NewAssociations

NEWS, ANALYSIS, OPINION FOR THE PSYCHOANALYTIC COMMUNITY | **ISSUE** 11 **SPRING** 2013

BRITISH PSYCHOANALYTIC COUNCIL

Democratizing psychoanalysis

By Christopher Bollas

PUSHING SEVENTY, I find myself in a time slot where one rather naturally looks back on life (sobering moments) and receives invitations to comment on the future, as if age in-itself bore wisdom. Or perhaps this is when we can see how and in what ways history repeats itself.

For example, the present arguments for 'evidence based' treatments, including the many manuals, examinations, certifications and regulations that relate to them, bear uncanny resemblance to the 'accountability' movement of the late 1960s and 1970s in the United States. Clinicians working in the JFK-sponsored community mental health centres found themselves spending so much time filling in forms to describe their interventions with clients that many psychoanalysts, and especially child therapists, simply left, exhausted by the dulling impact of increasingly intrusive and tedious questions.

In the early days an accountability sheet simply asked for verification that the client attended so the duration of treatment was accounted for. Then the forms began to require the clinician to state what *progress* had been made in the session. As managers of centres became pressurized to provide evidence of the effectiveness of their centres, yet more detailed accounts were demanded of what had been achieved in sessions, and clinicians were increasingly pushed towards pro-active interventions. (For a thorough examination of the community mental health centres in the United States please see Gerald N. Grob and Howard H. Goldman, *The Dilemma of Federal Mental Health Policy: Radical Reform or Incremental Change?* Rutgers University Press, 2006.)

Just like 'evidence based' research in psychoanalysis, accountability began as a good enough idea. In the 1960s, it led to an increased sense of the varied dimensions of therapeutic work in the community. Turning to the 1990s, without the evidence provided by longitudinal outcome studies, valuable psychoanalytically orientated in-patient institutions such as the Austen Riggs Center in the United States would not have survived. When insurance companies discovered, through this evidence, that psychoanalytical treatment did not lead to repeat treatments but had a very low recidivism level, they rethought the funding of long-term psychotherapy because it was proved to be cost effective.

However, accountability morphed into a doctrine of practice as clinicians were expected, for example, to be certain whether their clients had suffered any forgotten sexual abuse. A valid enough idea soon became the leading edge of a movement of zealots who saw the work of therapy as rooting out the source of trauma as evidence for potential prosecutions.

'The danger of dogmatism is obvious.'

The same worrying transformation is emerging amidst the modern advocates of evidence-based practice. A set of criteria (valid enough, if limited) for evaluating the outcomes of therapy has morphed into a movement that would set criteria for correct practice, followed by the inevitable machinery of state regulation that could result in certification examinations for psychoanalysts and psychotherapists.

The danger of dogmatism is obvious. For example, it might be taken as a given truth by advocates of manualization that all communications from the patient are transference enactments and should be so interpreted. Many psychoanalysts disagree with this position, and to make it a mandatory feature of practice would be to eliminate the richness inherent in the world of conflicting ideas present within psychoanalysis. The approaches of some psychoanalysts – the Lacanians for example – would be completely negated and they could even be eliminated from practice altogether if this aspect were to be adopted as a compulsory criterion.

The anxiety in contemporary psychoanalysis that there are clinicians out there for whom 'anything goes' has authorized an irrational sense of urgency that we must be evidence based. The phrase assumes an almost magical aura. Interestingly, the idea that evidence based criteria must be put into place to deter the impact of those for whom 'anything goes' is an hysterical transmission, not only not evidence based, but an iatrogenic effect of such loose thinking: i.e., the idea of their being clinicians for whom 'anything goes' enacts that statement! And this infectious idea has been employed for decades to bully and intimidate practitioners who were opposed to its hidden agendas (i.e. the promotion of a standard technique).

The ethics of such scare-mongering in what should be considerate intellectual thought and scientific research prompted an astonishingly frank debate in the United States sponsored by the American Psychological Association. *Evidence-Based Practices in Mental Health: Debate and Dialogue on the Fundamental Questions* by Norcross, Beutler and Levant (American Psychological Association, 2005) invites writers both for and against the assertions of an evidence based approach to debate the issues on behalf of psychologists in the United States. It is a book that honours participants on both sides of the issue and should be required reading for anyone engaged in this debate today.

It is incorrect, in my view, to question the motives of those who become the self-elected managers of psychoanalysis. I have no doubt that they sincerely believe in the validity of their views. However, psychoanalytical institutions are democratically vulnerable. They are too easily captured by groups determined to pursue agendas.

What can the psychoanalytic movement do to insure that initially good ideas do not become overvalued, that they do not gather advocates who become part of a political project to impose such governing principles upon the community?

Continues over the page

Editorial

Communicating and engaging

By Gary Fereday

PROFESSIONAL BODIES such as the BPC only retain long term credibility when properly representing the broad consensus of their members' views, but that's not always easy when the profession is psychotherapy. At a recent meeting, the chief executive of another similar healthcare professional body remarked to me how the intellectual power of BPC registrants could 'light up a small city'. It was a nice compliment, but one that also reminded me how the level of debate and intellectual discussion in psychoanalysis and psychotherapy can sometimes make reaching a consensus a tricky process.

This ability of the profession to passionately debate detailed issues and ideas can sometimes, to the outside world, look like angels dancing on the head of a pin. The BPC needs to provide a container for this debate but also articulate leadership and a strong voice to the outside world. However, as Christopher Bollas reminds us in his article, we need to ensure leadership doesn't become dominated by an oligarchy pursuing an unrepresentative agenda. To illustrate the danger he uses the example of how, in the 1960s, evidence of the effectiveness of psychoanalytic treatments morphed from something helpful into something unhelpful and dogmatic due to a lack of inclusiveness of a wider range professional views.

The BPC Executive and Council recognise this and have embarked on a re-structure of the organisation to create new committees and working groups to help engage more registrants, ensuring a wider range of views are heard and helping advise on our activity. We are also moving forward with our plan to appoint a Policy and Public Affairs Officer, to help engage the outside world and support a stronger voice, and are writing again to our member institutes with our proposals.

Communicating and engaging others is something of theme in this edition of *New Associations*. Estela Welldon's article explores how the Henderson Hospital successfully engaged residents in decision making and administration, creating a community that had a powerful and positive effect on so many. Reflecting on the parallels and links between religious philosophy and psychoanalysis, Alexa Walker comments on how an understanding and openness to listen to patients talking about their faith can 'be attuned to the patient's unconscious communication behind religious language'. The theme continues in the discussion between trainees, with one of the participants reflecting how he feels that 'a profession so much about communication has failed to communicate with the public.'

The articles by Andy Bell and Ian McPherson serve to remind us of the changing external environment and the opportunities that it may bring the profession if we communicate and make our case effectively. Ian, a friend of psychoanalysis, challenges the profession to engage in the wider debate about mental health care provision or 'not be surprised to find themselves being marginalised in future developments.' Strong words we need to heed.

The upcoming Psychoanalytic Psychotherapy NOW conference aims to help the profession engage in these wider debates. PP NOW has quickly established itself as the main psychoanalytically focused event in Britain, aiming to bridge the clinical and academic study of psychoanalysis with political discourse and social policy. This year the conference will be reflecting on psychoanalytic explanations of global political responses to the financial crash, the seemingly ever growing individualistic and narcissistic nature of society, and the effects on marginalized communities. I'm delighted that Professor Salman Akhtar (Jefferson University, USA) has agreed to give the keynote address, and the full programme is almost complete and will be announced very shortly. I hope to see you there in October.

Gary Fereday is the BPC's chief executive.

Democratizing psychoanalysis

Continued from previous page

We need to utilize tools to elicit a more democratic assessment of whether any idea is genuinely representative of the psychoanalytic constituency. We need to use referendums to discover the views of the membership. The road to referendum or plebiscite is through a petition in which a minimum number of names – perhaps one hundred clinicians – are required before any petition can be put to the vote. Time and space should be allotted for those for and against the petition to debate the issues, both in public meetings and in online forums. The results of the vote should be taken as final for a defined period of years, after which proponents of a defeated motion could return with a new proposal.

So, for example, the advocates or the opponents of manualization of psychoanalysis would state their proposal and give an outline of how the proposal would be implemented. Those proposing manualization might word this as follows: 'It is proposed that all psychoanalysts and psychoanalytical psychotherapists upon graduation from their training institutions in the UK pass an examination that determines if the graduate meets the minimal standards set for consensual clinical practice.' Those who oppose this idea could also petition to have a referendum that could be worded: 'It is proposed that because of the valid diversity of the many differing forms of psychoanalytical practice no standardized exam should determine a graduate's qualifications within the BPC and the UKCP.'

'Psychoanalytical institutions are democratically vulnerable.'

The advantage of this form of 'direct democracy' is that any constituency can take part in crucial decision making and the view of the whole community can be directly ascertained. Further, the political process involves debate *within* the psychoanalytical community. When the debate takes place, instead, in the media or through means such as the lobbying of government, this can unwittingly appear as a confession of incompetence on the part of the profession.

If the community's vote goes against one's own personal conviction, one can at least take solace in knowing that all views have been given a genuine and fair hearing and that no group with an agenda and a coterie of determined supporters can gain power within the institutionally fragile world of psychoanalysis.

As a result of the use of direct democracy, any group with the intent to introduce community-wide change of significance would have to alter their tactics from the attempt to seek influence by deploying advocates in significant positions of power to the more difficult but meritorious task of persuading the psychoanalytical community based on argument and debate. Reason, not power, would prevail. And the benefit to the community cannot be underestimated.

Direct democracy through referendum can also generate the long-term positive effects of 'indirect democracy'. For example a society, with an ethics committee of seven people, could be subject to a direct vote: 'Should the Ethics Committee have three members from other professions who are not psychoanalysts?' Because ethics committees can be paralyzed by internal political pressures they are often not effective, but if they included a number of lawyers, ethicists, doctors (etc.), there would be a more democratic process in place to offset cronyism and internal politics.

The issue of democratic process versus oligarchy is another way of discussing the movements of the life and death instincts. Democracy is inevitably a life instinct: it demands that members of the group relate to one another over a proposed issue, debate the merits and live with the result, which will be decided by vote, not by executive decree. Death drive movements – those that, to use Rosenfeld's concept, operate under the auspices of a gang leader – are disturbingly easy to form, highly effective when in place, and their actions may be irreversible.

The changes made in the BPC in recent years from authored articles to more open and transparent reporting of the BPC's thinking, with the creation of the online Newsletter and *New Associations*, are more than just a step in the right direction. The 'new' BPC is an exemplar of how to relate to a membership, how to be inclusive of as many views as possible, and how to avoid the imposition of edicts from those in positions of power ■

Christopher Bollas is a member of the British Psychoanalytical Society. His two most recent books are China on the Mind *and* Catch Them Before They Fall: The Psychoanalysis of Mental Breakdown.

NHS policy and mental health

By Andy Bell

Decisions made about the future of the NHS are crucial to mental health services, but historically mental health care has been an afterthought. Andy Bell, of the Centre for Mental Health, detects signs that this is beginning to change.

IN THE PREVIOUS edition of *New Associations*, Gary Fereday called on the psychoanalysis profession to 'speak with a voice that policy makers might take seriously.' He noted that the profession could offer a critique, not just of policies relating to psychological therapy, but also more broadly where it can contribute a distinctive and constructive perspective to public policy.

We are now more than half way through the current Parliament. The impact of changes made in a range of public services since the 2010 election is now beginning to become visible, while all the main political parties are beginning to position themselves in readiness for the next election in 2015. For people facing or living with mental ill health, policies ranging from NHS and social care reform to welfare and employment, education and criminal justice all have a considerable impact on their lives and life chances.

One of the earliest health policy decisions made after the 2010 election was to produce a cross-government strategy for mental health. Building on the previous Government's *New Horizons* strategy, its successor, *No Health Without Mental Health* (HM Government 2011), represented a major departure from previous approaches to mental health policy. First, it covered not just health and social care but the full range of public services as well as the wider economic, social and cultural issues affecting mental health. Second, it took a 'life course approach', addressing the needs of children and adults alike rather than separating them out. And third, it gave equal precedence to promoting positive mental health and preventing mental illness as it did to supporting recovery and improved quality of care to people with mental health conditions.

