised it felt somehow easy, and when I reflected on this I saw that my audience simply knew, from their experience of racism, what I was talking about. This allowed them to engage with the model of internal racism – my attempt to account for it – in a lively and spontaneous way. Usually I have to demonstrate that the phenomenon of racism exists in the mind, and then I am accustomed to a discussion that has powerful intellectual strands – unusual for practising clinicians – or else is all over the place. It was the contrast with the reaction of the black audience that made me aware of this – as if, in describing a rainbow, I had been outlining the theory of refraction to explain how a shaft of simple white light turns into a multi-coloured wonder, only to discover that my listener is completely colour blind. This helped me to consider my usual, largely white, audience’s reaction as defences (intellectualisation and fragmentation) against the very idea that racism exists in the mind, the proposition that, at a conscious level, was being taken so seriously. It highlights a degree of defensiveness about race in our profession – a collective blind spot – that I had come to take for granted, unconsciously, and accommodated myself to.

‘The price we pay is an outlook that unconsciously takes white as normative and marginalises the experience of other groups.’

Let me give a further illustration of our collective insensitivity to race. A trainee described an infant observation seminar. The family – black – described a visit to the zoo where the monkeys were singled out as cute and cuddly. The observer – white – said to the mother that the baby was her cute little monkey, a comment that was received in the spirit intended. The seminar discussed the mother’s sense of her baby as properly and securely attached, and her wish that he should grow into a healthy, smart, agile, and playful child, perhaps also cheeky and mischievous, all of which the observer was felt to be in tune with. The trainee, on the other hand, became increasingly distressed since, at this time, the racist abuse of black football players as monkeys – bananas were thrown onto football pitches etc. – and a growing anti-racist campaign against it were prominent in the news. How could her colleagues and the seminar leader not be aware of these connotations? How could they not at least consider that, however it is intended, a white observer calling a black baby a monkey might be seen as racial stereotyping, albeit unwitting? It was the complete absence of awareness of such considerations – for instance, might the mother fear that her child was being raised to be a prisoner of societal racism, like an animal in a zoo, never truly free, and that she was unable to protect him against these forces? – that she, the trainee, found so distressing. Like my patient, she felt that the burden of raising these racialised meanings was left to her, the only black person there, and when she did not do so they were passed over. Important as she felt these meanings were, however, she could not bring herself to draw attention to herself as black, which these comments would have done – she wanted to be there as an ordinary trainee. Like my patient, she felt that in other settings in Britain today such connotations would be recognised more readily. Why, then, the psychoanalytic profession’s collective blindness to them? Is the psychoanalytic community more racist than others?

I myself do not think so, yet it is undeniable that while the ethnic complexion of the professions around us has changed remarkably over the last thirty years or so, ours remains overwhelmingly and stubbornly white. The two examples I gave from black professionals suggest that the price we pay for this is an outlook that unconsciously takes white as normative

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Why so white?

Continued from previous page

and marginalises the orientation and experience of other groups, a form of ethnocentrism that most other disciplines have long since moved away from. We seem not even to get out of the starting blocks. Why is it so difficult for us?

One difficulty lies at the organisational level, where ways open to others to address institutional racism are not as readily available to us. Remedial action would recognise the political reality that Britain, particularly in its cities, is now multi-ethnic and we cannot any longer assume that everyone is the same – like us – and that colour doesn't matter. Action of this sort, however, would be seen as politically correct, and our profession does not do pc. Political correctness can be a ready social defence covering up true attitudes and feelings that pull in the opposite direction. Our way is to look deeper in order to illuminate the usually complex underlying dynamics from which the impulse to put things right springs. By getting to the heart of the matter we hope to minimise the risk of internal ambivalences, of which we may be unaware, undermining our interventions in the outside world.

Deeper engagement, however, requires a body of psychoanalytic thinking in the background to help us along, much as the psychoanalytic approach to feminism relied on a critical engagement with the theory of the Oedipus complex. However, the topic of race is largely invisible in psychoanalytic discourse.

'The topic of race is largely invisible in psychoanalytic discourse.'

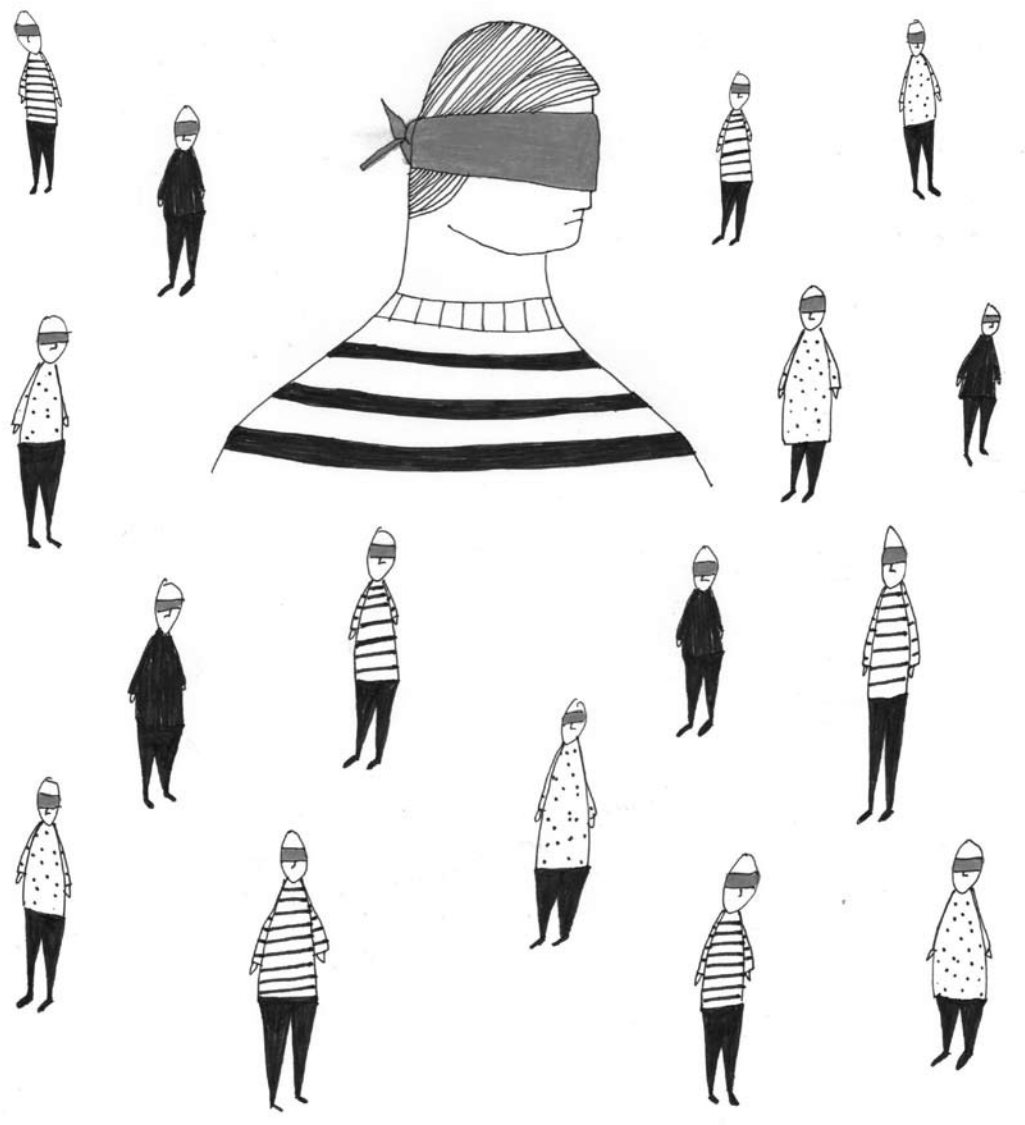
Clinically, we respond to this lack by doing what I did with my patient – we stay with what we know. On that Monday she became aware of very powerful feelings stirred up by being shunned, which she felt in relation to her white colleagues at the meeting. Based on the progress of the analysis, however, I thought she was beginning to make emotional contact with a rejecting internal object, and made a judgment that this work – on a key issue in the treatment – would best be taken forward by locating it between us rather than at the meeting. My decision was based on the clinician's imperative – a judgment of what would promote the deepest engagement possible with the patient's pathology. This is our clinical responsibility. Though I was on task, I had nonetheless changed the focus from her experience of racism to the more familiar theme of separation and rejection.

An unwarranted theoretical inference is then drawn from clinical accounts such as this. In a clinical seminar it would almost certainly be assumed that I chose to prioritise separation over my patient's context-specific experience of racism because the former is a universal and deeper psychic theme – our literature is full of it. A more correct theoretical perspective – that both are surface manifestations of deeply unconscious issues that can only be accessed via derivatives – slips out of view. From the former perspective, the fact that my intervention succeeded in moving the analysis on would confirm that a deeper vein had indeed been touched. In fact, this is incorrect as it confirms only that I made the right strategic call at that moment – a matter of technique. At other times, a focus on race (in the transference) turned out to deepen this patient's analytic engagement. However, the slippage between the clinical and the theoretical contributes to race being seen as more superficial and, in a discipline valuing depth, marginalised. This view is then applied in non-clinical settings.

In non-clinical settings the task is different from the clinical one. Although it draws on psychoanalytic theory, good teaching also requires an awareness of who the learner is; good observation relies on bringing in the meaning context in which we observe. My vignettes demonstrate tellingly how hampered we are when that background includes a black or minority ethnic presence. Unconscious resonances seem quite simply unavailable – free associations do not appear – as if the part of the mind from which these might spring is blocked. Moreover, given that we are a profession familiar with the processes that keep things out of conscious awareness, why are we so singularly unaware of even the fact that we may have this blind spot? It is no secret, after all, that racist strands or tensions attend multi-cultural living in the outside world.

The lack of visibility of race in psychoanalytic thinking contributes to the absence of tools with which we might approach the above experiences. We are empty handed. However, the need to keep channels to the unconscious open in our work means that we cannot avoid awareness of this as readily as others might. To prevent this a further assumption creeps in – that beneath the skin, deep in the unconscious, we are all the same. Themes we are familiar with (dependency, sex, aggression etc.) are now taken as the norm, and being 'in touch' with these deep inner issues comes to be seen as desirable. Hence the focus, in the observation seminar, on aspects of the attachment between mother and baby, to the exclusion of the very relevant themes the trainee highlights. If she were to insist that these be considered as central in the emotional reality of the mother, however, this would be seen as a personal preoccupation with race – her problem, as a black person, that has not been resolved and thus stands in the way of her being able to access the true psychic reality that resides in the depths. It would be seen, patronisingly, as a manifestation of her psychopathology. It is this outcome that her silence resisted.

And so, we remain a largely white profession with the odd splash of colour, a pleasing touch of the exotic. But the exotic, by its very definition, exists in the margins and cannot ever be mainstream…■



Fakhry Davids is a training analyst of the British Psychoanalytical Society and member of the Tavistock Society of Psychotherapists, in full-time practice in London. His book, Internal Racism: A Psychoanalytic Approach to Race and Difference, *was published by Palgrave Macmillan in 2011.*

Notes

1. I am using this term generically to refer to those from BME (black and minority ethnic) groupings within the white majority culture in contemporary Britain.

Race and Ethnicity

Diversity: a helpful first step

By Karen Ciclitira and Nena Foster

A study last year considered how issues of diversity were dealt with in the BAP, a training institution where minority ethnic trainees were in a significant minority. This is a summary of their findings.

