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## A blueprint for growth

By Malcolm Allen

**A** STRATEGY CONFERENCE in October representing all the member institutions of the BPC unanimously signed off a bold, forward-looking plan for expansion. Central to this ambitious blueprint is a capacious view of the profession the BPC now aspires to work for. It seeks to champion the whole of the psychoanalytic and psychodynamic sector, moving beyond the limited appeal to ‘frequency’ as the ultimate litmus test of what does or doesn’t constitute psychoanalytically-based work.

In its place, a statement that aims to capture the broad principles underpinning psychoanalytically-informed work will be the grounds for membership of the BPC. A statement of the BPC’s new strategic vision and the *draft* statement of principles, with the latter expected to be ratified by a November BPC Council meeting, are both published inside.

The statement of principles provides a basis for eligibility for psychodynamic organisations whose members train and work at lower frequencies than is traditionally the case with our existing membership to become BPC member institutions. Accrediting lower-frequency trainings was already agreed in 2008, providing they were attached to existing member institutions. Now an organisation based on a twice-weekly or once-weekly model can join the BPC in its own right.

Taking a cue from recent events in the Middle East, there is talk of a ‘psychoanalytic spring’. Growing numbers of people within the psychoanalytic community acknowledge that the massive challenges we face will not be overcome by recycling yesterday’s solutions. Conversations are taking place at all levels and in all organisations about the need for radical and innovative measures to maintain the future of psychoanalytically-informed work. Previously unthinkable ideas are taking shape and galvanising new energies. Rigid thinking and calcified ways of doing things are being questioned.

A new sense of purpose is in the air. A number of existing BPC member institutions are exploring the option of a merger. The BPC is in discussion with the Association for Psychoanalytic Psychotherapy in the NHS (APP) and the Association for Child Psychotherapists (ACP) with a view to creating a more united and powerful campaigning force for our approach. We are re-opening a conversation with the Institute for Group Analysis (IGA) to explore the possibility of developing a closer relationship. Our Registration Committee is now working harder than ever with a queue of organisations seeking BPC accreditation. In the meantime, we have been attracting new affiliate member organisations, including our first international affiliate: the South African Psychoanalytic Confederation.

### ‘There is talk of a “psychoanalytic spring”.’

One area where the ‘psychoanalytic spring’ is really making itself felt is homosexuality. For a long time, a quiet consensus has been growing within the BPC’s constituency that does not view as useful or even relevant the pathologisation of same sex relationships that has been promoted in the past. However, this has been implicit rather than explicit, and has not been articulated in a forthright way across the community, let alone beyond. It has been thought to be too ‘sensitive’, on the odd calculation that deference to past orthodoxies was more important than our relationship with the gay and lesbian community, especially potential trainees and patients. An irreversible change is now in train.

The last Psychoanalytic Psychotherapy NOW conference organised a lively break-out session on the issue which attracted significant numbers of participants. The next edition of the APP’s journal *Psychoanalytic Psychotherapy* is devoted to the subject. A special conference on psychoanalysis and homosexuality takes place on Saturday, 21 January 2012

which we hope will be well attended by many BPC registrants and other psychoanalytic practitioners. And finally, the BPC is moving towards a position statement that is expected to be adopted by the November Council meeting. Together these developments will give the pathologisation model the quiet retirement it now deserves, and hopefully allow for a new dawn of scientifically rigorous, psychoanalytic exploration of psychosexuality – at last reclaiming the movement’s original home ground.

This is also a necessary precondition to start to seriously address the issue of diversity for the profession, not out of anxiety about ‘political correctness’, but because a profession that is not able to engage with – and reflect – the diverse nature of contemporary demography isn’t going to carve out much of a place in the modern world. The decision that the BPC will develop a ‘realistic action plan’ in this area is vital; and the words are important. We have to move beyond easy rhetoric and abstractions, and start to think about what practical, incremental steps we can take that will begin to make a tangible difference.

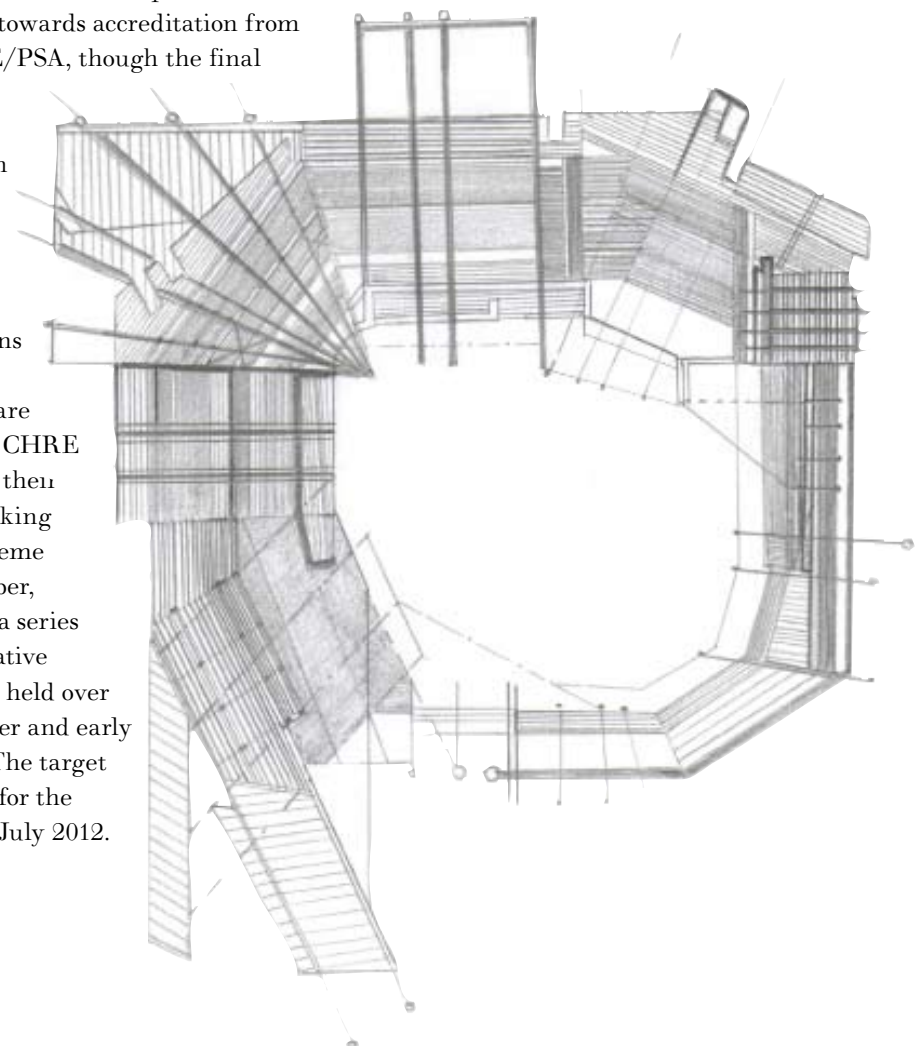
The Strategy Conference spent time considering the complex question of regulation, especially the government’s proposals around ‘assured voluntary regulation’ that the Council for Regulatory Health Care Excellence (CHRE), to be renamed the Professional Standards Authority for Health and Social Care, will be responsible for. The conference supported the view that the BPC should provide a form of regulation and registration for the profession, and will work towards accreditation from the CHRE/PSA, though the final decision on the application will be made when the full implications are clear. We are expecting CHRE to publish their latest thinking on the scheme in December, following a series of consultative workshops held over the summer and early autumn. The target start date for the scheme is July 2012.

The strategy for growth combined with the moves towards CHRE/PSA accreditation creates the need for significant changes to the structure of the organisation: at the levels of constitution, governance and management. The BPC Council already feels too large and meets too infrequently to function properly as a high-quality decision-making body; this can only get worse as we expand. In addition, accreditation is bound to require major changes to the way we do business. Our staff and management functions will also need to be re-organised around these new imperatives. This change process will be a major focus of work over the coming months.

The work of the Future Strategy Working Group, led by Helen Morgan and Alexa Walker in partnership with the Executive, laid the basis for the decisions taken at the Strategy Conference. The group is now turning its attention to questions of implementation, and in particular the major challenges around promotion and advocacy. This is to be the subject of a major Search Conference on Saturday, 28 April 2012.

In the face of the major challenges and setbacks being experienced recently, especially in the NHS, a new spirit of determined realism has begun to show itself. That old boiler of a philosopher, Friedrich Hegel, put it well: ‘Only when the dusk starts to fall does the owl of Minerva spread its wings and fly’ ■

Malcolm Allen is CEO of the BPC



# The BPC's new strategic vision

**THE FOLLOWING statement of the BPC's strategic vision was agreed by a special Strategy Conference held on Saturday, 1 October 2011.**

**The broad aims of the British Psychoanalytic Council (BPC) are:**

- to support and sustain a viable psychoanalytic/dynamic professional community
- to build an effective professional organisation serving the professional needs of that community
- to maintain and expand the availability and attractiveness of psychoanalytically-informed work to a UK population with diverse needs.

**To achieve these aims the BPC has agreed the following strategic objectives for the next 2 – 3 years.**

- 1. The BPC will seek to redefine and realign the profession around a trajectory of growth**
  - 1.1. The BPC will develop a formulation of the theoretical basis and boundaries of eligibility for membership of the BPC.**
  - 1.2. The BPC agrees the principle of accepting eligible psychodynamic organisations as BPC member institutions whose members train and work at lower frequencies than existing BPC member institutions.**
  - 1.3. The BPC will develop a realistic action plan that starts to credibly address the long-standing issues of equality and diversity within the profession.**
  - 1.4. The BPC will develop a realistic action plan to establish the BPC as a truly national organization rooted in the nations and regions of the UK.**
  - 1.5. The BPC will conduct purposeful discussions with like-minded psychoanalytic/ dynamic organizations with a view to achieve greater organisational cohesion in the short term.**
  - 1.6. The BPC will continue to build collaborative relationships with bodies such as United Kingdom Council for Psychotherapy (UKCP) and British Association for Counselling and Psychotherapy (BACP) that also represent psychoanalytic/psychodynamic practitioners.**
  - 1.7. The BPC will develop a scheme to enable and encourage individual and group affiliates, especially from relevant fields such as psychiatry, government, NHS, universities, etc.**
  - 1.8. The BPC will agree to give high priority to communicating effectively to our own registrants the importance of the BPC's strategic mission and objectives.**
- 2. The BPC will provide an appropriate form of regulation for the profession**
  - 2.1. The BPC will continue to act as the voluntary regulator for the profession of psychoanalytic and psychodynamic psychotherapy and counselling, maintaining a professional register.**
- 2.2. The BPC will work towards an application for accreditation from the Professional Standards Authority for Health and Social Care (currently the Council for Regulatory Health Care Excellence), though the final decision on the application will be made when the full implications are clear.**
- 2.3. The BPC will work on proposals around its governance and procedures that are deemed necessary to secure accreditation from the CHRE/PSA in the light of the emerging scheme.**
- 2.4. The BPC will play an active part as a stakeholder in the process of developing the CHRE/PSA's accreditation scheme.**
- 3. The BPC will shape a strategy for the promotion of psychoanalytically-informed work**
  - 3.1. The BPC, using the focus of the planned Search Conference, will develop a strategy for the promotion and advocacy of psychoanalytically-informed work in all sectors to enable our registrants and member institutions to compete more effectively within the contemporary market.**
- 4. The BPC will work with its member institutions to help rethink and reorganise the training of the future profession**
  - 4.1. The BPC, using the focus of the planned Training Conference, will work with member institutions to develop a comprehensive and diverse training infrastructure throughout the UK, capable of training future generations of psychoanalytically-informed therapists.**
- 5. The BPC will refocus our information and other services to support the profession**
  - 5.1. The BPC will refocus its information and other member services with a view to enable our registrants and member institutions to compete more effectively within the contemporary market.**



# A proposed formulation of the theoretical basis that defines the BPC and its boundaries

*The following describes the five broad principles that would have to be shared by any organisation joining the BPC as the basis for clinical practice. It is an attempt to define only what is necessary and sufficient as a statement of the basic criteria, and does not aim to be a comprehensive description of psychoanalytic/dynamic practice. The formulation is intended to cover psychoanalytic and psychodynamic work with children, adults, couples, families or groups.*

**1. The centrality of unconscious processes in the model of the mind employed within the approach to clinical practice.** This includes paying close attention to the potential for symbolic meaning revealed in dream and fantasy as indications of an internal emotional life that can be understood.