The strategy's six objectives (see box) thus covered a broad canvas and between them provided a vision for a future in which mental health is given the same importance as physical health – described as 'parity of esteem' – and in which a person's life chances are not unfairly compromised because of their mental health.

The strategy has implications for a wide range of public services, including but not limited to health and social care. Many of those have been spelled out in the subsequent implementation framework (HM Government 2012).

Mental health policy does not, however, exist in isolation. It is closely related, and normally secondary, to wider health and health care policy. Decisions made about the future of the NHS, including funding levels, commissioning systems and the way services are monitored and measured are crucial to mental health services, yet historically the application of these policies to mental health care has been a casual afterthought. Yet there are signs that this is beginning to change. The Government's Mandate for the NHS for 2013-15, for example, requires the Commissioning Board to bring about measurable progress in achieving parity for mental and physical health, including action to extend access to psychological therapies, to improve support for women with post-natal depression, and to develop liaison and diversion services in the criminal justice system (Department of Health 2012).

The six objectives of the mental health strategy

i **More people will have good mental health**

ii **More people with mental health problems will recover**

iii **More people with mental health problems will have good physical health**

iv **More people will have a positive experience of care and support**

v **Fewer people will suffer avoidable harm**

vi **Fewer people will experience stigma and discrimination**

The current round of NHS reforms, coupled with the impact of financial restraint, are therefore the primary drivers of the way mental health care is being managed, paid for and developed. With many more years of financial restraint to come, and demand for health and social care set to rise steadily as the population ages, the new NHS commissioning organisations, national and local, will face more and more spending pressures and difficult decisions. Last year, spending on both working age and older adult mental health services fell in real terms: while there was an increase in spending on psychological therapies and on secure hospital care, overall mental health spending reduced (Mental Health Strategies 2012).

'NHS commissioning organisations will face more difficult decisions.'

Spending pressures are not unique to mental health services. By comparison with other public services, the NHS is at present relatively protected from austerity measures. But for people with mental health problems, it is not just the NHS that makes an impact on health and quality of life but support with housing, employment and other basic needs. With major funding pressures affecting housing services, welfare benefits and most local authority services, what many people are experiencing is the cumulative impact of cuts in a range of forms of support. The impact of welfare reform, for example, is of far greater concern to many mental health service users than the changes taking place in the health service.

A very significant development across the policy landscape is the increasing devolution of decision-making to localities, from the creation of GP-led commissioning to the growing role of local authorities in promoting wellbeing and the election of Police and Crime Commissioners across England and Wales. The creation of Health and Wellbeing Boards, for example, has the potential to bring a range of local services together to promote positive mental health and improve support for people with multiple needs – but only if the significance of these issues is recognised by local leaders and given priority in resource allocations.

Linked to localism is the development across many public services of the payment by results system, opening up the provision of public services to more organisations with payments based on the outcomes they are required to measure. This approach is exemplified in the Work Programme but increasingly being used in a range of sectors including health care, drug and alcohol services and criminal justice. The impact of this approach will take time to become clear but there is a pressing need to develop robust and meaningful measures of outcomes for service users to ensure that providers get the right incentives to intervene effectively in people's lives.

The landscape in which mental health policy is made, and more importantly implemented, is thus changing rapidly and in some ways fundamentally. The Government's mental health strategy and its subsequent actions to make parity of esteem for mental health a reality have been widely welcomed. Achieving these objectives will be tough given the pressures public services face, but in the systems that are emerging, a strong and consistent advocacy for mental health both locally and nationally will be essential ■

Andy Bell is deputy chief executive at the Centre for Mental Health

Psychoanalysis and Religion

Psychoanalysis and religion

By Alexa Walker

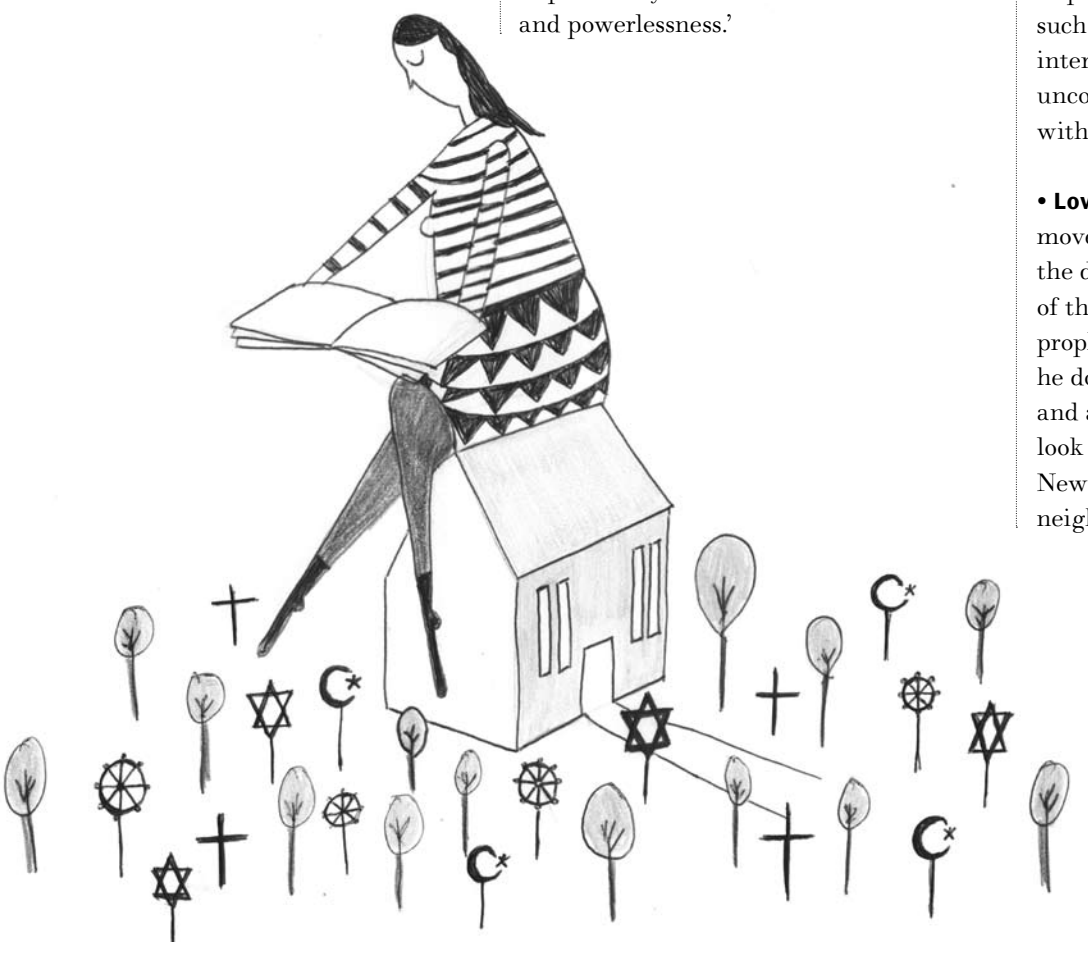
We asked several writers to consider the parallels between religious philosophy and the concepts behind the practice of psychotherapy. Alexa Walker introduces our metaphysical special section.

INTEREST IN the relationship between psychoanalysis and religion, and comparisons of their aims and insights into the human condition, has increased greatly in recent years. However, we don't as often think about these in relation to clinical issues surrounding work with the religious patient.

Some people with fundamentalist beliefs may be hostile to psychoanalysis and simply not arrive in the consulting room, but patients with religious affiliations do need and seek out psychoanalytic help. Some hold concrete beliefs about creation and biblical authority, and there are therapists who hold that this in itself makes such patients unsuitable for analytic work. Margaret Clark, in *Understanding Religion and Spirituality in Clinical Practice*, focuses on the clinical aspects, concluding boldly and firmly (and I agree) that the way of understanding spirituality and religion in clinical practice is to 'understand them in exactly the same way as understanding any other material. That is all.' But it is not possible to do so if raw countertransference gets in the way.

A major theoretical obstacle for psychoanalytic thinkers since Freud has been their truth claims about the existence of God and other doctrinal propositional statements, in the absence of the possibility of any scientific process for falsifying or verifying them. Such statements are thus deemed to be meaningless, and belief in them an illusion, or delusion. I would like to suggest that a preoccupation with truth claims could prevent theoretical understanding of the nature of faith, and restrict clinical experience of the subjectivity of the patient. My comments that follow focus on the Christian religion.

The recently retired pope, once a theology professor, stands in a long tradition of theologians in seeing faith as an 'understanding'. In his *Introduction to Christianity* he emphasises the root of the word as a physical place to stand in this world, a foothold. This foothold, he says, is a conscious decision to see reality as meaningful, as beyond knowledge that can be possessed. Rowan Williams, the former Archbishop of Canterbury, says in *On Christian Theology* that dogmatic language can become empty and even destructive of faith when it 'is isolated from a lively and converting worship and a spirituality that is not afraid of silence and powerlessness.'



The privileging of meaning, of lively engagement, of an ability to tolerate silence and powerlessness, the distinction between knowledge as possession and coming to 'know' (Bion's 'K'); these are psychoanalytic 'goods' too. In our consulting rooms I suggest we need a 'foothold' from which to view and reflect on the material our patients of faith bring us. Bion uses the term *vertex* to describe a vantage point or points that structure our thinking, transformations of the unknowable, 'O'. Here are some 'footholds' that have parallels with psychoanalytic thinking which I have found useful for looking at religion and religious material brought by patients:

• **Transitional space.** In her book *The Birth of the Living God*, Ana-Maria Rizzuto sees transitional space as the locus where God comes into existence. For Donald Winnicott, the feeling of being alive, being in touch, emerges from the interaction with a transitional object that is itself out in the world. For the religious person, this could be, for example, a holy narrative, a picture, a statue, a hymn or prayer. Meditation on them can allow something to emerge that feels vital and connected and has its being in the moment. In this sense the religious habit would be a commitment to seeking this kind of aliveness and connectedness, plumbing the depths with the intellect, and with the emotion to yield meaningfulness.

• **The intra-psychic and the inter-psychic.** There is a vertical (person-God) and a horizontal (person-person) dimension to the great religions (symbolised in Christianity by the two axes of the cross). Mystics, the most intensively 'vertical' practitioners – seeking an experience akin to God – have often had a strong 'horizontal' presence as leaders of or advisors to their communities. Meditation and prayer go hand in hand with love of fellow human beings, often demonstrated in practical ways. In the consulting room, such a 'cross' also exists, in the form of the interplay between reverie (openness to the unconscious) and direct communication with the patient.

• **Love.** It can be seen as the medium that moves us from the paranoid schizoid to the depressive position. The bible speaks of this shift over and over again. The prophets have God tell his people that he doesn't want their sacrifices (guilt and appeasement) but that they should look after the poor and the needy. In the New Testament, Jesus embodies love of neighbour. Religion is about living in a community and it is performed in an ongoing way as a community (in this it differs from the process of psychoanalysis).

• **Grace.** Grace implies humility, a relinquishing of omnipotence. It requires openness to receiving. An interpretation that has a profound effect, the moment in which both analyst and patient sense something transformational is happening, can feel like a gift, something coming from 'outside' us, not something that we have brought about.

• **Ritual.** Most ritual contains, I think, at least an element of enactment, the effect of which is an emotional experience of the past in the present. It has transformational potential. Christian communion does this, as does the Jewish Passover feast.

'We need a "foothold" from which to view the material our patients of faith bring us.'

These very briefly touched on 'vertices' can help create an openness with which to listen to patients talking about their faith. Antennae can then be attuned to the patient's unconscious communication behind religious language. They help us not to be stuck with countertransference clouded by personal experience and associations towards religion. I don't have to be in thrall to my feelings towards the church's preoccupations with sexuality and the role of women; or towards the history of wars and torture carried out in the name of God; or the appalling revelations of abuse in institutions; or the many contradictions and rivalries; nor to 'gut' distaste, or disdain of certainties. I suggest that if I take my 'stand' in such vertices, my patient's faith, whatever developmental stage it may reflect and defences it may demonstrate, can be experienced and becomes available for interpretation whether or not I am myself a religious believer. Its symbolic and transformational potential is not lost.