IN 2005 a Diversity and Equity Committee was set up at the British Association of Psychotherapy by Helen Morgan and Andrew Cooper. Members agreed that the BAP, as a professional training body, needed to address the issue of working with diverse patient groups to ensure that it was operating within the framework of equal opportunities legislation; and to become a more inclusive organisation, capable of treating and recruiting individuals from diverse social, cultural, educational, and ethnic backgrounds. This initiative involved running clinical and theoretical seminars addressing diversity, as well as carrying out a research project to explore issues of racism and diversity.

Karen Ciclitira, a BAP member and academic, led the research project with the assistance of Nena Foster and members of the research committee. This research aimed to consider how issues of diversity were dealt with in the BAP, a psychoanalytic psychotherapy training institution where minority ethnic trainees were in a significant minority, with a view to informing institutional practices and guidelines. This article briefly describes this research; the complete interview study has been published in greater detail in Ciclitira, K. & Foster, N. (2012), 'Attention to culture and diversity in psychoanalytic clinical trainings', *British Journal of Psychotherapy*, 28: 3, 353-373.

Research Project

The BAP membership (520) were sent open-ended questionnaires. Interviewees were recruited via the questionnaire and from purposive sampling from the three main sections of the BAP: the Child and Adolescent, the Jungian, and the Psychoanalytic Sections. Due to resource constraints, priority was given to interviewing minority ethnic members. 24 BAP members were interviewed: 21 women and three men.

The interviews were audio-recorded and transcribed verbatim. Participants were asked to self-report their ethnicity. 17 participants identified themselves as coming from an ethnic minority, and five participants reported themselves to be 'white'. Identifying details were removed from the transcripts and participants were given pseudonyms. The interviews focused on issues of difference, including ethnicity, social class, religion, gender and sexual orientation, and explored participants' experiences of their clinical training and their views about the institution. Participants were asked how they felt their ethnicity had impacted on their training, and were invited to give suggestions as to how the organisation could become more ethnically diversified.

Findings

Participants reported what could be considered as 'microagressions'; while these do not constitute overt racism, they make recipients uncomfortable (Constantine & Sue, 2007; Sue, 2003). Ina described this as follows:

> I have a British passport, but you don't forget you are a foreigner. People used to ask me: 'When are you going back?'… There are constant reminders that you're not really from here. It does not necessarily mean that you shouldn't be here, but a question of what are you doing here? And when I applied for the training I was asked if I would understand the patients, and as a mother how would I manage if the children got ill.

Participants were asked to discuss their experiences of their clinical seminars, theoretical seminars and infant observation. While the clinical seminars were enjoyed for their content, structure and interactive nature, it was noted that in clinical and theoretical seminars the opportunity for addressing issues of diversity was seldom taken.

Participants noted that the focus on the 'internal world' and the difficulty of incorporating the 'external world' into theory and discussion often made it hard for trainees to discuss certain experiences. Reshma commented that the dominance of the 'internal world' served as a barrier to discussing trainees' experiences of diversity issues:

> My impression was that the 'internal world' and the prevailing theories about it prevailed over everything really. For example, you'd go to a baby obs group, and it would be interpreted in terms of a theory that often got more and more bizarrely removed from what one felt was going on in the room.

'There are constant reminders that you're not really from here.'

Participants discussed their experiences of training analysis. This private space allows some the opportunity to explore their own identity and helps prepare them to work with diverse patient groups. However, there is a shortage of minority training analysts and an acknowledgement that some white training analysts may not be capable of dealing with social issues like prejudice and racism. Assumptions about diversity are not only a product of personal history, but also of social history and rooted in shared experiences. Barbara's analytic experience with a white analyst, although challenging, was positive:

> I remember once being *really* upset by something somebody said to me that was based on my colour… it was then difficult to go and just lie on a couch with a white analyst… I was carrying all this anger inside of me… what makes it difficult sometimes for the black trainee is how much do you think you can be yourself. At the end of the day do you have a good enough experience of the analysis if you feel that sometimes you have to hide behind something? If she, somehow, couldn't grapple with that I think then I just would not have continued with any confidence, because she would've been excluding a big part of me that was in tatters.

Conclusions

The research findings from the interview study highlighted a variety of areas to be addressed. Participants reported feeling insufficiently well equipped to work with diverse patient groups until post-training employment. Participants pointed to tensions that needed to be addressed for the organisation to move forward, diversify its training, and educate its trainees, trainers, and training therapists/analysts. These included the importance of recognising that the experience of being a minority trainee can be particularly challenging and isolating. Minority ethnic participants often reported feeling 'othered' or excluded during their training.

The research highlighted that issues of diversity such as gender, class, sexuality, disability and ethnicity should all be considered throughout the training. Psychoanalytic trainings will also need to address theoretical positions regarding the dominance of the 'internal world'. Existing resources need to be included in trainings (e.g. Auchinloss & Vaughan, 2001; Flower, 2007; Lynch, 2002; Dalal, 2002, 2008; Davids, 2003, 2006, 2011; Morgan, 2002).

Psychoanalytic trainings will need to reconsider their position on homosexuality so as to inform practices regarding homosexual trainees and enhance all trainees' preparedness to work with lesbian, gay, bisexual and transgendered patients. Action is needed to address the high cost of training to attract trainees from a wider class base. The time-consuming nature of the training also needs to be addressed, and the lack of job prospects for therapists: participants suggested that courses should also be targeted to current job opportunities, e.g. short-term work, once a week work, and cognitive analytic therapy. Diversity issues must be addressed to encourage new and prospective applicants to train; but there is also an ethical dilemma in attracting trainees to an expensive course with limited job prospects.

This research was seen as a helpful first step towards understanding some of the issues involved. The BAP members involved in various initiatives to address racism and issues of diversity are aware that they are well overdue, and are keen that they inform training in the newly formed British Psychotherapy Foundation.

Acknowledgements

We would like to thank all our research participants, the BAP administrative staff and the members of the research group who carried out interviews or supported this project in other ways ■

Karen Ciclitira, PhD CPsychol, is a psychoanalytic psychotherapist and a Principal Lecturer in Psychology at Middlesex University. Her research interests include racism, gender, psychoanalysis, sexuality, health, feminist research and discourse analysis.

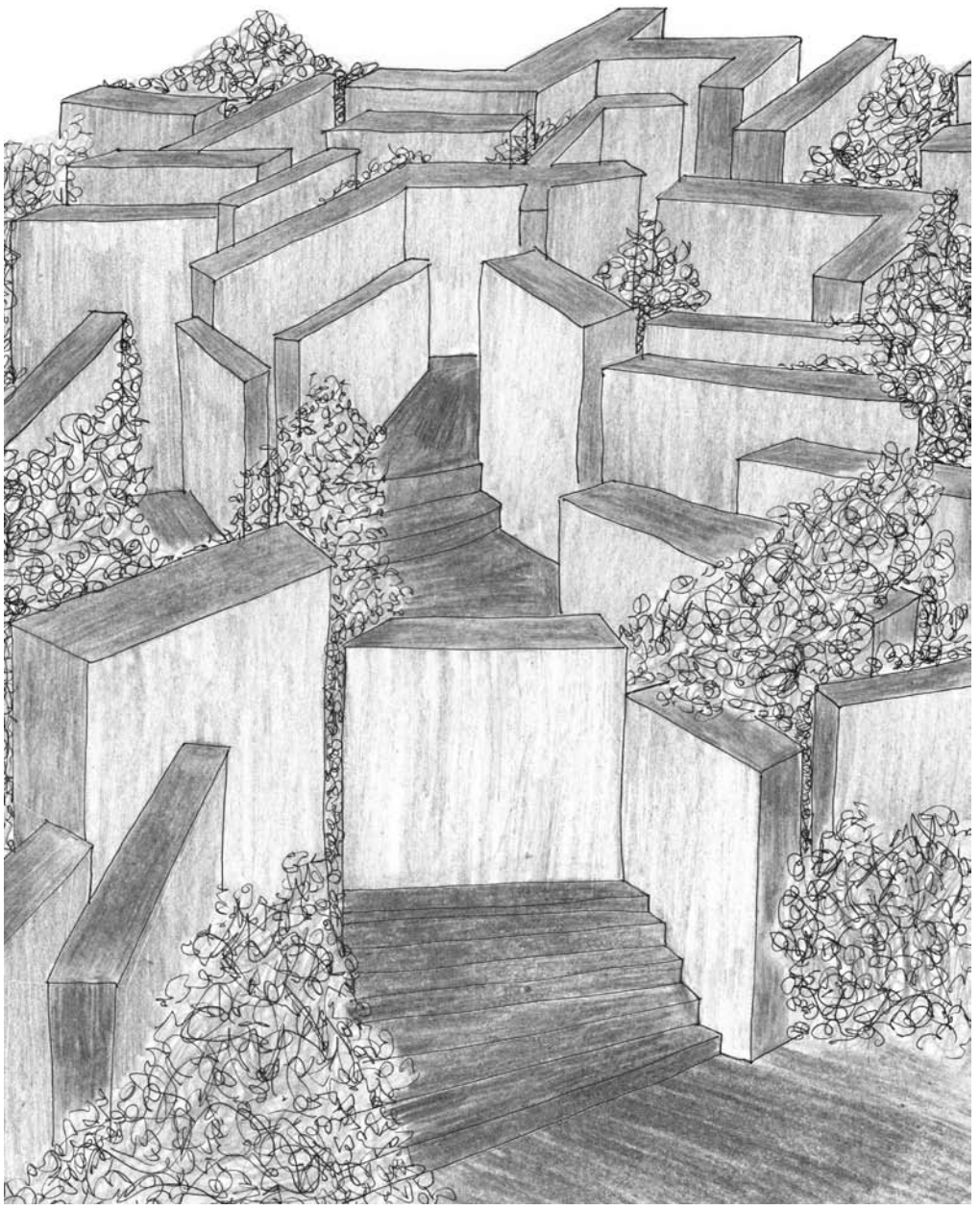
Nena Foster PhD is a Senior Lecturer in Public Health at the University of East London. Her research interests include diversity and culture.

Race and Ethnicity

Bending over backwards

By Onel Brooks

Onel Brooks relates a black practitioner's experience of applying to train in orthodox psychoanalysis.



IN SPITE OF warnings about their being 'out of touch,' 'up themselves' and 'probably racist', I applied to train at A and B, after being told they were the most 'rigorous' and 'thorough' psychoanalytic trainings.

A friend gave me N's number. N is not white. He trained at B. On hearing that I am a black man applying to train at B, N began to laugh loudly. I asked, 'Well if not B, then, where? A?' The loud laughter became louder. I said over his laughter, 'Well if not B or A then, where? Where would you advise me to try?' The laughter instantly ceased. The voice sounded suddenly sober, grave, without any trace of hesitation or doubt: 'Nowhere!'

Can a person want a clearer warning?

Initial Meetings

Interviewer Y from organisation A remarked that I had translated the 'vibrancy and colour' of my early years in Jamaica 'into Englishman', and claimed to know this because, being Irish, his experience is similar to mine.

I protested. Not everyone from Jamaica is 'colourful and vibrant'. I am like my grandfather in character, a man who had never left Jamaica and who referred to himself as an 'old African'. A gentle, quiet man, slow to anger, who claimed that loud, aggressive people vexed his spirit. My interviewer seemed to be too knowing about me and being Jamaican.

At B, they were particularly interested in my anger. I did not realise that for some, being black means that I am angry and hostile to white people; I did not know then that this was the beginning of something which would result in my being angry. I did not see then how the actions of A and B would contribute to making this stereotype of the 'inner world' of a black person more true of me: that they would help to make the world more like they insist it is, and take this as evidence of being right.

