New Associations

NEWS, ANALYSIS, OPINION FOR THE PSYCHOANALYTIC COMMUNITY | **ISSUE** 4 **AUTUMN** 2010

BRITISH PSYCHOANALYTIC COUNCIL

Gearing up to meet challenges ahead

By Malcolm Allen

AS THE GOVERNMENT announces, in its Spending Review, an expansion of access to psychological therapies, a hard-hitting report from mental health charity Mind highlights the key challenges that such services now face.

First, the Spending Review. Compared to other departmental budgets, the NHS settlement is as good as it could be with an increase of 0.1% a year 'in real terms'. However, the 'real' figures are based on estimates of general inflation – the GDF deflator, and the NHS inflation rate has historically been higher than this. This relatively slender increase (the NHS has been getting average increases of nearly 7% a year from 2000) will soon be swallowed up by things like pay increases, the increase in VAT, and meeting the costs of the structural re-organisation announced in the White Paper *Equity and Excellence: Liberating the NHS* (on one estimate between £2–3 billion). Together with increasing demands from a rising and ageing population, the NHS now faces an unprecedented level of challenge.

This is the context in which the Government announced an expansion of access to psychological therapies. At the time of writing, the amount of additional funding had not been confirmed – the original DH bid was for around £140 million. But it is without question a remarkable achievement, owed in part to the determined lobbying of Lord Layard, but also to the campaign of the We Need To Talk coalition (of which BPC is a member).

The coalition has recently published *We need to talk: getting the right therapy at the right time*, drawing on a report from Mind. Mind's report is based on a survey of 527 users of IAPT services and its conclusions are far-reaching for anyone concerned about the shape of such services in the future. The report reveals that only eight percent of those surveyed had a full choice in the therapy they received, but that people offered a full choice of therapy were *five* times more likely to be helped back to work than those who weren't. Also, people who had a choice of therapies were *three* times more likely to be happy with their treatment than those who wanted a choice but did not get it.

These results also sit interestingly with the National IAPT Data Review of the first IAPT roll-out sites by North East Public Health Observatory. The review found, for example, that the median number of sessions for low-intensity interventions was just two and for high-intensity interventions it was only three. This compares with NICE guidance that recommends at least six sessions for most low intensity interventions and up to *twenty* sessions for some high-intensity interventions.

The Mind report also makes clear that IAPT services have been more successful where they have been well integrated with other broader psychological therapy provision. However, in spite of DH guidance to the contrary, Mind's research has shown that IAPT money has sometimes been used to replace other psychological therapy services. The report states that 'this simply replaces, not improves, the provision of psychological therapies.' This also means that many existing therapists and counsellors (especially those based within GP surgeries) are losing their jobs, impacting adversely on the knowledge base and relationship networks of these services.

Delivering all types of psychological therapies services, including IAPT, will now be taking place within the context of the move towards GP commissioning together with the implementation of the £20bn quality, improvement, productivity and prevention (QIPP) programme. It will be a tumultuous time for the whole NHS, impacting on every corner of mental health care. The highly respected Kings Fund, which generally supports the need for reform, has warned that the scale and speed of the current reforms is likely to distract attention from the need to maintain quality and avoid cutting services.

How can our profession respond to these huge changes? How do we help make it possible for psychological therapy services to be organised along the lines recommended by the We Need to Talk coalition? And how can we help ensure that large numbers of high-calibre psychoanalytic and psychodynamic practitioners are not lost to the system in the years ahead?

The key to all this is *partnership*. The BPC has been working hard to help build alliances in support of the progressive platform set out in the We Need to Talk document, especially around patient choice. The coalition that produced the document is an excellent example of this in practice, and there are signs that the Government is listening. In a related initiative, the chief executives of BPC, UKCP and BACP have written a joint letter arguing that the next phase of IAPT roll-out must not simply replicate the CBT-dominated first phase. It is now an urgent priority for the professional bodies to sink their differences on a range of issues to focus on building a co-ordinated campaign to defend and improve counselling and psychotherapy services throughout the UK.

Coalitions at a national level will be meaningless without building corresponding alliances at a local and regional level – where the real decisions on funding and commissioning will be made. This is a difficult challenge for all of us, but again the professional bodies may be able to take a lead in facilitating and supporting this sort of local activity.

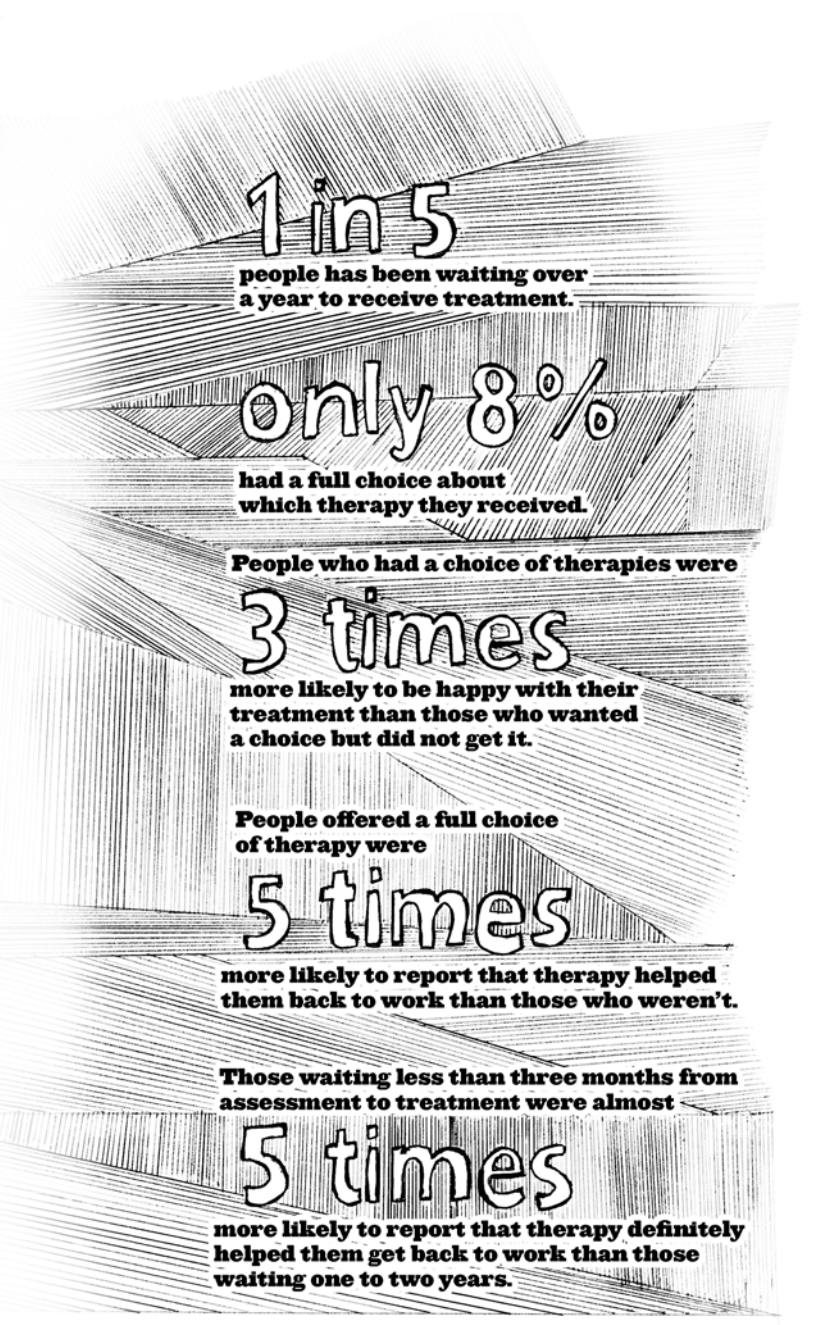
Psychodynamic practitioners in particular will need to get smarter and more organised in building relationships with local commissioners. Individual practitioners will increasingly need to group themselves into larger practices to compete effectively in the market place; the BPC will be looking at ways we can help build expertise across the sector in various forms of social enterprise.

Finally, the scale of these challenges highlights more dramatically than ever the incapacitating fragmentation of the psychoanalytic and psychodynamic community. Many of our organisations have begun to sense just how weak they are by operating in this isolated manner. The need to move from this broad perception to a position of purposeful strategic action is of course another matter. Our ability to bring our various organisations together into a disciplined and determined force for change is one of the biggest challenges we now face. ■

We must sail sometimes with the wind and sometimes against it – but sail we must and not drift, nor lie at anchor

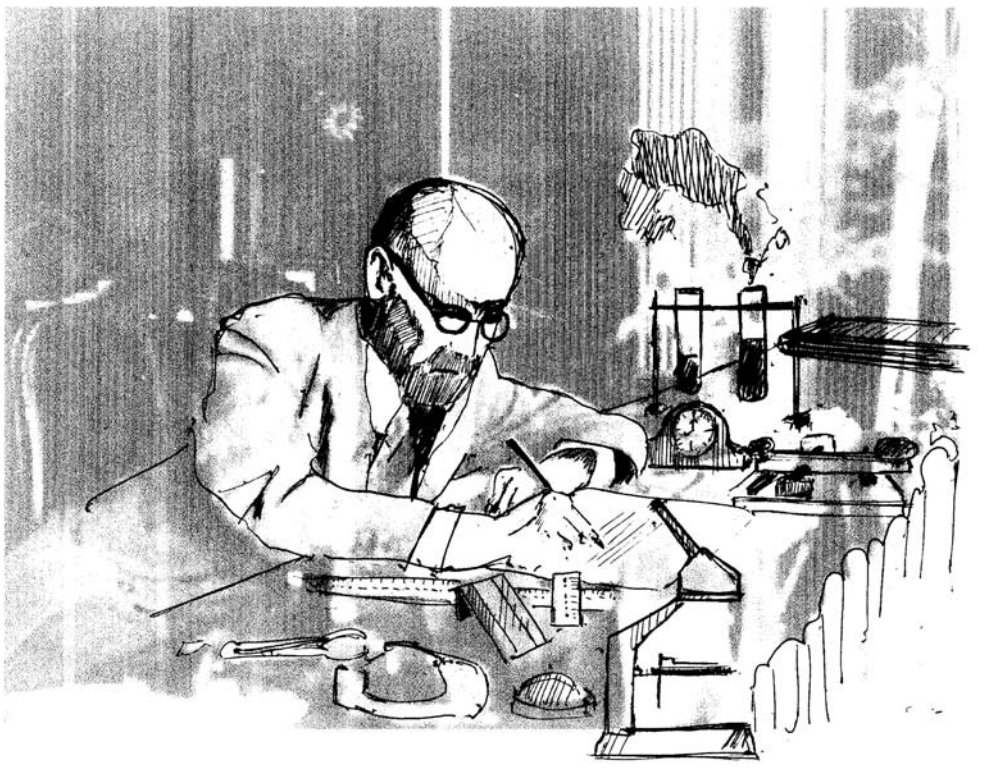
Oliver Wendell Holmes

Malcolm Allen is CEO of the BPC



Opinion

Should psychoanalysis be in the Science Museum?



An article in a recent issue of New Scientist, *by philosopher Mario Bunge (opposite page), questioned the appropriateness of the Science Museum giving space to psychoanalysis. Mary Target and an impressive roll-call of international colleagues responded in the 30 October edition; this is the longer, more comprehensive version of their letter.*

Dear Editor,

Re: 'Should Psychoanalysis be in the Science Museum?', *New Scientist* 2.10.2010, pp 22-23

We were very disappointed by Professor Bunge's intemperate and unscientific contribution to the debate on the scientific status of psychoanalysis. This is an important issue which sometimes receives far more sophisticated consideration. We would have welcomed a well-informed critique from a philosopher of science of the stature of Professor Bunge, and regret that he did not take this opportunity to address the issues seriously.

Far from being a discipline that has 'remained basically stagnant', psychoanalysis has creatively developed, producing (as well as the most profound clinical theory) substantial research contributions of interest to other fields. Many basic psychoanalytic propositions have been widely accepted. Examples include the impact of early childhood relationships on adult personality (e.g. the explosive growth of scientific attachment research and theory), empirical demonstration in academic psychology of the impact of unconscious thoughts and feelings on behaviour (e.g. the study of unconscious prejudice), among many others. Neurobiologist Nobel Prize-winner Eric Kandel MD sees the brightest future for psychiatry in a joining of psychoanalysis and neuroscience. Professor Bunge's claim of scientific irrelevance is untrue, and he goes on to make a series of statements which completely part company with the easily available evidence.

We are reluctant to accuse a distinguished colleague of poor scholarship, but cannot let pass the bizarre assertions that laboratory science has been absent from psychoanalysis throughout its existence, that we have not submitted papers to scientific journals, and that clinical trials have not attempted to examine the effectiveness of psychoanalytic psychotherapy, or that we are 'foreign to the scientific community'. A cursory literature search would have provided citations and abstracts of hundreds of psychoanalytic research articles published in mainstream scientific journals. Masling's series on 'Empirical Studies of Psychoanalytic Theories' alone spans 10 volumes and includes 389 pages of references.