If, however, I have emotional access to religious myth and other religious objects of faith through religion, or perhaps through music or art – my resonances become more directly available as material from which in the interplay with the patient new symbols can be formed ■

Alexa Walker is a psychoanalytic psychotherapist in private practice. She teaches and supervises at WPF Therapy.

Psychoanalysis and Religion

To grow into freedom

By Brendan Callaghan SJ

To be completely honest with oneself is the very best effort a human can make.[1]

Then you will know the truth, and the truth will set you free.[2]

I WAS RECENTLY at the funeral of Bernard Ratigan, who was turned down for classical psychoanalytic training in the 1970s in part because he was a committed and believing Catholic. (That he was an openly gay man didn't exactly help back then, either.) Freud's personal belief that religious belief was essentially infantilising and neurotic became part of the psychoanalytic canon very early, despite its epistemological status as a belief alongside other beliefs, and despite Freud's own comment that the theoretical approaches of psychoanalysis could and would be used to arrive at quite different and positive evaluations of religion.

What has slowly become clear – at least to some thinkers – is that the dimension of religion, like any significant dimension of our human experiencing, can be a context for transformational growth as well as for neurotic distortion. Turning the mirror the other way, it has also become clear – at least to some thinkers – that psychoanalytic culture has, alongside the qualities proper to a profession and an area of rigorous academic debate, some of the less healthy characteristics of a religious movement.

I write as a Jesuit, a catholic priest with a background in clinical psychology and an interest in psychoanalytic thought that has developed over three decades of teaching psychology of religion at the University of London. It seems to me that, at their best, Catholic Christianity and psychoanalysis are both struggling to provide the context and tools to enable people to grow into freedom, a freedom which rests on the awareness of and acceptance of limitation: a freedom rooted in the truth of the human condition.

Human growth takes place within languages of growth, and if the languages we use are seriously defective, then it is more difficult for them to provide contexts and structures that can permit, let alone foster, growth. Religions, understood as articulated patterns of belief and practice, have provided these contexts and structures for the majority of human beings for as far back as our varied scholarship can trace. Whether or not we look at religions from the viewpoint of a believer, we have to recognise that how patterns of belief and practice are articulated is influenced by cultural and historical factors: what a believer holds to be divinely revealed must be humanly expressed.

One of the great services psychoanalysis has done for religion has been to provide tools for understanding some of the ways in which our endeavours to articulate that which is most central in our lives are shaped (like all our human endeavours) by less than conscious processes and mechanisms. In some instances the tools of psychoanalysis have provided radically new insights; in others, the 'new' psychoanalytic language has brought a greater precision to insights that had long been formulated in a religious language. The area of our experience to which we refer as our 'conscience' provides examples both of the radical and the more precise, in the notions of the superego on the one hand, and obsessive-compulsive patterns on the other. Christian thinking had no real equivalent to that of the super-ego, while the religious notion of 'scruples', traditional though it was, was greatly enriched by psychoanalytic understandings of obsessive-compulsive behaviours.

What can religion offer to psychoanalysis? Perhaps above all the example of people struggling, as individuals and as communities, to formulate, to understand and to live out ever more adequate responses to the human condition: to hear, and to tell, and to shape the story of what it is to be a human person among people in the face of the transcendent ■

Brendan Callaghan SJ trained as a clinical psychologist in addition to his studies for ordination as a catholic priest and a Jesuit. He taught psychology of religion at Heythrop College, University of London for 30 years, as well as working in spiritual direction and the formation of young Jesuits. He is currently Master of Campion Hall Oxford.

Notes

1. Freud, quoted in Abraham Maslow, *Towards a Psychology of Being*, Princeton University Press, Princeton, 1962, p. 57.

2. John 8:32

To seek knowledge

By Dr Rizwan Saleem

I AM A BRITISH Muslim. After qualifying as a medical practitioner from Kings College London, I spent several years in the ancient city of Damascus sitting, in the time-honoured way of students of sacred knowledge, at the feet of Islamic scholars and receiving the knowledge and wisdom bequeathed to us by the Prophet Muhammad. The scholars, or 'Shaykhs', with whom I sat prided themselves in having an authentic unbroken chain of transmission, from teacher to student, in what now spanned forty generations, all the way back to the Prophet himself.

Back in the UK, and training in psychiatry, I learnt about psychoanalysis, spent time with analysts and gained experience in psychodynamic therapy. What drew me to psychoanalysis? It began with the company of a brilliant analyst of Freudian persuasion who sparked my interest in the possibility of experiences in infancy having profound and enduring psychological effects. My further study of psychoanalysis convinced me that Freud and later analysts had arrived at many deep insights through their systematic study of the various levels and modalities of the inner psyche.

How could I reconcile my own faith with Freudian atheism? This was never really a problem. Many in the West still make the ethnocentric error of generalising their experience of Christianity to all other religious traditions. Despite huge similarities between Islam and Christianity, the former has quite a different intellectual history, particularly in its relationship to Reason and Science.[1] The very first word revealed to the Prophet Muhammad had been 'Read!'[2] and he himself had advised his followers of the imperative to seek knowledge 'even to China'. Subsequently, the 'Golden Age' of Islam, traditionally taken as mid-8th to mid-13th centuries, saw a florescence of learning in which Muslim scholars soaked up the intellectual writings of the ancient civilizations of Greece, India, China, Persia and Rome. Medieval Muslim intellectuals, as recent studies are documenting, went on to set the foundations of Empirical Science as we understand it today.[3,4,5] 'Wisdom is the lost property of the Muslim,' the Prophet had said. 'He picks it up wherever he finds it.'[6] A profound confidence in their own faith had allowed the early Muslims to assimilate, analyse, criticise and benefit from the intellectual heritage of the world's ancient civilizations.[7]

This rational tradition as well as the imperative to seek knowledge wherever found allowed me to appreciate the empirical method employed by psychoanalysis in its systematic study of the deeper recesses of the human mind. I was struck at the similarity of Freud's structural theory of the mind with medieval Islamic works on psychology that I had come across, such as the 12th century philosopher-theologian Ghazali, who divided the psychical factors giving rise to human behaviour into four categories: the lower ego and carnal desires[8] (similar to the id), angelic inspirations (comparable to the superego), satanic inspirations, and the intellect (comparable to the ego) which negotiates between the various influences.[9]

Although Freud's empiricism had led him to dismiss God as psychological construct, I knew that many of the great rationalist philosophers, from Plato and Aristotle to Descartes and Kant, had all concluded that a Supreme Being must exist. The advances of modern science, in uncovering the complexity and organisation that characterise life, only reaffirm my faith. In this regard, I concur wholeheartedly with Carl Jung who replied, when asked towards the end of his life if he believed in God, 'I don't need to believe. I know'[10] ■

Dr Rizwan Saleem MBBS MRCPsych

Notes

1. Leaman, Oliver, 'Arguments and the Quran', 55-67 of Leaman (ed.) An *Encyclopedia of the Qur'an,* see p. 55.

2. Quran 96:1

3. *Islamic Science and the Making of the European Renaissance*, MIT Press (April 1, 2007)

4. Hallaq, W B (1993) *Ibn Taymiyya against the Greek logicians.* Clarendon Press, Oxford. p.xlix

5. Pines, Shlomo (1986), *Studies in Arabic versions of Greek texts and in mediaeval science, 2*, Brill Publishers, p. 339.

6. Tirmidhi, M. (1998). *Al Jami al kabeer, Sunan al Tirmidhi*. Publ: Dar al Gharb al Islami (Beirut). Vol.4, p.348

7. E.g. Gutas, D. (1998). *Greek thought, Arabic culture*. Routledge NY. p. 2

8. Ar. nafs

9. Skellie, W J (1938). The religious psychology of al Ghazzali. Hartford Seminary Foundation, Ph. D. Pub. 2010 by Fons Vitae as: Ghazali, M. *The marvels of the heart: The science of the spirit.*

10. BBC interview, 1959. Cited by Vernon, M., 'Carl Jung Part 8: Religion and the search for meaning', *The Guardian*, 18 July 2011.

Psychoanalysis and Religion

Splitting and integration

By James Low

BUDDHISM AND psychoanalysis are both attentive to the phenomena of splitting and both hold out hope of the possibility of an improved accommodation, and even integration, between the remnants of the split.

In Buddhism, splitting is not considered to be defensive, as it is held to occur prior to the existence of an individual psyche that might need protection from an invading or abandoning environment. Indeed, splitting is seen as the originatory moment of the fallen realm of samsara, a splitting or forgetfulness which continues as the basis of our experience of ourselves separate from our world. Our efforts to organise the confusion resulting from this split distracts us from the simplicity that has been lost sight of. Splitting is the momentary 'slippage' that presents experience as something reified. Splitting brings forgetfulness of the ground of being and a simultaneous perception of self and other as two independent domains.

Within this domain of lostness each individual participates in further diverse forms of splitting, conscious and unconscious, as they are obliged both to make sense of what is going on, and to hold themselves together. A huge and ongoing busyness is generated by the primal split; and it is this that we experience as ourselves, getting on with our lives, acting and reacting, creating and destroying but often with a sense of some sort of fundamental lack or dis-ease, a sense that our identity is not quite secure.

'Who is the one who protects themselves when engaging in splitting?' This question, if taken up as a direct enquiry rather than as food for thought, may open the door to that which is given, the basic continuity of our presence prior to and co-terminus with all our experience, whether split or otherwise.

Psychoanalysis, particularly the Kleinian trend, has also been attentive to splitting and its consequences. The phantasy that the safe can be separated from the unsafe, the nurturing from the harmful, is one that holds out the promise of omnipotence, of the annihilation of all that is troublesome and the securing of the paradise of the good object. However, as Klein indicates in *Symbol Formation and the Development of the Ego*, there is no such thing as a free lunch. The baby's phantasy is redolent with the fear of punishment for the gain of sustenance is in fact based on theft. The gift is not to be trusted because it is always part of a deal, the implicit contract of exchange that binds self and other.

Even with the possibility of moving from paranoid-schizoid splitting to the depressive position, there is still an ongoing tension between the vectors which are being held in proximity. So ill-at-easeness becomes our companion.

' "Who is the one who protects themselves when engaging in splitting?" '

For me, Buddhist practice opens a space of presence that is facilitative of relaxed spontaneous engagement with whatever the patient brings. Nothing formally 'Buddhist' needs enter the session. I believe this is to be more ethical and respectful than the prevailing tendency to decontextualise Buddhist practices and select bits to construct techniques such as 'mindfulness'. Expert-led interventions of this nature cause further splitting as their focused intention increases subject/object differentiation.

Clinically the critical factor for me is to find a way to remain unsplit, whilst within the maelstrom of splitting and projection that frequently occurs. This allows a degree of fearlessness, a sense that one's own basic presence and therapeutic availability will not be lost, no matter what arises in the force-field of transference/countertransference. It is this, I believe, that gradually awakens the patient to the possibility of freedom ■

James Low works as a Consultant Psychotherapist in the NHS.

He has been involved in Buddhist practice for forty years.

His Buddhist writings and translations are available at www.simplybeing.co.uk

'The pattern will emerge'

By Rabbi Howard Cooper

THE GREAT Jewish-American literary critic Harold Bloom once wrote that Freud's conceptual explorations of the human psyche 'have begun to merge with our culture, and indeed now form the only Western mythology that contemporary intellectuals have in common' (1986). Yet a quarter of a century on from Bloom's grandiloquence, postmodern discourse has, fortunately, subverted any notion of a single over-arching narrative through which humanity can understand itself.

As a rabbi and a psychoanalytic psychotherapist I find myself working within two intellectual traditions that offer contrasting (yet overlapping) modes of story-telling as the means by which people can be helped to think about their lives and construct meaning out of what occurs. Psychoanalysis, like Judaism, is a vast meaning-generating system. Whether meaning lies within the unconscious or in God's hands (to use one of the anthropomorphised poetic images that the Judaic myth offers), both systems are conceptual enterprises designed to cajole us into viewing life as being composed of events which have meaning – or out of which meaning can be made. Both suggest that everything that we do and everything that happens to us can be thought of as part of a larger picture, of which we can only know a part. Both help us defend ourselves against the fear-filled alternative: meaninglessness.