Organisation A told me to begin a full analysis, and return to be interviewed in not less than eighteen months. I soon found that saying that I began a full analysis because I wanted to train as a psychoanalytic practitioner tended to be viewed as evidence that I wanted to deny my need to be in a full analysis, and if I could not accept that I needed to be in a full analysis then this lack of self-awareness would of course cast doubt on my ability to become a psychoanalytic practitioner; therefore, I would obviously need more time in analysis to appreciate my need to be in analysis.

After five years and seven interviews, I received a letter from A saying they would not take me.

A

An interviewer from A, X, asked if my girlfriend was black or white. He then remarked, 'Oh, so you like *white* women?' Afterwards I verified that he is South African. I wondered how it came about that one of the few black applicants to A gets a white South African male who makes such a comment to him.

Apparently, I failed the 'Oh, so you like *white* women' interview by not getting angry with him 'in just the right way.' Simply stating that some girlfriends have been black, some have been white is not to respond to his obvious provocation. It is worth asking whether a black male who reacted to every provocation related to race would ever have made it through the education system in Britain or through adolescence without serious problems, and whether a tendency to fight at every slight would make it more likely that such a person would be imprisoned, 'mad' or dead.

In my third meeting with X, he invited *me* to tell him my thoughts about why I was not accepted, batting away each of my suggestions. When I referred to race and class, he looked surprised and hurt. He told me that A is a group of 'liberal and progressive' people, and if there is any bias at A, it would be a matter of it 'bending over backwards to let people from ethnic minorities in.' I remarked, '*So*, I wonder where this leaves *me*?' Had he not told me that, even bending over backwards and desperate as they are for ethnic minority trainees, who are not really up to scratch anyway, they could not take me? 'That's not quite what I mean,' he said.

'I did not realise that for some, being black means that I am angry and hostile to white people.'

A practitioner from A, laughing heartily when he heard this, claimed that they are so convinced that they are so liberal and progressive, and that they must therefore be naturally bending over backwards to let ethnic minorities in, that they consciously compensate and bend over as far forward as possible when it comes to admitting people who are not white.

I had begun my second interview with X by speaking about the double bind I was in: to talk about race may result in defensiveness in my interviewer, not to talk about race may lead to questions about whether I can talk about it. I am damned if I do, and damned if I don't. X said, 'Oh, but we talked about race last time.' He was right; we had spoken a little about it in our first interview. I was surprised, therefore, when X said during this third meeting, after apparently claiming that race had nothing to do with anything, that of course the committee discussed race when they discussed me (following his second interview with me) and they wanted to know if I could work with white patients as well as black patients. The committee wanted to know more about race and me; they felt that they did not really know enough.

I reminded him that I have lived in this country since I was seven. I went to school here. I went to university here. I did my social work training here. I was at the time working as a university counsellor. Most of the people I have worked with have been white. Why, I asked, was this even a question? Do they ask white candidates if they can work with black people? He insisted that they did. Having spoken to many white psychotherapists about their interviews, I did not believe him. We argued.

He revealed, eventually, that he had been unwell around the time of our second interview, and had almost cancelled it; this is why he had not explored race with me more, as he should have done. I wanted here to remind him that *I* had raised the issue in both my first and second interview with him and *he* had dismissed it in the second interview. I wanted to ask why, if he had been unwell and not spoken to me about something because of this, had he not simply contacted me to speak some more about this or re-interviewed me, rather than give me at least another year to

wait. Why do they think it all right to keep people hanging around for years? However, what I heard myself saying is that at least there is some evidence that I am in touch with reality; I explained that, after that second interview with him, I had said to my analyst that he, X, looked unwell, but she had interpreted this as my hostility towards him damaging him in my mind, and my therefore experiencing him as damaged in reality…

X advised me to reapply. I could not see why I would reapply for more of this treatment. Note, though, that A can of course cite this as another example of being unable to get suitable black applicants. They advised me to reapply; I did not. They can cling to the story that there is nothing amiss, all is well: they bent over backwards again, and it is the applicant's fault for not reapplying, as he was advised to.

B

I was the only African Caribbean in my year at B and the only man. I did not see another African Caribbean or African trainee in any of the years on any of the courses. My presence at B seemed to be disturbing. From what I understand, I was the only person in my year sent to a psychiatrist before being accepted. Seminar leaders made many references to the fact that I have a PhD. I was even asked if my having two PhDs was the reason I thought I had to know everything. References were made to my being a man. There were few references to my being black.

I was unprepared for the sense of violation I experienced at B. Chaotic, authoritarian, patronising and defensive, it blamed its trainees for its chaos, treated them like infants, and like many frightened people and organisations, it kept a close eye on any apparent failure to comply, interpreting them as pathology and attack.

Other trainees and practitioners trained at B, sharing my perceptions, advised me to toe the line, keep my head down, learn whom to avoid. For the system can only be changed from the inside. After you qualify you can say something, get into a powerful position and change things. I was convinced, however, that whilst you are in the system waiting to change it from the inside, it is slowly changing you from the inside. You become a part of it.

At B, keeping your head down and making yourself inconspicuous might be easy for a white woman or even for a white man, to some extent. It is a little harder for the only black man in an organisation that consists almost exclusively of middle and upper-middle class white women.

What does the black man in the group do? Does he join in the smiles and laughter when tutors say, as they did repeatedly, that the only way to do the course is to have a rich husband? (Who or what is being laughed at in this situation? Is it the husbands? Those who do not have wealthy husbands? Me? Or is it amusing that what is presented as a thorough training, has a lot to do with money and fitting in?) How do I render myself inconspicuous in this situation? Is their joke as funny as the one about a black man trying to make himself inconspicuous in a group that consists almost exclusively of white women who are joking about having rich husbands? Sitting there quietly with black skin making sperm without permission and not joining in is asking for trouble.

'I learned eventually that I was regarded as a problem.'

I was repeatedly told that I was too quiet *and* that I needed to learn to shut up! I was shouted down in a seminar by the seminar leader: loudly and repeatedly she insisted that I needed to learn to shut up. I eventually gave up trying to speak to her. The other trainees kept their heads down. At the end of the seminar, she commented on the fact that I had not said anything. The women had been talking and left no space for me, she remarked. (This turns my being silenced into my issue and a gender issue too – convenient given that everyone teaching on the course was female – rather than hers or the organisation's issue, and separates my silence from her silencing me. This is training in how to fail to think about our effect on others and to insist on attributing their behaviour to their 'internal world'.)

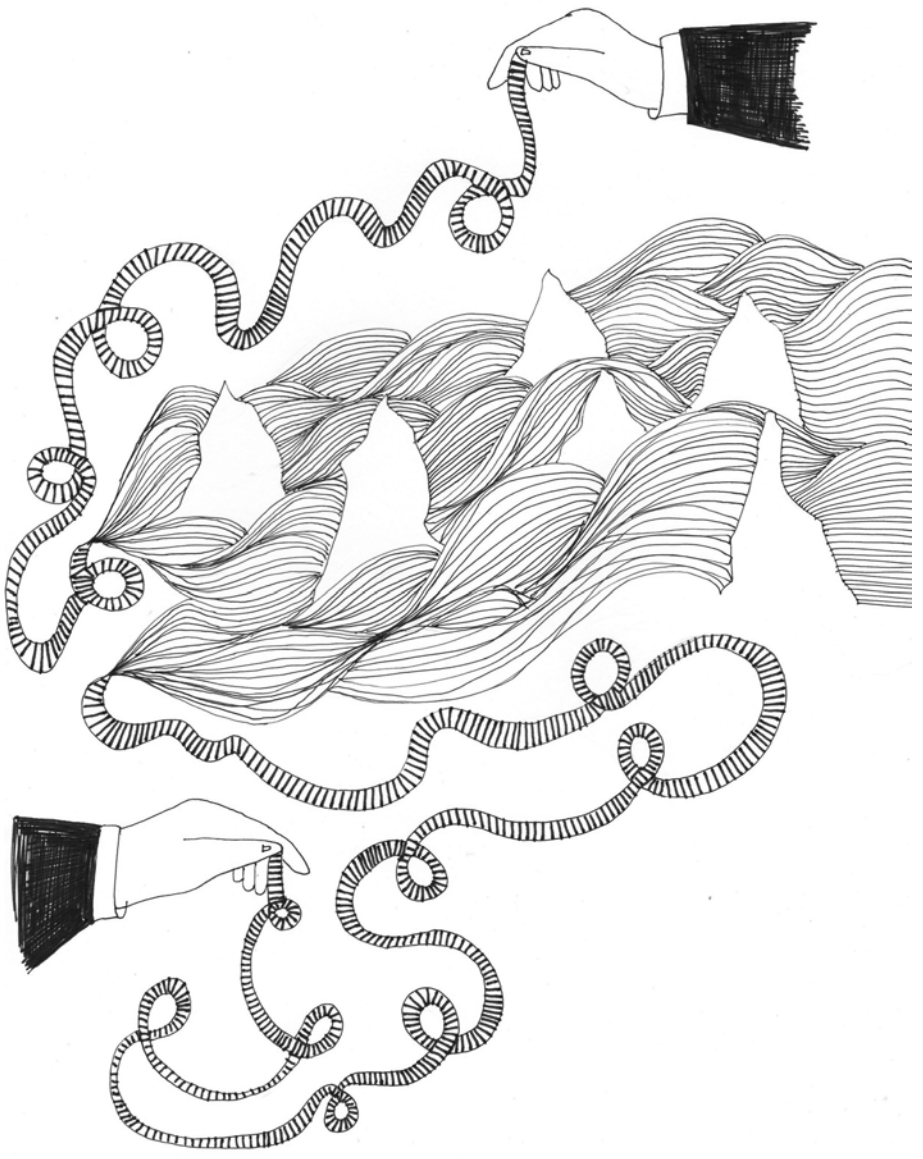
I learned eventually that I was regarded as a problem from when they saw my application form. I had made interpretations about my life, 'although you had not been asked to.' They interpreted this as my wanting to stop them from making interpretations. Does it follow that if I make an interpretation about myself, this stops anyone else from doing so? It did not stop B! Convinced beforehand that there must be a problem, B set about looking for one, thereby helping to create one, and then congratulated themselves on their insight. Black, male with a PhD might have been too much difference for B, when being the same as and fitting in seemed to be compulsory. Over seven years after starting a full analysis, I admitted defeat and left B and my analysis.

A and B can continue talking about how they bend over backwards to let ethnic minorities in; it is more accurate to say that, consciously or unconsciously or unwittingly, they tend to bend the ethnic minority person backwards to see if he breaks.

Conclusion

I am not suggesting that race is the only issue. Many people on psychoanalytic trainings experience violations, double binds and self-fulfilling prophecies, lack of civility, disregard for their feelings, knowingness, casual abusiveness, invidious assumptions and distinctions. A and B were said to provide a 'thorough' and 'rigorous' training. I now say doctrinaire, dogmatic, evangelical, frightened of questioning, and using psychoanalysis to support common prejudices. This profession is proud of its ability to think. Often it does not think; race is one of the areas in which this is evident ■

Dr Onel Brooks completed a doctorate in philosophy before working in the field of psychotherapy, training as a social worker and applying to two psychoanalytic trainings. He is a UKCP registered psychoanalytic psychotherapist in independent practice and a Senior Lecturer in Psychotherapy, Counselling and Counselling Psychology at Roehampton University, where he contributes to the Research Centre for Therapeutic Education in the Psychology Department. He is a member of the Philadelphia Association and contributes to the training there.