We readily accept that some specific developmental or psychopathological propositions put forward by Freud would not fare well in empirical testing, and that some details of his theories are probably incorrect or outdated. This is true of most bodies of knowledge evolving over 120 years, and would certainly be expected of any science. Contemporary psychoanalysis is not reducible to the study of the work of Freud, any more than contemporary physics stops with the study of Newton, or biology with Darwin. However, like other scientific frameworks built on fundamental insights into underlying reality, the basic psychoanalytic assumptions of a dynamic unconscious, actively shaping conscious experience, self-image and relations with others, have proved creative and convincing across many disciplines. There is welcome convergence, for example, with trends in current cognitive, social and affective neuroscience, being explored intensively by researchers in neuropsychoanalysis, which bridges these disciplines at a high level.

Psychoanalysts have been testing the outcomes of psychoanalytic therapies for decades, using randomized controlled trials and systematic follow-up studies, as Professor Bunge urges us to. Active academic researchers will form a minority of any clinical profession, but a committed international band of psychoanalysts have accepted the challenge to test the evidence for the effectiveness of psychoanalytically-based treatments. Recent literature reviews and meta-analyses of scientific studies of psychotherapy outcome (for example the series of papers by Leichsenring and colleagues) have found that effect sizes – a quantitative measure of treatment benefit – for psychoanalytic psychotherapy in randomized controlled trials are comparable to those for other therapies that are promoted as evidence based. The majority of trials have offered strong evidence of the effectiveness of psychoanalytic therapies, others have found stronger evidence for other therapies for specific conditions; the point is that psychoanalytic therapy has for a considerable period been tested in the same stringent way as have other approaches.

'Psychoanalysts have been testing the outcomes of psychoanalytic therapies for decades.'

We are entirely bemused by Professor Bunge's assertion that the original studies in Shedler's meta-analysis did not have control groups, which a glance through the article (*American Psychologist*, vol 65, p 98) would have disproved. (We do not claim, however, that patients in psychoanalytic therapy have been studied in double-blind trials; it is difficult to imagine adult patients in a talking treatment being oblivious of what treatment they were receiving.)

The 74 signatories of this letter have raised many millions of pounds from competitive public research funding to undertake just the kind of research Professor Bunge advocates. We have adopted respected, mainstream methodologies despite the challenges of doing so in this area, and published systematic, empirical psychoanalytic research in first rank, peer-reviewed scientific journals (e.g. *The Journal of the American Medical Association*, *Science*, *The Archives of General Psychiatry*, *The American Journal of Psychiatry*, *American Psychologist)*. We run twice-yearly, free research summer schools to offer consultation, training and ongoing mentoring to psychoanalysts and others wishing to engage in research of the kind Professor Bunge has been missing. Many early participants are now well-established psychoanalytic researchers. Although we would love to do more, this level of scientific contribution compares very well with that in other clinical professions.

We believe readers of this *New Scientist* debate will be reassured to know that psychoanalytic researchers are undertaking productive, cutting edge studies guided by psychoanalytic ideas, at world-leading universities, and helping younger colleagues to do so. We also believe that readers would expect contributors to their debates to be informed as to the facts. We fully agree that scientific progress requires a willingness to seek and learn from evidence, and in this spirit we respectfully offer a factual context in case the entertaining jibes of Professor Bunge might be mistaken for reality. ■

Yours etc

Professors Mary Target PhD, Peter Fonagy PhD, Anthony Bateman MD, Peter Hobson MD, University College London
Professor Falk Leichsenring DSc, University of Giessen
Professors Sidney Blatt MD and **Linda Mayes MD**, Yale University
Professors Otto Kernberg MD, Robert Michels MD, Barbara Milrod MD, Joseph Schachter MD, Stephen Roose MD, David Olds, MD, Frank Yeomans MD PhD, Richard C Friedman MD, Monica Carsky PhD, Weill Medical College of Cornell University & Columbia University Center for Psychoanalytic Training and Research
Professor Mark Solms PhD, University of Cape Town
Professor Jonathan Shedler PhD, University of Colorado
Professor Marianne Leuzinger-Bohleber PhD, Sigmund Freud Institut & University of Kassel

Distinguished Professor Mardi Horowitz MD; Professor George Silberschatz PhD University of California
Professors Ayelet Barkai MD, Raymond Levy PsyD, Harvard University and Medical School
Professors Helmut Thomä MD, Horst Kächele MD PhD, University of Ulm
Distinguished Professor Paul L. Wachtel PhD; Professors Diana Diamond PhD, Eric A. Fertuck Ph.D., Elliot Jurist, PhD, City University of New York
Professors Christopher Perry MD, Daniel Frank PhD, Martin Drapeau PhD, McGill University
Professor Kenneth N. Levy PhD, Pennsylvania State University
Professors Stephan Hau PhD, Andrzej Werbart PhD, Stockholm University
Professor Anna Buchheim PhD, University of Innsbruck
Professor Jeremy Safran PhD, New School for Social Research, New York
Professor Stijn Vanheule PhD, Reitske Meganck PhD, Mattias Desmet PhD, Ghent University
Professors Geoff Goodman PhD, Marvin Hurvich PhD, Philip S. Wong PhD, Long Island University
Professors Eve Caligor MD, Lewis Aron PhD, Richard Lasky PhD, New York University School of Medicine
Professors Morris Eagle PhD, Joel Weinberger PhD, Adelphi University
Professor Nancy McWilliams PhD, Rutgers University
Professor Michael Stuart Garfinkle, PhD, Mount Sinai School of Medicine
Professor Allan Abbass, MD, Dalhousie University
Professor Joseph Masling PhD, State University of New York at Buffalo
Professor Golan Shahar PhD, Ben-Gurion University
Professor Adela Leibovich de Duarte PhD, Buenos Aires University
Professor John Auerbach PhD, East Tennessee State University
Professor Henning Schauenburg MD, University of Heidelberg
Professor Dorothea Huber MD PhD, University of Munich
Professor Stephen Soldz PhD, Boston Graduate School of Psychoanalysis
Professor Phebe Cramer PhD, Bronfman Science Center
Professor Bethany Brand PhD, Towson University
Professors Louis Diguer PhD, Karin Ensink PhD, Stéphane Sabourin PhD, Universite Laval, Quebec
Professor Clara Lopez-Moreno, Universidad del Salvador
Dr Alessandra Lemma PhD, Visiting Professor, Essex University
Dr Saskia de Maat PhD, Mentrum Institute for Mental Health, Amsterdam
Dr Patrick Luyten PhD, University of Leuven
Dr Margaret R. Zellner PhD, The Rockefeller University, President and Chair, The Neuropsychoanalysis Foundation
Dr Mary Beth Cresci PhD, President, Division of Psychoanalysis, American Psychological Association
William H. Gottdiener PhD, Director, Addiction Studies Program, John Jay College of Criminal Justice
Dr David Taylor, Clinical Director of the Tavistock's Randomised Controlled Trial of psychoanalytic psychotherapy in the treatment of chronic and refractory depression
Dr Sherwood Waldron MD, Chair, Psychoanalytic Research Consortium
Dr Paolo Migone MD, Editor, *Psicoterapia e Scienze Umane*
Dr Henriette Löffler-Stastka MD, Medical University of Vienna ■

Extract from 'Should psychoanalysis be in the Science Museum?', *New Scientist*, 2 October 2010

…Psychoanalysis is a bogus science because its practitioners do not do scientific research. When the field turned 100, a group of psychoanalysts admitted this gap and endeavoured to fill it. They claimed to have performed the first experiment showing that patients benefited from their treatment. Regrettably, they did not include a control group and did not entertain the possibility of placebo effects. Hence, their claim remains untested (*IJPA*, vol 81, p513).

More recently, a meta-analysis published in *American Psychologist* (vol 65, p98) purported to support the claim that … psychodynamic therapy is effective. However, once again, the original studies did not involve control groups…

This does not mean their hypotheses have never been put to the test. True, they are so vague that they are hard to test and some of them are, by Freud's own admission, irrefutable. Still, most of the testable ones have been soundly refuted.

As for therapeutic efficacy, little is known because psychoanalysts do not perform double-blind clinical trials or follow-up studies.

Psychoanalysis is a pseudoscience. Its concepts are woolly and untestable yet are regarded as unassailable axioms. As a result of such dogmatism, psychoanalysis has remained basically stagnant for more than a century…

Mario Bunge is a philosopher at McGill University in Montreal

The full article appears at www.newscientist.com/article/mg20827806.200-should-psychoanalysis-be-in-the-science-museum.html

Letters to the Editor

A request

Dear colleague,

We are writing to ask your readers if they have any books that they would be able to donate to Kids Company's new library. We are developing training for all our volunteers and are committed to educating people in creative relational approaches to personal, social and emotional development. We would be very grateful for any donations of books that could help to resource our new library towards this aim.

We are particularly interested in books on the therapeutic relationship, child development, attachment theory, inter-cultural issues, arts therapies, social work and anything concerned with the well-being of children and young people.

We are interested in receiving books from every orientation in psychotherapeutic or counselling approaches including: psychoanalytic/psychodynamic, family/systemic, cognitive/behavioural, humanistic, person centred and integrative-humanistic perspectives.

Please contact Nikki Finning on 020 7202 2700 or nikki.finning@kidsco.org.uk for further information about how to donate books that are so desperately needed to start to educate a new generation of people to support children and young people.

With thanks,
Nikki Finning
Kids Company

Statutory regulation

Jeremy Holmes proposes 'ironic detachment' as the sound attitude to take towards state regulation (Letters, *New Associations*, Issue 3, Summer 2010). I'm not so sure that this is psychologically appropriate or politically effective. An aristocratic, Olympian and disdainful attitude may erroneously lead BPC registrants to conclude that HPC regulation won't bother them very much.

To the contrary, as I know from my job as Chair of UKCP, wherein I get to see all the papers, there are compelling reasons why BPC registrants need to start to take an active, informed, critical, conscious attitude towards what is happening in our profession.

For example, if there are no changes to HPC's Fitness to Practise system then something grotesquely inadequate for our work will be imposed on us – public, adversarial, legalistic. Or, to mention another conundrum, if BACP's view that there is no difference between psychotherapy and counselling prevails, our hard-won standing as a profession will be undermined. And, to my mind, there is something far too 'detached' about bystanding with regard to the very low standards HPC regulation depends upon.

Furthermore, I don't think BPC members can stay 'ironic' over matters closer to home. What is BPC going to do about its registrants who don't want to register with HPC, even if they are as immature and rebellious as Jeremy and Julian Lousada think they are? Can they stay in BPC or will they have to go? Does BPC want them to go?

Make no mistake about it, if you don't plan to register with HPC, you can call yourself a psychoanalyst or a Jungian analyst and, provided you stay within a high standard ethical framework, practise with a clear conscience – and not be interfered with by the state. This may be one way to promote the core values of psychoanalysis.

All of this needs to be opened up by the BPC leadership in dialogue with 'we, the registrants'. What is going to happen if the leadership cannot truly recommend HPC?

Andrew Samuels
Society of Analytical Psychology

PSYCHOANALYTIC PSYCHOTHERAPY NOW 2010

Meeting the challenge of complexity together

This conference was refreshing, and it strengthened in me the desire for collaboration across traditional borders and boundaries that have failed historically to generate the creativity and relatedness we need to survive the professional challenges of the modern world. Whilst I am profoundly informed by and passionate about psychoanalysis and analytical psychology, I chose to study, qualify and teach in the field of Integrative-Humanistic Psychotherapy for ideological reasons related to issues concerning race and culture, sexuality, gender, disability, age and religion. It would seem that the BPC are moving forward in all these areas, seeking to redress the problems that have perhaps held it back for years.

The **breakout session** chaired by Helen Morgan with presentations by Kamaldeep Bhui and Frank Lowe was particularly enthralling, and we probably needed six months of intensive work in the group to think through the processes and issues raised, such is the hunger to address these long-repressed concerns. How wonderful that Frank chairs a weekly group at the Tavistock Clinic reflecting on these themes.

The **debate** between Peter Fonagy and Peter Tyrer brought into sharp focus the inter-cultural issues between the different philosophical underpinnings for research methodologies. There is so much to think about for everyone who has the motivation and interest to engage with and participate in the development of research, including qualitative approaches and randomised control trials, as well as the inevitable conflicts between them with reference to both practical and ethical concerns. It would seem that the search for truths so characteristic of our field continues, whether it be narrative, existential, theoretical, transcendent or empirically scientific.

In particular I was inspired by Jean Knox's call for practitioner research, and had a vision that if we could manage to really work together and collaborate across all the orientations that comprise the fields of psychoanalysis, psychotherapy, arts-based approaches and counselling, we could perhaps be able to evidence more effectively in a myriad of ways what depth psychologies and relational methodologies have to offer our modern world in every area of our human development, social and cultural life.

'The search for truths so characteristic of our field continues.'

The choice of **awards** was moving and communicative, in particular the homage given to Camila Batmanghelidjh from Mary Target. I have participated in Camila's vision and struggle to apply psychoanalytic thinking and principles to practice in working with children and young people, and I know how much she deserved this tribute, which she received on behalf of Kids Company and the children.

The British Psychoanalytic Council is apparently in a period of renaissance and this is most heartening. I have been subject to periods of deep despair about our field in recent years with the CBT hegemony and the anti-regulation movement, and was much in need of an event that could lift my spirits.