'Psychoanalysis, like Judaism, is a vast meaning-generating system.'

Like the psychoanalytic myth, the mythologies and theologies of the monotheistic faiths involve strenuously creative attempts to deal with the potentially overwhelming, annihilatory anxiety of *tohu va'vohu*: the formless, chaotic black hole at the very beginning of Genesis (1:2) – which is analogous to (and a metaphor for) aspects of early infantile experience. Within the Biblical/Judaic myth, God fills the emptiness with creative activity, just as we have to fill our lives with acts of creativity (and love) to generate meaning in the face of the void.

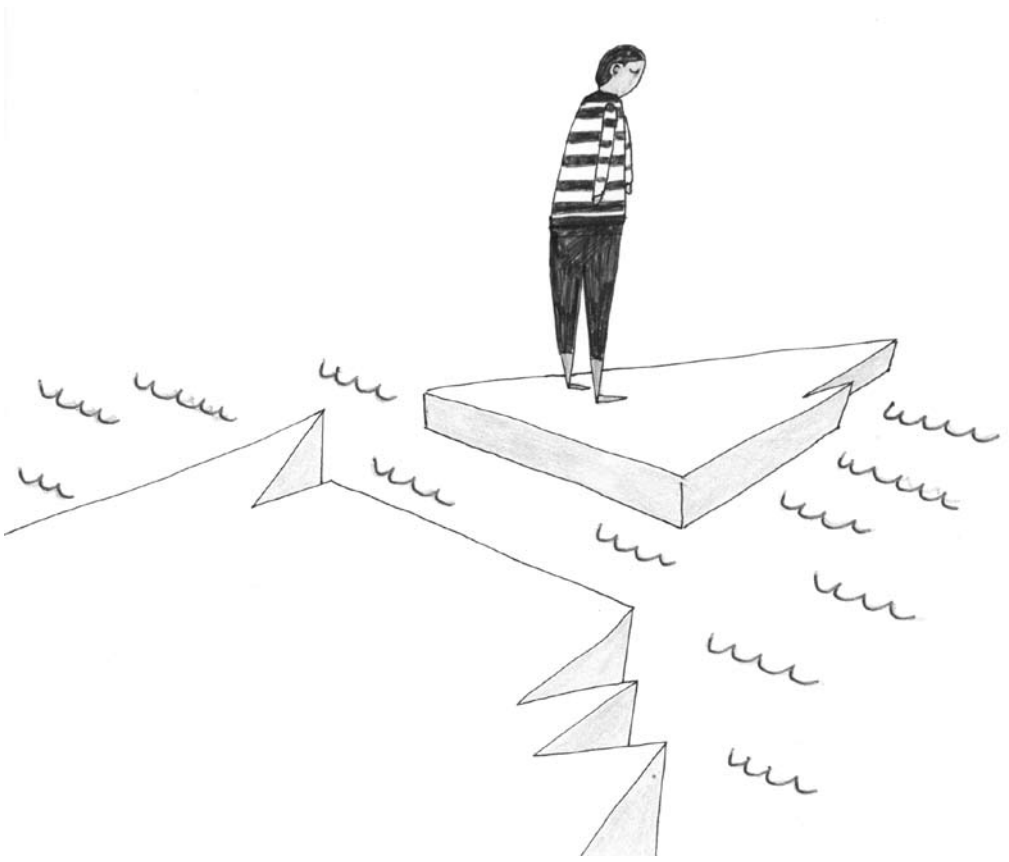
One of my recurring hopes is that in my rabbinic work I might be able to help Jews grow up. For, emotionally and psychologically, many Jews live in a pre-modern world, with infantile beliefs about God continuing to dominate thinking as if Kant and Kierkegaard and Freud had never existed. Immersed in inherited ways of believing and hallowed ways of behaving, such religious adherents – as well as their secularised co-religionists – continually romanticise and sentimentalise the Jewish past, or 'tradition', or 'ritual', or attachment to Israel, as ways of avoiding the anxieties and demands of the present. Individually or collectively, this 'compulsion to repeat' is, as Freud recognised, a resistance to remembering traumatic pain. This might be personal pain rooted in family life, or collective pain left over from the Holocaust. (I simplify: this is a complex topic.) But what we end up doing is unconsciously re-enacting that unresolved pain in the present: in family life, in Jewish communal politics, in relation to the Palestinians.

Bringing psychoanalytic thinking to bear on the realities of Jewish life – helping people understand projection, splitting, displacement, etc. – is an endless struggle against entrenched defensiveness and denial. For a rabbi it is sometimes, as any analyst will also know, a rather thankless task. And yet, as in the Biblical myth, revelations can occur. That there might be better ways to live; that compassion and forgiveness and generosity (towards one's self as well as in relation to others) are not only prophetic demands on the community but personal qualities that can be nurtured and that can be transformative; that sustained attentiveness to, and the interpretation of, the unfolding mysteries and dreams of everyday life is a psychological and spiritual discipline: all this involves acts of faith. And, in particular, the analyst's faith that if we listen in carefully enough – *'Shema, Yisrael': 'Hear,* O Israel' (Deuteronomy 6:4) – 'the pattern will emerge' (Freud) ■

Rabbi Howard Cooper is a psychoanalytic psychotherapist in private practice and Director of Spiritual Development at Finchley Reform Synagogue. He blogs on Jewish and psychological themes at www.howardcoopersblog.blogspot.com

On the Front line

Working with victims of torture



By Derek Linker

Derek Linker talks about the challenges of working psychoanalytically with victims of torture at The Medical Foundation – Freedom from Torture

WORKING WITH traumatised patients is part of everyday therapeutic work, whether in a public, private or organisational setting. I want to talk about a group of people who have been the victims of torture and are referred to The Medical Foundation – Freedom from Torture (FFT) in London, which has been in operation since 1985 and where I have worked for the past twelve years.

Within the FFT there is a whole range of activities and approaches: case workers, counsellors, psychotherapists, art therapy, gardening projects, and various therapeutic groups. The list goes on. I am going to talk about those clients for whom a psychoanalytic approach seems most appropriate. My ideas come from the perspective of a Jungian Analyst where the central focus is the process of Individuation.

Clients are self-referred to us from various agencies such as solicitors, GPs and social services. In 2011 they originated from over eighty different countries and regions, numbering hundreds from Iran and Sri Lanka. Most face the ongoing uncertainty that they could be detained and deported to face further persecution in the country from which they fled. The majority of our clients need an interpreter, and this brings the first challenge. Sometimes there is a difficulty trusting someone from their own country, fearing the interpreter might be an informer from their own region. This is not necessarily paranoia, it does happen. The Refugee Council, for example, use pseudonyms with clients when they make an appointment to see them.

Trust is the first issue. Having three people in a room is a powerful reminder of detention and interrogation. In the first meeting clients are often very fearful, glancing over their shoulder, fearing a sudden blow, or extreme tension at the sound of footsteps which in the past could signal torture. Maintaining an analytic position is not straightforward. A destitute client cannot be nourished by an interpretation that connects his present problem with past experiences of abandonment; that would be for a later date. The major challenge for an analyst is to temporarily abandon the analytic position and involve himself in practical help. For example, no accommodation or support, and threat of removal (deportation). There are immensely knowledgeable workers to deal with these problems but they are not available on tap, and often the analyst needs to act there and then.

Resolution of practical problems becomes a huge challenge for the analyst, reawakening in the unconscious of therapist and client the inner spectre of the great healer, the invincible warrior. The effect on the client is to see the therapist in the light of the invincible. In private practice I would hope the negative transference to surface and be acknowledged. How can a client attack the Saviour! It is imperative that neither therapist nor client are taken over by these archetypal figures.

Outcome measures are very current in the thinking of organisations for a number of reasons. I cannot measure outcome but I can recognise change. Most common to my clients (true of most, I believe) is the effect of Post Traumatic Stress. They suffer disruption in sleep patterns, nightmares, flashbacks to torture, severe depression and tremendous feelings of loss and shame. I find it helpful to have some image or conceptualisation of their inner world. It is as though their inner life comes to a standstill, the internal objects appear frozen; it is as if they live in a waking coma.

I have found clients don't want to talk about the actual experiences that caused them to seek asylum. The unbearable feelings of loss, abandonment and annihilation that the client cannot deal with are projected on to the analyst. Projective identification is harder to deal with than the horror stories which cause it. The analyst's ability to carry and process these feelings until the client is able to deal with them himself plays a large part in determining a positive therapeutic outcome.

Andres Gautier et al., in their recent book *Bearing Witness,* put it very well when they say that victims need not only someone to listen carefully, but able to offer a refuge for the pain of those who have no internal shelter, especially when nameless dread, a familiar concept in all therapeutic work, was no longer fantasy, but became fact.

'Maintaining an analytic position is not straightforward.'

This raises the question as to how a psychoanalytic approach can initiate a healing process. When I think about these clients as a group my main observation is that their thinking becomes very concrete and the ability to symbolise virtually disappears. In the early stages of therapy dreams are simply a repetition of torture. It is only later that the dreams become richer, and the ability to give associations and appreciate the creativeness of dream material develops. For example, the dreams of a young woman repetitively describe her experiences of torture until one day there is a change. In a series of dreams over time she dreams she is clinging to the roof of a car, in another dream she is sitting in the back seat of a car, later in the passenger seat and eventually driving herself, albeit hesitantly. Dreams that graphically chart the progress in her inner world of taking charge of her life, returning to the path of Individuation. The essence of my approach is to breathe life into the glowing embers of the inner world by restoring or reviving the symbolic function.

For many clients the advent of torture is akin to an earthquake. From one moment to the next life collapses. Everything they knew, place and people, no longer exist. As Rudyard Kipling's poem *If* puts it, they see their lives broken and have to build them up again with 'worn out tools': loss of the familiar, hopes and expectations torn to shreds, thrown from the path of Individuation in horrendous fashion.

It is not surprising that, following the disastrous experience of torture and tremendous loss, the client projects so much hope and power on to the analyst. Actual practical help confuses the transference. The 'As If' aspect of the transference is replaced by a concrete Good Father/ Saviour figure. A potentially destructive inflation.

There are pitfalls in any analytic relationship, but they are potentially deeper when the analyst is forced by circumstance to operate in the client's outer world, particularly when it demonstrates the seeming power to play a major part in determining the future and well-being of the client.

There is insufficient space here to do more than acknowledge the huge importance and impact of cultural differences, how it affects the therapeutic dialogue. Nor is there room to make more than a brief mention of the part the FFT itself plays in the healing process – the total acceptance and uniqueness of every individual as someone to be respected and cared about using all the varied resources the FFT has at its disposal is actually paramount in the road to recovery ■

Derek Linker is a Jungian Analyst and member of the SAP. He works in private practice, and is Clinical Lead at Freedom From Torture (formerly Medical Foundation) where he works with victims of torture and organised crime. www.freedomfromtorture.org

The Henderson

The Henderson circa 1964-67

By Estela V. Welldon

The Henderson Hospital in Surrey, which treated people with personality disorders, closed in 2007. Our correspondents look back on this much-missed institution.

VISITING THIS YEAR'S Turner prize, I was taken down memory lane to a precious and surprising place by one artist's piece, Luke Fowler's film called *All Divided Selves*. I was overwhelmed by the impact on me of his exploration of the life and work of Scottish psychiatrist R.D. Laing.

I had forgotten what the psychiatric atmosphere of the 1960s and early 1970s was like, but this film vividly brought back the feeling of that particular era, revealing how the relationship between individuals and society changes through time. It made me feel very nostalgic about that time in which I had the great fortune to work in one of the most exciting and revolutionary clinical institutions: the Henderson Hospital. This residential unit had been founded by Maxwell Jones in 1947 with the aim of the treatment of so-called psychopathic personalities, today, severe personality disorders.

The Henderson gave me a renewed sense of trust as a therapeutic place, which existed for the benefit of the patients and not of the staff. The enormous challenge of their treatment was met by a sound and adequate structure of democracy and division of labour in which everyone, patients and staff, shared not only the burden of their treatment but also the administration of the hospital.