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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

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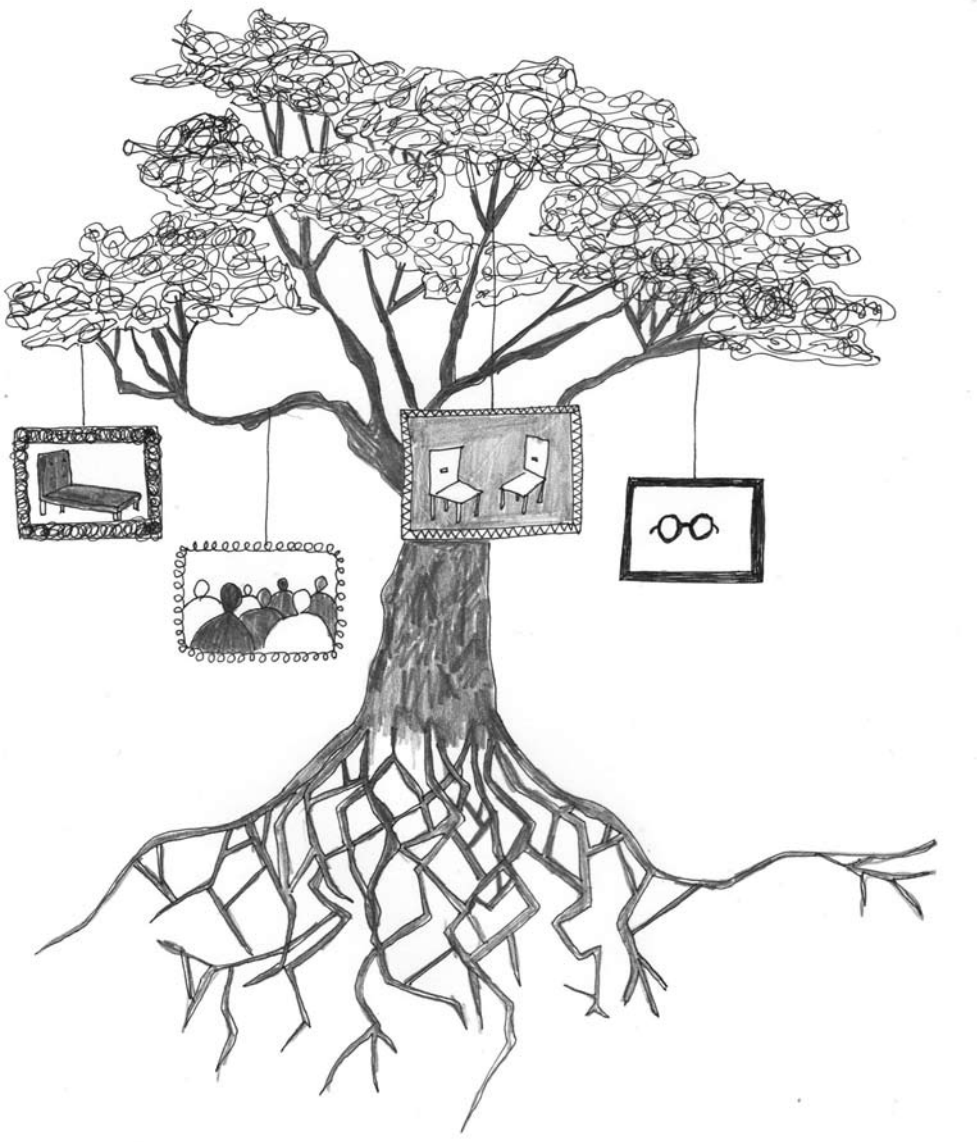
Race and Ethnicity

African psychology: another frame of reference



By Agnes Bryan

Agnes Byran argues for a radical approach in psychoanalytic therapy that has appeal for all cultures, and a shift toward clinical applicability rather than theoretical appropriateness.

MANY OF the intrinsic values of psychotherapy emanating from a western psychological tradition such as psychoanalytic psychotherapy can be used by people of African descent to enhance their personal wholeness, their relationships with others, and their ability to contribute their talents and skills to their communities and wider society.

However, there have been several concerns expressed by practitioners from African and black communities about western psychoanalytic/dynamic therapies. They feel alienated by an approach where the central focus is on the isolated individual and his or her needs, and which does not sufficiently consider the patient's attachment to, and sustenance received from, their cultural groups or communities.

The socio-cultural and socio-political context of patients, especially non-western patients such as people of African descent, is not addressed in much of the psychoanalytic literature or in teaching psychotherapy. A consequence of this is that psychoanalytic psychotherapy, along with other models of mental health treatment, may be experienced as yet another expression of racism by the white establishment which labels/mislabels and diagnoses/misdiagnoses in its failure to differentiate behaviour that is reactive to oppression. The general thrust of most of the arguments is that psychoanalytic/psychodynamic therapy is historically Eurocentric and not relevant to the worldviews and emotional needs of people of African descent.

Consequently the development of an approach from another frame of reference began to be addressed by some black psychologists. Their starting point was to develop a body of knowledge that is not only based on western understanding or values but also on latent African ones. They argue that most dynamic theories, in failing to embrace the social reality of the non-dominant groups in society, reinforce the values, cultural bias, and racial prejudices that are prevalent in society. Institutions that continue to use these theories exclusively still reflect the worldview of the more privileged in society who have the power to decide who is sick, what type of treatment they need, and how they provide it.

Another frame of reference: African Psychology

African psychology is interested in a perspective that reflects an African orientation to the meaning of life, the world and relationships. The African paradigm explores African values, social relations and ways of accessing knowledge, defining reality and making sense of behaviour. African Psychology represents an Afro-centric framework that is rooted in the cultural context of people of African ancestry. In this framework any phenomenon is analysed with a lens consistent with an understanding of reality that is based on methods of knowing that emanate from African communities' historical experiences.

In the African worldview, the person and community adopt an orientation to existence that is informed in ways not limited to intellect, conscious mind or physical senses. It grounds the person and community in an appreciation of and relationship to mind/soul/spirit, spiritual transformation, resurrection and after-life. African Psychology is anchored in the concepts of dynamic interdependence of community, nature and spirit.

Spirituality and religion have occupied significant spaces in the history of African-Caribbean and African-Americans, and most African, African Caribbean people have grown up in families or communities where religion or spirituality has been a potent force. Their experiences may vary widely, but nevertheless their feelings and attitudes and involvement in spirituality need to be acknowledged and explored in therapy if and when they feel ready to.

'The paradigm explores African values, social relations and ways of accessing knowledge.'

Many white practitioners find African Psychology indigestible and difficult to engage with. It may be experienced as an invasion of the mind, and paralysing, and often arguments emerge that are polarizing. Perhaps there is a fear that these ideas are an assault on western thought and that something will be attacked or murdered. The counterattack may result in a process that makes the 'other' feel vulnerable, and a dynamic of 'perpetrator' and 'victim' ensues. In that counterattack, what is difficult to deal with is split off and these ideas rendered inferior.

What is needed?

No one theory can appropriately respond to every African, Afro-Caribbean, African American seeking or needing services. Therefore it's a false assumption that an African-centred paradigm is always more appropriate than any other theory for the African and black communities in Europe or America. We need a radical approach that has appeal for all cultures, an approach that incorporates all psychotherapy professions in a manner that is cooperative, not competitive.

We need a shift toward clinical applicability rather than theoretical appropriateness, allowing therapists more flexibility in deciding what a patient may need given their particular circumstances and cultural background. It is reasonable to assume that no one theory will be useful for every problem or for any particular group of black people. Our therapy has to extenuate our European/western experiences as well as draw out the hidden, often despised, as well as denied, African ones ■

Dr Agnes Bryan is an Adult Psychotherapist, Clinical Supervisor and Trainer in practice over fifteen years. She also works independently as an Organisation and Management consultant and Executive Coach. She works part-time at the Tavistock and Portman Trust a clinician and presently Associate Dean of Training.

Race and Ethnicity

Thinking space

By Frank Lowe

The Tavistock's Thinking Space aims to bring issues of diversity from a hidden, subconscious or unconscious place to one that is more open, conscious and thoughtful.

THINKING SPACE is a learning forum at the Tavistock Clinic, set up in 2002 to promote thinking and learning about race, culture, and diversity in psychotherapy. The forum was established because psychotherapy training organisations have historically failed to think about racism and other diversity issues in the training of psychotherapists. There has been a tendency to regard race and racism as external (social and political) world issues, as if they play no part in mental life, our identities, relationships and clinical practice. This approach was in my view a defence against thinking about psychotherapy as an institution – its membership, its culture and its relationship with disadvantaged communities. But it is also a way of hiding from race and racism in internal reality, and in so doing helps to perpetuate a lack of openness towards thinking about these issues in the self and in patients.

So how does Thinking Space work?

Thinking Space is not about intellectual or abstract thought; it emphasises emotional truth, in particular getting to know the self and the 'different other' better. I had learnt from previous experience that bringing diversity issues into the open, in particular the subjects of race and racism, frequently aroused anxiety, fear, anger, guilt and shame to an intense degree. To cope with this emotional maelstrom, groups (and individuals) construct defences against thinking. Therefore I realised that if Thinking Space was to achieve its aims, containment had to be a primary function of the space. The role of leadership is critical in creating an exploratory atmosphere within clear boundaries and ensuring consistency and a genuine sense of common purpose – of struggling with this together.

In its aim to promote thinking rather to provide the answer or the 'truth', Thinking Space draws on critical theory and psychoanalysis, in particular the tradition of the Work Discussion Group at the Tavistock Clinic (Rustin & Bradley 2008). According to Rustin, 'The theory of work discussion as pedagogy is that the seminar leader's task is the creation and sustaining of an atmosphere of enquiry in the group characterised by curiosity, scepticism, fellow-feeling, debate, differences, so that the unknown can become less unwelcome and new thoughts, questions, and perceptions find fertile ground' (Rustin & Bradley, p. 12).

So, drawing on Bion's distinction between knowing facts and getting to know a subject, Thinking Space seeks to promote curiosity, exploration and learning in a way in which participants are encouraged to pay as much attention to experience (historically and in the moment) as to how they are learning (process), and not simply to what is being presented (content).

In short, Thinking Space seeks to create a safe place for participants to:

- explore, experience, and think about diversity
- formulate questions as much as to share experiences and views
- reflect on themselves, others, and their practice
- examine prior assumptions, knowledge and understanding
- appreciate the anxieties, especially of persecution, stirred up by these subjects
- develop the capacity to keep exploring and thinking (not fight, take flight, or become paralysed) when it feels frightening, difficult, painful, hopeless, and unbearable
- get better at recognising their own responses and behaviours
- develop the capacity to understand diversity issues more deeply, including its unconscious meaning in themselves and others

The ultimate aim is to enable participants to stay with these issues, so that their complex character, potential destructiveness, their clinical and political implications and the way they trigger deeply conflicted and unconscious aspects of ourselves, could be grasped more fully as a piece of experiential learning – and not be left neglected on the margins. In effect, to bring the rough beast of diversity from a hidden, subconscious or unconscious place to one that is more open, conscious and hopefully thoughtful.