From mythology Pandora's story tells that whilst evil, sickness, misery and pain exist, they can only be tolerated and survived by the presence of hope. My personal and professional vocation has always been endured by working and suffering in the midst of that hope, and if we can make these kinds of quantum leaps evidenced by the BPC, perhaps we could discover that we have everything to work towards together to reveal the quality of what we all know is so vital in essence about psychological therapies. I'm investing in visions of a future where we can make that contribution that could make a real difference to a society that so desperately needs what we have kept to ourselves for far too long. ■

Jocelyne Quennell is a Clinical Director at Kids Company, a UKCP Fellow and former Principal of the Institute for Arts in Therapy and Education.

As a psychiatrist specialising in cognitive behavioural psychotherapy I enjoyed attending your conference on behalf of my colleague Dr Bernard Ratigan.

I had feared I would feel an outsider and the material seem foreign. It was therefore a pleasant surprise to find my attention fully engaged during the opening session. The content of the papers spoke directly to my own interests and the emerging issues of concern were ones with which I could identify. My experience was not of a foreigner in a strange land but of a visitor made welcome on a neighbouring island.

I was surprised to see a breakout session entitled 'Is there a drift away from teaching about **sexuality in psychoanalytic training**? What part should the subject play in the training curriculum?' I had assumed that a detailed understanding of sexuality is fundamental to the practice of psychoanalysis, and that this subject would therefore occupy a prominent place within the curriculum. During the session we heard a frank account of the bruising experiences of voicing psychoanalytic theories within complex political arenas. We also heard a detailed description of the recently developed course on 'Sexuality and the Clinical Situation' in the psychoanalytic training at Columbia University. In the ensuing discussion there was agreement that a variety of fears have led to neglect of sexuality within the training curriculum and that this is a significant problem. The example of the Columbia model. with its broad base and inclusion of recent papers, generated enthusiastic interest from trainees and trainers – although it was noted that the caution exercised in teaching the course later rather than earlier in the training might be misplaced…

My response to this session led me to reflect on what I, as a psychiatrist and cognitive behavioural psychotherapist want from psychoanalytic psychotherapy. My conclusion is that the challenging questions asked by your discipline i n the face of complexity are profoundly helpful, even in situations when explanations generated from your theory lack face validity for me.

'My experience was of a visitor made welcome on a neighbouring island.'

In the evening it was a great honour to accept on Bernard's behalf an award in recognition of his outstanding leadership. This felt apposite and moving within the context of the day. Bernard's pioneering work alongside colleagues from other disciplines in delivering effective HIV services is a particularly fine example of how psychoanalysis can play a leading role in 'meeting the challenge of complexity together'. ■

Richard Fox, Nottingham Psychotherapy Unit

In the breakout session on **complex interdependencies** the question for the group was: What are the relationships between the individual, the family, and society as they impact on mental health and models of therapeutic intervention? The two speakers approached the topic in very different ways.

Susanna Abse, who is the Chief Executive of the Tavistock Centre for Couple Relationships, addressed the issue of how psychoanalytic thinking can engage with the larger political process. She drew attention to the ways in which poverty and deprivation are linked to children's well-being, with Britain being at the bottom of the Unicef list on well-being in children.

Most of the audience worked predominantly with individuals. She made us all think about relational issues and how to engage couples, parents and families to think about intergenerational transmission of ways of relating. She pointed out that parents getting on well together is important to children's well-being. When parents have become estranged and separated and there are high levels of conflict, children can get caught up in terror and upset at the extent of the adult aggression. From the floor one of the participants linked this aspect to what had been mentioned in the morning session by Vamik Volkan about the history of enduring conflicts between nations, and how difficult it is to break negative patterns of relating. She spoke about the aims of treatment, including the containment of more destructive aspects of relating, helping the individuals and the couple achieve a more realistic view of themselves and their partner. She drew attention to the family as the most potent agent of social change.

The next presenter was Jean Knox, a Training Analyst for the Society of Analytical Psychology and a Training Therapist for the British Association of Psychotherapists. She approached the question from an attachment perspective. Her focus was the interpersonal, relational context of the psychotherapeutic and mother-child relationships. She made the case that the achievement of a secure sense of self-agency lies at the heart of any successful psychotherapy, and she used developmental research, neurobiology and the use of language and metaphor as important aspects of communicative style.

She proposed that an analyst's interpretations can become a form of coercive communication, in the same way as negative attributions by a mother become an integral part of a child's sense of self – interpretations of the negative transference can be like this – deeply alienating. Her preferred style is one of co-constructing a narrative using the interpersonal agency of both analyst and patient, rather than having a specific theory being imposed. She warned against therapists who are driven by orthodoxy, rather than by a more curious and questioning state of mind.

There was comment from the audience on the theme of authority in the professional relationship, as well as lively discussion on paying attention to intrapsychic processes, while at the same time being in the real world of people who live in partnerships and families and need to talk about these aspects of their outside lives within the therapeutic relationship.

There was not sufficient time to take further the ideas about relational social policy that were proposed, for example the economic arguments of invest to save schemes like early years interventions which could lead to fewer families being referred to CAMHS. ■

Beverley Tydeman is chair of the Association of Child Psychotherapists.

The session on **Homosexuality – moving on** attracted a high level of interest. Participants very much welcomed the chance to explore the subject of homosexuality, and it was encouraging that the discussion was thoughtful and wide ranging. There was a sense of agreement that homosexuality remains one of the most problematic areas within psychoanalysis, all too often inadequately understood, theoretically inflexible and, at worst, attacking and pathologising. However, rather than the discussion being a chance to complain, participants genuinely grappled with their own professional and personal challenges as they impact on their outside lives within the therapeutic relationship.

'Participants genuinely grappled with their own professional and personal challenges.'

Amongst the ideas articulated there was consensus about the need for wider and more inclusive curricula on sexuality in psychoanalytic trainings. Participants expressed concern about the difficulty of finding both analysts and supervisors who had experience of or were open to thinking about homosexuality in a non-pathologising yet rigorous way. They also voiced concerns about the negative and intrusive manner in which some candidates for training are questioned about their sexuality. Others spoke of the need for the BPC to issue a position statement to formally declare a non-pathologizing view of homosexuality, and that attempts to alter a patient's sexual orientation are unethical. Participants were pleased to hear that work on this is currently ongoing within the BPC, though it was recognized that there will be challenges. Justin Richardson reminded us that the American Psychoanalytic Association had issued its own position statement in 1999[1], and he described the long and difficult battle in the US to remove homosexuality from the Diagnostic and Statistical Manual of Mental Disorders (DSM) – successfully achieved in 1986. He explained how once this had happened, further changes in theory, practice and attitudes followed.

There was some anxiety about the pace of change. Several participants felt that more time was needed to take on board the changes in practice and attitudes which were being discussed. However, there was a strong feeling from others that people had had long enough to adjust and that change was needed now. The facilitators reflected their concern about a delicate balance between making and sustaining progress, whilst simultaneously engaging with those who might still view homosexuality as pathology and developmental derailment. As the session closed, many said how much they welcomed the chance for discussion and their wish to contribute to the continuation of this dialogue. The facilitators were pleased to announce that alongside the various strands of work underway in this area, the next PP Now Conference for 2011 will be on the subject of homosexuality, and preparations for this are currently well underway. ■

Leezah Hertzmann is a clinical lecturer at the Tavistock Centre for Couple Relationships.

1. American Psychiatric Association: Position statement on psychiatric treatment and sexual orientation. *American Journal of Psychiatry* 1999; 156:1131

'What I liked most was the open engagement in the need for change within the analytic community.'

'I had difficulty in choosing which breakout sessions to attend – I was spoilt for choice!'

'I enjoyed listening to people talking about frontline services... they all managed to engender exciting links between practice and models of thinking and of making a difference.'

'The conference had a good overall format with an excellent opening plenary.'

'The stimulating topic of applications in "tough" settings was what I enjoyed the most.'

PSYCHOANALYTIC PSYCHOTHERAPY NOW 2010

Awards

The Psychoanalytic Psychotherapy NOW conference once again featured an awards ceremony to celebrate achievement in the psychoanalytic community. This year we presented four awards.

Early Career Achievement Award

This award recognises an outstanding contribution to advancing psychoanalytic knowledge or practice from someone in the early stages of their career as a psychoanalytic or psychodynamic practitioner, normally within seven years from qualification.

The award was presented to
Nicholas Midgley

Nick was the first Anna Freud Centre child psychotherapy trainee to complete a Professional Doctorate, in 2003, his outstanding doctoral research being published shortly afterwards. He is now a leading researcher of UK child psychotherapy, co-author of a landmark review of its outcome literature, and key process researcher on the highly important IMPACT study of adolescent depression. The enthusiasm of child psychotherapists about joining this RCT reflects a sea-change to which Nick has greatly contributed. He has held most positions related to child psychotherapy research, as well as other positions of authority and trust in UK psychoanalytic psychotherapy organizations and journal boards.

In addition to over 20 book chapters and peer-review articles (Routledge/JCP Research Essay Prize, 2005; Anna Freud Foundation Prize, 2007), Nick has taught on many psychotherapy training courses and supervised 50 research dissertations. He was director of professional doctorate studies at Essex until 2007, where he established a clinical doctorate in psychoanalytic psychotherapy for the SAP, Tavistock and LCP; he then helped the BAP establish their Birkbeck doctorate in child psychotherapy. His UCL/AFC postgraduate psychoanalytic theory teaching consistently gets excellent feedback, inspiring young people to train as clinicians and researchers. He regularly lectures internationally; a recent presentation, at the major Society for Psychotherapy Research conference in California, was reportedly the most interesting presentation of the Conference.

Two years ago Nick became Head of the AFC Programme for Children and Young People. His development of diverse clinical, research and training projects has been extraordinary. He quickly turned deficit into strong surplus, on a budget over £1 million. He has a gift for facilitative management and creative collaborations, helping others attract new funding above £370,000.

Award for Outstanding Professional Leadership

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

The award was presented to
Bernard Ratigan

Bernard Ratigan has worked in the field of psychotherapy since the 1970s. In his early career he was responsible for setting up one of the first student counselling services within the UK at Loughborough University. In 1988 he was appointed with Department of Health approval to work at the Nottingham Psychotherapy Unit as a consultant grade psychotherapist. During his career he was influential in establishing the place of adult psychoanalytic psychotherapy within NHS mental health services. He played a particularly active role in establishing psychotherapy in the curriculum for a range of health professionals, and was instrumental in the development of the South Trent Training (full time NHS provincial UKCP training). He has been tireless in his advocacy of psychoanalytically informed services for minority groups with high levels of need. He was instrumental in establishing HIV psychotherapy within Nottingham GU services and developing the Nottingham Gender Identity Clinic, which is now the largest in the UK outside London. He has made significant academic contributions within his areas of clinical interest.

Following retirement from full time NHS work he has continued his active contribution as a psychoanalytic psychotherapist and as an independent scholar. His interests are in the contested space between psychoanalysis, religious belief, the (homo-)sexualities and the arts. His academic investigation of otherness has recently focussed on splitting within the representation of Jews and Judaism in Northern European early renaissance art. His studies are supported by the Woolf Institute (University of Cambridge) and earlier this year he presented a paper at IARPP in San Francisco. The Professor of Art History at Harvard University (who worked as Peter Gay's research assistant whilst writing Freud's biography) has expressed regret at not having had such a simple idea himself.

Bernard is currently working on a larger series of papers and a book on psychoanalytic approaches to the seven sacraments.

Psychoanalysis and Culture Award

This is an award to someone outside the profession for a special contribution to the understanding of psychoanalytic or psychodynamic work through culture (in its widest sense). The award this year was for a lifetime contribution to intellectual culture.

The award was presented to
Michael Rustin

Michael Rustin was nominated for this award to acknowledge his lifetime achievements as one of the leaders in the field of psychoanalytic interdisciplinary studies. He has had a deep involvement in psychoanalysis for his entire professional career. In his role as Professor of Sociology at the University of East London he developed a department that has become internationally renowned for its psychoanalytic engagement. He developed the academic link between UEL and the Tavistock (where he is visiting professor) and has inspired generations of students, through lectures, seminars and supervision of a very large number of doctoral theses. He was made an Associate Member of the British Psychoanalytical Society (an honour given to only a handful of people) where he is Chair of the Applied Section, the only person ever to chair a committee of the British Psychoanalytical Society/Institute of Psychoanalysis who is not a psychoanalyst.

His books include *The Good Society and the Inner World* (Verso, 1991), and Reason and *Unreason: Psychoanalysis, Science, Politics* (Continuum, 2001). Two further books are in press: a jointly-authored book (with Margaret Rustin), *Reading Klein*, to be published by Routledge and the Institute of Psychoanalysis in 2011; and *The Philosophy and Methods of Clinical Research in Psychoanalysis and Child Psychotherapy*, to be published by Karnac in 2011.

Award for Innovative Excellence

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

The award was presented to
Camila Batmanghelidjh and Kids Company

Camila Batmanghelidjh, the founder and director of Kids Company, has been a psychotherapist for more than twenty years. In her early twenties Camila founded her first charity, The Place To Be, which is now a national organisation reaching thousands of children. In her early thirties, Camila founded Kids Company in six converted railway arches in London. During the first few months, the team spent time integrating with the local young people, who tested their resilience and commitment with the challenging behaviour that had given them the label 'hard to reach'.