**2. A model of psychological development that recognises the key contribution of early childhood experiences** in shaping characteristic patterns of emotional distress, psychic conflicts and anxieties, and the defences instituted to manage these. From this derives the ability to work appropriately with patients' needs, anxieties and defences.

**3. The centrality of the therapeutic relationship as a primary means of promoting psychic change.** This leads to a focus of attention on the transference and counter-transference as a fundamentally important means of identifying and processing relational patterns as they become dynamically activated in the therapeutic relationship. The way these are worked with may vary depending on a number of factors including the intensity, frequency and type of work

but will always indicate the need for the therapist to respect the potential transference dynamics by behaving in a well-boundaried and relatively neutral way with low levels of personal disclosure.

**4. The specific symptoms which may lead a patient to seek treatment are regarded as manifestations of internal psychic distress.** Thus the aim of the work is to take the presenting symptoms seriously and, as well as directly addressing them, to engage with and explore the internal dynamics to which they point, with the ultimate aim of developing psychological capacities and resources and becoming able to face life's challenges with greater flexibility and freedom.

**5. The approach to clinical practice will include the therapist's commitment to maintaining an open-minded, emotionally available and self-reflective attitude** as a means of facilitating the exploration, articulation and containment of the full range of the patients' experience.

The titles 'patient' and 'therapist' are used as generic terms and are not meant to preclude other preferred terms ■

## BPC chief executive moves on

Malcolm Allen, the BPC's chief executive for the past five years, is to become the new Dean of Postgraduate Studies and Director of Education and Training at the Tavistock and Portman NHS Foundation Trust. He will start the new post at the beginning of January 2012.

Malcolm said: 'I am immensely looking forward to meeting the challenges of the new post at the Tavistock. But I will be leaving the BPC with great sadness. The last five years has been amongst the most richly rewarding of my professional life, and I have enjoyed massive support from every section of the BPC constituency. I believe that together we have achieved a huge amount, and that with the new strategic vision in place, the BPC is poised for a new wave of growth and success. I am proud to pass on that legacy to my successor.'

Julian Lousada, Chair of the BPC, writes: 'One of my first acts as Chair of the BPC was to be a member of the panel that appointed Malcolm Allen. Quite simply this was probably the best decision I and the BPC Executive have made in the past five years.

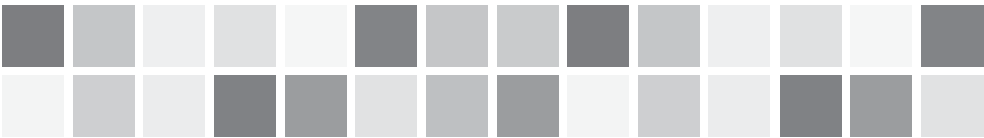
'Malcolm has been an outstanding CEO. Our community does not easily take to being 'led' by a non clinician. It is a testament to his skill and intelligence that he has earned such a degree of admiration and gratitude. Above all he has demonstrated how a professional organisation can play an important part in the promotion of the psychoanalytic project. His contribution can be measured in the wide range of working relationships he has developed both within the BPC and beyond. For myself it has been an inspiring partnership and it goes without saying that we shall miss him greatly.

'Whilst managing our sense of loss I do also believe that no organisation depends on one person and I feel confident that we shall make another good appointment so that we can continue the work Malcolm has made such a creative contribution to.

'The consensus that the recent BPC Strategic Council achieved is in no small way an illustration of Malcolm's achievement in helping our community collaborate and develop.'



**The 5th annual New Savoy conference arrives at a time of significant change in the NHS commissioning landscape. Psychological therapy services will need to understand this landscape if they are to navigate the NHS efficiency drive intact, and expanded, in line with the government's promise to invest a further £400M. Who and what should guide the clinical commissioning decisions in the new GP-led NHS?**



Thursday 24 and Friday 25 November 2011  
Savoy Place, London, WC2R 0BL

To book your place please visit

[http://www.healthcareconferencesuk.co.uk/psychological\\_therapies](http://www.healthcareconferencesuk.co.uk/psychological_therapies)  
or for further information contact  
[kerry@healthcareconferencesuk.co.uk](mailto:kerry@healthcareconferencesuk.co.uk).

Letters to the Editor

Psychotherapy services in the NHS

I read the article ‘Psychotherapy services in danger’ on the BPC website with great interest and wanted to share some of the ‘dangers’ that I have noticed within the NHS Trust I currently work for.

I am not trained as a psychoanalytic psychotherapist, instead having gained a Practitioner Doctorate in Psychotherapeutic and Counselling Psychology from the University of Surrey. However, I highly value this way of working and have reasonable knowledge and experience in this model. I therefore really value the relationships I have formed with the psychoanalytic/dynamic therapists who work within the same NHS Trust as I. During my training one of the four psychoanalytic departments in the Trust provided a placement for me where I received the opportunity to work and be supervised with both individuals and analytic groups. Subsequently to qualifying, the same department allowed me to join a supervision group where I could continue to reflect on my work with the aid of an analytically trained therapist and the other group members. I have also benefitted from consultation on complex cases/organisational dynamics and the ability to refer clients who might require a more ‘in-depth’ therapy than I myself am able to provide.

However, over recent years I have noticed that posts, within these already under-resourced departments, are not being filled when members leave. More worrying still, the Trust recently implemented a ‘redesign’ of its adult mental health services and those psychologists who ‘survived’ the process were told that we were receiving ‘too much supervision’. Our supervision arrangements have now been limited and I am no longer allowed to participate in the additional monthly psychoanalytic supervision group I used to benefit from.

More worrying still is the general attitude within the Trust that seems to favour the cognitive-behavioural model (using NICE guidelines to support this). Within the next year the Trust is to implement the ‘Payment by Results’ model of working (as advocated by the Institute of Psychiatry I believe), with the related ‘clustering’ of clients at assessment and standardised interventions that this entails. Having seen the draft interventions proposed for each cluster, psychoanalytic/dynamic therapy is nowhere to be seen. The interventions are heavily weighted towards CBT and its off-shoots such as IPT, mindfulness etc. It is not clear, but I have heard talk that the psychodynamic therapies will be offered as ‘second line treatments’ for those who do not benefit or do not wish to be pushed into CBT. As mentioned, this thinking is justified

by the use of NICE guidelines, despite objections from some clinicians (such as myself) that within secondary and tertiary care there are no guidelines for the ‘complex, severe and enduring’ client group that we have to work with.

It seems to me that these changes significantly disadvantage psychodynamic therapies and therapists (including those such as myself who are informed by this model and appreciate the consultation and supervision required to work in this way). It is also very worrying for those clients who benefit from psychoanalytically informed practice. I fear that this trend, if carried to conclusion, would all but eradicate these therapies from the NHS, by the removal of analytic work offered directly by analysts, and by the removal of their ability to consult/supervise those of us whose work is often informed in this way.

Whilst a psychologist rather than psychoanalyst, I feel that pluralism is needed, especially to work with complex cases, and that many need the approach that psychoanalytic thinking offers. I am extremely concerned over the way things are going.

I hope that this information will, in some way, be useful to future attempts to redress this balance ■

Dr Roly Fletcher  
Chartered Counselling Psychologist

PIPES and Therapeutic Communities

I was surprised reading Nick Benefield’s article on ‘PIPES and personality disorder’ that there was no mention of therapeutic communities. I gather PIPES aims to create something similar to that provided by therapeutic communities; a therapeutic environment in which serious psychological work can be done. Therapeutic communities I know of dealing with people diagnosed with personality disorder were the Henderson Hospital, closed down by the previous government, and a therapeutic community in Grendon Underwood prison. The Cassell Hospital, still in existence as far as I’m aware, works with dysfunctional families including those struggling with personality disorders.

Research projects carried out at the Henderson, and no doubt elsewhere, showed positive results in treating this difficult patient group. When I worked at the Henderson I saw how individuals changed positively over the six to nine months they stayed there. I, and other members of staff, would even years after come across previous residents of the Henderson now leading fulfilled productive lives, grateful for the experience which changed their life.

The mental health provision for the Royal Borough of Kensington and Chelsea used to provide therapeutic community day centres individually tailored for a range of mental health problems. That was dismantled in the 1990s in favour of the latest fashions in mental health where buzzwords were ‘user involvement’ (ignoring the fact that therapeutic communities have genuine, meaningful user involvement), and ‘directions of change’ with apparently no clear idea of what ‘direction of change’ to go in.

It seems from Nick Benefield’s article that the wheel is being reinvented; than none of the experience and knowledge gained from the once thriving therapeutic community movement is being drawn upon for this initiative. Can I refer him to the considerable body of writing covering the theory and practice of therapeutic communities, including the *International Journal of Therapeutic Communities* and the book *Dealing With Deviants* by Stuart Whitely, Denise Briggs and Merfyn Turner ■

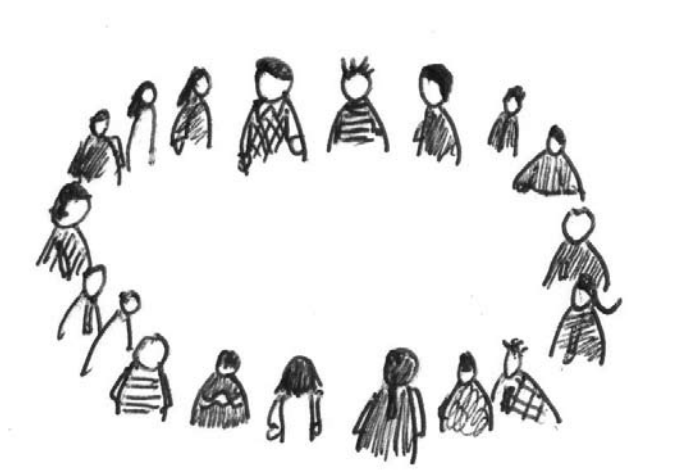
Catherine Wilson  
Senior Member, BAP Jungian Analytic Section

Nick Benefield responds:

As Catherine Wilson will have noted from the article, PIPEs are not a model of treatment but rather the development of conditions in which more focussed psychological work can be supported. The objective is to establish the setting in which relational work is more likely to take place. They are not watered down versions of the therapeutic community (TC), which is a complex model of social therapy with a long history dating back to the early years of the 20th century. PIPEs are not, as she seems to suggest, an attempt to create a TC ‘lite’ model of treatment. Therapeutic communities are not referred to in the article precisely because it would confuse the concept of environment rather than intervention. The TC is an established model of treatment. PIPEs provide more psychologically informed and supportive conditions in residential and custodial settings where psychological treatments are more likely to be taken up, supported, and the process of change in the individual sustained. To achieve this we need to improve the ground on which these models are planted. The wider work on Enabling Environments (EEs) by the Royal College of Psychiatrists, with the development of PIPEs, aims to create better environmental conditions, and organisational cultures in which TCs and many other psychological treatments can grow and be shown to be effective.

The closure of TCs in recent years relates to the many changes in health and social care policy, and in particular the increasingly economic and evidence eye applied to public service commissioning. However, their demise has as much to do with a failure in communication and understanding in our relationship to the non-psychotherapy world as with an attack on psychotherapeutic work per se.

Whilst this matter cannot be debated here, I raised many of these issues in my Maxwell Jones lecture 2005, and it might be helpful that we consider these issues afresh through future articles in New Associations ■





# New review supports psychodynamic therapies

By Nick Midgley

FOR MANY YEARS psychoanalytic and psychodynamic therapies have been considered to lack a credible evidence base, and have consistently failed to appear in lists of ‘empirically supported treatments’. Partly this has been due to a degree of reluctance among psychodynamic practitioners to support the kind of empirical research that would help to establish such an evidence base; whilst other approaches – especially cognitive behavioural therapy – appear to have been more active; but partly it is due to the fact that the research which has been done has not been gathered together and widely disseminated.