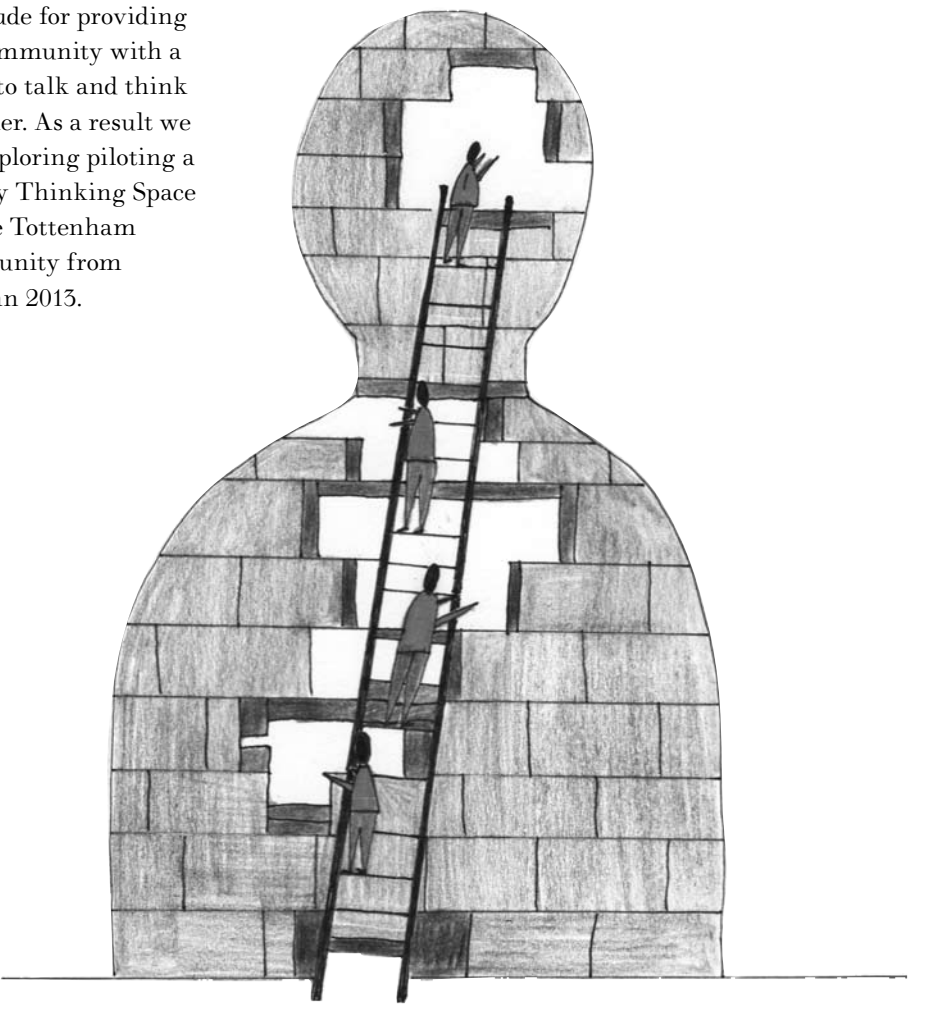
So are we there yet?

Although in recent years there has been increasing attention paid to diversity issues, in particular race and homosexuality, these issues are still avoided or at best marginal subjects within most training organisations. It has been encouraging that Thinking Space has not only survived but has grown, from being just an internal learning forum for staff and trainees to having regular seminars open to others from outside the Trust. But diversity is still not an integral part of psychotherapy training and practice, and radical work still needs to be done. However, there is undoubtedly less anxiety and more discussion about diversity in psychotherapy than ever before, and it is my impression that a sea-change in attitude may be afoot in the profession.

'There is less anxiety and more discussion about diversity in psychotherapy than before.'

Thinking Space for the community

In September 2012 we held a Thinking Space event in Tottenham to explore the psychological impact of the riots on the Tottenham community, one year on. Approximately fifty people attended, and it was an emotionally powerful and raw experience. There was immense rage expressed about the chronic violence and trauma suffered by people living in Tottenham for decades before the August 2011 riots. It was stated that the community needed long-term interventions based on an appreciation of chronic problems in families and the wider community, and must engage with all sections of the community in ways which make a difference to their lives. Despite many criticisms about how the event could have been better organised, many expressed gratitude for providing the community with a space to talk and think together. As a result we are exploring piloting a weekly Thinking Space for the Tottenham community from autumn 2013.



Thinking Space – the Book

On our tenth anniversary in 2010, we decided to publish a book to share our learning based on presentations at Thinking Space, and I am hoping this will contribute to the momentum for change. Thinking Space the book will be launched later this year as part of the Tavistock Series. Papers include: Race and our Evasions of Invitations to Think, Onel Brooks; Between Fear and Blindness, Helen Morgan; Is it because I am White?, David Morgan; Being Black in the Transference, Jonathan Bradley; The Complexity of Cultural Competence, Britt Krause; Class is in you, Joanna Ryan; An Exploration of Irish identity in British Organizations and Society, Aideen Lucey; Dehumanisation, Guilt and Large Group Dynamics with reference to the West, Israel and the Palestinians, Martin Kemp; and two chapters by Frank Lowe, Thinking Space the Model and The Riots 2011: Them and Us.

As we face the next stage of the journey as a profession, probably it is helpful to hold in mind Freud's view that one needs three things to succeed in an analysis – the first is courage, the second is courage, and the third is courage (Roazen, p. 54) ■

Frank Lowe is a psychoanalytic psychotherapist and Head of Social Work in the Specialist Adolescent and Adults Directorate at the Tavistock & Portman NHS Foundation Trust

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Race and Ethnicity

Challenged and inspired

By Gail Lewis

Becoming a psychotherapist presents challenges and possibilities for any practitioner. Gail Lewis looks back on a training in which questions of racism, culture and ethnic identity are made central to the work.

EMBARKING ON the Tavistock's D59 course in Intercultural Psychodynamic Psychotherapy was both frightening and exciting. I had completed its sister and preliminary course D58 (the Qualifying Course in Psychodynamic Psychotherapy) as an ingénue in terms of any kind of psychodynamic practice, and had been profoundly stimulated by the challenges and possibilities posed by entering this world for the first time. Although I had performed sufficiently well to be able to progress onto D59 with the hopes of gaining qualification as a psychodynamic psychotherapist, I was still aware of just how inexperienced I was, and that further development required me to dig deep and find the resources inside myself that would enable me to keep up that pursuit.

The challenges were obvious: how was I going to learn to work as a therapist?! My experience as a patient told me a huge amount about just how skilled and demanding this was and how it required patience, sensitivity, courage and a commitment to sustained curiosity – and now I was daring to think I might enter that world in some tiny way. Hope and desire was indeed audacious.

But the challenges extended beyond this, for if I were a newcomer in terms of psychotherapeutic practice I was an old hand in the sociology of race, racism and gender, as I worked as an academic with those areas of interest. So D58/59 posed me a profoundly felt dilemma: how would it be possible to hold a perspective that both recognised and respected the external realities of racism, ethnic identity and cultural pride, and yet also had a theory of human subjectivity that did not collude with and/or sustain forms of racist thinking that reduced human groups into racialized categories? From this position I was excited by the fact that D59 was explicitly concerned with addressing these issues whilst, together with D58, also being a qualifying course.

At the beginning of this four-year journey I had a mixed experience. From the very start I was aware of being on a huge journey of personal development, and I drank in the learning I was being offered. But this was tempered by what I experienced as some quite persistent resistances to the idea that questions of racism, culture and ethnic identity were of profound and continuing relevance to the intra-psychic dynamics in the minds of patient and therapist and the inter-subjective interaction between them. This was hard for me, but I was also committed to holding my position as a learner, and I felt that this required me to hold and see what would emerge.

'The centrality accorded to thinking about racism, culture, ethnicity was in the spirit of deepening psychodynamic work.'

D59 was a breath of fresh air, and I have to say perhaps the best learning experience of my life – and I have had many by now. It is testimony to the commitments and direction of Elisa Reyes-Simpson. The questions that were at the forefront of my mind were central to D59, without any weakening (as far as I could see) of the principles of psychoanalytic thinking about human subjectivity, psychic life and mental pain. Particularly important and exciting to me was that it was as if the centrality accorded to thinking about racism, culture, ethnicity was in the spirit of deepening and broadening psychodynamic work, not just as a means of making it more relevant and sensitive to diverse populations. It also seemed to be about the development of understanding about the ways in which racism gets inside us and enters into the workings of the mind and carries its toxicity into the minutiae of interpersonal interaction. This was a journey I wanted to embark upon, as a learner and (I hoped) a developing practitioner. It was challenging – not least because no-one is exempt from scrutiny, and the more I came to understand the more I had to (re) examine my own life, relationships and practices. I cried, I laughed, I thought and I talked – and I think I have developed through it all – not just in that I did qualify, but in that I think I am a little bit more able to face and examine internal and external difficulties with a little more courage and lot more attention to the emotional truths of love and hate, including those related to racism and ethnicity ■

Gail Lewis, after many years at the Open University, recently joined the Department of Psychosocial Studies at Birkbeck College, University of London. She is now undertaking the M1 at the Tavistock.

News

Betty Joseph, 1917-2013

The pioneering psychoanalyst Betty Joseph passed away on 4 April.

Betty Joseph, a training and child analyst at the British Psychoanalytical Society, was the last survivor of a group of innovative clinicians who learned from Melanie Klein and her collaborators. She was a teacher, supervisor, and founder and convenor of the renowned 'Betty Joseph Workshop', and her work became an indispensible part of analytic education. She received many accolades, including the Sigourney Award of the IPA and a distinguished fellowship at the BPAS.

NHS Services Update

A proposed reconfiguration of the medical psychotherapy service at Broadmoor Hospital could result in a 50% cut in service provision for psychotherapy, effectively a service reduction of 80%. This follows a 30% reduction in January 2012.

The BPC has written to Broadmoor's medical director to voice its concern over the proposals. Broadmoor has an international reputation for the provision of humane and effective services for some of the most disturbed and troubled members in society, as well as pre-eminence as a centre of training.

OBE for leading BPC registrant

Peter Fonagy, the Chief Executive of the Anna Freud Centre and Freud Memorial Chair and Head of the Research Department of Clinical, Educational and Health Psychology at UCL, was recognised with an OBE in the Queen's birthday honours in June.

He said: 'My career is a testament to the value of collaboration in science. I have worked with colleagues throughout the last thirty years and it is their cumulative achievement which was recognised by this wonderful award.'

'Gold' discovered at the University of Giessen

Psychoanalytic psychotherapy has been found to be effective for multiple presenting mental disorders across multiple randomised controlled trials – the form of evidence that NICE considers 'gold standard'.

One of the world's leading experts in meta-analysis, Professor Falk Leichsenring, a psychologist and psychoanalyst who advises the German authority that is responsible for provision of psychotherapy in their public health system, will be delivering this year's Phil Richardson Memorial Lecture at the 20th September AGM of the Association for Psychoanalytic Psychotherapy in the NHS. 'Body of Evidence' will review what we can confidently now claim about psychodynamic treatments that have been shown to work, followed by a discussion about how we can use this evidence to persuade the new commissioning bodies to invest in NHS-funded services.

Professor Leichsenring's visit, and the annual APP event which is open to everyone (students and service users can attend for free), are also timed to coincide with the centenary anniversary of the British Psychoanalytic Society's founding in 1913. The Society is holding a centenary party on 21st September 2013 at the Royal College of Physicians. For details of the APP event see page 15. Details of the centenary party will be appearing at www.beyondthecouch.org.uk

Bowled Out

David English's Bunbury Celebrity Cricket Team (featuring the Weasley Brothers from Harry Potter) played the Mike Brearley XI, featuring cricket greats Clive Radley, Ed Smith, Paul Downton, Angus Fraser, Mark Alleyn, Russell Cake and John Lever, at a charity match at Lords in aid of Camden Psychotherapy Unit.

Former England cricket captain Mike Brearley, who worked at the CPU in the 1980s, led his team onto the pitch for the fundraiser on 25 May.