For thirteen years Kids Company has survived largely due to the support of charitable trusts, businesses and many wonderful individuals. It has often been a 'hand to mouth' existence for the organisation and Camila has kept united a staff team who accept that the future is always uncertain. On two occasions she has re-mortgaged her flat to see Kids Company through its lack of funding. To date, she and the team have raised £50m since Kids Company began in 1996.

In April 2008 Kids Company was awarded government funding of £12.7 million over three years through the Department for Children, Schools and Families, to fund its work with the 400 most disturbed young people over the age of 14.

Camila has created a unique and pioneering approach in delivering services to vulnerable children. She has always focused the organisation's activities on the needs of the most vulnerable client group without making compromises in order to hit current trends or government priorities. ■

‘In Treatment’: writing from life

By Keith Bunin

The first time I went to see a psychiatrist, I was eight years old. My parents sent me to take an IQ test to see if I would qualify for the gifted and talented program at my new elementary school. I had a lot of fun taking the test – I was one of those rare kids who liked taking standardized tests – they always seemed like a game to me. A year later, I went to see a psychiatrist for the second time. This time it wasn’t any fun at all. I was having a rough time in school, and an especially tough experience with my teacher, who yelled a lot. I was a really sensitive kid, and one day after my teacher had screamed at me, I came home from school, wrote a note to my mother that was a little suicidal, and then climbed out my window and sat on my roof, thinking about jumping.

Of course our roof wasn’t that high, and if I’d jumped I probably just would’ve broken my leg. I was mostly hoping that my mother would climb up to the roof and stop me, but my language was a little vague, so my mother didn’t really understand what the note meant, and when she didn’t come upstairs for a while, I just climbed down off the roof and came back inside.

But understandably, at this point, my parents decided that I should see a psychiatrist. The psychiatrist they chose seemed to me at the time to be just as gruff and hostile as my teacher, so when he asked me, ‘Why do you think you’re here?’ I burst into tears and kept crying for the whole session. Finally my parents decided to talk to the psychiatrist themselves, while I sat in the waiting room and read *Great Expectations*. All of which is to say that I had a fairly intense and difficult experience in therapy when I was a kid.

The good news about being a writer is that even your most traumatic and painful experiences can be turned into profit-making enterprises. So when in the fall of 2008 I was hired to write the story of Oliver, a preadolescent boy in therapy, for the television series *In Treatment*, it was kind of nice to know that I’d finally be able to put my experience to good use.

Between its first and second seasons, the show had moved production from Los Angeles to New York, and an almost entirely new group of writers had been hired. Warren Leight, the new executive producer and showrunner, was a playwright as well, and filled the staff with other playwrights. It made sense: while many scenes on most television shows last no more than ninety seconds, every episode of *In Treatment* is a conversation that lasts almost thirty uninterrupted minutes.

One other unusual thing about the show is its structure, which comes from the original Israeli version of the series. There are five episodes per week: for the first four episodes, we follow Dr Paul Weston with four different patients – and on the fifth day, we see Paul with his own therapist. Therefore, Warren hired five writers and assigned each of us our own patient. We would create our own characters, based on the template of the Israeli series, and we’d have true ownership over those characters for the entire season. Warren would work with all of us to make sure that the journey of Paul’s character was consistent and strong.

Because of my own experiences in therapy as a child, I was determined to make Oliver’s story as true-to-life as possible. I wanted to make sure that his story didn’t become melodramatic or heightened – I wanted to be true to my own experience of therapy as a child – how difficult and slow a process it can be for both therapist and patient, and how enormously all-encompassing the problems of a child can feel, how hard getting through a week or even a day can seem when you’re ten years old.

As a freelance playwright and screenwriter, I write most of my early drafts alone in my room. So it was such a huge change to work together with a room of incredibly talented writers, and it was especially gratifying to be able to bounce ideas off each other, to help solve each other’s problems.

For instance, early on, while we were talking about Oliver, one of the other writers suggested that he have a school assignment that would somehow carry over across the weeks he came to see Paul. A second writer suggested that Oliver have to take care of an animal, and a third writer suggested that the animal be a turtle. I immediately knew this was a great idea, and wrote the turtle into the script. So when it came time to shoot, we had a professional turtle and a turtle wrangler on the set.

This kind of communal creativity kept playing out, even outside the writer’s room. When our costume designer read the script, he instinctively understood that Oliver identified with the turtle, and dressed him in a green shell jacket, so he even sort of looked like a turtle in his shell. And when our psychiatric advisor, Justin Richardson, read the script, he pointed out to me exactly how and why Oliver as the overweight child of a messy divorce would identify with the turtle – why wouldn’t he see an image of himself in a slow-moving animal that carries its house on its back?

Now seems like a very good time to talk about Justin’s specific contributions to the show as our psychiatric advisor. Warren was very committed to making sure that Paul was as good a therapist as possible. He knew that on many occasions the show would have to sacrifice verisimilitude for drama, but whenever possible he wanted the show to give a positive and accurate representation of psychotherapy.

When we were all in the writers’ room, plotting out the season ahead, we would talk to Justin about each of our characters, and he would comment on them, giving us his essential diagnosis of their neuroses and their psychological issues. All the writers would look forward to the days when Justin would come and visit with us: it was a time when we could all discuss the psychology of our characters in detail, away from the daily pressures and deadlines of television writing.

It was also a way for the writers, who had all been therapeutic patients, to get a sense of what it was like to live on the other side of the couch, to get an understanding of the theory and practice that goes into being a good psychotherapist. And even more than that, it was a way for us to see the interesting congruencies and divergences of the writing profession and the therapeutic profession – the different ways in which both jobs are about striving to get to the bottom of the ocean of human behaviour.

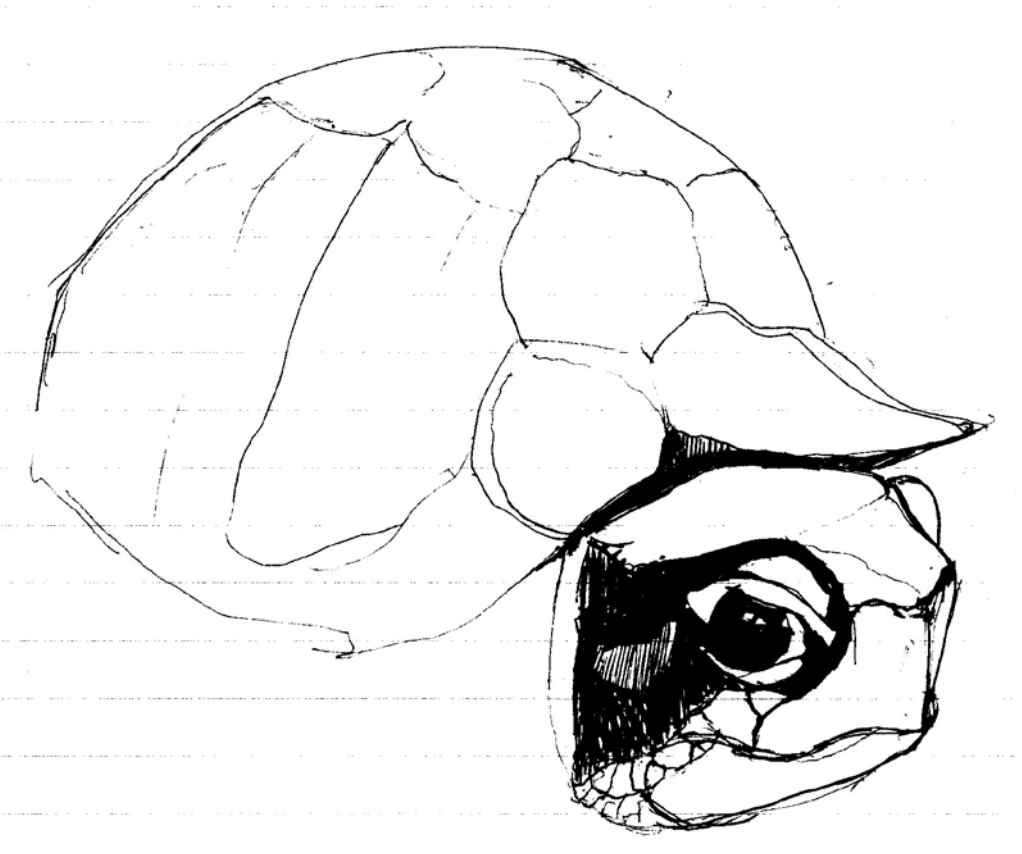
It was when we submitted our first drafts that Justin would really earn his keep. I would receive my first drafts back from Justin with impeccable handwritten notes in the margins, detailing more precise or correct ways that Paul could respond to the patient – he’d show me where Paul was missing an interpretation, where Paul was saying too much, where he was saying too little. And in virtually every case, he did this so gracefully, it was incredibly easy for me to rewrite Justin’s interpretations into my dialogue, to figure out how to put his thoughts into Paul’s mouth.

Now, as I said, there were a lot of times when we sacrificed the truth of psychotherapy for the sake of pacing, drama, and suspense. When people asked me if *In Treatment* was a truthful depiction of therapy, I always said it was probably a little closer to an actual therapy session than your average TV courtroom drama is to an actual courtroom – but not by much. We looked at Paul’s sessions as a crucible where drama could happen – sometimes a boxing ring where Paul and his patients would circle each other, and sometimes a safe harbour where the patients would find a way to be completely vulnerable and open with him.

For me, I was always looking for a way to be truthful to the nine-year-old boy I used to be, who sat in the therapist’s office, terrified and frightened and completely alone. And I also wanted to figure out how to inhabit the skin of the doctor who was sitting across from me, trying very hard to reach me. ■

Keith Bunin is a writer on Season 2 (‘Oliver’). Keith’s latest screenwriting work includes Which brings me to you *for the Oscar nominated director Susanne Bier. He is currently writing a film for Michel Gondry and a television pilot for HBO.*

Season 2 is soon to be released in the UK on DVD.



Regulation, accountability and fitness to practise

By Anna van der Gaag

Anna van der Gaag, Chair of the ***Health Professions Council*** *(HPC), reflects on the regulators' role in considering allegations about practitioners and what this might mean for psychotherapists and counsellors, and discusses her thoughts on how this links to wider developments in accountability across the professions.*

THE ROLE OF A PROFESSIONAL regulator in considering allegations about registered professionals is arguably its most pivotal one. I thought it might be useful to begin by reflecting on one of the wider societal shifts that underlies why we have such systems in place in the UK.

The last few decades have seen an increase in public appetite for accountability amongst those who occupy positions of trust and provide services to the public – whether they be a dentist, priest or politician (O'Neill, 2002). This has arisen, at least in part, from changes in society's expectations and perceptions of professionals. Improved access to information and specialist knowledge, greater public confidence, as well as political and media interest in well-documented failures in public services, for example, have certainly played a part. The era of 'unquestioning' trust in professionals has passed and no one who provides services to the public is untouched by this social change.

Richard Smith (2007) has argued that the 'quality and safety' movement is one part of this change within society – an example of a social movement driven to imbue professionals with more self-reflection, a desire to drive up standards and a commitment to continuous improvement. Professional regulation is part of that – created to enhance protection for the public by setting standards and holding those regulated to those standards. But it is only one part of a much broader quality and safety matrix in the UK – which includes service regulators, professional bodies, the ombudsmen services, voluntary sector organisations, user groups as well as individual practitioners who share the desire to provide high quality services to the public.

One of the tensions in any regulatory or legal system is between setting standards and 'boundaries' and ensuring they are adhered to, and ensuring that individuals are free to exercise their own judgement, free of unnecessary external interference. As a professional regulator, we want to ensure that we regulate in a way that strikes the right balance here – safeguarding the public whilst respecting the freedoms and rights of practitioners to provide services to the public.

'The era of "unquestioning" trust in professionals has passed.'

Underlying principles

So how does HPC strive to strike this balance?

Our approach is clearly and explicitly based on mutual trust. Those on our Register have personal responsibility for their own practice and continue to make their own decisions about therapy together with their clients, free of any day-to-day interference from the regulator.

The standards we set are not prescriptive, but instead overarching, enabling standards for safe and effective practice, developed via consultation with professionals, their representative organisations and the public. For example, we do not and would not prescribe what should happen during each therapy session, and we recognise that professionals on our Register might meet our standards in a variety of different ways, depending upon, for example, their professional background, their personal preference, and the needs of individual clients. As Val Huet, Chief Executive of the British Association of Art Therapists commented in the February 2010 edition of *New Associations*: 'Nobody from the HPC is going to stand at your elbow and say you must do this or that. Their concern is public protection.'

We aim to be as 'light touch' as possible in making sure those standards are met, respecting registrants' personal responsibility and freedom and only intervening when we need to.

What is the fitness to practise process?

These principles apply equally to our process of considering allegations about professionals on our Register.

Our fitness to practise process is the way in which we can consider allegations about someone on our Register (called a 'registrant'). If we receive an allegation we first consider whether it relates to 'fitness to practise'. We only deal with allegations which are about the fitness to practise of a registrant – i.e. a matter which might raise concerns about a registrant's competence, behaviour or health and their ability to practise safely and effectively.