In the field of psychodynamic treatment of adults, the situation has finally begun to change over recent years, with the publication of a series of important reviews and meta-analyses culminating in the landmark publication of Jonathan Shedler’s paper on ‘The efficacy of psychodynamic psychotherapy’, published in the *American Psychologist* (2010). This paper brought together the evidence from a number of randomised controlled trials, showing that effect sizes for psychodynamic therapies are at least equal to those of other forms of treatment long regarded as ‘evidence-based’, and that patients who receive such treatment not only appear to maintain their therapeutic gains after treatment ends, but in many instances continue to improve after treatment ends.

Whilst the situation may have changed in relation to the treatment of adults, research examining the efficacy and effectiveness of psychodynamic treatments for children and adolescents has lagged behind. In 2004 Eilis Kennedy was commissioned by NHS London to undertake a systematic review of the literature, and in 2010 (with further support from the Association of Child Psychotherapists) I joined her to update and revise the review. In conducting such a systematic review of the research, our intention was to provide as complete a picture as possible of the existing evidence base for individual psychodynamic psychotherapy for children aged between three and

eighteen, thereby enabling more refined questions to be asked regarding the nature of the current evidence and gaps requiring further exploration.

Using a systematic search strategy, we identified 34 separate studies that met criteria for inclusion, including nine randomised controlled trials (RCTs), the so-called ‘gold standard’ of outcome research. Full details of our findings are reported in an article in the *Journal of Child Psychotherapy* (volume 37.3), which comes out in December 2011. But overall, our review of the research literature suggests that there is some evidence to support the effectiveness of psychoanalytic psychotherapy for children and young people, although many of the studies reported in our paper are small-scale, often lacking in carefully selected control groups, thus making it difficult to draw any firm conclusions with confidence.

Although the evidence base for psychodynamic psychotherapy with children and adolescents is still at a relatively early stage in its development, these studies have begun to give some tentative indications about who is likely to benefit most (or least) from psychodynamic child psychotherapy. Key conclusions from the review included the following:

- Although there are relatively few studies of psychodynamic therapies with children and adolescents compared to those focusing on the treatment of adults, those that exist indicate that this treatment can be effective for a range of childhood disorders, as measured by well-validated, standardised research instruments.
- Where direct comparisons have been made, psychodynamic treatment of children and adolescents appears to be equally effective to comparison treatments, with mixed findings across studies - some suggesting psychodynamic therapy is more, some less, and some equally effective as other forms of therapy.
- There are some indications that psychodynamic treatment may have a different pattern of effect to other treatments. For example, when

- compared to systemic family therapy, depressed children appeared to recover more quickly when receiving family therapy, whilst improvements for those receiving individual psychodynamic therapy appeared to be slower but more sustained, with some young people continuing to improve after the end of treatment. A similar pattern of more gradual improvement, but with improvement continuing beyond the end of treatment, was found in a study of children with emotional disorders, giving some evidence of a possible ‘ sleeper effect ’ in psychodynamic therapy.
- Certain children appear to be more responsive to psychodynamic treatment than others. Where age groups have been directly compared, younger children appear to benefit more than older ones, with the likelihood of improvement during treatment declining with age. However, there are also studies that suggest that older children and adolescents can also benefit from psychodynamic therapy.
- Certain disorders appear to be more responsive to psychodynamic treatment than others. Children with emotional or internalising disorders seem to respond better than those with disruptive/externalising disorders.
- Children and adolescents with disruptive disorders are more difficult to engage and more likely to drop out of psychodynamic treatment; but where they have engaged in treatment there is some evidence that it can be effective.
- There is a particularly strong evidence base emerging for the treatment of children and young people with depression. One RCT conducted by Trowell et al. (2007) was so sufficiently well-designed, with impressive findings, that it led to psychodynamic treatment being identified as an evidence-based treatment in the NICE guidelines on child and adolescent depression in the UK.
- There is also a range of studies that suggest that psychodynamic work is effective with children who have experienced abuse, maltreatment and trauma, although the group is too diagnostically diverse for this to

- be reflected in empirically-supported treatment guidelines.
- In samples that can be assumed to have lesser degrees of difficulty, either because of the setting or selection criteria, short term and even minimal interventions were shown to be effective.
- When children present with more marked difficulties, e.g. with conduct disorder or severe emotional disorder, the intensity of the treatment may be important.
- There were some indications of potential adverse affects. One study suggested that if psychodynamic child psychotherapy was offered without parallel work with parents, this could be counter-productive. Another study suggested that for adolescents, receiving more intensive therapy (three to five times per week) rather than once weekly therapy did not improve outcomes, and that more intensive work could, in some cases, add to the adolescent’s sense of ‘ stigma ’.

One positive message taken from this review is that the amount of research investigating the efficacy and/or the effectiveness of psychodynamic psychotherapy with children and adolescents has increased decade by decade from the 1970s through to the present day. Indeed, fourteen of the 34 studies included in the review had been published in the last seven years. This is a promising sign that we are beginning to gain some understanding of ‘ what works for whom ’ in regard to psychodynamic treatments for children and young people ■

*Nick Midgley is a Child Psychotherapist and Program Director of the MSc in Developmental Psychology and Clinical Practice at the Anna Freud Centre / University College London. Nick was awarded the Early Career Achievement Award by the BPC in 2010*

References

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The online version of the paper can be found at: <http://www.tandfonline.com/doi/abs/10.1080/0075417X.2011.614738>

# Asylum: one step beyond

By David Morgan

*How can those of us in the psychological professions hope to bring any internal asylum or respite from suffering to people in such extreme states of deprivation and trauma? David Morgan seeks some answers.*



**A**S FOR MANY, the scene in the film adaption of Ken Kesey's *One Flew Over the Cuckoo's Nest* when the native American chief, who has been incarcerated for many years in an asylum, tears a water fountain from its mounting and hurls it through the hospital wall then lopes his way to freedom, seduced me. The filmic images of institutionalised human beings constrained by authority made me passionate about the need for revolutionary action to free the oppressed. In those days Laing saw asylums as repressive institutions and psychosis as more of a spiritual journey than a disturbing psychiatric meltdown. The closure of the large mental hospitals during Thatcher's government apparently following the theories of Italian psychiatrist Franco Bassaglia, although questionable under that government, seemed a good thing, and the espousal of 'Care in the Community' a progressive step. Bassaglia was even quoted by the then health minister.

The true intention of that government's policies soon became clear. It had nothing to do with placing people back into society but was an excuse to close refuges, to save money. The 'Community Care' that was set up to 'contain' patients was in many cases 'community neglect', leading to a massive increase in suicide and the tragic cases of the unwell and dispossessed enacting their anxieties on others.

Like Cameron's pre-election slogan of the 'Big Society', the real aim of 'care in the community' was a cynical one, to encourage an espousal of charitable community values as a cover for saving money at the expense of the most vulnerable.

There followed at that time a lack of care for the mentally ill, who were then dumped into the care of the community: a public driven to earn more money to shore up flagging mortgages, who had no time or mental space to manage such complex problems in their midst.

The plight of those earlier dispossessed vulnerable people continues even more extensively. Those in need of asylum, be it for psychological or economic reasons, under the present global economy have even greater problems now. The need for safe places, where the lost can get a sense of identity or belonging, apparently has no place in an economy driven by market forces. The people who are unable to function as part of society due to psychological illness, or because they are dispossessed and outside our cultural norms, or cannot keep up with the need for economic striving, are not too different from the much maligned category of 'asylum seekers', now a term of abuse in many quarters; though asylum, as we all know, originally meant nothing other than a place of safety. Why, then, does society now hate those who seek or need safety? Are they reviled because they make us aware of our own vulnerable position? Our own struggle with life and death anxieties?

**““Community Care” was in many cases “community neglect”.”**

As with the destruction of the old mental hospitals, when the Berlin Wall crashed down along with the repressive communist dictatorships behind it, there was some hope that the removal of the physical emblem of control and authority could bring greater freedoms. Perhaps in some respects it has, but its effect has also been to reduce choice and to demonise societies with ideals other than the pursuit of profit. What profit can there ever be in providing asylum?

We can see the worldwide effects of this relentless market-driven society in our newspapers. In India tens of thousands demonstrate against the ruling elite, in Israel there are demonstrations for social justice, in China cyber critics blame their government for putting wealth creation

above social welfare, and we also saw the spring uprisings against the kleptocracies in Egypt and Tunisia and Syria, plus the rather pathetic riots in London that disturbed our holidays. All this anger is about one thing, as Pankaj Mishra in *The Guardian* said: 'extreme and seemingly insurmountable inequality' between the 'haves', the 'have-mores' and the 'have-nothings' in our society. In a market economy there is no asylum for the have-nots.

Protesters everywhere are driven by the conviction that the power structures of corporate and government work together to screw the broad middle and working classes. A few people, it seems, those self-satisfied bankers, have got rich while a majority remain poor.

The most vulnerable victims of this inequality are children in trouble, the aged the physically and mentally ill. In India, Pankaj says, hundreds of thousands of farmers have committed suicide despite their society being more successful than ever before. And now in this country it is our turn, of course: the educated and aspiring middle classes worry about our futures, or our children's. A child's failure to get three starred A's can feel like the beginning of sinking down through the social order to Skid Row. In other quarters this sense of helplessness leads to denouncing the corruption in politicians, businessmen and bankers, a corruption that leaves us helpless without a voice. We have a condition of prosperity without equality, wealth without peace.

Lest I appear a hypocrite, I admit that I benefited from house price increases, but like everyone else I too face an uncertain future where the idea of meaningful professional work for my children, doing what I was able to, where they might help others, is becoming a scarcity because sickness is not a profitable business. I never thought I would attend a meeting in the NHS where the patients were described as products but this has come to pass. Child psychotherapy is now beleaguered because it takes a long time,

so colleagues are being trained in quicker treatment methods because time is money. NHS Direct, that five-minute phone refuge that amplified what the NHS could offer, and the excellent Sure Start are being or have already been dismantled. Both offered refuge for the troubled and were in fact a pre-emptive strike on future more expensive interventions.

**‘The truth is we are all asylum seekers.’**

What I really want to get across is the asylum we all need to have and the hope we have of finding it both internally and externally. I believe it used to be a backdrop of our society, and even recently under the last government the importance of care for the underprivileged existed. The truth is *we are all asylum seekers*. The longing for respite from life and death anxieties, whether generated in our internal world, or all too apparent in crumbling external worlds whether from socio-economic or political causes is, I believe, a fundamental human drive.

The number of bankers I have assessed (privately, of course!) who feel they have lost their souls to the machine they created has increased. One man dreams he is being pursued by living dead zombies and a man in a taxi cab is helping him escape from their threat, to make him one of them, but the taxi is very, very slow, he screams at the driver, presumably me the analyst, to go quicker but he doesn't, keeping up the same plodding pace. This is a man who worked seven days a week, used cocaine, prostitutes etc., and had panic attacks on Sunday night. The panic attacks were perhaps the justifiable alarm of this man's beleaguered soul.

From my perspective, achieving the capacity to bear uncertainty and the terrors of life depends on having safe places both outside and, of course, inside. My profession as a psychoanalyst working at times with very disturbed and unhappy



people is mostly focused on trying to help restore or create for the first time an internal capacity to bear uncertainty and loss without too many psychotic defences, such that very frightened and troublesome people can attain some feeling of respite from mental torture. This is in my view a really important form of personal asylum. But I remain mindful of the fact that although my domain is that of mental torture, there is an external world of torture too.

The conflict brought about in trying to work with people whose loss of identity and dispossession is both mental and societal was brought home when working with groups of refugees and asylum seekers. Their awful helplessness that one assumes to bear can be unbearable, all that they may have dear they may have lost – family, dignity and home – leaving the therapist feeling helpless, fat and privileged.

Our task as therapists is supposedly to enable traumatised individuals to manage their psychological symptoms, anxiety, depression, chronic fear and constant risk of breakdown, when our own position at times can feel precarious. I remember at the height of the then soaring Thatcherite interest rates and, as for many at the time, my mortgage was a constant persecutory presence. It can be difficult at these times to process enormous need while simultaneously experiencing our own struggle to keep body and mind together. I was lucky in that I had some private patients at the time; thus I subsidised my work and paid the mortgage which the NHS salary no longer covered. The risk of homelessness was not a real threat, but I was aware there was little financial cushion for many to fall back on. That time, as now under the present government, felt like a win or lose society: if you failed you went to the wall. There were scenes of home repossessions, including that of a young unemployed architect next door to me. I do not of

course compare these middle class fears with the monstrously deprived people in my group, but I knew I had frissons of anxiety that related to theirs daily, and to my guilt I knew that compassion could fluctuate.