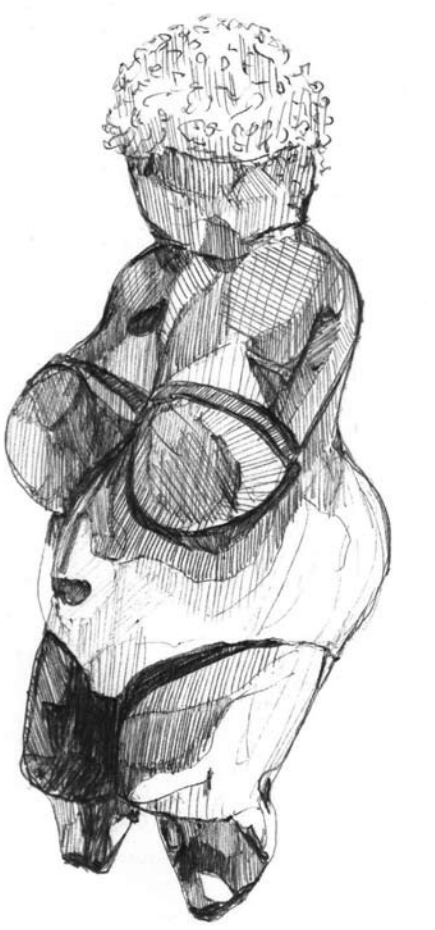
The Bunburys won by one run.

Opinion

Return of the repressed?

By Johnathan Sunley

Reflections on the death and life of Margaret Thatcher: what kind of object was she in our national psyche?



THE PASSIONS stirred up by the death of Margaret Thatcher already seem like a distant memory. Was it really only a couple of months ago that such a furious debate was raging in the media and in everyday conversation about her character and achievements? And having laid her to rest in a ceremonial funeral, the scale of which appalled some and delighted others, are we again at peace with ourselves as a society? Or simply relieved that we can go back to ignoring the conflicts in our unconscious (both personal and collective) that she unfailingly brought to the surface?

I want to explore some of these conflicts and to ask what kind of object Margaret Thatcher was in our national psyche. Without this perspective, I think it is difficult to explain the outpouring of emotion that greeted her death – and the need there evidently was to try to bring closure to this through the spectacle of her funeral.

Addressing the congregation in St Paul's, the Bishop of London described Margaret Thatcher as a 'mythological figure'. As with all such figures, the facts of her life cannot easily be separated from their meaning. One way to tell this story is as follows. A gifted girl is propelled out of provincial obscurity by a burning sense of mission. As an adult she heroically transforms the land of her forefathers – and in doing so earns the undying gratitude of many of its people. But her popularity and talents attract envy. Eventually her advisors find a way to overthrow her. Unable to cope with this shock, the Iron Lady shatters. In her final years she becomes a shadow of her former self.

Another version of these events might portray Margaret Thatcher as someone for whom confrontation was not just a way of life but a means of psychological survival. Seeing enemies everywhere (at home the trade unions, abroad the forces of communism), her policies divided opinion and split the nation in much the same way that, so a psychotherapist might conjecture, her internal objects were split into the unrealistically good and the irrevocably bad.

For me these accounts are two sides of the same coin. Or rather the two sides of the archetype of the Great Mother, an all-powerful figure who is both loving and hateful, creative and destructive. In myths, legends and religions this archetype takes many forms, but always possessing both positive and negative attributes – since she who has the power to give can also withhold. Constellation of either aspect, writes Jungian analyst Anthony Stevens, triggers extreme emotional responses: 'When the Good Mother rules all is peace and contentment; but should the Terrible Mother be activated, pandemonium is the result' (Stevens, p. 110).

'We probably all bear some sense of guilt for Thatcher's political death.'

Looking back on Margaret Thatcher's eleven and a half years as prime minister, it does seem that there was an unusual amount of pandemonium and contentment. One thinks of the miners' strike and poll tax riots on the one hand, and rising levels of prosperity and jubilation at the ending of the Cold War on the other. Following her death in April, critics of Thatcherism took to the airwaves to stress the former while admirers of her legacy spoke with equal fervour about the latter. Suddenly it was like being back in the 1980s – as though by reliving the traumatic upheavals of that period we might somehow master them.

But perhaps the real trauma we went through then was of a different kind. Perhaps having a woman as prime minister was an infantilizing experience we long to forget but which we are bound to remember. In 1950 Winnicott wrote a fascinating essay about the psychological demands of living in a democracy. He saw these as considerable since, before deciding where he puts his cross on a ballot-paper, a voter will have to tolerate some degree of conflict within himself. While confident that in the Britain of his day there were enough emotionally mature individuals to make democracy viable, Winnicott doubted whether a woman would ever be elected to the position of (as he puts it) 'political chief'. According to him, this was because both sexes have a deeply-rooted fear of woman derived from the period in their lives when they were dependent on one for their very survival. 'The original dependence is not remembered, and therefore the debt is not acknowledged, except in so far as the fear of woman represents the first stage of this development' (Winnicott, p. 242).

Did Winnicott misjudge his country's psyche? In 1979 Margaret Thatcher won her first of three general elections. But that was only after decades of doing battle with the unconscious fears of her party – initially to find a winnable parliamentary seat, then to rise within its ranks and finally to be chosen as its leader. No doubt the opposition she encountered was not based on misogyny alone. But I think it is telling that one of the labels that has stuck to her name from a ministerial position she held during those years is 'Mrs Thatcher, milksnatcher' – bearing in mind that a symbol of the archetypal variant of the Good Mother is the flowing breast. I think it is also interesting that as prime minister she was frequently depicted in newspaper cartoons and commentaries as being more of a man (having bigger balls) than the men in her cabinet. This conjures up the spectre of the phallic woman, a terrifying – though also exciting – figure who renders men redundant by appropriating their potency.

Whether or not Margaret Thatcher was good for Britain depends ultimately on your point of view. A democracy provides for the expression of both love and hate towards its political representatives. As Winnicott observes, this is why voting puts such a strain on our emotions. But as he also observes, having a woman as 'political chief' stirs up anxieties of a far deeper and more dangerous kind. Perhaps these are simply too overwhelming to be processed at a conscious level through the act of voting? If so, that might explain why it proved impossible to make up our minds about Margaret Thatcher through the ballot-box. The more elections she won, the more we resented her for exposing our needs and dependence. In the end, the only way out of this unbearable situation – not just for the Conservative Party but for the country as a whole – may have been the in-house coup that removed her from office in the autumn of 1990.

And yet the underlying anxiety remained. 'The dictator can be overthrown and must eventually die,' writes Winnicott (p. 243), 'but the woman figure of primitive unconscious fantasy has no limits to her existence or power.' But there was worse. For now everyone involved in this act of matricide found themselves facing a huge burden of guilt.

It would be easy to say that this is a problem only for the Conservatives – and to note the turmoil the party has been in since April. My own view is that insofar as the fantasies and fears described by Winnicott are universal ones, we probably all bear some sense of guilt for Margaret Thatcher's political death. Almost 25 years later, the spectacular funeral she received was without precedent for a peacetime prime minister. Among the many unconscious needs served by this occasion, I suspect that one of them was a widely-felt wish to atone ■

Johnathan Sunley is a psychotherapist in training at WPF Therapy.

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Psychoanalysis in Europe

By Hansjoerg Messner

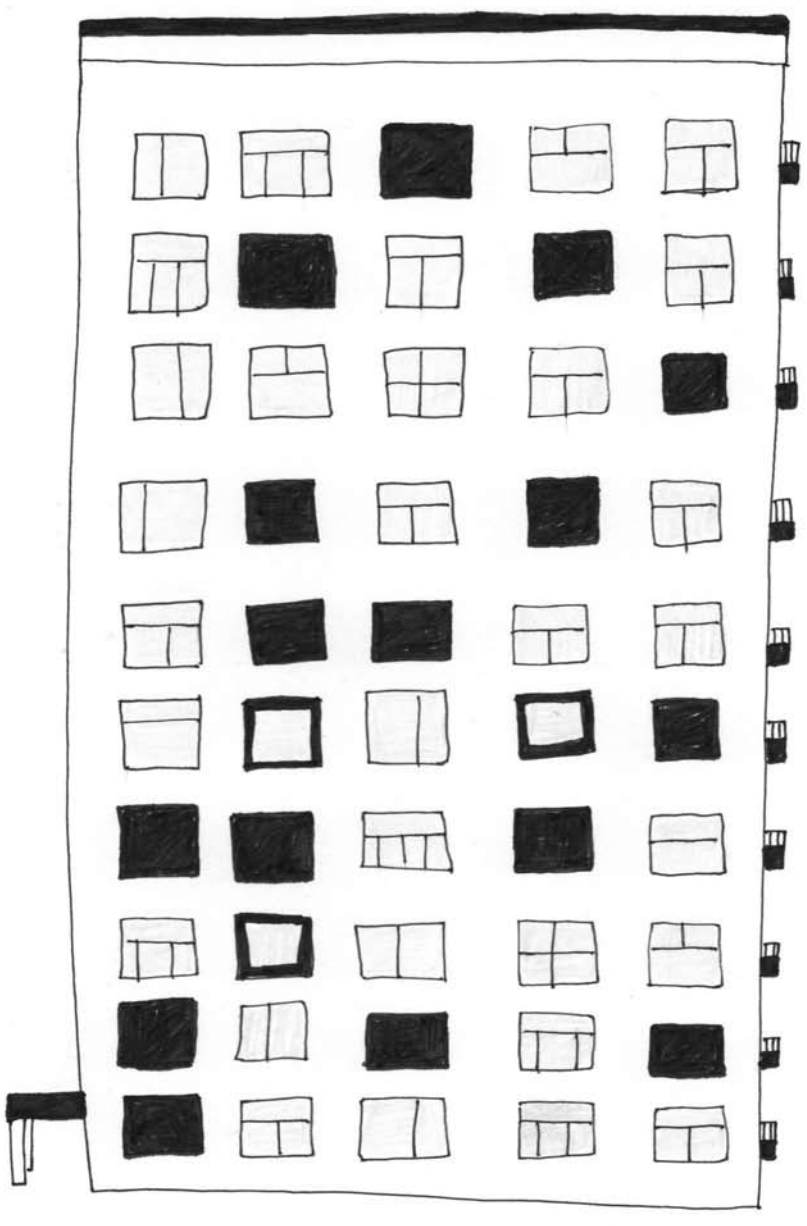
How does psychoanalysis fare in Europe today? Hansjoerg Messner looks at the impact of the two main European healthcare models on its provision.

THE AVAILABILITY of psychoanalysis and psychoanalytic psychotherapy as a treatment model within the public sector varies significantly among European countries. There are a number of modalities with some variants when it comes to universal health care provision in Europe. In my view, these modalities can ultimately be surmised as two clearly distinct categories through which universal health care across Western Europe is provided to the population at large.

One of those systems (system A) is financed through general taxation and often controlled by the central government – sometimes, as in Sweden, in conjunction with local government, and often as a combination of the two. It is therefore more susceptible to financial pressures and economic downturns, and highly vulnerable to budgetary squeezes of the ever-expanding health care costs. This leads to determined attempts by some governments to streamline and manage services, impose strict links between diagnosis, treatment method and results, and brings with it the risk that medical care is no longer regarded as 'a social good but rather as a commercial commodity.' In this system psychoanalysis and psychodynamic psychotherapy are increasingly deemed too expensive, and consequently marginalised.

The United Kingdom as one example has for a long time enjoyed psychoanalytic psychotherapy in primary and secondary health care provision. This is swiftly disappearing and often practically no longer the case in the public sector.