Admission and discharge procedures were only a part of the philosophy of the place in which patients had not only their say, but also could make decisions regarding the discharge of patients. At times this was hard to bear. I remember often getting back to London in tears in the train feeling so angry and frustrated with the 'bloody community' for discharging a patient who had broken the existing rules and who I thought I could have successfully treated if only they had been allowed to stay. It took me a long time to learn that the community understood the matter better than myself. It was the arrogance of the medical profession, which made me feel otherwise.

At the time of my starting work there, the medical director, an elderly gentleman, Dr Taylor, was away on leave. Two weeks later, the nice 'honeymoon' established between the community and myself was suddenly and unexpectedly brought to a close. When the medical director returned, he announced in the community meeting his decision to retire in a month's time. This took everyone by surprise, which soon gave way to the patients' indignation and tremendous grief. Fantasies ran wild and gave me, if not the first indication, then a very strong sense of the powerful transferential response evoked in these patients when faced with separation from someone they have learnt to trust. Delinquent behaviour was rife. Shoplifting excursions to the local shops, joyriding and pregnancies were some of their ways of expressing their distress.

'It took me a long time to learn that the community understood better than myself.'

Patients were devastated about the old man's departure and angry, even livid at my own staying. Staff members were also split about this reaction; some felt relieved and others in competition for the 'heir' role. The split was powerful since they saw him as a frail and fragile nice old man and me as the rotten young bitch ready to take him over. It was all a bit too much for them. The next move was not only to blame *me* for his leaving, but also they decided that the director *had* to leave the post, because I, a young woman at the beginning of her training, was avid for power and had successfully managed to grab the medical director's post.

The Henderson in those days treated a hundred patients, and the intensity of expression of feelings was extraordinary. Whatever interpretations of the splitting processes were made were of no avail. On the contrary, for many days to come, at the time of the Doctors' group (a therapeutic group run as a small group by each doctor), patients of my small group formed a circle around me, spitting all sorts of verbal abuse with the occasional attempt to throw a chair at me (the fact that the chair never hit me gave me the hint they did not *really* want to get rid of me). This powerful negative transference was not easy to take, even if intellectually understood. That was a therapeutic challenge that had to be taken seriously. I then learnt of the powerful countertransferential response evoked in myself, which made me feel vengeful, angry and sad.

At that time there were in England two formal institutes for the training of mental health workers, including psychiatrists. These were viewed as opposite and opposing schools. One was the Maudsley Hospital, which used to be the 'sacred', 'respectable' institution, very conservative. And the other was the Tavistock Clinic, whose staff was composed of psychoanalysts who were considered at the time rather unorthodox.

Alongside these there was the quite anarchic and revolutionary Kingsley Hall, led by Dr R.D. Laing and his close colleagues, Drs. David Cooper and Aaron Esterson. This was a residential institution for severe mental problems such as psychoses where freedom of experience and of expressing emotions in whichever way was not only allowed but also encouraged.

At the Henderson there was a rigorous system of rules and regulations created by both staff and at the time still called patients (later to be changed for 'residents') which if broken could lead to the expelling of patients. Some of the patients exhibited what I used to call 'show-off' violence. In those days the Maudsley staff, comprising young students in training and well-seasoned psychiatrists, used to come every Thursday, with the aim of learning about therapeutic communities. I used to resent those visits since our patients would 'put on a show', with the purpose of shocking the conventional traditional psychiatrists, in which they'd attempt to throw objects at everybody and use the most terrible language. It was all really showing off because we were never touched. There was quite a bit of violence among them, but the place was very containing. In fact, the amount of containment among the patients was quite amazing; one of the reasons, I believe, for this to happen, is that they felt respected and dignified for the first time in their lives.

'Days were full with new learning which included much pain, but also unexpected reward.'

Patients and staff were assigned to different workshops, and, of course, being a woman, I was assigned to the homework workshop, which meant that we were in charge of cleaning the whole hospital. It was rather tiresome, and we looked forward to any crisis in order to get out of cleaning. At times my countertransference feelings were a bit too much when humiliation and shame came to the fore. For example, during our first Christmas I offered to cook dinner for the full community (these were one hundred patients plus staff) just to be told by the community that I was playing at being the nice, generous girl or the Virgin Mary or even more to the point a Jesus Christ in his last supper.

Despite my initial reaction of wanting to leave immediately, this being my own acting out, I decided to stay. The following three years gave me a wonderful share of the community life with the richest interaction between patients and staff. Days were full with new learning which included at times much pain, but also unexpected reward observing those patients who were able

Estela with Stuart Whiteley at his retirement from the Henderson in 1988

to leave the Community after achieving inner changes.

One of the added reasons I stayed for so long is that when the new director, Stuart Whiteley, was appointed he asked me to stay because he did need someone who had been there for a while with the unorthodox role of 'training' him – even though I was ready to move on because I was still in training myself. I think he felt he had to offer me something in exchange. At the time, my father was unwell and I had no money to pay for my trip back to Argentina, so he suggested I work my passage home as a ship's doctor. He said he'd done it, and I could go all the way to Argentina for six weeks for free. I said that six weeks was too long; nobody had been allowed to leave for more than two weeks. I'd already taken the issue to the staff meeting, and they had said 'No way.' I said in a rather provocative fashion that in that case I would take my request to the patients and the community meeting.

So when the 'doctors' spot' – a period of two minutes when doctors could talk – came, I was trembling and shaking a lot, and I said I'd really like permission to see my father, and wanted to work as a ship's doctor because I didn't have the money to pay for my ticket. To my colleagues' surprise, all the patients said, 'Of course, Estela, of course, you go. You've got to see your old man.' The previous decision was overturned and I was able to go for six weeks.

Of course I was delighted about being allowed to go although later on, during my trip, I grew increasingly concerned about my patients' welfare and my six-weeks' absence, keeping in mind the extreme severe transference issues in the work with these patients. With the help of my colleagues I was able to understand more and more about our patients' early emotional deprivations and their 'acting out' behaviour which was their way of expressing their bereavement for someone they had valued and missed and their hate at me for staying with them.

'What sadness that this magnificent therapeutic place has been closed forever!'

On my return, I was wearing a beautiful suit of kid leather that my friends had given me in Argentina. I arrived at the hospital on a Monday morning, full of trepidation about the patients' anger against me for being away for such a long time. To my enormous surprise, I was very moved – they'd placed an enormous red carpet full of holes on the driveway. On the front of the building a hanging read: 'Welcome home Estela'.

During my absence I had felt particularly concerned and preoccupied about the welfare of a patient, a homosexual prostitute who was extremely attached to me. I had little or no expectation of seeing him again after being absent for six weeks. I was. And who was the first patient I saw but this guy, who came rushing up to me, saying, 'I hate you, you fucking bitch I love you.' Then he tried to touch me, fingering my leather suit, and said, 'Oh fucking bitch, you're wearing PVC.' I wasn't indignant about him calling me fucking bitch, mind you, but indignant about this wonderful leather being called PVC!' I said, 'This isn't PVC, this is leather!' Then he said, 'Oh, don't be a stupid bitch, and I have the proof.' When I asked what he meant, he replied, 'When I touch real leather I get an erection and look at me now, I haven't got one!'

What do you do at such confrontation but just announce you are back and to notice with them how this return means a great feeling of care and real concern for them all?

What sadness then that this magnificent therapeutic place has been closed forever! Recently I was confronted by a young person who said in a rather alarmed way: 'What do you mean: that patients were paid and they all got treatment for free in such a democratic system?' Her shocked response and her complete absence of belief made me aware of the terrible losses we have gone though the last few decades in our NHS and that we sadly have felt quite impotent and useless to deal with. These are tragic outcomes and denial and an apparent ignorance of what went on before are our best defence: NOT to deal with reality. Everybody seems to be concerned with cold data and research results, but that film at the Turner prize was so full with life, spontaneity, hope and acceptance that for a while it looked as if it were from a golden age. Yes, sadly I realize this had been quite a golden age, and although I had appreciated it as such I had not been fully aware of its uniqueness ■

Dr Estela V. Welldon MD DSc (Hon) FRCPsych is the Founder and Honorary Elected President for Life of the International Association for Forensic Psychotherapy, a Fellow of the Royal College of Psychiatrists, an Honorary Consultant Psychiatrist in Psychotherapy at Tavistock Portman NHS Clinics.

John Adlam, Principal Adult Psychotherapist for the Henderson Outreach Service Team from 2001 until the Henderson closed in 2008

The Henderson and its sister therapeutic communities Webb House and Main House were the only inpatient units within the NHS where the residents controlled admission and discharge. It was endlessly challenging and unnerving (and an immensely creative process) to find oneself on terms of equality – of personhood, of humanity, of authority – with the residents. This of course says a lot about the inequalities we so often assume and allow to go unquestioned in more conventional psychiatric settings.

I remember vividly my first experience, on the interview day, of sitting in the daily community meeting (the '9.15') and feeling so very much the outsider, among people who had perhaps most of their lives been left to feel that position so acutely and painfully. This feeling never quite left me, partly because I worked in the Outreach Service, which was often viewed by both staff and residents of the Community through a lens of intense ambivalence. We were often thought of as too 'outside' to understand the workings of the residential part of the service. Perhaps I had my own ambivalence about being 'too far in'.

It was always nerve-racking to book an outreach patient into a 'selection group' (much more nerve-racking for them, of course!) and to have to wait to find out if the person had been accepted into the Community. No doubt referring teams felt much the same way, and in the end the Henderson was just too different to the rest of the system of care for comfort. The eventual closure of the Henderson was a regrettable and perhaps cynical exercise but the Service often brought hostility upon itself and perhaps got too caught up in the outsider role for safety.

Of course it was not for everyone. There were some that we couldn't reach or engage with, but there were so many over the years who found meaning and hope in their lives through the democratic therapeutic community experience in a way they had never imagined possible. My years there have massively influenced my own thinking and practice. The Henderson is closed now but that model of working is still very much alive ■

The Henderson

Andy, attended from July 2005 to July 2006

The belief that you can effectively 'treat' people who have been labelled 'personality disordered' has often been questioned by psychiatry. How can a tablet mend a broken soul? Numbing the pain won't make it go away.

You can't open yourself up for 'soul surgery' and then go back home after a few hours either. Living at the Henderson was essential. For people like me it provided everything I needed to do this safely. Anyway, what is 'home'? The context for your misery? Where you were buried alive? If I wasn't resident it would have been too risky, like shaking up a bottle of Coke together then leaving you to clear up the mess on your own, when the top blows off.

If you've been running away all your life, to stop, turn around, and meet yourself takes a lot of courage. I often refused to see what was reflected back, but after a few months I started to experience that 'hall of mirrors' effect. Seeing all my old behaviours and distorted thinking in the newer residents forced me to see those parts of myself again, giving me a powerful example of how far I'd come.

When I joined I didn't have any friends because I felt like a total c**t. If you're not around people it feels like you don't exist. So to be 'seen' and 'known' again is very anxiety-provoking. Learning to trust and allow yourself to be vulnerable is a very gradual thing; it took me a long time to settle.

Talking about your stuff exposes you to its 'charge', like cracking open big containers of radioactive waste at the bottom of the sea. I had so much charge inside me I felt like a human bomb. The groups help you find the detonator and cut its wires before you mindlessly act out all of that feeling. Eventually, after a lot of sharing and listening, its intensity wanes.

The community is a beacon of hope; it shone insight and awareness through a collective magnifying glass, like a concentrated beam of sunlight illuminating the darkest recesses of your soul. To be open to receive it is very challenging, but it enabled me to see through my quarterised self-image and drop the mask. To live in that light is to find real acceptance.

I began to realise I was perpetually feeding a black hole in my psyche. I decided to try and focus my energy on the here and now rather than breathing life back into the anger, hate and hopelessness of yesterday.