The pressing concerns of these people can involve housing, clothing, food and other basics. But they also have other needs too; more human, social and hard to administer, they needed help and a feeling that others could retain a sense of them as human even in the face of some of their experiences of rape and torture. The strongest impulse of many of those brought into contact with them was to turn away. I could sense my own pressing need to shore up my own sense of security in the face of their reminder of the traumatic possibility of loss.

‘Having to take in the profound loss and terror of others is very demanding.’

Since I have always needed inspiration to keep my hope alive and find ways to work with the hopeless, I turn to writers like John Berger:

*The poverty of our century is unlike that of any other. It is not, as poverty was before, the result of natural scarcity, but of a set of priorities imposed upon the rest of the world by the rich. Consequently, the modern poor are not pitied [have no asylum no way out no representative]... but written off as trash. The twentieth-century consumer economy has produced the first culture for which a beggar is a reminder of nothing.*

In my countertransference at that time with refugees and asylum seekers, I felt dispossessed and exiled from my identity

as a psychologist. It seemed that my academic tools of insight and empathy could be nothing against the powerful drive I felt: the need either to turn away and shut my eyes and ears, or to become a one-man charity centre for this group. The Bleeding heart. The Champagne socialist. This was a dilemma that can never be easily resolved.

It's important to get help, contact social workers to deal with acute problems of homelessness and neglect, all the while trying to keep the therapeutic space as a place where thinking and managing the sense of helplessness is valued. The sense of helplessness was on both sides, they who had experienced such loss and abuse and me who felt torn about what resources were needed and could be used. I learnt a lot from that group of patients.

How can those of us in the psychological professions hope to bring any internal asylum or respite from suffering to people in such extreme states of deprivation and trauma? I learnt very painfully and personally that there is a drive in me, which I think we witness constantly in all our hate-filled responses to people in need, to turn away and to reject. Having to take in and identify with the profound loss and terror of others is very demanding, and I think there is always a drive to push out the bad feelings through rejecting and demonising those who fill us with terror, thus repeating for them all their experiences of rejection and cruelty. We all have to find our own ways of fighting the battle to keep hope and compassion alive for both our work and ourselves. I find that it is through the collegiate experience of thinking with others and reading that sustains me, and recent reading brought me this, from John Berger again:

*One of the fundamental reasons why so many doctors become cynical and disillusioned is precisely because when the abstract idealism has worn thin they are uncertain about the value of the actual lives of the patients they are treating. This is not because they are callous or personally inhuman: it is because they live in and accept a society which is incapable of knowing what a human life is worth.*

For ‘doctors’ let us read us all. I believe it is only through fighting for a society which is truly committed to providing asylum in all respects, social and mental, for our most deprived that we individually and collectively affirm the worth of human life. We let our care institutions crumble at our peril. Remember please: *We are all asylum seekers* ■

*This article is based on a lecture given at St Anne’s College, Oxford, as part of the Children in Troubled Worlds Conference, 23 September 2011: A Step Beyond. Asylum. David Morgan is a psychoanalyst and member of the BPAS and BPA.*

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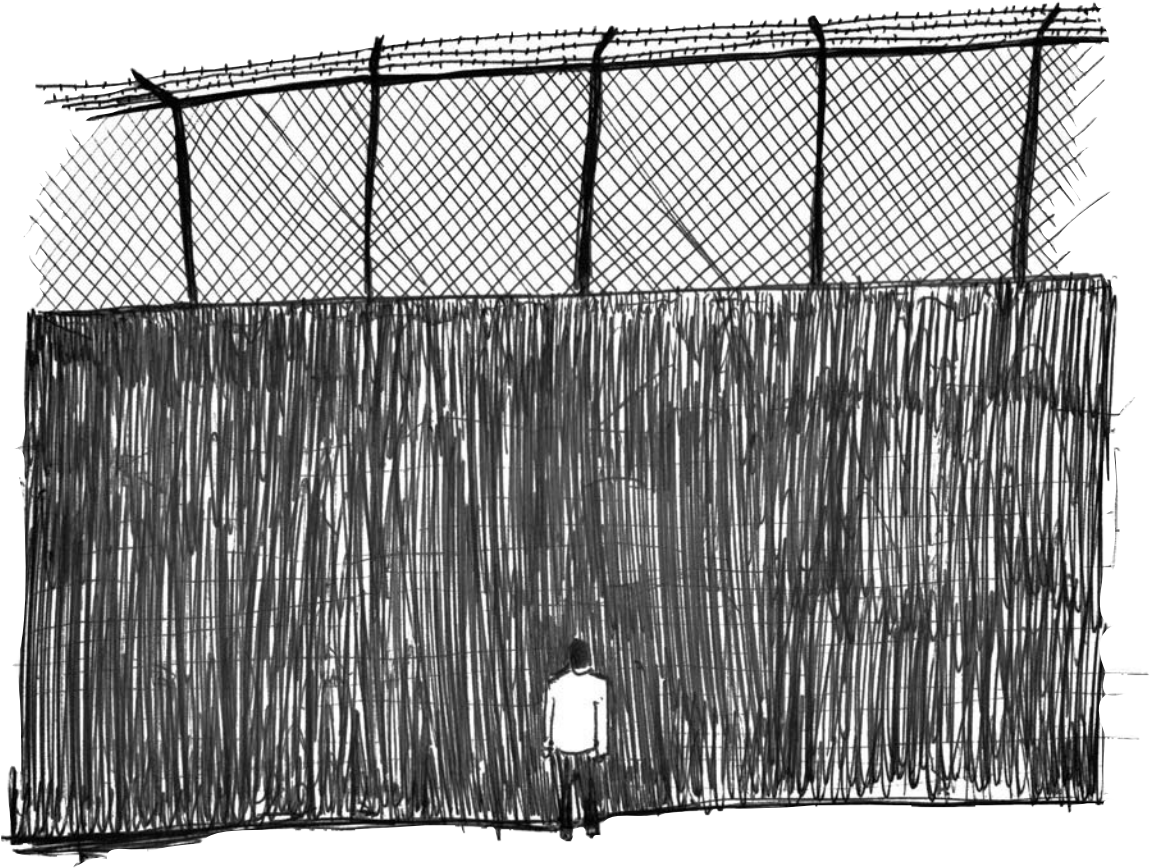
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# The best defence

By Gwen Adshead

*Although social defences are necessary to manage anxiety in institutions, they are problematic in two ways. First, the defence may not contain the anxiety, especially if it is chronic or extreme, leading to dysfunctional acting out as the anxiety grows. Second, both the defences and the acting out can impair an individual's capacity to perform their task. Gwen Adshead discusses how institutional defences operate in forensic settings..*

**F**REUD IS CREDITED with first describing how people defend themselves from overwhelming anxiety through the use of beliefs, values and attitudes that unconsciously work to relieve anxiety. Interest has increased in how *groups* of people deal with anxiety, and whether social groups too use defences; even groups as large as businesses and organisations.

In 1959, Isabel Menzies commenced a ground-breaking study which has influenced health care staffing and training. She utilised a psychoanalytic approach to help hospital staff to think about nurse training and retention by viewing their difficulties of student nurse allocation as the 'presenting problem'. She discovered that this 'actual problem' arose because a third of nurses were not completing their training, due to high levels of anxiety and distress. Others frequently took time off due to minor illnesses. She concluded that nurse absences, and the organisational processes that structured their training and employment, were unconscious defences against distress and anxiety entailed in general nursing care.

Menzies also concluded that these social defences operated to help both individual and organisation avoid the experience of anxiety, guilt and uncertainty. However, these defences were ineffective: staff still felt anxious and distressed, but the social defences meant that they were not allowed to know their feelings or express them. No attempt was made to enable the individual nurses to confront their anxieties and distress, and they were therefore unable to develop a capacity to bear these anxieties more effectively. It was inevitable that staff would drop out of training. Menzies later wrote, 'Unless staff know what they are doing, there is little hope of doing it effectively.'

Elizabeth Bott, who applied Menzies' thinking to a psychiatric setting, found a number of conflicting aims of the task of the organisation: a need to control the madness that society could not tolerate, a need to provide care for people who

required respite from their intolerable difficulties, and the need to offer treatment and cure to patients suffering from illness. That these aims were not compatible either went unrecognised or was not accepted by the hospital staff.

## Residential forensic settings: the demands of care

In forensic psychiatry, care is principally delivered through the medium of long stay residential care at different levels of security. High secure hospitals typically offer care for at least five years, medium secure care for two to five years; although these numbers are averages in both cases there may be people, patients and staff, who stay much longer.

This means forensic staff live cheek by jowl with patients for hours of days of weeks of years. Staff in these settings will spend more time with patients than with their own families; and their units and hospitals can become like enclosed communities of both staff and patients. In one case known to me, both a patient and his primary nurse had entered the hospital at the same time 23 years previously: they had both 'grown up' together in a high security hospital.

## 'Forensic staff will spend more time with patients than with their own families.'

Forensic nursing staff therefore have to manage the emotional demands of long term care for people with severe mental illnesses who do not recover quickly. However, they also have to try to make therapeutic relationships with patients who have committed horrifying and disturbing acts of violence. Normally, such people are shunned by others; instead, forensic nurses have to try to care for them, and nurses are faced with this challenge each time they enter the hospital. We can imagine, using both Menzies' and Bott's formulations, that staff have to defend themselves not

from *unconscious* fear alone, but from *conscious* fear of the patients, who have been identified as highly risky people. The emphasis on security measures means that nursing staff are being encouraged to provide a personally supportive relationship to patients, while at the same time being suspicious of the danger they pose.

Unconsciously, staff fear the madness in the patients, envy their care, and hate the hopelessness that their situation seems to provoke. Defensive manoeuvres to keep these feelings out of consciousness include distancing themselves from the patients as much as possible (for instance by withdrawing into the office or kitchen); rubbishising attempts to help the patients, and seeing patients as either 'all good' or 'all bad'. The latter is clearly an example of splitting, and represents both a manic defence against the reality of what the patients have done, and a cruel identification with the hopelessness of their position. Perhaps the most common form of institutional defence is found in policies and procedures that support either a collusive or a punitive stance towards patients, as demonstrated in the findings of two public inquiries into the work of high secure hospitals.

## Additional demands

There are three other problems peculiar to work in forensic residential institutions, which give rise to particular anxieties and defences. First, the vast majority of forensic patients not only have severe treatment resistant mental illnesses, but also suffer from moderate or severe personality disorders. Patients with personality disorders may not only relate in immature and fragmented ways; socially, they also elicit care from professional carers in hostile and toxic ways. In outpatient settings, staff may respond by distancing themselves from the patient; in forensic settings, this may not be possible.

Caring for forensic patients entails listening to accounts of both their offences and their personal backgrounds. Since the majority of forensic patients have been childhood victims of extreme abuse,

what they have to say is usually very disturbing to hear, and staff may not know what to say. Some patients engage in an unconscious symbolic re-enactment of either their abuse or the offence, so that the nurse ends up feeling either like a victim or a perpetrator of abuse.

Patients may relate to nurses as significant parental figures from a patient's past; especially since the nurse is someone who both cares for the patient and controls them, much like earlier attachment figures. Nurses can find themselves on the receiving end of rapidly oscillating attitudes from the patients (either needy or hostile) which leave them feeling bewildered and deskilled. For example, a patient with a persecutory and abandoning past care-giver will engage in a hostile way to a nurse who offers support in a kind and concerned way. The nurse experiences a hostile rejection and abandonment, just as the patient experienced in the past, and may be tempted to either abandon the patient, or respond aggressively, much as the past care-giver did. If they do so (and even the best of us may), the re-enactment has taken place. It is *essential* that all staff learn to understand this process to prevent further damage to the patient.

Second, the conflict of purpose that Bott described in the old style asylums is even more intense in forensic institutions. Are the staff there to help the patients feel better or behave better? How can they work towards patient recovery and discharge when it is not at all clear that their recovery is welcomed by society? Without care, patients will be institutionalised and hopeless, and the 'nursing' purpose will be gone; but even with the best care, patients may be so damaged that they continue to pose unpredictable risks to others. The conflict between the need to 'care' and the need to protect others is a crucial one for forensic nursing staff, and it leads to a multiplicity of unconscious behaviours that allow avoidance of thinking.