Psychodynamic psychotherapy models, including psychoanalysis, are in these times often viewed with political intentionality as anachronistic treatment methods that are not only too expensive but also not very effective, and hence increasingly deserve to be marginalised. Necessity, as they say, is the mother of invention, and necessity apparently requires treatment models that can be streamlined and delivered at low cost. In various domains this affects the relationship between doctor and patient, and as far as psychoanalysis is concerned the central focus of its treatment model is the personal relationship with the patient. As a health minister in Sweden said: 'Psychoanalysis might be a good treatment method but it's simply too expensive!'



As far as treatment methods are concerned, strict links are increasingly being imposed between diagnosis, treatment and predictable outcome. Public agencies and professional organisations demand increasingly evidence based practice, empirically supported techniques and standardised treatment manuals. The problem is that these sort of standardisations create a culture that make it increasingly difficult for psychoanalysis, and all it stands for, to compete in the public sector.

A number of other countries in Europe, however – Germany, Austria, the Czech Republic, Switzerland and Hungary – use an alternative system of universal health care provision (system B) in which there is a much stronger link between individual payment and the consumption of health care. In this system the power to purchase services tilts in various ways in favour of the patients.

One such structure is health insurance, as seen in Germany for example, mandated to the individual by the government, and acquired through regulated but self-managed insurance companies. Its operations are often financed by statutory contributions from the insured and contributions from the employers. Other and similar structures combine a number of components, including one related to earned income, contributions from employers, local government and state contributions. The amount of GDP spent on health care in systems A and System B of health remains approximately the same. This system of health care provision is not to be mistaken for private health care or what we know in this country as private health insurance. The universality of health care provision, for example, rests anchored in government regulation to assist low-income groups, and protects patients with pre-existing illness.

According to some analysts system B has three key benefits: there is no artificial cap on health care spending; individuals are motivated to be cost conscious; and providers are constantly motivated to improve their services for fear of losing custom.

I believe this latter system for the provision of health care is more effective in maintaining a more diverse treatment spectrum, and is successful when it comes to recognising psychotherapy as a viable treatment model by leaving the choice of treatment modality to the public. Furthermore, these two distinct models of financing health care across the European continent are not only intimately linked with the presence – or indeed, increasingly, absence – of a psychodynamic and psychoanalytic treatment model of psychotherapy; I believe that they have much wider implications for our profession as a whole, especially with a view to the future.

With the marginalization of the psychoanalytic treatment method in national health provisions, psychoanalytic thinking becomes marginalised in a society as a whole. This has a bearing on the national narrative, not only in terms of mental health and mental illness, but also on how we perceive ourselves as people with unconscious and conscious minds and what it is that informs us in our ongoing experience.

'Standardisations make it increasingly difficult for psychoanalysis to compete.'

With psychoanalytic thinking marginalised, the interest of potential and suitable new candidates to come forward for training in psychodynamic psychotherapies and psychoanalysis, and to invest in a future in the profession, erodes quickly. With little prospect or guarantee of making a living in the profession, many of the most talented candidates stay away or go elsewhere. I understand that for example in Denmark it is very difficult to find candidates for training in psychoanalysis and psychoanalytic psychotherapy, and this is a concern that haunts psychoanalytic societies in a number of European countries, including the UK.

Some argue that psychoanalysis will have to retreat to the private sector and be better for it, because it can regulate itself in line with the required setting, the treatment objectives, confidentiality and so forth. In the long run, however, I fear the professional standing eroded in the public sector will erode its standing in the private sector as well.

In countries where health insurance has a stronger 'purchaser' component, psychotherapy is regulated by statutory law and the various treatment modalities are clearly defined. This allows psychoanalysis as a recognised modality to compete on a level playing field with other treatment methods in the public sector. A psychoanalytic treatment model, as we all know, depends on the reality of the unconscious process and the subjective response to this process on the part of the analyst. These aspects are of course non-negotiable, but I think that the

The psychotherapy profession

Where the profession is regulated by statutory law:

Germany, France, the Netherlands, Finland, Switzerland, Hungary, Austria, Italy, Latvia (some countries like France have title protected but not the profession)

Some of these countries accept only medical doctors or psychologists to practice in the profession

No statutory law or law currently in the pipeline:

Ireland, Portugal: no statutory regulation

Czech Republic; Poland: law in pipeline

UK: assured voluntary registration

Denmark: title of psychotherapist not protected

importance of professional autonomy is not incompatible with the fact that the profession should and could be regulated by statute if that ensures a level playing field for our model of working with patients.

Christer Sjödin makes a convincing case as to why psychoanalysis is increasingly becoming an 'impossible profession within the public welfare system' in Sweden (*International Forum of Psychoanalysis*, 19: 3, 2010). Its health care system mirrors in large parts that in the UK, and currently experiences the same radical cuts and shakeup of the system, and its radical 'ideological' underpinnings in which health care is seen increasingly as a commercial commodity rather than a fundamental social good. Sjödin argues that the demand by public agencies and professional organisations for evidence based practice, empirically supported techniques and standardised treatment manuals ultimately affects the doctor-patient relationship and infringes on professional autonomy. With the overlapping of health care professionals and management tiers it ultimately erodes confidentiality between doctor and patient.

The individual patient is left with little choice in the public sector, and can potentially make his/her choices in the private sector if he/she has the means to do so, or is indeed aware of the existence of alternative treatment models to those offered in the NHS.

The amount of GDP spend for health care across western Europe remains approximately the same, independent of the system of delivery (from seven to 12 percent) but there is evidence, as suggested by the data in Germany summarised below, that the system which has a stronger link between the individual stakeholder and health care provision is the system that provides psychoanalytic treatments as a method of choice far more effectively and in the process maintains the profession in robust health.

This clearly has a long-term effect on the capacity of the profession to regenerate itself, to attract candidates for the profession, and to remain an attractive treatment method for the population at large.

It comes therefore as no surprise, to my mind, that in countries where this system prevails, namely Germany, Austria, Switzerland and to a certain degree France (here the insurance companies are state controlled and have never gained self-management responsibility), but also in Eastern European countries like Hungary and the Czech Republic, psychoanalytic psychotherapy plays a more central part in the public sector.

It might be historically relevant to the development of this particular health care system procurement that central European countries have wrestled with universal health care for far longer then the UK, and their system of health care provision has organically grown over time. It might also be relevant that psychoanalysis is more deeply entrenched historically in the public conscious and hence in the political process of central European nations.

It is interesting, however, that Finland and Norway, with national health service provisions under system A, offer to the population a range of treatment options including psychoanalysis, and they seem to remain committed to a diversity of treatment modalities with the patient choice intact. I am not sure exactly why this is. A factor might be that these two countries have small populations and remain relatively affluent, but there is also evidence that research there is very rigorous, and they apply clinically what works best for the patient in the long term.

German data

Data coming out of Germany makes for interesting reading. It is also an important indicator for the application of psychoanalysis and psychodynamic psychotherapy in the public health sector. To a large extent it is applicable to other countries that subscribe to health system B, alas with some variables.

In 2011, 86 assessors for psychodynamic and analytical psychotherapy of the various statutory insurance companies in Germany considered 164,857 reports (requests for this type of therapy). About four percent of those applications were rejected, while amendments where requested for about 11 percent. Added to this are the treatments paid for by private insurance, which amount to approximately one fifth of the total amount accepted by statutory insurance companies. Furthermore, approximately ten percent of treatments are pre-financed by the patient and later reimbursed by the insurance companies. In these cases no report or assessment is necessary.

This amounts to about 215,000 treatments, not including the four percent of rejected proposals. By comparison, when it comes to behaviour modification therapy the figures are similar. In the same year, 73 assessors compiled 151,465 reports. Rejection of applications amounted to three percent and the costs of nine percent of the applications where not accepted without further amendments or corrections. The ratio of the private patients is here lower, while the number of later reimbursements is probably higher in CBT. Therefore there are about 400,000 psychotherapeutic treatments per year in Germany alone.

Eastern Europe

The picture looks a bit different when we consider Eastern European and Balkan countries. They have emerged from more or less totalitarian rule over the past 20 years. But some of these countries are quickly reconnecting with traditional modalities, or indeed introducing new ones. The psychoanalytic tradition is gradually re-emerging.

In Poland and Hungary the profession is regulated or about to be regulated by law; in the Czech Republic the profession is not regulated. The Czech Republic and Hungary subscribe to an insurance system (system B) which covers about 95 percent of the population. There is a sense also that in these countries a level playing field exists for different treatment modalities, which include psychoanalytic psychotherapy.

'The psychoanalytic tradition is gradually re-emerging.'

From what I understand the situation in Slovakia as well as in the countries of former Yugoslavia to be, psychoanalytic psychotherapy is predominantly practised in small numbers in private practice. These small societies in countries of Eastern Europe are often dependent on supervision and financial aid from abroad in order to develop their institutions, training facilities and a presence in the public mind. The European Federation of Psychoanalytic Psychotherapy (EFPP), of which the BPC is a member, is helping to revive these institutions in Eastern Europe with clinical and financial help.

It is perhaps worth acknowledging that most countries in Eastern Europe spend about four to seven percent of GDP on national health care, considerably less than Western European countries, which has an impact on the total expenditure of mental health.

Southern Europe

Countries in Southern Europe have greater difficulties in having psychotherapy recognised by the public health system. Greece, Portugal and Cyprus do have very limited specific psychotherapeutic health care provision unless it is inpatient care or treatment prescribed by a psychiatrist. The profession in these countries is neither regulated nor recognised; nor is the title 'psychotherapist' protected ('psychologist' is). Since in these countries psychotherapy does not seem to be high on the list of mental health care provision, mostly pharmacotherapy is prescribed by psychiatrists to patients suffering from depression.

What strikes me about the Southern European situation in particular, and this is perhaps most evident in Portugal, Greece and Cyprus, is that in the absence of a psychotherapeutic tradition and, more to the point even, in the absence of a core profession or regulated title of 'psychotherapist', psychotherapy remains but an addendum to the medical profession rather then a profession in its own right.

Italy in this regard is the exception and the norm. While having a rich tradition in psychoanalysis and dynamic psychotherapy, and a profession that is regulated by statutory law, psychotherapy remains attached to psychiatry and psychology but is not recognised as a profession in its own right.

Conclusion

Psychoanalysis and psychodynamic psychotherapy are alive in most European countries. In some, however, the discipline still forms very much part of a treatment option available in the public health system. This is so because analysis remains a treatment of choice on a level playing field, financed by the mandatory insurance policy each citizen is obliged to hold. It can operate in the private and public consulting room in line with its required setting and confidentiality while remaining in the public domain. It is the insurance company that either pays directly for the treatment or reimburses the patient for treatment received or procured.

In other countries, however, psychoanalysis is increasingly banished to the private sector and is losing relevance in the public health sector, and is in fact in danger of losing relevance in the public domain.

This has potential repercussions in terms of the attractiveness of the profession for suitable candidates for psychoanalytic institutions, and may potentially condemn these organisations to a very marginal existence unless we act. With this in mind, it remains imperative to find ways and means to keep the profession as both a viable treatment model and a relevant set of ideas alive ■

Hansjoerg Messner is a psychoanalytic psychotherapist in private practice, and currently the BPC's delegate to the adult section and a board member of the EFPP. He is also chair of the Psychoanalytic Psychotherapy Association of the newly founded BPF.

Interview

Mark Rylance: on Broadmoor

Interview by Joan Thompson

Mark Rylance, who recently played Richard III at the Globe Theatre, discusses his performances at Broadmoor and his relationship with Dr Murray Cox.

Joan Thompson: Freud claimed that Richard's villainous ambition was a consequence of his childhood deformity. I quote: 'Richard is an enormous magnification of something we find in ourselves as well. We all think we have reason to reproach nature and our destiny for congenital and infantile disadvantages; we all demand reparation for early wounds to our narcissism, our self-love.'[1]

Do you agree with Freud? That Richard's sense of vengeance and grievance are driven because he's had to live with deformity and a lack of love?