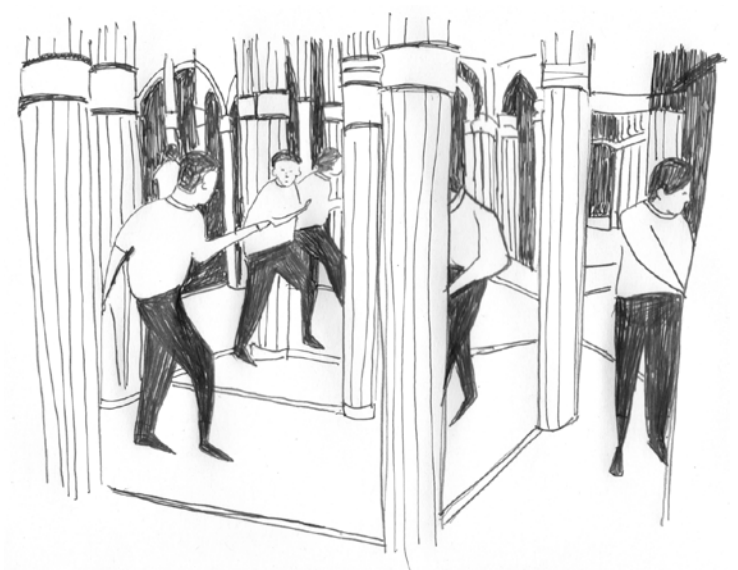
'It was the first place where I found a true sense of belonging.'

I wasn't a victim, I was a 'part' rather than 'apart'. Seeing myself in this different context changed everything. I'd never put down roots before because I never felt wanted. But I planted myself there, where I felt valued and needed, even loved. It was the first place where I found a true sense of belonging. Henderson took out the separation, knowing what you are to the group and what the group is to you is like a drop in the ocean realising it is [it] the ocean.

I've heard arguments against taking people out of their lives, but I needed that long period of incubation to find myself, to begin to grow, to build strength and resilience, to learn how to live. If I had been forced to go back and face it all earlier nothing would have jelled together.

Henderson was its own ecosystem; if you'd taken something out it wouldn't have worked properly because everything was so inter-related. It's a tragedy that there is nothing like it now. These new therapies are nonsense, whoever invented them is like a farmer who thinks he can grow his seed without the sun, rain and soil.

I see everything now in terms of pre and post Henderson; to me it was where my life really began. It taught me a better way of being and seeing the world ■



Classifieds

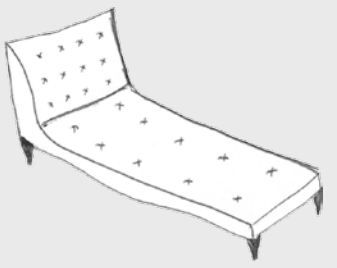
ISPS conference. The International Society for the Psychological & Social Approaches to Psychosis. Warsaw August 22-25. Warsaw University , Warsaw Old Town, UNESCO World Heritage Site.
Rich opportunities for exchanges between experts of all major psychotherapeutic modalities for psychosis. See www.isps.org / www.isps2013warsaw.pl for more details

FOTOGRAPHIC.EU Need a stylish, elegant, personalised web or graphic design? Experienced professional specialised in websites and stationery for psychoanalysts and psychotherapist – keen to satisfy all your graphic needs.
Costanza Umilta Web Design & Graphics
info@fotographic.eu / www.fotographic.eu
0208 671 23 56/ 07513 457884

Earl's Court rooms 3 minutes from underground. Couch & two chairs in each room. £50 for 4 hours (am) £50 for 4 hours (pm) £45 for 3 hours (evening). Reduced cost for whole day.
Contact Clare Millar 07795 205855 Christine Campbell 020 7581 3374

Consulting Rooms, W1. Comfortable, spacious consulting rooms suitable for analytic work in group practice two minutes walk from Oxford Circus, and close to Harley Street W1. Very reasonable rates and collegiate atmosphere. Contact Ed Marriott at edmarriott@aol.com

Victoria Psychoanalytic Practice. Consulting room to let. Good location for referrals. 1 minute from Victoria Station, excellent transport links.
For more info pls write to Mary Thomas at mary.thomas@nsimail.co.uk or Fatima Martinez del Solar at Fmtz@psychoanalysisinvictoria.org.uk



Have you a couch or any psychotherapy books you want to sell? Are you looking for consulting rooms, or have one you would like to rent out?

Prices for classified advertisements start at £20 for 40 words. Please contact Leanne Stelmaszczyk for more details on 020 7561 9240 or email leanne@psychoanalytic-council.org

News

PP NOW Awards

The Psychoanalytic Psychotherapy NOW conference will once again feature an awards ceremony to celebrate achievements in the psychoanalytic community. This year we will be seeking nominations for the following awards:

Innovative Excellence This award celebrates a striking example of ground-breaking work. The innovative nature of the work can be in terms of clinical practice, research, or socially inclusive practice, such as working with selections of the community who may traditionally find access to therapeutic treatment difficult.

Outstanding Professional Leadership
This award recognises a significant contribution to developing the position and/or influence of psychoanalytic/ psychodynamic psychotherapy in the wider world.

Bernard Ratigan Award for Psychoanalysis and Diversity This award applauds an individual or organisation who has significantly improved and/or developed inclusivity in psychoanalytic practice and/ or therapeutic treatment.

Please send your nominations by 31 July to leanne@psychoanalytic-council.org for consideration by the awards committee.

Regulation update

The BPC and the Association of Child Psychotherapists (ACP) are to jointly apply as partners to have their registers accredited by the Professional Standards Authority (formerly the CHRE), under the Assured Voluntary Registers scheme. It is anticipated that the application documentation, which is nearly complete, will be submitted in May.

Debate

A personal journey

Interview by Chloe Diski

On a chilly Sunday afternoon in January, four BPC trainees got together to talk about their training. They began by discussing whether their experience of psychoanalytic training met with their expectations

Marina: My training is a great personal journey, whilst also being a very lonely one. It's a way of being, I suppose, and it becomes difficult at times to separate life and work because it inevitably affects the way I perceive the world. Part of me feels I'm doing really important fulfilling training, and another part feels it is an unrealistic choice as it takes up so much effort and money, of course.

David: I'm in the final year of my course and intend to move on to the WPF psychoanalytic training, but already I am thinking I don't want to go into private practice, simply because it will be too lonely. The work is incredibly tough. We choose to take that on, but it can be very troubling at times.

Helen: It takes a particular personality to tolerate the intensity and loneliness of the work, and if you can end up as therapist you need a feeling of community with your peers. I do get that support within my course, but I have done a previous training where I experienced that sense of isolation.

Jennifer: At NEAPP trainees have to travel over large areas to get together, and analysts are few and far between. At the beginning of the training, regular meetings provided a lot of peer support but as training progresses there can be a real sense of isolation. Going back to David's point about not wanting to work privately, I started out as a registrar in psychiatry and have recently got a Consultant post. I notice that many senior analytic colleagues have their jobs under threat. I'm very tempted to go into private practice, which is a strange position to be in because I always saw myself in the NHS.

David: In the context of all job scarcity and insecurity, I ask myself 'what value does the training have for me?' The only way I can get my head around these obstacles is to make a decision based on it being a personal journey, and I struggle with that because this is supposed to be about trying to provide help to other people.

Marina: I feel that because of the amount of time this training demands, I sometimes have no energy to think about the politics of the profession. It seems important to know that after the completion of training there would be a secure job waiting for me.

'It takes a particular personality to tolerate the intensity and loneliness of the work.'

Helen: It is a difficult time in the NHS and it's easy to be pessimistic about the future. I think psychoanalytic psychotherapy will continue to have a place in mental healthcare as there will continue to be patients with difficulties that can't be helped with CBT and more 'cost effective' ways of working. Jennifer, I am also a medic and have friends in general psychiatry posts. A number of them in their late forties and early fifties are desperate to retire, and yet people doing this sort of work at sixty, seventy, eighty, are still full of enthusiasm and commitment. There is something there that is more important than money.

Jennifer: That something is the only thing that can keep you going! I was particularly keen to work in my current NHS post because an analyst was part of it. He moved his family from London to do the job, and then was made redundant. I have plenty of ideas and plenty of enthusiasm, but how do I maintain it in the current environment?

Marina: I feel this is a very British problem, which astonishes me because I moved from Greece to study in London because of its rich psychoanalytic history. Why is there such an attack on psychoanalysis here?

David: I feel quite strongly that culture has moved on, and the profession hasn't kept up. I'm talking fundamentally about marketing and research.

Helen: But there is research. Everyone says CBT therapists have clinical evidence and that's why it is so popular with commissioners, but there is also a strong research base for psychoanalytic psychotherapy. How does it get put across to commissioners and wider society? The answer lies in marketing.

David: I am doing this because I know it worked for me. That's the only evidence I need. But a profession so much about communication has failed to communicate with the public.

Jennifer: Maybe that's to do with analytic therapists being more in touch with the limitations of the model and not professing to 'cure', which holds them back from shouting from the rooftops like other models might do in a superficial way. Our silence, paradoxically, can be a superior position to take.

Marina: I think psychoanalytic culture in the UK is quite split. There are older therapists who have learnt to work in a specific way and don't want to give it up, and a new wave of younger people who want to make this way of thinking more contemporary. At a recent BAP event called 'We need to talk about money', some therapists saw it as outrageous to introduce internet banking, arguing an important aspect of the analysis would be lost. A cheque does bring a lot, but we have to be adaptable, and sometimes we use psychoanalysis to cover our own difficulties with change.

David: Culture is moving on to a point where people are communicating in disconnected ways through technology. Children today can't imagine they will find themselves in analysis because culture is running in a different direction.

Helen: I have a teenager who thinks even email is outmoded, but children still want to speak to someone every day about what is happening. Is that so different from five times a week analysis?

David: The issue for me is with the quality of the communication taking place.

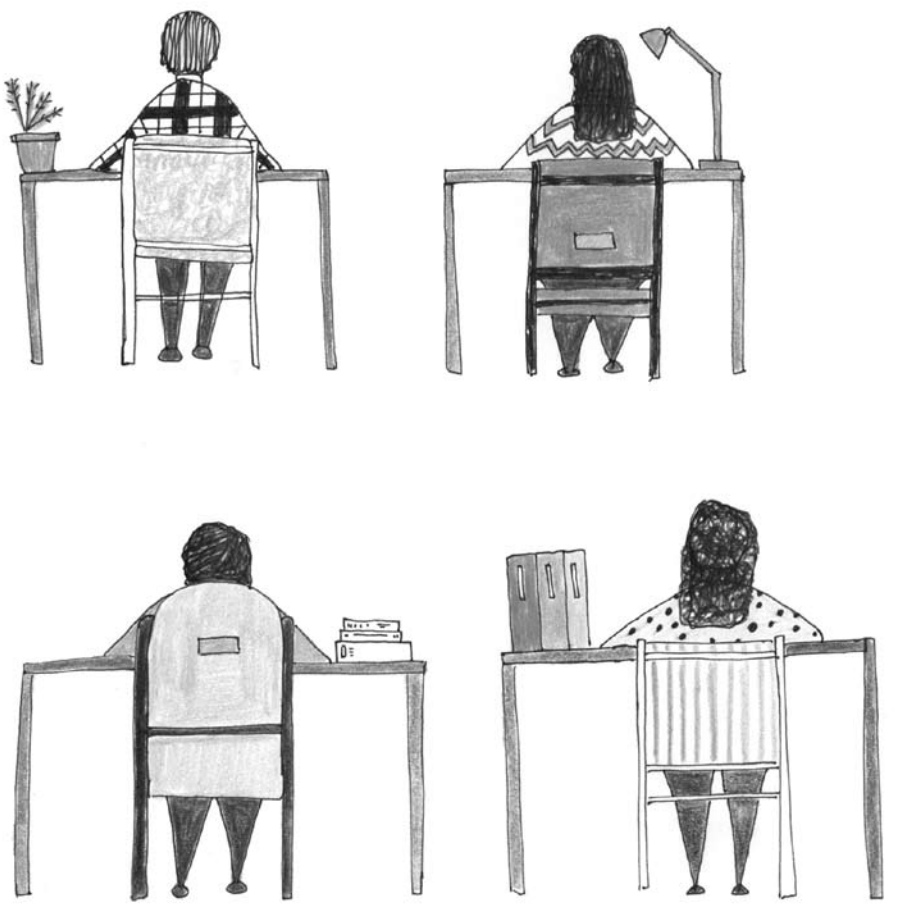
Marina: I think there is a world out there that we fail to communicate with, but we also fail to communicate with each other. Analysts who are more established tend to forget how difficult it is to train, perhaps because it was such a trauma!