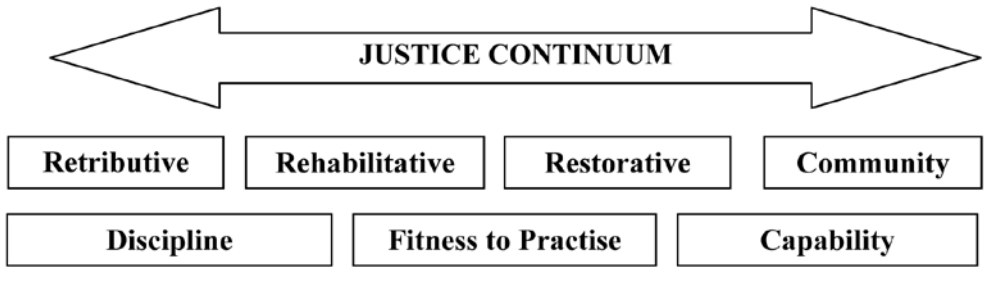
The process involves a number of stages. At the first stage we gather information from any relevant parties and invite the registrant who has been complained about to respond. All the information is then considered in private by a panel which decides whether the complaint is something we should look into further at a public hearing.

The panels at every stage are made up of professional and lay people and there will always be at least one person who is from the same profession as the practitioner. We refer to these individuals as our 'partners' and they provide the expertise we need to make decisions in a number of key areas, including assessing education and training programmes and international applications for registration. If we were to regulate psychotherapists and counsellors, we would recruit new partners across the different modalities to undertake this work for us.

If a panel finds that a registrant's fitness to practise is 'impaired' (negatively affected), it has a range of different options available to it. This includes placing conditions on a registrant's practise, suspending them from the Register and, in the most serious of cases, striking them off the Register.

HPC's approach to justice

The fitness to practise process is a key way in which we protect the public. However, the process is not designed to punish but to decide whether a registrant's fitness to practise is 'impaired' and what action, if any at all, is necessary to protect the public. To help demonstrate what this means practically, panels are advised to consider each of the 'sanctions' they have available in turn and apply the minimum sanction necessary for public protection – for example, to place conditions on a registrant's registration if appropriate and consistent with public protection rather than removing a practitioner from practise. In this sense our approach to justice is aimed at being rehabilitative and restorative rather than retributive.



Transparency, openness and sensitivity

Our purpose is to protect the public, and because of this we need to make sure that our process is as open and accessible as possible, so that members of the public, and members of the profession, can feel confident enough to raise concerns with us. Where an allegation is considered at a hearing, we adhere to the 'open justice principle' used throughout the UK, which means in general that our hearings are held in public. It is important for any regulator to avoid the criticisms often levelled in the past – that of decisions being taken 'behind closed doors', solely in the interest of the profession and at the expense of the protection of clients.

We know, however, that this is part of the difficult balance between ensuring that the public can have confidence in regulation and in the regulated professions whilst avoiding the perception of a 'naming and shaming' approach. We can and do conduct all or part of hearings in private where appropriate to do so: for example, to enable a vulnerable witness to give evidence, or to protect the private life of the registrant. Panels are able to make a public and a private decision at the conclusion of a hearing to further protect the private lives of those involved. We also need to be sensitive to the needs of clients who might be attending a hearing, and we have a dedicated system of witness support to help them through the process.

I think it is important to acknowledge the wider public protection value of knowing about the outcome of a hearing – making clear what the profession and the public considers to be unacceptable behaviour, allowing the opportunity therefore for the profession to demonstrate to the public its commitment to high standards.

Creating an environment in which the public and professionals alike feel confident and secure in raising concerns about practitioners is certainly an ongoing challenge for organisations involved in considering complaints. There are often anecdotal reports in many professions about the reluctance of professionals to report their concerns. In our experience regulation can be constructive because practitioners and the public alike can raise their concerns with an independent organisation with the necessary 'legal framework' to follow up concerns and take action where necessary to protect the public.

What might this mean for psychotherapists and counsellors?

Many psychotherapists and counsellors have discussed with me the complex nature of their work with individuals. Depending on their approach to practice, they explain this in different language, but one of the common themes that comes across is that therapy almost always involves risk – and some argue that any kind of 'talking therapy' is inherently risky. People who come for therapy can be 'damaged' by events and circumstances, vulnerable, abused, experiencing a wide range of emotions, including anger, as well as searching for greater levels of insight and understanding. The risk therefore of misinterpretation, retaliation, or disappointment is often high, and the therapist enters into therapy with a degree of awareness that the client may or may not derive benefit, and may or may not find the experience of therapy to be a positive one. Indeed, some will undergo therapy that becomes difficult, painful, confusing and challenging; though in the majority of cases the outcome will leave the person feeling that therapy has been a rewarding and strengthening experience.

Therapists have emphasised to me the importance of ensuring that the system of fitness to practise can take account of this particular and often highly charged therapeutic environment, recognising, for example, the potential for negative transference as a feature of the therapeutic process. I believe that the system of regulation delivered by HPC is able to do this because it does rely on those with knowledge of the profession to make judgements.

Our fitness to practise process is about deciding whether a professional remains fit to practise. Sometimes a client might be dissatisfied about their therapy or their therapist, for example, because they didn't find that the therapy met their expectations. We have to consider the complaints we receive individually, but we only need to take action where a practitioner's fitness to practise might be impaired and where we need to take action to protect other members of the public. To illustrate the kinds of cases we deal with, the fitness to practise of a therapist who engages in sexual activity with a client during therapy sessions is very likely to be 'impaired'. In this example most fellow therapists and members of the public would reasonably conclude that this was not appropriate behaviour by the therapist.

'One of the common themes is that therapy almost always involves risk.'

The standards we use are designed to enable us to make informed decisions which are focused on fitness to practise and public protection. With each new profession we regulate, we change and learn from their particular experience, and we acknowledge their expertise. If we were to regulate psychotherapists and counsellors, individuals with knowledge of the discipline and the range of approaches within it would be involved at every stage of the process, ensuring that those with relevant expertise are involved in the decision making process. We have recently reviewed one set of our standards, the standards of proficiency, in light of concerns about some of the content and terminology, and are currently consulting on the revised standards.

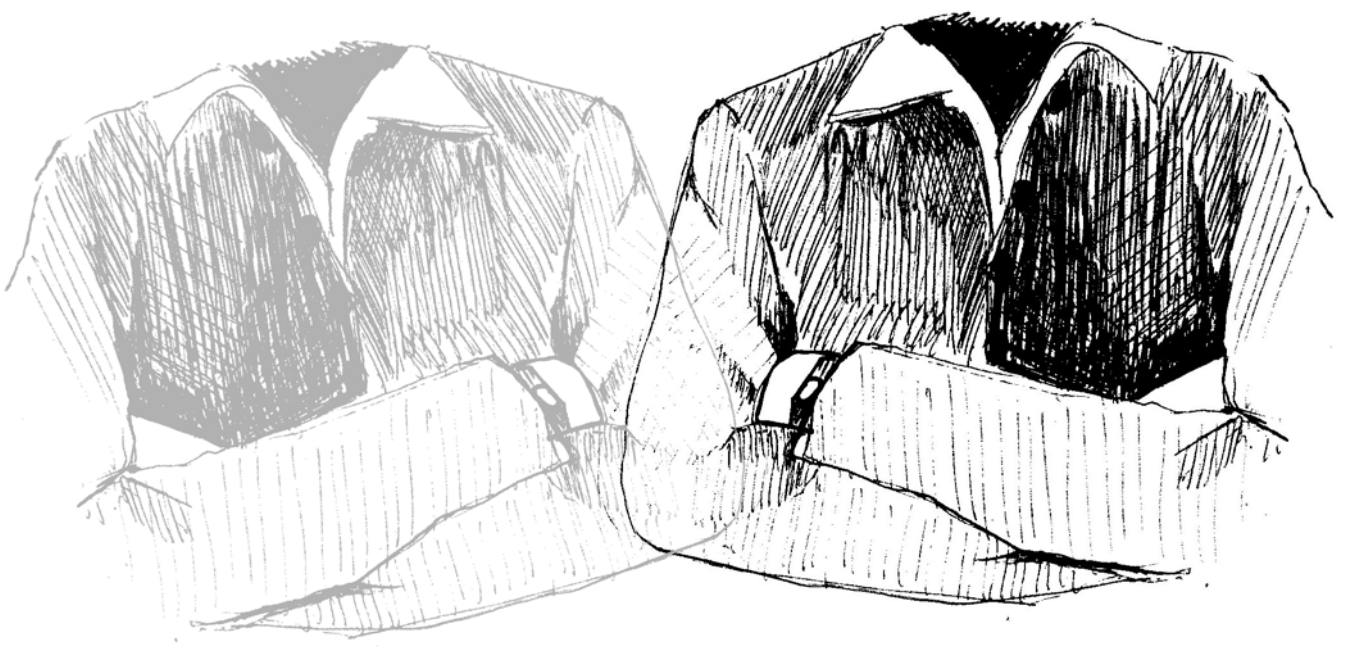
Similarly, we have heard feedback from psychotherapists and counsellors about the use of mediation to resolve disagreements between practitioners and clients and heard arguments that there are some disputes between therapist and client that may be more amenable to more informal means of resolution. We are currently doing some work to look at how such approaches are applied. This review will inform our decisions about if or whether such approaches might be appropriate in the future.

Summary

I have sought to situate the HPC fitness to practise process within the wider move towards accountability in society, illustrating how the process we follow balances public protection with the rights and freedoms of practitioners.

Our work on revising our standards of proficiency and exploring mediation processes illustrates our commitment to continuous improvement and we look forward to continuing to work with our stakeholders to improve the way we work. ■

Anna van der Gaag is Chair of the Health Professions Council. She is a research speech and language therapist and Honorary Research Fellow in the Faculty of Medicine, University of Glasgow.



References

HPC Fitness to Practise Annual Report 2009
www.hpc-uk.org/publications

HPC's Approach to Justice and Impairment Council papers, March 25 2010, Enclosure 9.

Onora O'Neill (2002) *A Question of Trust.* BBC Reith Lectures

Smith, R (2007) *Learning from social movements*
Keynote at the International Forum on Quality and Safety in Healthcare
Barcelona, 2007.
http://barcelona.bmj.com/plenary-2/

Follow the progress of the HPC's Professional Liaison Group at www.hpc-uk.org/aboutus/professionalliaisongroups/psychotherapistscounsellors/

News In Brief

We Still Need to Talk

The We Need to Talk coalition, headed by Mind, has launched the next phase of its campaign, calling for 'a full range of evidence-based psychological therapies to all who need them within 28 days of requesting a referral.'

Representatives of the WNTT coalition met on 28 October with Paul Burstow MP, minister for care services, to present their report. They welcomed the government's commitment to psychological therapies and their promise of additional funding. £70 million is confirmed for this year.

The minister, who had been instrumental in securing the continuation of funding for talking therapies under the Comprehensive Spending Review, said the intention is still to roll out the IAPT programme nationwide. They also intend to pass the baton of leadership in mental health strategy to 'society', that is, to the private and third sectors.

The report, *We need to talk: Getting the right therapy at the right time*, can be downloaded from: www.mind.org.uk/campaigns_and_issues/we_need_to_talk

Peter Fonagy wins award

Peter Fonagy has been annouced as one of the four recipients for the 2010 Sigourney Award.

The Sigourney Award is named for Mary S. Sigourney, whose will established a Trust for the purpose of recognizing past achievements by individuals and organisations whose significant contributions have generated new interest and activity in psychoanalysis and related disciplines. Nominees are evaluated on the basis of their work during the ten years proceeding the year of the award. The other recipients this year are Franco Borgogno (Italy), Jean-Michel Quinodoz (Switzerland), and Rolf Sandell (Sweden).

Peter and his fellow award recipients are due to receive their awards at the January 2011 APsaA meeting in New York.

A Dangerous Method

David Cronenberg's new film *A Dangerous Method*, described as 'a look at how the intense relationship between Carl Jung (Michael Fassbender) and Sigmund Freud (Viggo Mortensen) gives birth to psychoanalysis', has completed shooting and is scheduled for release toward the end of 2011. The film also stars Keira Knightley as Sabina Spielrein.

BPC approves new trainings

The BPC has just accredited two WPF Therapy psychodynamic trainings. Graduates of the Postgraduate Diploma in Psychodynamic Theory and Practice and the twice-weekly Psychodynamic Psychotherapy qualification will become members of the Foundation for Psychotherapy and Counselling.

The Exeter University training in Psychodynamic Psychotherapy has also been approved. This training has four centres for clinical work in the geographical catchment area of Exeter, Plymouth, North Devon and Cornwall.

The BPC is delighted to welcome the graduates of these trainings.

BPC Trainees' Association news

Following the success in May of the 'Making Contact' conference, the nascent BPC Trainees' Association is discussing a trainee event for next year and beyond. Anyone with ideas for a theme for the conference should contact Lee Smith, association Chair (lee.smith@ukonline.co.uk). With a mind to engaging more trainees from all areas of the country there is support for holding future Trainee conferences outside London hosted by one (or more) of the out-of-London BPC accredited trainings.

The conference is just one way to include trainees in the life of the new Association. Current activity is focusing around how to 'make contact' with member institutions and their trainees. At the recent PP NOW conference flyers we made available about the Association, inviting people to get in touch. The Trainees' area of the BPC website is one way of doing this. Login details can be obtained from the BPC office (mail@psychoanalytic-council.org). It is hoped that a broad definition of 'trainee', to include those in their first year or so after qualification, will not deter those within sight of qualification from getting and remaining involved.