Finally, an anxiety that all forensic professionals try to keep as far from

**Continues on page 10**



# On the edge of nameless dread

By John Gordon

To get in touch with forensic patients, staff members must develop a method to get in touch with themselves and to reflect on their findings. John Gordon offers an example of what happens.

I WORK IN A VERY SMALL psychotherapy department in a very large forensic psychiatry service. There are about two and a half whole time equivalent posts, one a whole time Consultant Psychiatrist in Psychotherapy/Forensic, and three or four other part-timers, mainly analysts. We're a drop in an ocean of hundreds of patients and even more staff. In describing our clinical interventions, we have highlighted a psychoanalytic compass with which to orient ourselves: the countertransference responses to working with patients in an atmosphere redolent of classical Greek tragedy<sup>1</sup>. In effect, staff members are in the position of Creon as he faces the situation in Thebes after Oedipus' murder of Laius:

*I saw Plague, the killer of us all.  
Then the dreadful shrieks of Horror and  
blind Fury filled the air:  
There Grief stood, tearing at her hair:  
Disease, hardly able to stand at all,  
stumbled forward...  
I saw each wretched creature.  
The blood stopped still in my veins,  
and like a spike stuck into the earth,  
I could not move.<sup>2</sup>*

Forensic patients, whether psychotic or personality disordered, characteristically communicate through action rather than words; they are 'out of their minds', out of touch with themselves, and so cannot symbolically represent their mental states. Consequently, mental health workers may only become aware of what is going on in their patients through paying attention to their own feelings, reactions and experiences. In the forensic setting, the hammer-blow impacts on staff minds and the fear of assaults on heads are constant. To get in touch with their patients, therefore, staff members must develop a method to get in touch with themselves and to reflect on their findings. Reflective practice, consequently, becomes a key intervention in order to provide staff with a mental seatbelt to sustain their researches into their patients' dismantled minds by attending to those fragmented remnants which can still be glimpsed in their own minds, and which often also

present as impacts on the psychotherapist-consultant. Here is an example of what may happen.

I came onto the secure ward of a forensic hospital where several weeks previously I had arranged to meet regularly with multidisciplinary professionals to discuss their work. We had agreed the time and place, but on the first two occasions I had found myself alone for fifteen minutes. When I went out of the appointed room to ask at the nursing station whether people were planning to come to our reflective practice, I was informed that it hadn't been put in the diary for that week. Eventually my appearance outside the glassed-in nursing office would be noted, and members of the staff would file into our room.

Shortly after this inauspicious 'launch' of the group, I was sitting with the Consultant Psychiatrist, a nurse and a health care assistant. The Consultant, a regular attendee and major force behind the initiation of the group, was wondering aloud to his nurse colleagues whether any more of their peers intended to come. They were at a loss, commented that the ward was 'very busy today', and we all lapsed into a perplexed, helpless silence tinged with annoyance at what was pretty clearly emerging as resistance to, if not outright sabotage of, the reflective practice. I was not particularly surprised by this reluctance which I had experienced many times in forensic and other staff groups – including ones to which I belonged as a participant rather than a facilitator. But I had never experienced what was about to happen in this reflective practice group.

Suddenly the door opened and six male staff members burst into the room. Their faces showed utter perplexity while we were startled and stared as they stood, silently towering over us for what seemed forever. Finally I asked what was going on. To our collective amazement, one of the arrivals managed to stammer that they had just been called by the nurse in charge – this ward was divided into two geographically separate areas, one acute,

the other a smaller rehabilitation section where they had been telephoned by the charge nurse on the acute ward where the group takes place – to respond to an emergency. The spokesman, increasingly joined by his incredulous co-responders, told us that, arriving on the ward, they had been directed by the nurse in charge to the reflective practice room where they were expecting to find a dangerous, aroused patient causing chaos and possibly severe damage to their colleagues. They could not believe their eyes to find four people sitting in silence around a table, and we could not believe what we were being told.

**‘The hammer-blow impacts on staff minds and the fear of assaults on heads are constant.’**

Eventually, the 'response team' joined us at the table; we continued for a while to grin at each other trying to absorb the implications of what we had just witnessed ; and then some of these implications began to be spelled out, both in this meeting and others that followed. For reflective practice had suddenly been energized by our joint experience. The members of the 'response team' expressed their sense of having been utterly betrayed and lied to by a senior colleague. How could they have been set up in such a serious and frightening way by members of their own profession? This sentiment was seconded in spades by those who had already been in the meeting. Amazement

gave way to anger and then to a despairing cynicism which reconfirmed for many that no one could be trusted in such a dangerous setting. But this event seemed to show that even members of your own professional tribe would not be watching your back. On the contrary, they might deliver you into the hands of the enemy.

Many succeeding reflective practice meetings were spent in trying to identify this dangerous enemy as... *thinking about their work at all*. Whether it was a deceptive senior colleague, a manager or I myself who might be held responsible for forcing them to attend reflective practice; even an unconscious and disowned part of one's own mind advocating the usefulness and survival value of thinking creatively under pressure to 'make the best of a bad job': this object could not be perceived as authoritative, helpful and caring but only as treacherous, attacking and destabilizing. Through dramatizing the latter quality, we began to understand how the charge nurse had reflected this negative internal presence, patently corrupt, unworthy of loyalty and respect and mandating fight/flight. And at a subsequent meeting we found out more about the anxieties which maintained such an ominously malevolent image of authority.

I arrived to find a number of group members already present, passing around and laughing over a brochure on the



The best defence

Gwen Adshead, continued from page 8

consciousness as possible is the fear of identification with these violent and cruel patients. Those who work with forensic patients may have unresolved feelings of hatred and cruelty that they long to act on, but cannot; they may wish that their capacity for cruelty and violence was cared for in the same way as the patients. This may be especially true for those staff members who have actual histories of childhood victimisation. Professionals like ourselves may be drawn to this work because we also unconsciously long to be cruel, or seek revenge for past hurts, or are unconsciously anxious about our capacity for destructive anger. Whatever the reason, a variety of defensive acting out behaviours by staff may be driven by the anxiety that we psychologically resemble the patients.

Something understood: taking care of the carers

The forensic residential setting represents a place of containment and safety, for the patient and for society. Physical security is paramount; however, it is also evident that *psychological* security is important, not only to manage the seriously damaged and traumatised offenders residing within, but also to assist the staff in this most demanding task of both caring for and containing potential violence.

If we understand that social defence systems act to make organisations feel psychologically secure, and to make individual staff members the carriers of intolerable anxiety, then this might assist us to put in place structures and policies that help them reduce destructive acting out. This in turn will allow care-giving organisations the chance to become more resilient. The extent of the anxiety felt in forensic institutions should not be underestimated, as unconsciously indicated by the sign in the canteen in a forensic unit: ‘This building is alarmed’ ■

Gwen Adshead is a forensic psychiatrist and psychotherapist. She trained at St George’s Hospital, the Institute of Psychiatry and the Institute of Group Analysis. She has worked at Broadmoor Hospital, setting up and running psychodynamic groups for offenders. Gwen has research interests in attachment theory applied to forensic populations; and moral reasoning in antisocial men and women.

This article is based on a chapter written with Amanda Lowdell.



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On the edge of nameless dread

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table. The main theme of the meeting was that managers only came to the ward to criticize, otherwise you never saw them. And if a patient complained about you, the investigation would be arduous: a third degree. Examples from group members’ experiences were given. As I was listening I found myself trying to decipher the, for me, upside down writing on the cover of the brochure, which had ended up at the other end of the table from where I was sitting. It dawned on me that this was an advertisement for a theme park roller coaster, and the name of the ride emerged: NEMESIS INFERNO!!! I said that I thought this was exactly what they feared reflective practice was; and that by demonizing it – helped immeasurably by the nurse in charge whose deception had legitimized their (and his) continuing rebellion against attending – it was possible to protect themselves as a team from anxiety that open engagement in the group could only reveal humiliating individual inadequacy, failure and probably worse qualities in themselves. They believed that contacting their feelings about the work would contaminate their ability to continue to care for their patients.

We are still riding the roller coaster. But that is what working in secure forensic settings is. The proto-constituents of the

‘minds’ of forensic patients, including inchoate and unmetabolized emotional states, are externalized and dispersed though their interactions with staff on the ward, just like the real damage they have already wreaked in the external world. And among the emotions which some patients may never be able to tolerate, and others become psychotically depressed or acutely suicidal when they approach , is persecuting guilt: a constituent of the NEMESIS INFERNO which turned up in our reflective practice group ■

John Gordon is a Psychoanalyst and Group Analyst. He is Honorary Senior Lecturer at Imperial College Medical School and Buckinghamshire New University and Former Consultant Adult Psychotherapist at West London Mental Health NHS Trust

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# Psychosis and psychoanalytic approaches: some hope?

By Brian Martindale

I HAVE BEEN DISMAYED in recent months to hear of the loss of so many psychoanalytic psychotherapy posts in the NHS. Oak trees take a long time to grow and only a short time to cut down, and this article is written in the hope that it might encourage some medical and non-medical psychoanalytically-trained practitioners, rather than leave or have to leave the NHS, to consider seeking employment in *psychosis* services where they might be able to utilise and develop their skills.

Most psychoanalytic psychotherapists who work as such in psychological therapy services must feel very exposed and vulnerable at present, and need every help they can be given to survive. However, with certain provisos, I consider the psychosis field as possibly having an exciting growth potential for the psychodynamically minded. In doing so I am mindful of a distinguished French colleague who, in a debate about the psychotherapy field, remarked that it was much easier to hide/survive in the jungle: the psychosis field is certainly that at the moment. By referring to hiding in the jungle, I am also hinting at what I regard as the necessity for a completely different style / technique compared to those used with other problems if the psychodynamically minded are to frequently succeed in relating to patients, families and even colleagues in psychosis services. I will touch on this later.

UK readers may not be aware that in all of the Scandinavian countries, it was psychoanalyst psychiatrists who played leading roles in developing first episode psychosis services (mistakenly known as EIP or early intervention services in the UK, as few services are yet resourced to do all the sophisticated community work needed to reach people much earlier). Although it would be an error to generalise, there is some truth in stating that a far larger percentage of mental health professionals in Scandinavia believe that it is the slings and arrows of outrageous fortune that contribute far more to severe mental illness than biological factors, and hence there is a more natural acceptance of psychosis being an unconscious and dynamic way in which a new reality or new realities

are created in an attempt to try to steer clear of personal realities that are just too painful, overwhelming or otherwise ‘unwanted’.

For a long time in my career as a consultant *psychiatrist in psychotherapy*, our psychotherapy services regarded psychosis as a contraindication to psychoanalytic psychotherapy. I have undergone a radical conversion (greatly influenced by Scandinavian colleagues as well as the late Murray Jackson and others), and for six years I worked full time as a consultant *psychiatrist* within an early intervention in psychosis (EIP) service. EIP services were one of the major developments in the mental health field initiated by the last Labour government in the late 1990s. For me, there were three crucial features: the relatively low case loads for the core staff, the explicit increased emphasis on ‘psycho-social’ interventions in guidelines, and above all the expectation that patients should be offered three years of treatment within the service. This frame makes for the *possibility* of a relatively substantial period of psychotherapeutically informed work.

With more than six years of experience now of fulltime work in a EIP service, I would emphasise first of all the need for all ‘psychosis’ practitioners to become very comfortable at working in a very flexible style, both in the *setting* in which they meet the patient and his family and friends, and in *the way* in which they relate to the patient and his family. Outcomes depend significantly on the professional’s capacity to engage and sustain engagement with very scared and suspicious young people, often with low self esteem and a long complex problematic relationship with authority figures. It is vital that right from the beginning there is a tuning into what is going to be experienced as helpful and unhelpful by the patient and the family. Otherwise one may not get a second chance for a long time when the situation may have become even more serious.