Helen: Part of the reason I volunteered today was because I want to communicate more and to hear about other people's training. I am part of the BPC Trainees' Association, and we are trying to get social events going where people from different trainings can come together. We have got to stick together.

David: There are 460 trainees in total and 80 new people on BPC accredited courses this academic year. That's not bad. My sense is that after qualification people lose touch. To my mind the BPC are probably in the best position to create and sustain a community of people, which could act as a cure for the loneliness we were talking about earlier.

Helen: Yes, we have to find a strong culture within the trainee community. The Trainees' Association meet once a month, but there are not many of us, and some trainings aren't even represented. We would love more trainees to join and get together to carry on this conversation ■

BPC trainees are all members of the Trainees' Association. Not all trainings are represented on the TA Committee, so if you're interested in joining please contact Li Markakis via the BPC office, mail@psychoanalytic-council.org



Infant observation: seeing, sharing

By Leila Bargawi

From the observer…

THE INFANT observation I undertook in preparation for my child psychotherapy training was with a first time mother and her son John. For one hour a week for two years I would cycle to her home, initially in her mother-in-law's house, then in the young family's own flat. I watched the seasons change, first cycling through the cold winter air after John was born in February, then seeing the first blossom and the days getting longer and warmer before the leaves fell in preparation for another winter.

I grew and changed in that time as well, navigating the difficulties of finding a position as an observer, something that was a new skill for me. With time, both John's young mother and I became increasingly comfortable in each other's presence and could relax into the quiet, weekly time together.

I learnt so much in those two years about the process of observation, child development, the intensity of states of mind of an infant and how these are negotiated within the relationship of a mother and baby. I suppose it is rather obvious, but it really is an experience that stays with you, and since finishing the observation six years ago I have thought back to it at different stages and through different lenses as my life changes.

Initially, as a student, my interest was in the development of the baby's mind and personality and the negotiation of transitions within a relationship. More recently, as a new mother myself, I have again been reflecting back on those two years and, with hindsight, I am initially touched by the fundamentals of welcoming a stranger into one's home at such a raw and emotional time. For example, the musing John's mother did about whether John might be dreaming in his first few days when he suddenly smiled or grimaced in his sleep; the concerns she expressed aloud about his cries and what he might need. She did not know what to do, but was willing and able to do the 'not knowing' in my presence, not expecting herself to have an immediate solution, or for me to know what to do.

Having experienced some of these struggles myself, I can see now that just being a mother in front of a stranger can be very difficult and painful, and I can appreciate more what I took for granted then. I have learnt how much self-doubt and questioning you do as a mother, how the demands of a baby can make you feel inadequate, frustrated and ineffective, and I have experienced the powerful feelings you receive as a mother. The generosity of letting someone share that with you I find now more than ever very moving.

There was something unique in the space we shared for that hour every week when the daily grind seemed distant and our focus was on John and his impact on his mother. Of course there were also moments of ordinary everyday activity, but it is the pause of these activities when there is time and space to really look, feel, think and wonder that strikes me, looking back. In most of my observations mother, baby and I settled into a quiet time together, watching, thinking, feeling.

'Since finishing the observation I have thought back to it as my life changes.'

As a first-time mother I now realise how much there is always to do. It seems difficult to recreate that time to muse, to feel, or to just be together. It is as if you need that third to make it happen, someone looking in with you. I wonder whether a by-product of the process of observation was the creation of this space, an idea that I had never considered before I had insight into the constant demands of being a new mother.

I take part in the things my local area has on offer: baby groups, children's centre activities, even a new parents group. All of these activities are structured with set activities, again a lot of 'doing'. Of course with my daughter I have also really enjoyed and at times have needed the structure and activity, but I have also missed the just being together and the thinking that comes with a situation like an observation, a third looking in from the outside alongside me, that seems absent amongst the many things to do.

Of course there were moments during that observation that were uncomfortable. First there were times of observing the intimacy of the mother/baby couple in love, as an outsider. But there were also very painful times: I remember John and his mother fraughtly negotiating their separation, first when she stopped breast feeding and then when she returned to work.

Despite having witnessed strong and raw emotions as an observer, becoming a mother has made me aware that what I saw, felt and shared was only a tiny glimpse of what you are exposed to as a mother. There was one occasion when I arrived and was asked to return on another day. It was when John, nine months, had just started at full time nursery and was being weaned. I had seen him in various moments of distress, but as I spoke to the father on the intercom I could hear him totally dissolved in the background. It is only now that I have an idea of the pain he and his mother must have been going through in those weeks.

I can also now see that the strength of emotions, both the intimate love and the pain, happen mainly between the mother/father and baby couple when no one is looking, and I suspect that the main struggle at the time of John's weaning must have happened when I was not there. I have experienced moments of sheer terror when up in the night with my ill daughter as she struggles to find a way to let go and go to sleep: not able to comfort her for hours was frightening. We also have our games that seem to only take place when we are together, another presence always seem to interrupt them – even describing them here seems too intimate, too private.

It is these new experiences of motherhood that make me see the observation in a slightly different light. I am aware now that many distressing and intimate moments must have been kept from me, understandably so. They are to be negotiated within a couple: mother, father and baby making their own unique relationship with each other, quietly in private. I feel more aware now of how much I did not see or experience in my observation, but that does not take away from what I was invited into and what we did all share in that unique space, and my appreciation of the courage of John's mother to allow a stranger into her emotional world at that time ■

Leila Bargawi is a Child and Adolescent Psychotherapist in Doctoral training.

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

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

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

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

Design Studio Dempsey
Managing Editor Gary Fereday
Production and editorial
Janice Cormie and Chloe Diski
Illustrations Leanne Stelmaszczyk
Printer Advent Colour

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

Deadlines: The next issue of *New Associations* will be published in June 2013. The deadline for article proposals is 26 April 2013. Contributions and letters to the Editor should reach us no later than 24 May 2013.

ISSN 2042-9096

Just the three of us

By Leanne Stelmaszczyk

…and the observed.

I WAS ABOUT three months pregnant when my colleague showed me a post on the BPC website trainees' bulletin looking for a mother and baby to observe. My work as the BPC's development officer had allowed me see the importance of the profession in a way I never acknowledged before, and I thought volunteering would be a way to offer support.

I got a really good feeling from my observer when my partner and I first met with her, and didn't get any initial sense that infant observation would be something intrusive or hard to deal with. We thought nothing deeper than 'let's give it a go.' It was only after the first couple of visits, which were strange because I was so preoccupied I didn't really register her with us, that it finally weighed on me what infant observation was and what we were doing. In the early weeks of our son's life, even making the smallest decision, like what time she should come, was hard and felt very important. We eventually settled on a time, although I sometimes questioned that decision when I had been up all night. I often dressed as the doorbell rang.

When I tried to talk to the observer I didn't get much response and quickly accepted that she wasn't there for a chat. But even in her silent interaction I never felt ignored. She wasn't a negative presence, and managed to somehow silently project warmth. That helped with those early feelings of 'who is this stranger who doesn't talk?' A few times in the early days when I found breastfeeding quite difficult I had surges of embarrassment, and felt anxious that maybe she knew exactly what to do; then that quickly disappeared. She was just so good at melting into the environment. I remember nearly halfway through the year when I had got into a routine of nursing my son to sleep on our bed, she would just sit in the background watching us, and I thought, 'wow, how amazing that we can get to this point and it not feel strange.' It didn't feel like it was an element of support, more that she was just part of our routine, part of this whole experience of being a mum.

It was only towards the end of the year that I understood more about what it meant to my son, and I definitely wondered how he felt about their interaction, or more accurately, the lack of it. For quite some time Olek had recognised her, and tried to entertain or engage with her as soon as she arrived. I think maybe he found it strange that someone just sat there, smiling. During the final observation he even tried handing her a book that he wanted her to read, and I could see she found it hard. He has a secure attachment to her, as he is very calm around her, which is great to see because it confirms that he has enough of an attachment to us to feel secure enough to want to play with that other lady.

I did feel lonely sometimes but having that third person there, even not talking, felt like something was happening and that I wasn't talking to myself. There was also comfort in that regularity during a time that was so chaotic and scary. It was a constant I would almost look forward to.

The observation lasted a year and ended in January. It feels really strange to think that someone who was very much a part of such a momentous and amazing year, right from the beginning, wasn't going to be there any more. She is definitely going to be missed. A few weeks ago she said she would also find it quite strange not to come back, that she would miss him. She asked if we would mind her coming back on a more ad-hoc basis. I'm sure it would be a shock for Olek not to see her and I'm happy for that to continue for as long as she, and he, wants. Perhaps in time maybe he could give his own perspective and comprehension of the situation. I definitely would find it interesting to see what he feels or thinks about it. God forbid it would be something like: 'why did you put me through this?!'

'It finally weighed on me what infant observation was and what we were doing.'

Overall, the experience has reaffirmed the role of psychoanalytic psychotherapy and the fact that it needs promoting. It gave me an insight into the depth that practitioners go to understand human development, social interaction and emotional attachments. I mean, for quite a long period of our observation my son would be asleep for almost the entire session and I remember thinking sometimes, 'even I wouldn't watch him sleep for an hour and he's my own son!' That's the thing that impresses me the most about the profession; it's very serious and thorough ■

Leanne Stelmaszczyk is the mother of Olek and the BPC's Development Officer..

Diary

MARCH

15 March 2013

BAP 30TH ANNIVERSARY CONFERENCE: OUR PARADOXICAL 'IDLE BRAIN'

Speakers: Mary Sue Moore, Monica Lanyado
BAP, 37 Mapesbury Road, London NW2
Contact: admin@bap-psychotherapy.org

15 March 2013

BECKETT AND BION: EVACUATION, CONTAINMENT, AND FOOD FOR THOUGHT

Speakers: Laura Salisbury, Chris Mawson
112a Shirland Road, London, W9
Contact: marjorygoodall@iopa.org.uk, 020 7563 5016

15 March 2013

PSYCHIC 'GEODES' – THE PRESENCE OF ABSENCE

Speakers: Joan Raphael-Leff, Christopher Clulow
TCCR, 70 Warren Street, London W1
Contact: 020 7380 1970, jbending@tccr.ac.uk

16 March 2013

BOARDING SCHOOL SYNDROME: BROKEN ATTACHMENTS A HIDDEN TRAUMA

Speakers: Joy Schaverien, Nick Duffell, Penny Pickles
Tavistock Centre, 120 Belsize Lane, London NW3
Contact: clericalofficer@thesap.org.uk

16 March 2013

PSYCHE, LAW AND JUSTICE – JOINING UP HUMAN RESPONSES TO ECOCIDE

Speakers: Polly Higgins, Sally Weintrobe, Sandra White
Refugee Therapy Centre, 1A Leeds Place, London N4
info@climatepsychologyalliance.org

17 March 2013

SCREENING CONDITIONS: TROUBLED CHILDREN – THE KID WITH A BIKE

Speakers: Jean Pierre, Luc Dardenne, Andrea Sabbadini
ICA, The Mall, London SW1
Contact: ann.glynn@iopa.org.uk

21 March 2013

THE DEVELOPMENT OF PSYCHOANALYTIC CONCEPTS: WILFRED BION

Speaker: David Bell
B04, Birkbeck, Malet Street, London WC1
http://psychoanalyticconcepts6.eventbrite.co.uk/

21 March 2013

PSYCHOANALYSIS IN TEHRAN

Speakers: Gohar Homayounpour, M. Fakhry Davids
Freud Museum, 20 Maresfield Gardens, London NW3
Contact: 020 7435 2002, eventsandmedia@freud.org.uk

21-23 March 2013

FORENSIC PSYCHOTHERAPY IN THE COMMUNITY

Speakers include John Adlam, Gwen Adshead, Martin Humphrey, Celia Taylor, Jessica Yakeley
Zentrum für Psychiatrie Reichenau and Konstanz University, Germany
http://forensicpsychotherapy.com/

22 March 2013

BPC TRAINEES SOCIAL EVENT AND FILM SCREENING

BAP, 37 Mapesbury Road, London NW2
Contact: mail@psychoanalytic-council.org

22-24 March 2013

WORKING ALLIANCE IN ISTDP: HELPING OUR PATIENTS TO OVERCOME THEIR PERSONALITY DISORDERS

Speakers: Josette ten Have-de Labije, Kees Cornelissen
Priory Street Centre, 15 Priory Street, York YO1
Contact: mark.stein@swyt.nhs.uk or angela.cooper@swyt.nhs.uk