We are delighted by the inclusion of two trainees, Gearoid Fitzgerald and Alan Colam, in the BPC working party on homosexuality. This invitation signifies the value the wider organisation places on the trainee voice, and in addition to the two places with voting rights on the Council of the BPC, is another important development. It is hoped that there will be trainee participation in the Future Strategies working party, something that was enthusiastically discussed at the most recent Trainees' Association meeting.

Sally Beeken, Trainee, NEAPP

Living with dementia

By Rachael Davenhill

'I know now that my biggest difficulty was not her illness itself, not our pre-existing relationship, not even my limited time, but the fact that I knew nothing about dementia.... The district nurse from her GP practice didn't mention the word, didn't mention diagnosis, didn't mention memory clinics or drugs for dementia, or the Alzheimer's Society or support groups or respite care...The hardest thing for me was, and still is, that I was unable to provide her with a decent quality of life, at a time when she was utterly dependent on those around her to do so – and when, moreover, that quality of life was possible, if I and others had known what we did not know. I don't blame myself. I don't even feel guilty, just terribly sad, that what was possible did not happen for her, and that she had some truly awful experiences which need not have happened.'

Rosemary Clark, 'State of Grace', *Telling Tales About Dementia'*

The despair expressed so cogently by Rosemary Clark, a psychotherapist who looked after her mother with dementia, will be shared by many who have cared or will care for a relative, friend or colleague with dementia. A recent survey indicated that it is dementia, not cancer, stroke or heart attack, that is now top of the list in terms of the illness people fear getting the most. In mental health services, old age has always been marginalised in terms of funding, and dementia has always been on the margins of old age – the Cinderella of the Cinderella services.

There is a double jeopardy regarding dementia in terms of both the loss of mind and the association dementia has with old age. Whilst dementia has been described as a 'semi-psychotic state' (Kitwood, 1990), and there have been no shortages of psychoanalysts working and innovating in the area of psychosis, I could count on the fingers of each hand the number of colleagues from our profession who are currently working directly in the area of dementia. Perhaps we are not immune as a profession to veering away from an area that can arouse such acute anxiety, for at the heart of the dementing process is loss of awareness of self and other, the loss of mind, the very tools of our trade. Whilst psychoanalysis in its pure form has traditionally had little to say about dementia, psychoanalysis in its applied form has everything to say in terms of its contemporary relevance to dementia care, with recent years heralding an enormous increase in academic and applied papers from colleagues drawing on psychoanalytic theory (Sinason,1992; Davenhill, Balfour, Rustin,1998; Waddell, 2000; Davenhill,2007; Morton, 2007; Evans, 2008; Malloy, 2009; Ng, 2009). Psychoanalytic concepts provide a very strong armoury for workers in the field of dementia in terms of articulating the processes of splitting, fragmentation, denial, projective identification which are at the bedrock of any therapeutic work, along with the unconscious transference-countertransference dynamics at work in organisations who care for them which, if left untended, can wreak havoc on the provision of safe, containing practice for patients, families and staff.

For people with early onset dementia, and their spouses and family members, a meaningful quality of life can be expected and sustained for quite some period of time if only we can know what is known, as Rosemary Clark so accurately points out. And there is a lot that is known about improving the quality of life for people with dementia and those involved in their care once we start to engage with the actual work itself.

'Psychoanalytic concepts provide a strong armoury for workers in dementia.'

I developed the Age Matters Dementia Assessment, Psychotherapy and Counselling Service in direct response to the experience I had some years ago when I drew a complete blank after being approached by a senior colleague wanting to know if I could find psychotherapeutic support for a colleague with early onset dementia. Despite knowing all the old age services in the area, and drawing on all my professional contacts, I was unable to find anything within the NHS at that time. I was deeply shocked by what I discovered and this experience was one of many which gave me a window into the lived experience of people diagnosed with dementia and those who cared for them in terms of the absence of a thoughtful, well-grounded psychotherapeutic programme which could provide the necessary space and time to digest the implications of the illness.

I thought of Hanna Segal's paper on silence being the real crime. I wanted to find out more, wanted to learn more about the processes involved in the gaping abyss patients and their families seemed to be left to fall into during and after diagnosis. For a year I undertook a psychodynamic observation of a dementia assessment unit to track the patient pathway. This enabled me to come closer to both patient and staff experience. I understood more about my colleagues' experience of diagnosis and the way in which the process of obtaining and receiving a diagnosis can, in and of itself, be a traumatic experience on top of the trauma of the actual illness.[1] I began to see people with early onset dementia and their families, often therapists or counsellors who knew of my interest in the area. In their allowing me to work with them, I came to develop a flexible but rigorously framed psychoanalytically informed therapeutic programme supporting people through the process of diagnosis and providing room to digest and work with the outcome afterwards.

'The first year is extremely precious and there is no time to lose.'

What I have learned, more than anything, is that the first year post diagnosis is extremely precious and there is no time to lose. A great deal of rewarding work can be undertaken in terms of individual psychotherapy for people with dementia who wish to think about their experience whilst they can. The awareness of knowing that the capacity for self-awareness will diminish provides a clear focus for time limited treatment. Similarly there is a strong evidence base showing that support for carers is essential in reducing carer depression and enabling people to continue over a long period of time to continue caring for a relative, or make a decision about residential care if that becomes necessary. Couples psychotherapy and working in consultation with families as and when needed are similarly crucial components of an integrated dementia programme. It seems to me, and certainly to people with dementia and relatives coming for consultation, that every moment of the time there is can be used to the full if there is a receptive mind to think, yes, about death (after all dementia is a progressive illness, with all the pain and work of loss and mourning that is required), but also about life, tackling life and how to continue living life with dementia.

The danger with the word *dementia* is exactly the same as the 'Big C' in cancer care twenty years ago in terms of the taboo surrounding the illness and the projections of anxiety, hopelessness and deadly inertia into an illness that has the capacity to be managed and funded far more effectively. In 2009 the National Dementia Strategy was launched in a flurry of publicity: 'Dementia now has its place in the sun and we have the opportunity to put the focused attention of the system on dementia' (NHS Chief Executive, day of launch). Wonderful aims there were and are: raising public awareness about dementia, tackling prejudice, setting up memory clinics in every town (clouds already sweeping in over the horizon, note, with the word 'clinic' not 'service', services cost money), better support for carers, better education and training for staff, and so on.

But the societal clouds have been gathering with a vengeance, and by the time readers see this article the Spending Review will have been announced. When slash and burn cuts kick in, it is the most vulnerable who suffer. If you are old, have dementia and have no strong advocate, and even if you do, then you are in the land of the most vulnerable.[2] Which is why, if it is not to be plus ca change plus c'est la meme chose, it is precisely now and in the coming months that as many voices as possible from the world of psychoanalysis and psychoanalytic psychotherapy are needed more than ever to ensure that basic services for people with dementia and those who support them are preserved, and psychotherapeutic provision for people with dementia is pursued. We need to develop and use our combined and unremitting powers of persuasion in engaging with government, with funding bodies and with each other to ensure that the case for psychotherapeutic as well as drug and information-based support in dementia care is not forgotten. ■

Rachael Davenhill is Director of Age Matters and Fellow of the Institute of Psychoanalysis. Age Matters is a clinical, training and consultation service, offering workshops, courses, and clinical supervision. Contact details: www.agematters.org.uk; info@agematters.org.uk

1. For experience based evidence see Dartington, A. & Pratt, R., *My unfaithful brain – a journey into Alzheimer's Disease*, Chapter 16

2. For research evidence see Davenhill, R., 'No truce with the furies: issues of containment in the provision of care for people with dementia and those who care for them', Chapter 12, and Balfour, A., 'Facts, phenomenology, and psychoanalytic contributions to dementia care', Chapter 13 in: *Looking into Later Life: a psychoanalytic approach to depression and dementia in old age* (2007, Ed. Davenhill, R., Tavistock Series, Karnac).

A cure for masculinity?

By Ian Simpson

Review of *Is There A Cure For Masculinity?* by Adam E. Jukes.
Free Association Books, London, 2010

THIS IS A BOOK about the darker sides of masculinity. It is the third book Adam Jukes has written on the subject of men and masculinity and it is certainly the most accessible. He brings his many years of experience working with men and his customary enthusiasm, energy and audacity to the work. Although the examples offered are from his clinical experience of working mainly with abusive, violent men, the book is also an attempt to understand 'normal masculinity'.

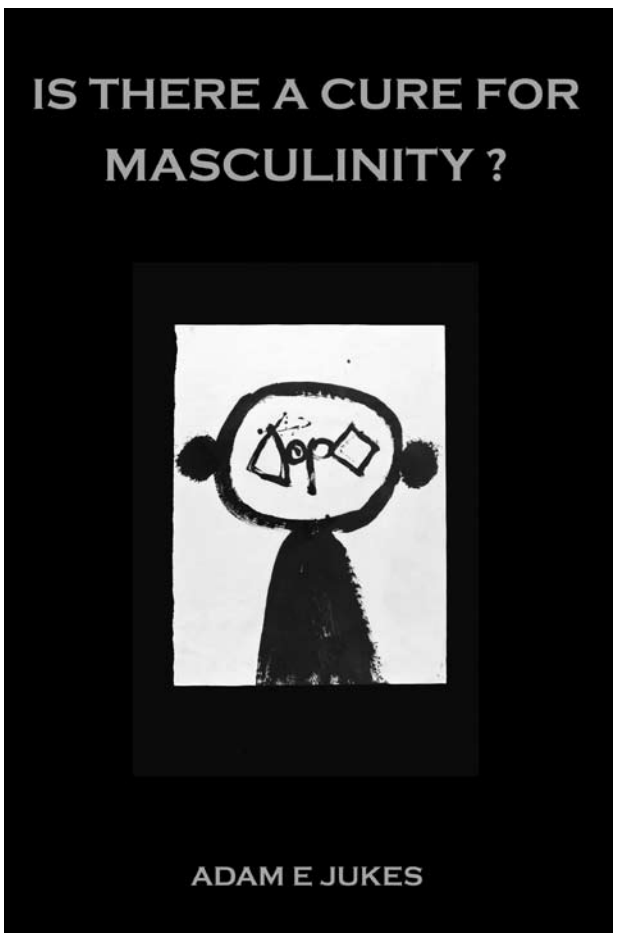
Differing from his previous books *Why Men Hate Women* and *Men Who Batter Women*, it not only focuses on the genesis of male violence towards women, it also has much to say on male violence (and the insecurity lying behind it) in its own right. He takes as his starting point the belief that any theory of male individuation necessarily involves a deep narcissistic wound which results in an inescapable fear of dependency upon women and a terrible rage at the original maternal 'betrayal'. Men must, in the development of masculinity and male individuation, of necessity reject the m/other to become separate individuals. They must also defend themselves against the 'feminine' and distance themselves from intimacy with women for the original betrayal, by maintaining power and control over them. The defensive structure which is created applies, by extension, to other men as well, albeit in a different form, essentially through the stereotypical male traits of aggression, rivalry, competitiveness and the acquisition of status and power.

The loss of primary attachment and the vulnerability and shame associated with this must be defended against at all costs. As masculinity is predicated on a basic fault which is the consequence of loss, it leads to attachment and commitment problems and to profound separation issues. These, of course, will be compounded by actual lived experiences of abusive or neglectful parenting and by cultural and social conditioning. This goes some way to answering the question raised by his earlier books as to why some men are more prone to violence and abuse than others. All men have the propensity but this is defined by their personal experience. Jukes understands masculinity to be a set of defences against attachment anxieties and anxieties about loss, either already suffered or feared. These anxieties arise during the separation/individuation phase of development and reach their apogee during the onset of the phallic phase, the beginning of the construction of phallic narcissism. Masculinity is constructed out of phallic narcissistic defences against an underlying basic fault deriving from the loss of and separation from the maternal and primary object and it is formed in the crisis of the Oedipal complex.

> *'….masculinity is not a crisis, but rather that masculinity is effectively a state of crisis, or a crisis management strategy, by virtue of its being effectively constructed on a structural fault.' (p.27)*

The significance of the Oedipal drama is that it elevates and affirms the significance of the penis in the emerging male psyche. It comes to symbolize all that masculinity is and should be. The relationship between the structural fault and the penis is what defines this book and the many expressions of masculinity Jukes meets in his clinical practice. The combination of a desire for the mother and a fear of the retaliating father is focussed around the penis. Examples abound of what men are prepared to do in order to pre-empt symbolic castration or regain their masculine status, providing evidence of the significance of shame in male psychology and the lengths to which men will go to avoid the evidence of shame and public humiliation. This feared collapse into failed phallic narcissism which is profoundly connected to the more basic narcissistic wound evokes the experience of being unlovable and intrinsically damaged or unworthy. As Jukes says, 'The penis is a rather insignificant piece of flesh, although it supports a mighty weight.'(p.40)

Jukes brings together attachment and classical analytic theory to elaborate and elucidate his position, with examples of pathological 'hyper-masculinity', to highlight his concept of 'normal masculinity'. The central tenet in his view of the development of masculinity and individual male autonomy is that of a rigid adherence to a defensive, detached maleness, an inward-looking desperate search for self-control and containment. Men typically have great difficulties with feelings and intimacy. This is because of the way they respond to shame, and shame-related emotions like embarrassment, humiliation and guilt. As a consequence, all the softer, caring empathic feelings or expressions of vulnerability or weakness normally associated with 'feminine' character traits must be defended against to keep control of potency. He posits a phallocentic world in which men dominate and oppress women. Violence and abuse are used to maintain control and as a defence against a feared intimacy which will return them to a shameful and anxiety-laden state where vulnerability, impotence and castration anxiety (symbolic and real) threaten their sense of self. Men must separate from their mothers to become men, but this not only involves a deep fear of women but also of intimacy or dependency upon the other, including



other men. The narcissistic wound is so painful and threatening to his sense of self and to autonomy that the male infant must not only armour himself against dependent relationships in the future, but he also needs to punish all women for this original betrayal. The roots of misogyny are located in the male infant's separation trauma. In this world, real intimacy with a woman (and by extension with other men) is no longer viable. Only its shadows and substitutes, sex or male rivalry and competitiveness are available and these are inevitably cursed by a desire which sees women as little more than objects to use and control and where men are constantly reduced to attempts to measure their potency against other men.