Much of my engagement work and that of my colleagues occurs in patient’s homes, sometimes over quite a long period of time. I have become convinced that when

we engage the family well from the beginning our outcomes are far better and families will more readily contact us at early signs of relapse. Family meetings are not instead of individual work, but this early involvement with key family members means that conflicts over confidentiality are very rare. The *rapid* response to the patient and their family (and friends) in their home for as long as it is needed with a focus on *slowly* helping all in finding words where none existed for the key family issues (rather than an exclusive focus on symptoms) is the hallmark of the Finnish Open Dialogue approach,<sup>1</sup> which is an evolution of the Finnish Need-adapted approach pioneered by psychoanalyst Yrjö Alanen.<sup>2</sup> The Open Dialogue outcomes with psychosis are some of the very best in the world. But their publications do not have the word *psychodynamic* in them and I regard this as another example of the success of ‘hiding in the jungle’.

## ‘The psychosis field has exciting growth potential for the psychodynamic minded.’

A more local example of jungle life was illustrated in the work of an ISPS<sup>3</sup> UK research group trying to identify psychoanalytic psychotherapists currently working with psychosis, and finding quite a number of psychologists who have obtained CBT training but who ‘quietly’ use their earlier psychodynamic training and understandings in their daily clinical work without formally ‘coming out’.

There is of course a relative dearth of English-language modern RCT research to satisfy formal advocacy and commissioning of psychoanalytic therapy in psychosis, but it is important to note the work of Danish psychoanalyst Bent Rosenbaum and his colleagues who have published promising controlled trial outcome studies<sup>4</sup> of a year of individual weekly supportive psychodynamic therapy for psychosis, as well as the cohort studies of analysts Yrjö Alanen and Johan Cullberg from Finland and Sweden respectively.

Many of the people I have mentioned have been key contributors to the ISPS, which has a lively and large UK membership of whom a reasonable number have a psychodynamic background. The ISPS was founded 55 years ago by psychoanalysts interested in psychosis, and in the last two decades has become a multi-modality organisation offering a range of ‘products’ that support psychological approaches and in which psychoanalytic practitioners have less of a need to hide amongst their colleagues of different hues. The organisation is also a vehicle for sharing what is going on in other parts of the world. For example both Bent Rosenbaum and his late colleague Lars Thorgaard

have offered supervision and training here in the UK, and there are plans to publish the Danish manual of supportive psychodynamic psychotherapy in English in the near future in the ISPS book series. I have myself recently concluded that psychodynamically informed family therapy with psychosis is fully compatible with NICE guidelines in the area.<sup>5</sup>

It is important to emphasise how fascinating the work is for those with a psychodynamic approach (as well as often challenging). There is such a wealth of opportunity to study psychodynamic mechanisms and theories of psychosis, and to be creative in the way one works with the patients and their families. Richard Lucas<sup>6</sup> and Murray Jackson<sup>7</sup> have written books that demonstrate this. I will give one brief clinical example, that can be enjoyed at many levels.

A man with a steady deterioration in functioning over some time was admitted, and revealed no signs of psychosis to the ward staff following their direct questions to him. The staff wanted to discharge him as someone with a personality disorder. In a non-directive informal meeting with a staff person with a psychoanalytic training (that fact unknown to the patient), the patient started to mention the computer chip behind his eye and the messages that Tony Blair sent to him on the news each evening. The therapist said to the patient that he was aware that he had not mentioned anything of this to the ward staff in the last two weeks. The patient immediately said, ‘Of course not, they would think I was crazy.’

I encourage the BPC to make sure it has a good space for psychoanalytic psychosis practitioners in its publications and conferences ■

*Brian Martindale is Consultant Psychiatrist in EIP to the Northumberland Tyne and Wear NHS Foundation Trust, and a psychoanalyst and currently chair of ISPS and Honorary President of the EFPP. [bm@bmakm.plus.com](mailto:bm@bmakm.plus.com)*

### Notes

1. Seikkula, J., , Aaltonen. J., Alakare, B., Haarakangas, K., Jyrki Keränen J., Lehtinen, K. (2006) Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies. *Psychotherapy Research*, 16(2): 214-/228.
2. Alanen, Y. (1997) *Schizophrenia: Its Origins and Need-Adapted Approach*. London: Karnac.
3. ISPS stands for International Society for the Psychological Treatments of the Schizophrenias and other Psychoses, [www.isps.org](http://www.isps.org)
4. The Danish National Schizophrenia Project: prospective, comparative longitudinal treatment study of first-episode psychosis. *The British Journal of Psychiatry* (2005)186: 394-399
5. Martindale B, and Smith J, 2011 Psychosis: Psychodynamic work with families. *Psychoanalytic Psychotherapy* Volume 25, Issue 1, , pages 75-91
6. Lucas. R 2009. *The Psychotic Wavelength: A Psychoanalytic Perspective for Psychiatry*. Karnac Books
7. Jackson, M. & Williams, P. 1994. *Unimaginable Storms: A Search for Meaning in Psychosis*. Karnac Books.

## News In Brief

### New BPC Affiliate Members

The BPC welcomes the Anna Freud Centre as its third Affiliate Member in September. The AFC is internationally renowned for its innovative clinical services for children, and for its training and research programmes.

Another exciting development is the application by the South African Psychoanalytic Confederation to become the BPC's first International Affiliate.

The Anna Freud Centre and South African Psychoanalytic Confederation join the North West Institute of Dynamic Psychotherapy and the Institute of Group Analysis as BPC Affiliates.

Peter Fonagy, chief executive of the Anna Freud Centre, said: 'The BPC is the key strategic organisation for 21st-century psychoanalysis in this country. All those who want to have their say and influence decision-making in relation to development of the profession in the UK must belong and be active within the BPC' ■

### Conference report: Glen Gabbard, Understanding and Treating Borderline Personality Disorder

This was an inspiring and immensely valuable conference on several levels. Professor Glen Gabbard (Professor of Psychiatry and Brown Foundation Chair of Psychoanalysis; former Joint Editor-in-Chief of the *International Journal of Psychoanalysis*) and Dr Gwen Adshead (Consultant Forensic Psychotherapist at Broadmoor Hospital) proved an irresistible draw for 250 delegates to the inaugural South of England Psychotherapy Conference at Winchester University on 18 June.

Many in the packed auditorium had travelled a long way to participate. It was an unusually diverse and welcome audience for a psychoanalytic conference. Many were not psychotherapists; a good number were psychiatrists, most of them young to middle-aged.

As important as all this is, it was the content of the conference that made it so memorable. Dr Gwen Adshead set the scene, urging young psychiatrists not to 'let the psyche go' in their work. She modestly described her brief, erudite and stimulating talk, 'How to do things with words: psychotherapy for complex problems', as 'merely the hors d'oeuvre' for Professor Gabbard.

Gabbard's masterly presentation on Borderline Personality Disorder used PowerPoint to drive home his hypothesis: the way brain pathways are different among his specific group of patients

from those of a control group; that the amygdala in these patients does not communicate with the prefrontal cortex in the usual way, so that a borderline patient swings from one intense emotion to another, without having the capacity to think about the feelings; and about an opioid deficiency in such patients, meaning that when they use opiates they do not get the more usual 'high' that drug-takers seek, but rather the opiates merely bring their responses up to a normal level. Professor Gabbard showed how at least seven different therapies are effective in allowing the internal chaos of these patients to mediate, but said that long-term change in the neural physiology could be brought about only by long-term work, which would take a lot of effort – as anyone with such patients in their practice knows very well.

Gabbard moved seamlessly between findings from neurobiology, psychiatry, clinical psychology and psychoanalysis to paint a rich and multi-layered picture of both the brain and the internal world of this challenging and troubling group of patients. He made a compelling case for modifications in technique with these patients, whom Freud had originally deemed unsuitable for analytic work. One was left wondering if Gabbard's success with this rigid, intractable patient group derived in part from his freedom to adapt his technique to what his patient can manage at any given moment. His inspired advice – quoting Fred Pines – to 'strike while the iron is cold', so the patient will be able to think about what he says, was particularly resonant.

He emphasised neuroplasticity, building his case that psychotherapy can potentially modify earlier neurobiological mechanisms. He showed that, in the same way that neural circuitry affects how we think, how we think can impact upon neurological structures. Indeed, Gabbard shifted fluidly between neurobiological and psychoanalytic paradigms. In a clinical vignette, he described asking his suicidal borderline patient, who had returned after missing her weekly face-to-face session, 'What did you think I was thinking when I was waiting for you to come?' On a neurobiological level, the aim is to quieten the amygdala by activating the prefrontal cortex; in more familiar language, to promote reflectiveness or, citing Bion, alpha function. As Gabbard put it, 'The therapeutic frame is an envelope within which a way of thinking is imposed upon unbearable affect states which cannot be borne by one person alone.'

His ideas raise questions in the current debate about what constitutes psychoanalysis versus psychoanalytic psychotherapy – is it frequency of sessions, use of the couch, interpretation of (or 'in') the transference, or the mode of therapeutic action? Was Gabbard

stretching the boundaries, or creating a firm setting within which analysis could take place? Or was he redefining the parameters of analytic space? How do we conceptualise borderline states, and what implications does that have for therapeutic aims and technique?

The findings from neuroscience – supporting Gabbard's definition of borderline pathology in terms of affective dysregulation – added weight to some serious technical dilemmas: how does one work in the transference, when the attachment to the therapist can stimulate hyperarousal?

What came across strongly was Glen Gabbard's spirit of optimism, creativity and humanity in the face of profound technical difficulties. Controversially, he argued that the establishment of a working treatment alliance – the single most important factor for mediating therapeutic change – is possible with this refractory patient group. He then demonstrated this in action, playing himself in a compelling video-taped dramatisation of two consecutive sessions with a borderline patient, in which the audience enjoyed the 'main course' Gwen Adshead had promised, and was still left with appetite for more.

This was a stimulating and inspiring conference in a lovely space, and beautifully organised. Full credit should be given to the South of England Psychotherapy (SOEP) committee – Prof Paul Williams (BPAS), Sally Saunders (LCP), Penni Swinden (LCP) and Jackie Charbit-Middleton (BAP) – who provided an excellent example of BPC collaboration in Hampshire. Keep an eye out for details of the next SOEP conference in 2013 ■

*Jan Harvie-Clark (BPA, Chair of Outreach)*

*Astra Temko (Child and Adolescent Psychotherapist, Candidate, BPA)*

### Collected Writings of D.W. Winnicott

The Winnicott Trust is planning a 'Collected Writings of D.W. Winnicott'. If you have access to materials – unpublished documents, correspondence, videos or audio – that you wish to be considered for inclusion or for use in preparing it please contact the General Editor, Dr Elisabeth Young-Bruehl: [youngbruehl@gmail.com](mailto:youngbruehl@gmail.com)

Original documents donated will become part of the Winnicott Archive at the Wellcome Institute for the History of Medicine in London. A website is also being set up where visitors can subscribe to a newsletter and contribute to a discussion group.

The Trust also welcomes financial support for this important scholarly project. Please contact the Chair of Trustees, Dr Lesley Caldwell, University College London, at [l.caldwell@ucl.ac.uk](mailto:l.caldwell@ucl.ac.uk) ■

### An homage to Tony Parker, and to psychoanalysis in the NHS

*Janet Low writes:*

Earlier this year, I discovered Tony Parker. I was handed his seventeenth book, *Life After Life* (1990): twelve monologues by men and women held within the British penal system, each of them convicted of murder. How each person accounted for his or her crime was both a shock (it seemed to just pop out of their story) and deeply moving (as they grappled with the responsibility for what they had done). I couldn't put it down.

The simplicity of Parker's work is that he lent his ears ('a national treasure', according to Anthony Storr, who should know about ears, having been a famous Jungian analyst in his time) and invited people to tell their story. He sometimes worked for as long as two years to accumulate what he needed and then to find the key to cut the mass of words into a pithy monologue. He taped the conversations and transcribed them, and listened to and read them over and over again. This hard work paid off with lucid, simple, compelling stories, each one touching a truth.

His twenty-two books give truthful glimpses not only of convicts (with whom he began his work), but also lighthouse keepers (*Lighthouse*, 1975), miners (*Redhill*, 1986), people living on the Heygate Estate in Elephant & Castle (*The People of Providence*, 1985), denizens of Kansas (*A Place Called Bird*, 1989), the people of Russia in a time of cataclysmic transition (*Russian Voices*, 1991), citizens of Belfast (*May the Lord in His Mercy Be Kind to Belfast*, 1993), single mothers (*In No Man's Land*, 1972), and even Studs Terkel (1997). Before he died in 1996, he had begun to interview GPs as his next group and was planning to tackle psychoanalysts after that.