23 March 2013

UNDERSTANDING GROUPS

IGA Taster Day
Carswell House, 5/6 Oakley Terrace, Glasgow G31
Contact: 07876 584 097, glasgowenquiries@groupanalysis.org.uk

24 March 2013

STEPHEN GROSZ IN CONVERSATION WITH JOHN LAHR

Connecting Conversations CPU Fundraiser
Tricycle Theatre. 269 Kilburn High Road, London NW6
www.connectingconversations.org

26-28 March 2013

INTER-AGENCY WORKING: EXPLORING ITS COMPLEX REALITIES

Group Relations Conference: children, young people and families
Tavistock Centre, 120 Belsize Lane, London NW3
www.tavistockandportman.ac.uk/interagency2013

APRIL

12 April 2013

INFIDELITY AND THE SEXUAL RELATIONSHIP

Workshop: when infidelity impacts on the couple's sexual relationship
TCCR, 70 Warren Street, London W1
Contact: 020 7380 1970, jbending@tccr.ac.uk

20 April 2013

WORKING WITH PSYCHOSIS

Speaker: Philip Hill
WPF, 23 Magdalen Street, London SE1
Contact: 020 7378 2050, training@wpf.org.uk

20 April 2013

AESTHETIC CONFLICT IN ART AND PSYCHOANALYSIS

Speaker: Meg Harris Williams
LCP, 32 Leighton Road, London NW5
Contact: LCP, 020 7482 2002, info@lcp-psychotherapy.org.uk

20 April 2013

THE PULSE AT THE CENTRE OF BEING

Speakers: Sally Jakobi, Daphne Lambert
Friends Meeting House, 91-93 Hartington Grove, Cambridge
Contact: 020 7435 7696, clericalofficer@thesap.org.uk

20 April 2013

WINNICOTT: AN INTRODUCTION

Workshop Leader: Stephen Crawford
WPF, 23 Magdalen Street, London SE1
Contact: Mayra Angulo, 020 7378 2054

20 April 2013

BECOMING AN ENLIGHTENED WITNESS TO A HIDDEN "ADDICTION"

Workshop leader: Dean Whittington
WPF, 23 Magdalen Street, London SE1
Contact: 020 7378 2050, training@wpf.org.uk

26 April 2013

COUPLES AND MONEY – WAR OR PEACE?

Workshop: Couple relations with money
TCCR, 70 Warren Street, London W1
Contact: 020 7380 1970, jbending@tccr.ac.uk

27 April 2013

UNCERTAINTY & ECONOMIC LIFE: DENIAL OF REALITY IN PURSUIT OF THE PHANTASTIC

Speakers: David Tuckett, Elisa Reyes-Simpson
Governors Hall, St Thomas' Hospital, Lambeth Palace Road, London
Contact: 020 7978 1545, clinic@lincoln-psychotherapy.org.uk

MAY

10 May 2013

IN SEARCH OF A SOULMATE: LOOKING FOR THE PERFECT OTHER

Working with individuals and couples
TCCR, 70 Warren Street, London W1
Contact:020 7380 1970, jbending@tccr.ac.uk

11 May 2013

THE MATERNAL LINEAGE: IDENTIFICATION, DESIRE & TRANSGENERATIONAL ISSUES

Paola Mariotti with Alessandra Lemma
32 Leighton Road, London NW5
Contact: LCP, 020 7482 2002, info@lcp-psychotherapy.org.uk

11 May 2013

WORKING WITH GROUPS

IGA Taster Day, Manchester
Contact: 0161 728 1633, administrator@groupanalysisnorth.com

17-18 May 2013

PSYCHOANALYSIS, LITERATURE AND POLITICS: CELEBRATING HANNA SEGAL'S CONTRIBUTIONS

Speakers: David Bell, Geoffrey Baruch, Irma Brenman-Pick, Ron Britton, Donald Campbell, Égle Laufer, Jean-Michel Quinodoz, Vic Sedlak, Ignes Sodre, John Steiner, Riccardo Steiner, Sally Weintrobe
Regent's College, London NW1
Contact: marjory.goodall@iopa.org.uk

18 May 2013

THE INDEFINABLE SELF: CONCEPT, EXPERIENCE AND TOTALITY

Speaker: Warren Colman
SAP, 1 Daleham Gardens, NW3
Contact: 020 7435 7696, clericalofficer@thesap.org.uk

21 May 2013

CIVILISATION AND ITS DISCONTENTS, A CONTEMPORARY PERSPECTIVE

Speaker: David Bell
B04, 43 Gordon Square, London WC1
www.bbk.ac.uk/events-calendar/david-bell-workshop

31 May 2013

IGA GROUP WORK TASTER DAY, YORK

Workshop Leaders: Christopher Davies, Sally King
Contact: 01904 633996, info@yorkgroupwork.com

JUNE

7 June 2013

TRANSFERENCE AND COUNTER-TRANSFERENCE WITH SOMATIC PATIENTS

Speaker: Marilia Aisenstein
112a Shirland Road, London W9
Contact: 020 7563 5016, Marjory.Goodall@iopa.org.uk

8 June 2013

SEEING AND BEING SEEN: EMERGING FROM PSYCHIC RETREAT

Speaker: John Steiner
32 Leighton Road, London NW5
Contact: LCP, 020 7482 2002, info@lcp-psychotherapy.org.uk

15 June 2013

THE DARK SIDE OF THE SELF: JUNGIAN PERSPECTIVES ON DISSOCIATION AND PSYCHOSIS

Speakers: Maggie McAlister, Barbara Levick
Friends Meeting House, 43 St. Giles, Oxford
Contact: 020 7435 7696, clericalofficer@thesap.org.uk

22 June 2013

THE MIRACLE OF ABSENCE

Speakers: Arthur Sherman, Martha Stevns
Friends Meeting House, 91-93 Hartington Grove, Cambridge
Contact: 020 7435 7696 , clericalofficer@thesap.org.uk

22 June 2013

THE EMBODIED PSYCHE - A JUNGIAN WHOLE PERSON APPROACH TO DYNAMIC PSYCHOTHERAPY

Speakers: Margaret Wilson, Elizabeth Gray
SAP, 1 Daleham Gardens, NW3
Contact: 020 7435 7696, clericalofficer@thesap.org.uk

COMING SOON

5 October 2013

PSYCHOANALYTIC PSYCHOTHERAPY NOW

Speakers include Salman Akhtar, Susanna Abse, Andrew Cooper, Paul Hoggett, Jean Knox, Anna Motz, Rosemary Rizq, Jessica Yakeley, Biddy Youell
Holiday Inn, Bloomsbury London WC1
www.psychoanalytic-council.org

Opinion

Preparing for a post-IAPT NHS

By Ian McPherson

Ian McPherson explains how things might look from the perspective of policy makers, by considering some of the opportunities and challenges of a post-IAPT NHS.

IN MY ROLE as Director of the National Mental Health Development Unit, overseeing the development and implementation of the Improving Access to Psychological Therapies (IAPT) Programme, the strength of feeling within the psychoanalytic and psychodynamic communities that arose in response to this has not been lost on me.

To those less familiar with the world of psychological therapies, such as Department of Health Ministers and civil servants, plus those responsible for various aspects of the NHS, it often seemed puzzling that this major level of investment – resulting in over 600,000 people completing therapy in the last three years and almost 4,000 new psychological therapists – appeared to be regarded by certain groups with deep suspicion, if not on occasion an almost visceral antipathy.

Operating between the worlds of policy and practice and trying to create some greater synergies between them, it was my role to try to reconcile these conflicting opinions, often by explaining how things might look quite different from the other side, which is what I will try to do here in setting out some of the opportunities and challenges of a post-IAPT NHS.

At the present time the future of the national IAPT Programme remains unclear, but even if it does continue it seems most unlikely that it will retain the same influence within the restructured NHS. In this respect, the changing NHS climate, with clear moves away from centrally led and funded programmes towards local determination of priorities and responses to these, might be seen as creating the opportunity to promote the contribution of approaches and modalities not available through IAPT.

It has to be recognised, however, that it is not only policy and structures that are changing, but that all of this is occurring in a context of unprecedented financial pressures in the NHS, with the need to take at least £20 billion of resources out of existing services over the next three years to be reinvested in areas of increasing demand due to demographic changes.

This raises the question of how prepared are the psychoanalytic and psychodynamic communities to engage in this post-IAPT world and to address not only issues that have been highlighted a consequence of IAPT but also those which are a function of the impact of austerity across the NHS and the wider public sector. Some of the key issues are outlined below.

• IAPT has contributed to a wide acceptance that a large number of people presenting in primary care can benefit from psychological approaches to understanding and dealing with their problems. Given the prevalence of psychological problems, what can psychoanalytically informed practitioners offer to GPs and Clinical Commissioning Groups under pressure to deliver services to more people while at the same time to reduce overall expenditure?

• Even IAPT's strongest proponents acknowledge that around 50% of people presenting with mental health problems in primary care will not benefit from IAPT services. Can psychoanalytically informed practitioners demonstrate that they are willing to work with IAPT-style services to try to help those with different needs?

• All major political parties are committed to the expansion of choice among NHS funded providers, which could be an opportunity to promote modalities that have been favoured by the public but do not feature in IAPT. However, the systems such as Any Qualified Provider and Payment by Results that are being introduced with the intention of facilitating greater choice, while still in the early stages of application in mental health, are already raising concerns in many areas. How engaged are psychoanalytically informed practitioners in trying to ensure that their approaches will be recognised among the increased range of choices that will be available?

• Many people now seek information and support via social and digital media for all aspects of their lives, including dealing with psychological problems. As well as the pragmatic advantages of reaching wider numbers and groups who may be less willing to seek conventional forms of therapy, this can be seen as potentially transformational in the nature of the relationship between people seeking help and professionals providing this. What are the implications of this for how psychoanalytically informed practitioners might offer services both now and in the future?

• One of the biggest challenges to the NHS comes from the increasing demands on services from an ageing population with multiple long-term physical conditions such as heart disease and diabetes. Many of these individuals also experience significant levels of depression and anxiety but their psychological needs are rarely addressed. Can psychoanalytically informed practitioners help break down the mind-body dualism that still permeates the NHS and offer practical ways of supporting such people and taking pressure off services?

'The changing NHS might be seen as creating the opportunity to promote other approaches and modalities.'

I suspect that the initial response to the above questions from many in the psychoanalytic and psychodynamic communities may be that they would not start from here, or, perhaps more robustly, that addressing these issues is not their role. Even the use of the term 'psychoanalytically informed practitioners', to make a distinction between drawing on a body of knowledge to inform a range of practice in different settings and using this primarily in psychotherapy, may be thought to weaken the core of what the communities have to offer.

These are perfectly understandable reactions, but they could also be interpreted to suggest that current professional practice and training are not reflecting some of the key issues facing the post-IAPT NHS. As such, unless they can show a willingness to start addressing these, the psychoanalytic and psychodynamic communities should not be surprised to find themselves being marginalised in future developments.

This time, however, it will not be possible simply to argue that IAPT is the prime source of their lack of influence; rather it may be an unwillingness to try to see the world from the perspective of those who are charged with commissioning and providing services with ever diminishing resources for a larger proportion of the population and for whom traditional distinctions between therapeutic modalities may seem fairly irrelevant.

Fortunately there are increasing examples of psychoanalytically informed practitioners addressing these issues, as reflected in a number of recent contributions to *New Associations*, and also of leaders within the psychoanalytic and psychodynamic communities being willing to work with the emerging NHS system with all its faults, rather than simply criticise it for not appreciating the value of what they have traditionally offered.

This approach may well raise significant conflicts both for individuals and within and between the communities, but it is more likely to ensure that the post-IAPT NHS will provide a platform for further developments in psychological provision including the wider application of psychoanalytically informed practice ■

Dr Ian McPherson until 2011 was Director of National Mental Health Development Unit, which was responsible for the delivery of the IAPT Programme. He is now a Director, Advisor and Non-Executive Director with a number of mental health organisations but writes here in a personal capacity.