The book moves through the various stages in the development of masculinity, linking theory with examples from the author's clinical practice. Male destructive and self-destructive behaviours are explored and examined, with a particularly novel and inspired chapter on sulking, which he argues should be recognised as a clinical condition located in the transitional stage between the paranoid and depressive positions. He also places emphasis on how men can feel disrespected with an accompanying deep sense of injustice if their contribution or status is questioned (real or otherwise), how they may react to the birth of children, and how reactive, defensive mechanisms like hyper-masculinity, perversion and dramatic acting out are used to ward off anxiety and depression. Nowhere is this so apparent as in work with men who are sexually perverse. The link between perversion and shame is a major issue for many of the men Jukes has seen for psychotherapy. He provides clinical examples of this and extends the definition of perverse sexual behaviour to include the use of pornography for masturbation. This is a much more inclusive definition and he links it to male shame and its causes. Perversion, as he sees it, is a defence against serious mental distress. However, its expression also leads to powerful feelings of shame as it occurs if we fail to live up to an ideal of behaviour we have set ourselves. Jukes argues that men defend against the fear of intimacy by indulging in perverse sexual behaviour (of whatever degree) and this inevitably leads to shameful feelings. The vast consumption of pornography on the internet certainly seems to point to a largely hidden, secretive, onanistic (shameful) male agenda which has now become culturally normative.

Whenever men are threatened with a shaming or humiliating experience most will escalate their defences and will become determinedly more masculine, with all the potentially destructive or self-destructive behaviours outlined above. Jukes asks, 'Is there a cure?' He believes there is, and gives examples of strategies he has found successful in his work with men. Some resolution is possible if men are willing to acknowledge and accept their vulnerability and fallibility, allow themselves to trust that they can be held and their fears contained by and with others. Individual and group psychotherapy offers the context for this, as do educational programmes which explore masculinity and its effects. If men can move outwards as opposed to inwards, share rather than hide, there is some hope that shame and guilt can be dissolved and integrated. Perhaps we cannot 'cure' masculinity any more than we can 'cure' depression or anxiety but in working through the difficulties they present us with we can learn to deal with them better and minimise their disabling and destructive potential. ■

Ian Simpson works at the Psychotherapy Service, St Thomas' Hospital, London.

Is There A Cure For Masculinity? (2010, £14.95) is published by Free Association Books, www.fabooks.com

On The Frontline

‘Therapy is like a mother feeding the child’

By Aida Alayarian and Lennox Thomas

The Refugee Therapy Centre helps refugees and asylum seekers deal with their psychological difficulties by providing specialist counselling, psychotherapy and support.

THE REFUGEE THERAPY Centre (RTC) was established in 1999, in response to the growing need for a therapeutic service in the community that would respect and work with the cultural and linguistic needs of refugees and asylum seekers. Our central purpose is to help refugees and asylum seekers to feel empowered to deal with their psychological difficulties. The Centre delivers a culturally and linguistically appropriate intercultural therapeutic service in 21 languages that addresses the gap in service provision for refugees and asylum seekers. We offer individual, couple, family and group therapy, giving priority to children, young people and their families and to those who have been in the UK for less than ten years. We hope to help them regain a sense of meaning and improvement in the quality of life, after the considerable trauma they have endured.

It is important to understand the range of effects of trauma from an intercultural perspective in order to distinguish between different types of trauma, such as interpersonal or violation of human rights by a state authority. This external trauma in adult life can mask developmental problems, perhaps accrued earlier. We are also careful of the level of interpretation and the pacing of the treatment to ensure a better outcome. Most of the Centre’s staff have a refugee or immigrant background and bring with them a wealth of linguistic, cultural and shared knowledge and experiences. Patients can choose to receive support in English or in their own language. Some people prefer not to see a therapist from their own cultural background because of feelings of mistrust, guilt, shame or embarrassment about what has happened to them; it may also be due to the intensity of feelings of pain when talking in their own language. Some simply do not want to have contact with professionals from their own background because they feel rejected by their own people and country.

Refugee and asylum-seeking young people may encounter a range of new difficulties upon entering a host country, including adjusting to a new environment, language barriers, uncertain citizenship and material poverty. As a result, the inner worlds of many young refugees are populated by experiences of abuse and horror that often bear little or no resemblance to their present situations here. This can prevent them from settling and integrating into their new environment, which then leads to new anxiety, depression and stress. Some act out their distress with parents and teachers with aggressive and violent behaviour, whilst others become withdrawn or may develop eating disorders. Poor concentration and memory impairment are also common reactions.

‘Some feel rejected by their own people and country.’

The young people with whom we work have been subjected to various forms and levels of stress, such as the stress and fear of war, whilst others have witnessed appalling atrocities against members of their families or community. Young refugees and children of refugees often adjust to new host cultures and languages more quickly, and are therefore often used as mediators by adults in the family who may not be able to fulfil their parental responsibilities. As a result, young people may develop psychological difficulties, and the trauma that their parents have experienced may be transmitted to them due to parental suffering and the effect of role reversal. Some children make the journey to this country alone, and may not know what has happened to the rest of their family and whether or not they are alive. Some have lost one or both parents; others have lost their entire families. Some have themselves been arrested, and even tortured or raped. Though each has had a unique experience, all of these individuals have had to deal with displacement from their homes and familiar environments and have had their normal life routines severely disrupted. Unaccompanied children may find themselves living with distant relatives who are unable to act as parental substitutes, and who are in some cases unkind to, or neglectful of, the children in their care; or they may live in children’s homes or with foster families. In many of these situations, young refugees or children of refugees may feel isolated, alone and unloved, feeling they have no one they can talk to about their difficulties.

Some of our young clients may be overwhelmed by fearful recollections of traumatic experiences, often expressed in a variety of unconscious, non-verbal ways. These can evoke strong negative feelings in the people around them, particularly those charged with their educational and social care. Sometimes trauma in young children can ‘incubate’ until it finds expression in the teenage years.

We primarily use a psychodynamic or psychoanalytic approach in our assessment and treatment. Working through their experiences in a safe and supportive environment offers children insight into their problems and provides them with a space for their own sense-making, helping them to verbalise feelings which they may have feared or suppressed through aggressive or harmful behaviour. One young person told us, ‘Sometimes it is easier to talk with a stranger, to tell your feelings openly without fearing. Therapy helps me to understand a situation, to find a way to pass the problem. It makes me feel not alone.’

We also offer group therapy. Nadia, a member of a women’s group at the Centre, said: ‘Therapy is like a mother feeding the child. Initially when I joined the group, it was strange, but now it feels like going to a loving family home. Therapy has been a strong source of support for me, which has also helped me to even talk about my jealousy and envy.’ While each refugee’s experience is unique, there are some issues common to particular groups. This not only includes those coming from the same environment who speak the same language, but also commonalities among people who have experienced identical persecution in different cultures and communities. In a mixed language/ethnicity group this can be a positive unifying factor.

These experiences may have involved political or state violence, persecution, imprisonment, torture, domestic, family abuse or rape. In some cultures, women face blame for being raped, and are scared to speak out for fear of being ostracised and rejected; many women bear the secrecy as a heavy burden. Men are also raped and, having had the courage to disclose this in therapy, struggle with the difficulties of seeing this as personal and emasculating or as a political act. Our supportive groups provide an environment in which participants can feel the relief and support of genuine human contact, breaking the ring of isolation.

We work with couples to provide them with space and encourage them to verbalise their thoughts and feelings in a holding environment. With the help of the therapist they can think through the origin of their difficulties and consider how migration and trauma have compounded this. We can also provide help for the family as a whole. The therapeutic approach we use can help all the members of the family to see how and why they may project their feelings of persecution on to those around them.

‘Sometimes it is easier to talk with a stranger.’

Bilingual Support Outreach / Community Development Workers (CDWs) offer confidential help and support with understanding and getting to know services available in the new environment; accessing services such as health, education for children, and English or computer courses for adults, as well as finding work or volunteering opportunities. They can also provide a ‘listening ear’. CDWs can therefore act as a filter for people who need some supportive therapy but have first made an approach for practical help.

The CDWs developed the Parenting Workshop in January 2010, working with refugee and asylum seeker parents who are finding the parenting role challenging in their new society. After a successful pilot, the Community Development Project has now set up a series of monthly workshops for parents. They have also initiated an Open Surgery with our local MP and patron Jeremy Corbyn, MP.

Even fully qualified and experienced professional psychologists, psychotherapists, psychiatrists and counsellors come for fortnightly supervision sessions at the Centre. Working with people who have been refugees and asylum seekers requires understanding of life events which may be painfully difficult to tolerate, may seem strange, unfamiliar, and unbearable. It is a relief, to experienced as well as less experienced staff, to be able to recount what they have heard, consider how they might have responded, get over the pain and shock, and have the support they need in order to face the task with renewed confidence. ■

Aida Alayarian is Clinical Director of the RTC, and Lennox Thomas is a supervisor. www.refugeetherapy.org.uk

Resilience, Suffering and Creativity: The Work of the Refugee Therapy Centre (Karnac) provides information on the work of the Refugee Therapy Centre and the specific approach used to support refugees and asylum seekers who have endured unimaginable losses, displacement and violation of their basic human rights.

Diary

NOVEMBER

Ongoing
PSYCHOANALYSIS:
THE UNCONSCIOUS IN EVERYDAY LIFE
Science Museum, London SW7
www.beyondthecouch.org.uk

12 November 2010
OBSERVATION, REFLECTION AND CONTAINMENT: A psychodynamic approach to work with parents and children under five
Centre for Emotional Development, 18a Clermont Road, Brighton BN1
Speaker: Louise Emanuel
Contact: 01273 561511, info@emotionaldevelopment.co.uk

13 November 2010
MEN IN THE CONSULTING ROOM
23 Magdalen Street, London SE1
Speaker: Brid Greally
Contact: 020 7378 2054, training@wpf.org.uk

13 November 2010
WHY THE MAINSTREAM NEEDS ITS MARGINS: The function of the marginalised in psyche and society
CPS, University of Essex, Colchester
Speakers: Simon Clarke, Colin Samson, Karl Figlio, Jeffrey Murer, Eamonn Carrabine, Tim Dartington, Joan Busfield, Aaron Balick
Contact: 01206 873640, cpsadmin@essex.ac.uk

17 November 2010
BRINGING THE TEAM TOGETHER
Science Museum's Dana Centre, 165 Queen's Gate, London, SW7
Speakers: Michael Brearley, Leon Kleimberg
Contact: 020 7942 4040, tickets@danacentre.org.uk, www.beyondthecouch.org.uk

19 November 2010
THE EXPERIENCE OF PSYCHOANALYSIS
Lauderdale House, London N6
Speakers: Robin Anderson, Angela Joyce, Josh Cohen, Elizabeth Wolf
Contact: 020 7563 5016, www.beyondthecouch.org.uk

20 November 2010
THE EGO AND THE SUPEREGO
73 Fortune Green Road, London NW6
Speaker: Bernard Barnett (Squiggle Foundation)
Contact: 07534 422 117, squigglefound@sky.com

20 November 2010
HIDE AND SEEK: Thinking about Psychic Skin whilst working with psychotic and narcissistic states of mind
Friends Meeting House, Oxford OX1
Speaker: Martin Schmidt
Contact: 020 7435 7696, training@thesap.org.uk

21 November 2010
SCREENING CONDITIONS: Blind Love (Juraj Lehotsky, 2008)
ICA London
Speakers: Andrea Sabbadini, Irma Brenman Pick
Contact: ann.glynn@iopa.org.uk

21 November 2010
WALKING WITH FREUD
BBC Radio 3, Music Matters, 9:30pm
Speakers: David Matthews, Anthony Cantle
www.bbc.co.uk/bbcthree/

24 November 2010
THE CAMBRIDGE SCIENTISTS AND PSYCHOANALYSIS IN THE 1920S
Institute of Psychoanalysis, London W9
Speaker: John Forrester
Contact: 020 7563 5016, www.beyondthecouch.org.uk