Of course, there were those who criticised Parker's work on the grounds that listening isn't really work. It was too easy, they said anyone could do it. His response was to invite them to go ahead and try.

I'll take up the challenge! I don't suppose it's easy, but I do think it worthwhile. I propose to pay homage to Tony Parker by listening to psychoanalysts whose work touches on the NHS. From where I stand, psychoanalysts seem a little bit like the lighthouse keepers he wrote about doing a vital, lonely and risky job, clinging on between a rock and a hard place, little known, barely understood, and about to be wiped out by the creeping commodification of medicine and health happening all around them.

If you would like to be part of this project, or know someone who might, please get in touch. You can track the progress and get more information at: <http://homagetotonyparker.blogspot.com> Janet.low@mac.com, 020 8455 4549 ■



# Relational psychotherapy

By Jean Knox

IN HIS EXCELLENT discussion of session frequency in the last issue of *New Associations*, Jeremy Holmes suggested that most people would agree that the key features of psychoanalysis ‘include working with transference and making interpretations rather than suggestions and encouragement,’ the latter being what most people think of as the hallmarks of supportive psychotherapy. He went on to argue that there is therefore nothing intrinsic to frequency that makes it quintessentially psychoanalytic, and that the hierarchy which regards four sessions a week as the gold standard is arbitrary and may not reflect real and fundamental differences between therapies of different intensity.

I entirely agree with Holmes’ conclusion that low intensity work can be mutative, but would like to highlight some of the relational processes that evidence shows to be effective in psychotherapy – it is not just interpretation or working with transference that make psychotherapy of any intensity effective in bringing about real and lasting psychic change. For example, Wallerstein found in his original study that, among other factors, corrective emotional experiences correlated with a good outcome, but interpretation by the therapist or insight on the patient’s part actually showed no such correlation with outcome. Shedler, in his recent meta-analysis, found that the therapist’s facilitation of a positive working alliance was important, as well as verbal exploration of the patient’s emotions and thoughts about self and discussion of interpersonal relationships and relationships with early caregivers. It seems to me that this kind of research shows us how important the unconscious relational experience with the therapist is, even when this is not interpreted.

In a recent book, *Self-agency in psychotherapy: attachment, autonomy and intimacy* (2010), I have suggested that there are three fundamental processes that underpin the change in psychotherapy, namely affect regulation, mentalization, and the development of self-agency. In many ways, these function under the radar, as it were, depending on the implicit intersubjective dynamics of the clinical interaction, rather than on conscious understanding.

### Affect regulation

The non-verbal patterns of relationship and communication between therapist and patient have been extensively described and thoroughly researched by the relational/attachment models of psychoanalysis by, among others, the Boston Change Process Study Group. These ‘non-interpretive mechanisms’ in the intersubjective dynamics of the clinical process operate at a far deeper level than suggestions and encouragement, and contribute to a good outcome in any psychotherapy as much as the verbal exchanges between therapist and patient. They depend as much on tone of voice, facial expression and the rhythm of the dialogue as on what is actually said. Together these provide the experience of affect regulation, through the processes of on-going emotional regulation, heightened affective moments and disruption and repair.

**‘It is not just interpretation or working with transference that make psychotherapy effective.’**

In addition, neuroscience studies are providing further evidence for the importance of non-verbal aspects of relationship in human psychological and emotional development; much of this research is described in a recent book by Ruth Lanius and colleagues, *The Impact of Early Life Trauma on Health and Disease: the hidden epidemic* (2010), as well as in the extensive research of a number of other authors, such as Allan Schore and Jaak Panksepp.

### Mentalization

At first sight, mentalization might seem to be the capacity that most depends on the explicit verbal exchanges between therapist and patient. But it also has implicit, automatic relational aspects that are just as important and underpin empathic imitation of gesture and the turn-taking that is so fundamental in human communication. The example Jeremy Holmes gave in the last issue illustrated this well – he did not make a definitive statement about what was in

Adam’s mind, but offered a tentative invitation to Adam to imagine what it might feel like to be in five times a week therapy, to which Adam responded by mentalizing – reflecting on his own conflicting feelings about separateness and independence.

A mentalizing approach in psychotherapy requires a therapist’s intuitive ever-shifting perspective-taking that does not attempt to pin the patient’s mind down with definitive interpretations. The therapist’s focus of attention on the meaning-making process itself is more of an implicit attitude than being directly and explicitly stated. The evidence I have touched on strongly supports the view that what makes effective clinical practice is the co-construction of meaning between therapist and patient, rather than the meaning being determined by the therapist’s interpretations.

### Self-agency

Language is itself a form of action and reaction, with its own communicative rules which have been identified across cultures, races and languages. In the study of conversations, it is the response of the hearer to the previous turn, and the production of the next turn in the conversation, rather than the interpretations of an outside observer, which provide the evidence for what meaningfulness is. From this perspective, psychotherapy is a two-way conversation, whose successful outcome actually depends on the patient having an opportunity to repair the therapist’s misunderstandings and other disruptions between them. This therapist-patient turn-taking is a cooperative meaning-making effort on the part of therapist and patient that is far removed from the patient as a passive recipient of the analyst’s interpretation of his or her unconscious. Too didactic a form of interpretation can become a way for the therapist to tell the patient what is ‘really’ going on in his or her unconscious, rather than facilitating the patient’s gradual ability to relate to, fully experience and find what his or her own memories, hopes and fears actually mean.

In an intersubjective, relational approach, the therapist and patient co-construct a sense of the meaning of the patterns of communication and relationship

between them, but the therapist also helps the patient to gradually make his or her own sense of his or her own past experience. The patient’s own sense of self-agency plays a vital role, both in relationship with the therapist and in terms of making sense of his or her own emotions and memories. I think that the example Jeremy Holmes gave illustrates the importance of the patient’s agency very well – when invited to consider what five times a week therapy might feel like, Adam replied that the gap between sessions give him a sense of resilient independence, a response that conveyed his capacity to make his own mind up about what he needed and to survive on his own.

The co-construction of interactive patterns and self regulation plays a crucial role in the therapeutic potency of psychotherapy. It depends on patterns of emotional interaction between therapist and patient, which are implicit patterns of collaborative turn-taking and repair of ruptures and misunderstandings that are fundamental to all human interaction, whether verbal or nonverbal. They are the major guarantors of intersubjectivity, of shared understandings, which are fundamental to a relational model of the mutative nature of psychotherapy, whatever the frequency of the sessions. Indeed, each therapist-patient dyad needs to find the rhythm of interaction that best facilitates the patient’s development of affect regulation, mentalization and agency, and there is no one pattern of frequency that works for everyone ■

*Jean Knox is a Training Analyst with the SAP and BAP. Her book Self-Agency in Psychotherapy: Attachment, Autonomy and Intimacy was published in December 2010.*

### References

Knox, J. (2010) *Self-Agency in Psychotherapy: Attachment, Autonomy and Intimacy*. New York London; WW Norton

Lanius, R.; Vermetten, E.; Pain, C. (2010) *The Impact of Early Life Trauma on Health and Disease : the Hidden Epidemic*. Cambridge University Press



Diary

NOVEMBER

**11-12 November 2011**  
**THE RED BOOK TWO YEARS ON**  
13-15 Arundel Street, London WC2R  
Speakers include Paul Bishop, Christian Gaillard, Sonu Shamdasani, Murray Stein, plus clinical panel  
Contact: 020 7435 7696, [claire@thesap.org.uk](mailto:claire@thesap.org.uk)

**12 November 2011**  
**'COULD IT BE MAGIC?': IDENTIFYING THE DYNAMICS OF CHANGE IN COUPLE THERAPY**  
TCCR, 70 Warren Street, London W1T  
Speakers: David Hewison, Mary Morgan  
Contact: Matt Williams 020 7380 1975, [mwilliams@tccr.org.uk](mailto:mwilliams@tccr.org.uk)

**12 November 2011**  
**INTERNET PORNOGRAPHY: WORKING WITH CLIENT PREOCCUPATION**  
WPF, 23 Magdalen Street, London SE1  
Workshop Leader: Jenny Riddell  
Contact: 020 7378 2054, [mayra.angulo@wpf.org](mailto:mayra.angulo@wpf.org)

**13 November 2011**  
**TOPIC OF CANCER**  
LCP, 32 Leighton Road, London NW5  
Speakers include Helen Bender, John Woods, Martin Schmidt, Sue Saville  
Contact: LCP, 020 7482 2002, [info@lcp-psychotherapy.org.uk](mailto:info@lcp-psychotherapy.org.uk)

**15 November 2011**  
**MURDERED FATHER; DEAD FATHER**  
B01, Clore Management Centre, Torrington Square, London WC1  
Speaker: Rosine Perelberg  
Contact: [j.eisner@bbk.ac.uk](mailto:j.eisner@bbk.ac.uk)

**17 November 2011**  
**ETHICS, SELF-DECEPTION & THE CORRUPT PHYSICIAN**  
120 Belsize Lane, London NW3  
Speaker: Glen O. Gabbard  
Contact: Jane Vogler 0208 938 2606, [www.tavistockandportman.ac.uk](http://www.tavistockandportman.ac.uk)

**18-19 November 2011**  
**ORGANIZATIONAL AND SOCIAL DYNAMICS**  
Ambassadors Hotel, 12 Upper Woburn Place, London WC1H  
Speakers: Kathleen Pogue White, Michael Rustin  
Contact: 020 7736 3844, [conf@opus.org.uk](mailto:conf@opus.org.uk)

**19 November 2011**  
**THE UNSPEAKABLE AND THE UNBEARABLE**  
BAP, 37 Mapesbury Road, London NW2  
Speakers include Jean Knox, Julian Lousada, Janine Sternberg, Joscelyn Richards  
Contact: 020 8452 9823, [admin@bap-psychotherapy.org](mailto:admin@bap-psychotherapy.org)

**19 November 2011**  
**DESTROYING THE KNOWLEDGE OF THE NEED FOR LOVE**  
Primrose Hill Community Centre, 29 Hopkinson Place, London NW1  
Speaker: David Morgan  
Contact: 0207 978 1545, [clinic@lincoln-psychotherapy.org.uk](mailto:clinic@lincoln-psychotherapy.org.uk)

**22 November 2011**  
**JUNG AND ALCHEMY**  
SAP, 1 Daleham Gardens, London NW3  
Speaker: Bob Withers  
Contact: 020 7435 7696, [clericalofficer@thesap.org.uk](mailto:clericalofficer@thesap.org.uk)

**24 November 2011**  
**ISSUES OF 'RACE' IN SUPERVISION**  
120 Belsize Lane, London NW3  
Speaker: Frank Lowe, chair Helen Morgan  
Contact: 020 8938 2285, [events@tavi-port.ac.uk](mailto:events@tavi-port.ac.uk)

**24-25 November 2011**  
**PSYCHOLOGICAL THERAPIES IN THE NHS**  
Savoy Place, London  
[www.healthcareconferencesuk.co.uk](http://www.healthcareconferencesuk.co.uk)

**26 November 2011**  
**CHANGING MINDS IN THERAPY: THE WAY FORWARD**  
Friends Meeting House, 91-93 Hartington Grove, Cambridge CB1  
Speaker: Margaret Wilkinson  
Contact: 020 7435 7696, [clericalofficer@thesap.org.uk](mailto:clericalofficer@thesap.org.uk)

**26 November 2011**  
**REAL AND ILLUSORY SPACE IN THE MIND OF THE MOTHER**  
Friends Meeting House, 43 St. Giles, Oxford OX1  
Speaker: Gerry Byrne  
Contact: 020 7435 7696, [clericalofficer@thesap.org.uk](mailto:clericalofficer@thesap.org.uk)

DECEMBER

**1 December 2011**  
**MAYA CENTRE CHARITY EVENT**  
Free Word Centre, 60 Farringdon Road, London EC1R  
Speakers: Melissa Benn, Jill Dawson, Margaret Drabble, Helen Simpson, Sarah Waters  
Contact: Free Word, 020 7324 2570, [info@literaryconsultancy.co.uk](mailto:info@literaryconsultancy.co.uk)