Mark Rylance: Sir Francis Bacon has always been a big influence on me, and he said similar things about Shakespeare's writing, about the consequences of deformity in a human being and the different paths that people can follow. Bacon would agree with Freud. Playing Richard, I increasingly felt that he has intense problems with women. Shakespeare uses Richard's mother to illustrate the problematic relationship between a deformed child and their mother.

JT: Richard yearns for his mother's love but never receives it?

MR: No he doesn't. I've now taken to spitting in her face and slapping her!

JT: He gets the crown but not maternal love. It's a very powerful scene when she curses him.

MR: There is an undercurrent in the play that suggests a transpersonal effect of curses and prayers. As you say, it's a powerful thing. We don't really have people openly cursing each other, other than they may swear, 'You fucking bastard' or something, but actually taking the imagination and aiming. I know a shaman who protects himself from curses. He bounces them back somehow on the person who sent the curse.

JT: Well, in the end that's what happens.

MR: Yes, he curses himself. Elizabeth gets him to curse himself.

JT: When Richard dreams of the people he murdered in Act Five, I think he begins to grow a conscience and identifies himself as a murderer. Do you think he actually has the capacity to suffer guilt, or is Richard a psychopath, as some have argued?

MR: With psychopaths it's very difficult to find a root. There isn't a rationale for the phenomenon. It's just a phenomenon in nature it seems, from what I've read about it. But I've traced too many things in the author's imagination of the character of Richard that are hints of causes of his behaviour. The fact that he's written as deformed and talks about that, the isolation that he feels. I feel very isolated playing the part.

In rehearsals I thought, 'No, he's not a psychopath.' Shakespeare placed a conscience in this man who didn't have a conscience. As Kevin Spacey said to me, it is a play about a man that doesn't have a conscience and grows a conscience. I don't think psychopaths dream either.

Richard is more of a sociopath than a psychopath; he never mentions any remorse for anyone else, it's all self-pity, it's all completely about him, it's all about how pathetic he is. He is an incredible narcissist.

JT: I heard that you went to a psychiatric unit to specifically prepare for the role of Richard III.

MR: No, I didn't go specifically to prepare for Richard III, but in 1989 I first visited Broadmoor Special Hospital when Dr Murray Cox was alive. I met Murray when I was playing Hamlet at the RSC. We met after the show and I accepted an invitation to give a talk to him and his fellow doctors. Murray was an avid Shakespearean and I always learnt a great a deal from him. I inherited his library and my copy of *Twelfth Night* has his notes along the side, underlining lines from performances he'd seen. I love owning his copies of Shakespeare.

Murray invited us to Broadmoor to do a number of Shakespeare plays and modern plays. The last time I went was in 2005 to do *Measure for Measure* but it got very difficult after Murray died, because the authorities became much more wary. So we devised a different plan in his name. We are actually sitting on a bench dedicated to him.[2] His name is inscribed on the bench with a quote from *Twelfth Night*: 'So full of shapes is fancy that it alone is high fantastical.'[3]

We raised money in Dr Murray Cox's name to buy theatre tickets for people in medium security wards, like Bethlem Royal Hospital. They come in groups of twenty to thirty with their doctors and nurses, and if I am in the play I'll talk to them afterwards. They are a wonderful audience because they spend all their time considering themselves and learning who they are.

'They are a wonderful audience because they spend their time learning who they are.'

JT: What did you learn from the patients?

MR: I always found their apparent innocence, but I suppose I mean experience, very interesting because they cross over a boundary that most of us just won't cross. They have a perspective that is completely different. What Murray found fascinating in regard to Shakespeare is that so many characters have crossed boundaries. Murray told me a story about a man. Murray had asked: 'Why did you kill this person?' and the man said, 'Well I didn't have a life so I took a life.' Murray was always fascinated by that. Then a Broadmoor patient anonymously submitted an essay about *Macbeth* for an A-level exam. A patient had written from his own experience and was correcting Shakespeare about what it felt like to murder a person. We were curious about what some poor A-level paper marker would have made of this paper. After that conversation, Murray said it's a shame they can't experience the theatre, and I said, 'Well why can't they? Why can't we come to them if they can't come to us?' So, we played in the visitor's hall with about eighty of the four hundred Broadmoor patients.

The patients also put on plays themselves. They did a very funny English, middle-class, Alan Ayckbourn play once. The patients were excited and enjoyed themselves. Family, friends and staff all came to watch. I remember one glorious evening in the great Victorian hall with the setting sun. It was a very beautiful, rare kind of occasion.

It was the nurses who got us in. The doctors were all very nervous that we would awaken all kinds of problems. The nurses said, 'No, let them come. If they upset the patients all the better.' The nurses knew that only when the patients got upset that they were beginning to get better.

I remember being told about a man who was banging his head against the wall until it was raw to the bone. So, two nurses held him for 24 hours a day in shifts for many months. It was incredible, it would have made a wonderful play and maybe one day I'll put it on.

JT: Did the patients ever talk about their sentences?

MR: I never asked people what they did, although some of them told me that they'd killed their mother or their father or some treacherous thing had happened. I felt it was important that we were neutral: we weren't family; we weren't doctors; we weren't police; we weren't like anyone else they'd met. They were quite staggered by that. Why would we want to come? Why would you come and do plays for us? They were always on very friendly terms with us when we came and you could feel they were delighted. When I went back, some of them would wave and say, 'Hello Mark.'

I knew from the first performance at Broadmoor that honesty was all that

was acceptable here. The women were harder to talk to but the men were very interesting. They had such lively minds and were somehow able to talk about what had happened to them and what they'd done. It would make me weep it was just so moving. All of their stories were tragic. It was like seeing an athlete, an incredible athlete, who had spent years working on something. They had worked so hard to own who they were and not be angry, but also to know what their triggers were. Some of them were highly conscious of their triggers. It is similar to alcoholics or people like that, who have really got on top of their natures. It's very, very humbling work ■

Mark Rylance is an English actor, theatre director and playwright. As an actor, he found success on stage and screen. For his work in theatre he has won Olivier and Tony Awards among others, and a BAFTA TV Award. His film roles include Ferdinand in Prospero's Books *(based on Shakespeare's* The Tempest*), Jay in* Intimacy *(after a novel by Hanif Kureishi) and Jakob von Gunten in* Institute Benjamenta *(after a novel by Robert Walser). He was the first Artistic Director of Shakespeare's Globe in London, from 1995 to 2005.*

Joan Thompson is a psychoanalyst and psychoanalytic psychotherapist working in private practice at the Margaret Street Practice in London (www.margaretstreetpractice.co.uk). She trained at the BAP and the BPA.

Notes

1. Some Character-Types Met with in Psycho-Analytic Work', *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, Volume XIV (1914-1916

2. Bench in the courtyard of The Globe Theatre, London

3. *Twelfth Night*, Act 1, Scene 1

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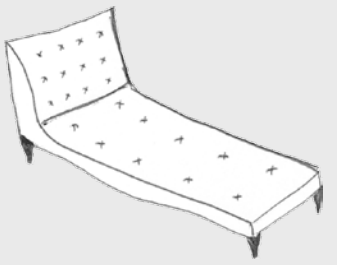

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5 October 2013
PSYCHOANALYTIC PSYCHOTHERAPY NOW 2013
Getting to grips with society's ills: a psychoanalytic perspective
Keynote speaker: Salman Akhtar
Holiday Inn, Bloomsbury London WC1
www.psychoanalytic-council.org

5 October 2013
DESTROYING THE KNOWLEDGE OF THE NEED FOR LOVE
Speaker: David Morgan
Mansion House, Canynge Road, Clifton, Bristol BS8
www.sipsychotherapy.org/public/lecture.html

12 October 2013
OUT OF THE MAINSTREAM: HELPING CHILDREN WHEN A PARENT HAS A MENTAL ILLNESS
Speakers: Rosemary Loshak, Angela Foster
BPF, 32 Leighton Road, London NW5
Contact: 020 7482 2002, blankaw@bpf-psychotherapy.org.uk

14 October 2013
GILES FRASER IN CONVERSATION WITH SUE EINHORN
Kings Place, 90 York Way, London N1
www.connectingconversations.org

19 October 2013
UNCONSCIOUS PROCESSES IN COUPLES CHOICE
Leader: Jenny Riddell
WPF Therapy, 23 Magdalen Street, London SE1
Contact: www.wpf.org.uk

25-27 October 2013
WORKING WITH OTHERS – TOGETHERANDAPART
A three-day non-residential Group Relations Event sponsored by the BPF
BPF Kilburn, London NW2
www.britishpsychotherapyfoundation.org.uk

31 October to 3 November 2013
SEVENTH EUROPEAN PSYCHOANALYTIC FILM FESTIVAL
Theme: 'Secrets'
BAFTA, 195 Piccadilly, London W1
www.beyondthecouch.org.uk

NOVEMBER

9 November 2013
EXPERIENCING ENDINGS AND BEGINNINGS
Speaker: Isca Salzberger-Wittenberg
BPF, 32 Leighton Road, London NW5
Contact: 020 7482 2002, sophinak@bpf-psychotherapy.org.uk

15 November 2013
5TH JAMES MACKEITH MEMORIAL LECTURE
Speaker: Gregorio Kohon
Institute of Psychoanalysis, 112A Shirland Road, London W9
www.beyondthecouch.org.uk

ADVANCED TRAINING SCHEME

bpa British Psychoanalytic Association

Introduction

The British Psychoanalytic Association (BPA), a Component Society of the International Psychoanalytical Association (IPA), fosters and supports psychoanalysis and psychoanalytic professional development. This Advanced Training Scheme (ATS) is aimed at experienced psychoanalytic clinicians who have already shown commitment to in-depth intensive analytic work and who would like to develop their work further by undertaking additional training at the BPA in order to become a psychoanalyst, a member of the BPA, and consequently of the IPA.

The training consists of clinical work under supervision/consultation and clinical and theoretical seminars, for a minimum of two years. Theoretical seminars cover major schools of psychoanalytic thought and traditions.

The ATS is the responsibility of the Advanced Training Scheme Committee of the BPA.

Whom this course is for

Psychoanalytic Psychotherapists with a university degree and who are registered by the British Psychoanalytic Council (BPC) to work with adults or late adolescents and young adults. More detailed criteria applies.

Application Procedure

Anyone interested in applying now or in the future for this Advanced Training Scheme should arrange to meet with a member of the Advanced Training Scheme Committee for a preliminary discussion. For further details call 020 8452 9823. The Committee can be contacted at advancedtraining@psychoanalysis-bpa.org

Regional Applicants

The BPA Advanced Training Scheme will welcome applicants from the UK regions and Ireland. Some of the requirements could be fulfilled by telephone. The Advanced Training Scheme would require a minimum of at least one face-to-face monthly supervision with the first supervisor and a minimum of once a term for the second and third supervisor/consultant. For both Clinical and Theoretical seminars, personal attendance is required for half of the seminars.

Completion of the Advanced Training Scheme

Following satisfactory completion of all curricular requirements, and satisfactory reports from supervisors and seminar leaders, the Advanced Training Scheme Committee will recommend to the Board that the candidate be accepted as a member of the BPA. Upon the Board's acceptance of this recommendation, the candidate will be invited to be a member of the BPA and consequently of the IPA. The Candidate will also join the British Psychotherapy Foundation (BPF).

Course fees

The course fee is £1600, which can be paid in instalments. Fees for supervisions and consultations are individually agreed. There is a non-refundable application fee of £220.