26 November 2010
CHINESE HEART & SOUL: Encountering the Chinese Psyche
BAP, 37 Mapesbury Avenue, London NW2
Speakers: Heyong Shen, Gao Lan, Hester Solomon
Contact: 020 8452 9823, www.bap-psychotherapy.org

26-27 November 2010
BRAIN MAPPING
Brunei Gallery, Thornaugh Street, London WC1
Speakers: Daniel Glaser, Liz Hall, Ruth Lanius, Jean Knox, Nuri Gene-Cos, Dan Siegel
Contact: www.confer.uk.com/brain-mapping.html

27 November 2010
MONEY MAKES THE WORLD GO ROUND: OR DOES IT?
Friends Meeting House, 91-93 Hartington Grove, Cambridge
Speaker: Jan Wiener
Contact: 020 7435 7696, training@thesap.org.uk

27 November 2010
INTERNET PORNOGRAPHY:
Working with client proccupation
23 Magdalen Street, London SE1
Speaker: Jenny Riddell
Contact: 020 7378 2054, training@wpf.org.uk

30 November 2010
FIDELITY
The School of Life, 70 Marchmont Street, London WC1N
Speaker: Christopher Clulow
Contact: www.theschooloflife.com/Psychotherapy/Fidelity

DECEMBER

2-3 December 2010
PSYCHOLOGICAL THERAPIES IN THE NHS: Science, Practice and Policy
Savoy Place, London WC2R
Contact: 020 8541 1399, matt@healthcare-events.co.uk

4 December 2010
LISTENING TO VOICES, HEARING A PERSON
Avenue House, 17 East End Road, Finchley, London N3
Speaker: Roger Bacon
Contact: Vicky Raingold, 07534422117, info@squiggle-foundation.org

4 December 2010
NARCISSISM: A TROUBLED WAY OF RELATING
23 Magdalen Street, London SE1
Speaker: Pat MacDonald
Contact: 020 7378 2050, training@wpf.org.uk

4 December 2010
LEADERSHIP AND NARCISSISM
LCP, 32 Leighton Road, London NW5
Speaker: Michael Brearley
Contact: LCP, 020 7482 2002
www.lcp-psychotherapy.org.uk

4 December 2010
CHANGE: GENDER AND SEXUALITY
IGA, 1 Daleham Gardens, London NW3
Speakers: Barbara Lloyd, Cherry Potter
www.groupanalysis.org/imissite/events/events_summary.asp

10-12 December 2010
WHAT IS SPECIFIC ABOUT PSYCHOANALYSIS TODAY
Christopher Ingold Building, UCL
Various speakers
http://www.ucl.ac.uk/psychoanalysis/events/events.htm

JANUARY

15 January 2010
OBJECT RELATIONS THEORY AND CHRISTIANITY
Marino Conference Centre, Dublin 9
Speaker: Chris McKenna
Contact: www.confer.uk.com/dublin4.htm

16 January 2010
DEVELOPING IDENTITY
Science Museum's Dana Centre, 165 Queen's Gate, London SW7
Speakers: Elizabeth Bradley, Robin Anderson, David Morgan
Contact: www.beyondthecouch.org.uk

22 January 2010
WINNICOTT: AN INTRODUCTION TO HIS WORK AND IDEAS
23 Magdalen Street, London SE1
Speaker: Stephen Crawford
Contact: 020 7378 2054, training@wpf.org.uk

29 January 2010
WINNING AT ALL COSTS: A psychological exploration of sporting greatness
SAP, 1 Daleham Gardens, London NW3
Speaker: Ian Williamson
Contact: 020 7419 8896, training@thesap.org.uk

29 January 2010
ENDURING PAIN, ENDURING SPIRIT
Friends Meeting House, 43 St Giles, Oxford
Speaker: Lauren Kaye
Contact: 020 7435 7696, training@thesap.org.uk

FEBRUARY

4 February 2011
THINKING ABOUT TIME AND AGEING
Institute of Psychoanalysis, London W9
Speakers: David Bell, Danielle Quinodoz, Anne-Marie Sandler
Contact: 020 7563 5016, www.beyondthecouch.org.uk

5 February 2011
SELF-ANALYSIS THEN AND NOW: From Jung's 'Red Book' to the Countertransference
Friends Meeting House, 91-93 Hartington Grove, Cambridge
Speaker: George Bright
Contact: 020 7435 7696, training@thesap.org.uk

11 & 25 February 2011
IMAGERY AND THE UNCONSCIOUS
October Gallery, 24 Old Gloucester Street, London WC1N
Speaker: Tessa Adams
Contact: www.the-site.org.uk

12 February 2011
HMMM! A TIME OF POLITICAL UPHEAVAL
120 Belsize Lane, London, NW3
Speaker: Malcolm Rushton
Contact: 020 7419 8896, training@thesap.org.uk

12 February 2011
SEXUAL COMPULSIVITY AND THE PARAPHILIAS
23 Magdalen Street, London SE1
Speaker: Thaddeus Birchard
Contact: 020 7378 2050, training@wpf.org.uk

23 February 2011
CAN PSYCHOANALYSIS BE A SCIENCE?
Institute of Psychoanalysis, London W9
Speakers: Mary Target, Jim Hopkins, Michael Lacewing
Contact: 020 7563 5016, www.beyondthecouch.org.uk

26 February 2011
RELIGION AND SPIRITUALITY
SAP, 1 Daleham Gardens, London NW3
Speaker: Margaret Clark
Contact: 020 7419 8896, training@thesap.org.uk

MARCH

2 March 2011
SATISFYING MOTHER
SAP, 1 Daleham Gardens, London NW3
Speaker: Mary Anne O'Donovan
Contact: 020 7419 8896, training@thesap.org.uk

5 March 2011
DREAMS AND ARCHETYPES
SAP, 1 Daleham Gardens, London NW3
Speaker: George Bright, Valerie Roach
Contact: 020 7419 8896, training@thesap.org.uk

8 March 2011
TRANSFERENCE AND PSYCHIC REALITY: Identification and primitive imagos
G16, Birkbeck College, London WC1
1.30pm to 3pm
Speaker: Gregorio Kohon
Contact: j.eisner@bbk.ac.uk

9 March 2011
THE HORROR IN DREAMS
Science Museum's Dana Centre, 165 Queen's Gate, London SW7
Speakers: Donald Campbell, Rosine Perelberg
www.beyondthecouch.org.uk

Review

PSYCHOANALYSIS:
THE UNCONSCIOUS IN EVERYDAY LIFE

'Museums exhibit objects,' writes Nicola Abel-Hirsch in the catalogue to this exhibition at the Science Museum. 'The practice of psychoanalysis involves few such material objects. There is the couch on which people being analysed lie, and child psychoanalysis makes use of toy figures of people and animals, but beyond this, there is little. The curator of this exhibition, Caterina Albano, has chosen not to do this, but to link objects and ideas in a different way to illustrate the theme of the unconscious in everyday life.' **Peter Silverton** *interprets.*

Psychoanalysis, a slight return

To Exhibition Road on a Friday afternoon, in mid-October.

I was invited so I went – to a preview of a show at the Science Museum. Entitled *Psychoanalysis: The Unconscious In Everyday Life*, it is small, tenderly curated and intelligent.

It's just off the main entrance, up a flight of steps. The light is low – giving a sense of the couch and the consulting room. A fine and private place.

The show's title gives little indication of the contents or approach, though. It is, in fact, a collection of objects which exemplify and dramatise psychoanalytic thought and concepts. So there is stuff from Freud's room – predictable in essence but given depth by the accompanying exploration of their significance by psychoanalyst David Bell.

He was scurrying around the show at the preview, explaining things and herding people the way he does. He is also a wonderful speaker, a true believer whose views of psychoanalysis – as the central organising subject of human thought, effectively – are made acceptable – if not true or entirely believable – by his wit and eloquence.

Other stuff in the show includes toys – as used to analyse children, by Margaret Lowenfeld and Betty Joseph. Basic idea: children aren't capable of talking coherently about their inner life – ie via free association – so analyst gets them to play with toys and then analyse the deeper meaning of their play.

There are also drawings made by Melanie Klein's young boy patient Richard. Pictures of Spitfires and Messerschmidts shooting and burning – it was war time. There are Winnicott's squiggle pictures. Basic idea: analyst draws squiggly line on paper, child extends it, analyst explains meaning of child's squiggle. (Put like that, it can sound daft. But I'm not sure it is. In fact, I'm sure it's not. If we can't find meaning and emotion in the shape and rhythm of a line, we would never visit art galleries and Picasso would have been out of work straight away.)

And there are art works. One is directly sexual. Of course it is. It's by Tim Noble and Sue Webster – YBAs, famous for their rubbish pieces (description, not judgment). There is an electronic piece. Of course there is. It's Arnold Dreyblatt's *The Wunderblock* – a tablet screen which displays a paper of Freud's which compared the way memory works to the child's toy known, in German, as a Wunderblock. In English, a mystic writing pad – you write on it, you see what you've written, you lift the wax sheet you've written and it's all gone. On Dreyblatt's the text is electronic, speeding and drifting past, constantly rearranging and re-emphasising itself. Unfortunately, it's the one thing in the show which isn't well described or explained.

There is also a gorgeous Grayson Perry pot – his wife is, of course, an analytically inclined therapist. There is a 'Cabinet of wish fulfilment' – votives and pieces of tattooed skin from the Science Museum's own collection. (You can imagine the justifying explanation by the curator who collected them, can't you. Come on, he or she would have said, there's bound to be a show someday when we'll need a few ancient small carved penises and hands. Trust me, there will.)

What's most intriguing about the show, I guess, is its concreteness. Psychoanalysis is the most cerebral – or, perhaps, most mental – of disciplines. It's about words – silences and gesture, too, but mostly words. This show gives it, I suppose, body. ■

Peter Silverton is a journalist blogging at http://petersilverton.blogspot.com

Until 15 April 2011
www.beyondthecouch.org.uk

Human skin with various tattoos
France, 1850–1920
Picture credit: Science Museum

Part of the collection belonging to a French military surgeon, that Henry Wellcome acquired in 1929, these tattoos exemplify a long standing and cross-cultural body practice, still in vogue today. The psychoanalytical valences of tattooing are multiple suggesting complex relations between interiority and exteriority, body and self, desire and loss, displaying and displacement.

Joseph Kosuth
'O.&A./F!D! (To I.K. and G.F.)'
1987
Picture credit: Courtesy of Sigmund Freud Museum, Vienna

Created for the Freud Museum in Vienna, 'O.&A./F!D! (To I.K. and G.F.)' merges text – a page from Freud's The Interpretation of Dreams – and images – a photograph of the entrance of the museum, Freud's former house. The result of this 'condensation' is both intriguing and disquieting, inviting us to look beyond appearances searching for associations and meanings.

Grayson Perry
In Praise of Shadows
2005
Glassed ceramic
Picture credit: Collection of Victoria and Warren Miro, London

This pot is inspired by Hans Christian Andersen's fairytale The Shadow, a sinister story of a man whose shadow first leaves him and then returns to haunt him. Psychoanalytically, the shadow in the story represents an alter ego or a disowned part of the self. Perry evokes the dark and hallucinatory narrative and with it the ghostly images of the mind. The effect is heightened through the glittering effects of light on the pearl glassing on the pot surface.

Tim Noble and Sue Webster
Bloody Haemorrhaging Narcissus
2009
Picture credit: Courtesy of the artists and Gagosian Gallery, London

The work stems from a residency of the artists at the Freud Museum in London and revisits self-portraiture in the light of the Narcissus complex. The silhouette shadows of the profiles of the artists intercept a silicon sculpture composed of interlacing casts of Noble's penis and Webster's hand: the shadow of the self born out of wounded libido.

New Associations is published by the British Psychoanalytic Council, Suite 7, 19-23 Wedmore Street, London N19 4RU
Tel. 020 7561 9240
Fax 020 7561 9005
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Three issues of *New Associations* are published each year in February, June, and October.

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

Editorial Board
The *New Associations* Editorial Board is currently being convened. Details will be posted on the BPC website.
Managing Editor: Malcolm Allen

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

Design Studio Dempsey
Designers Mike Dempsey, Stephanie Jerey and the BPC
Illustrations Leanne Cannon
Printer The Nuffield Press, Oxford

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Deadlines: The next issue of *New Associations* will be published in February 2011. The deadline for article proposals is 24 December 2010. Contributions and letters to the Editor should reach us no later than 14 January 2011.

ISSN 2042-9096

NPSA Research Study Group London, 2010

Neuropsychoanalysis in London

Discuss Neuropsychoanalysis on Thursdays!

As you may know by now, an **NPSA** Study Group has been formed in London, now in its second year.

It meets at **6:00 pm on the first Thursday** of each month of the academic calendar at the **Institute of Cognitive Neuroscience (ICN)** in London WC1.

This interdisciplinary group is modelled on the many other successful NPSA groups that exist internationally. The aim is to provide a venue for **clinicians and researchers** with an interest in neuropsychoanalysis. Each meeting consists of a presentation of psychoanalytically-informed clinical work with a neurological patient, followed by extensive (clinical and/or scientific) discussion by the group.

If you read this for the first time, and are interested in joining or visiting this group, please contact: **Katerina Fotopoulou** at a.fotopoulou@kcl.ac.uk, providing 2-3 lines indicating your discipline and the nature of your interest, and feel free to tell your friends and colleagues about the group!

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