**3 December 2011**  
**UNDERSTANDING AND WORKING WITH ABUSE IN COUPLE RELATIONSHIPS**  
TCCR, 70 Warren Street, London W1T  
Speakers: Judith Siegel, Christopher Clulow, Damian McCann  
Contact: Joanna Bending 020 7380 1970, [jbending@tccr.org.uk](mailto:jbending@tccr.org.uk)

**3 December 2011**  
**WINNING AT ALL COSTS: A PSYCHOLOGICAL EXPLORATION OF SPORTING GREATNESS**  
SAP, 1 Daleham Gardens, London NW3  
Speaker: Ian Williamson  
Contact: 020 7435 7696

**3 December 2011**  
**ADULT LOVE AND ITS ROOTS IN INFANCY**  
Anna Freud Centre, London NW3  
Speakers: Lisa Appignanesi, Bernard Barnett, David Morgan, Anna Furse, Estela Welldon  
Contact: [www.freud.org.uk](http://www.freud.org.uk)

**9-11 December 2011**  
**RON BRITTON TODAY**  
Cruciform Building, UCL, London WC1  
Speakers: Ron Britton, Liana Chaves, Peter Fonagy, Mary Target, David Taylor, David Tuckett  
[www.ucl.ac.uk/psychoanalysis/](http://www.ucl.ac.uk/psychoanalysis/)

JANUARY

**21 January 2012**  
**PSYCHOANALYSIS AND HOMOSEXUALITY: MOVING ON**  
Resource for London, 356 Holloway Road, London N7  
Speakers include Malcolm Allen, Nicola Barden, Jeremy Clarke, Peter Fonagy, Leezah Hertzmann, Trudy Klauber, Alessandra Lemma, Julian Lousada, Paul Lynch, David Morgan, Bernard Ratigan, Mary Target  
Contact: BPC, 020 77561 9240, [janice@psychoanalytic-council.org](mailto:janice@psychoanalytic-council.org)

**23 January 2012**  
**PATERNAL FUNCTION AND THIRDNESS IN PSYCHOANALYSIS AND LEGEND**  
B20, Birkbeck, Malet Street, London WC1  
Speaker: Rosine Perelberg  
Contact: [j.eisner@bbk.ac.uk](mailto:j.eisner@bbk.ac.uk)

**28 January 2012**  
**FACING SEXUALITY**  
18 Holyrood Park Rd, Edinburgh EH16  
Speaker: Brett Kahr  
Contact: 01728 689 090, [www.confer.uk.com](http://www.confer.uk.com)

**28 January 2012**  
**THE DEVELOPMENTAL MODEL IN POST-JUNGIAN PSYCHOLOGY: THE CONTRIBUTION OF MICHAEL FORDHAM**  
SAP, 1 Daleham Gardens, London NW3  
Speaker: Elizabeth Urban  
Contact: 020 7435 7696, [training@thesap.org.uk](mailto:training@thesap.org.uk)

FEBRUARY

**4 February 2012**  
**THE TRANSCENDENT FUNCTION IN ADOLESCENCE**  
Friends Meeting House, 43 St. Giles, Oxford OX1  
Speaker: Marica Rytovaara  
Contact: 020 7435 7696, [clericalofficer@thesap.org.uk](mailto:clericalofficer@thesap.org.uk)

**10 February 2012**  
**WORKING THROUGH IN THE COUNTERTRANSFERENCE REVISITED**  
TCCR, 70 Warren Street, London WC1  
Speaker: Irma Brenman Pick  
Contact: 0207 380 1975, [mwilliams@tccr.org.uk](mailto:mwilliams@tccr.org.uk)

**11 February 2012**  
**MOTHERS, INFANTS, AND MATERNAL MENTAL ILLNESS**  
Friends Meeting House, 91-93 Hartington Grove, Cambridge CB1  
Speaker: Elizabeth Urban  
Contact: 020 7435 7696, [clericalofficer@thesap.org.uk](mailto:clericalofficer@thesap.org.uk)

**25 February 2012**  
**JUNG AND GENDER IDENTITY**  
SAP, 1 Daleham Gardens, London NW3  
Speaker: Jean Thomson  
Contact: 020 7435 7696, [training@thesap.org.uk](mailto:training@thesap.org.uk)

MARCH

**3 March 2012**  
**DEPRESSION: A PSYCHOANALYTIC PERSPECTIVE**  
23 Magdalen Street, London SE1  
Workshop Leader: Stephen Crawford  
Contact Mayra Angulo, 020 7378 2054

**9 March 2012**  
**TEMPORALITY IN THE UNCONSCIOUS – A MATTER OF TIME: FROM CHURCHES TO SCULPTURE**  
112a Shirland Road, London W9  
Speaker: Gregorio Kohon  
Contact: [Marjory.Goodall@iopa.org.uk](mailto:Marjory.Goodall@iopa.org.uk)

**17 March 2012**  
**WITNESSING THE UNSPOKEN**  
120 Belsize Lane, London NW3  
SAP Annual Lecture: Wendy Bratherton  
Contact: 020 7435 7696, [clericalofficer@thesap.org.uk](mailto:clericalofficer@thesap.org.uk)

**17 March 2012**  
**PSYCHO-SOMATIC? HYSTERICAL? PHYSICAL?**  
23 Magdalen Street, London SE1  
Workshop leader: Mary Pat Campbell  
Contact: 020 7378 2050, [training@wpf.org.uk](mailto:training@wpf.org.uk)

**17 March 2012**  
**NATURE CRISIS: RETHINKING PSYCHOANALYSIS FOR THE ENVIRONMENT**  
The Eden Project, Cornwall  
Speakers: Phillip Derbyshire, Greg Garrard, Stephen Gee, Paul Kingsnorth, Sally Sales, Joe Suart, Paul Zeal  
Contact: 01707 649788, [the-site@the-site.org.uk](mailto:the-site@the-site.org.uk)

**29 March - 1 April 2012**  
**THE INITIAL PSYCHOANALYTIC INTERVIEW AND THE TREATMENT PROCESS**  
Marriott Paris Rive Gauche Hotel  
EPF Annual Conference  
[www.epf-fep.eu](http://www.epf-fep.eu)

FORTHCOMING

**12 May 2012**  
**BPC TRAINEES' CONFERENCE**  
West Yorkshire Playhouse, Leeds  
Contact: [mail@psychoanalytic-council.org](mailto:mail@psychoanalytic-council.org)





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The Divided Brain and its Importance for the Understanding of Mind – Ref: CPD/27

Half-day Conference – Saturday 5th May 2012

Iain McGilchrist, Psychiatrist and author of the ground-breaking book: The Master and his Emissary: The Divided Brain and the Making of the Western World, argues that the two hemispheres of the brain have not merely different skills, but wholly different perspectives on the world. He will be presenting this argument at the conference and Helen Morgan, Senior Member, British Association of Psychotherapists will explore the implications for psychoanalytic work in a response. Fee: £40 (Trainees: £35)

Beyond Words – Art and Image in Psychotherapy – CPD/3

Six seminars, covering a range of topics related to creativity and image-making from a Jungian perspective. Each workshop will begin with a talk by a Jungian Analyst, followed by experiential and clinical discussion groups, with the opportunity for participants to bring images from their clinical practice. Aimed at professional therapists and arts therapists who want to deepen their thinking about the area of images and art in relation to analytical therapy. Fee: £350

Weekend Course: The Foundations of Psychoanalytic Theory & Practice – Ref.INT/4

Aiming to provide an understanding of key theoretical concepts, this course helps participants explore how psychoanalytic ideas can be applied both directly when working with patients and also in understanding the underlying dynamics in the work place. Weekends include theoretical seminars, small group discussions and experiential groups. Suitable for those interested in exploring psychoanalytic ideas or considering further training. Four weekends: February, March, and May & June 2012. Fee: £780

Infant Observation – A Jungian Approach – Ref. INT/12

The experience of observing an infant from birth to two years old is invaluable in understanding the unfolding of the self. By reflecting on participants observations in a group, we endeavour to build up a picture of the developing inner world of the infant and their relationships. Joining the course is possible at the beginning of any term. Seminars are held in South and West London. Fee: £690

For further information and application forms, please contact Sandra Pereira: Tel. 020 8452 9823 or via external@bap-psychotherapy.org

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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 February 2012. The deadline for article proposals is 23 December 2011. Contributions and letters to the Editor should reach us no later than 20 January 2012.

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# Psychoanalysis and homosexuality: moving on

A one-day conference co-hosted by The Anna Freud Centre, Association for Psychoanalytic Psychotherapy in the NHS, British Psychoanalytic Council, Tavistock and Portman NHS Foundation Trust, and Tavistock Centre for Couple Relationships

## Saturday 21 January 2012

Resource for London, 356 Holloway Road, London N7

For some time, much of the psychoanalytic community in the UK has been conspicuously silent on the issue of homosexuality, and by extension on the area of sexuality in general. There has tended to be a de facto retreat from the pathologisation model that was promulgated in the past, but with little in the way of explicit articulation or theorisation of a new consensus. A movement that once made the fearless exploration of human sexuality its very hallmark has become a little coy.

But an irreversible change is now in train. Earlier Psychoanalytic Psychotherapy NOW conferences have highlighted the need to deal with this issue in a more direct and forthright way. A special edition of the journal *Psychoanalytic Psychotherapy* published in December 2011 is devoted to the subject. And the British Psychoanalytic Council (BPC) is adopting a position statement.

This conference seeks to define and explore the current state of mind within the psychoanalytic community on this subject, ranging across some of the key scientific questions to what changes need to be made to ensure that the profession fully opens up to gay and lesbian trainees and patients. In so doing, it is hoped to allow for a new dawn of psychoanalytic thinking on its original home ground of psychosexuality.

### Outline programme

9.30 – 9.45am	Welcome and introduction: Malcolm Allen
9.45 –11.15am	<b>PLENARY</b> A scientific theory of homosexuality for psychoanalysis Chair <b>Alessandra Lemma</b> Paper <b>Peter Fonagy</b> Discussant <b>Nicola Barden</b>
11.45am – 1.15pm	<b>BREAKOUT SESSIONS</b> <b>1.</b> Scientific discussion continued <b>Bernard Ratigan in conversation with Nicola Barden</b> <b>2.</b> Creating a gay-friendly profession <b>Paul Lynch and Jeremy Clarke</b> <b>3.</b> Exploring the complexities of conscious and unconscious sexual orientation in the clinical relationship <b>Leezah Hertzmann and Mary Target</b> <b>4.</b> Clinical perspective: the uncertain patient <b>David Morgan</b>
2.15 – 3.35pm	<b>PLENARY</b> Training curricula and training practices – what needs to change? Presentation <b>Paul Lynch</b> Respondents
3.50 – 5.00pm	<b>PLENARY</b> Next steps Chair <b>Helen Morgan</b> Panel <b>Julian Lousada, Trudy Klauber, Jeremy Clarke, Bernard Ratigan</b>

Booking details at [www.psychoanalytic-council.org](http://www.psychoanalytic-council.org)



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**Half Day Conference**

**Understanding and working with abuse in couple relationships**

Abusive couple relationships raise concern at public and private levels and pose real dilemmas for couple therapists. The conference will address this tension, extending our understanding of abusive relationships from object relations and attachment perspectives.

**Date:** Saturday 3<sup>rd</sup> December 2011 **Time:** 9.30am-2.00pm

**\*New Professional Development Course\*: Contemporary Perspectives on Attachment, Psychoanalysis and the Couple Relationship**

Reading Seminar with Christopher Clulow & Amita Sehgal  
**Date:** January 2012 **Time:** Tuesdays, 3.45pm-5.15pm;  
2 terms of 9 weeks each

**Attachment Theory: The Impact of Attachment Security on the Couple Relationship**

Course Leaders: Amita Sehgal and Stella Vaines

**Date:** Friday 20<sup>th</sup> January 2012 **Time:** 10.00am-4.00pm

**Enid Balint Lecture: Working Through in the Counter Transference Revisited**

Speaker: Irma Brenman Pick

**Date:** Friday 10<sup>th</sup> February 2012 **Time:** 7.30pm

**CONTACT:** [jbending@tccr.ac.uk](mailto:jbending@tccr.ac.uk) - **TEL: 0207 380 1970**





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