New Associations

NEWS, ANALYSIS, OPINION FOR THE PSYCHOANALYTIC COMMUNITY | ISSUE 18 SUMMER 2015

BRITISH PSYCHOANALYTIC COUNCIL

4 Queering analysis

9 Experience of a gay trainee

12 Talking about culture

14 Training in couple therapy

Rethinking our approach to Helen

By Juliet Newbigin

IN THIS ISSUE of *New Associations* we hope to introduce you to some of the work of the BPC's task group which was set up to consider ways of making the profession more open and welcoming to gay, lesbian and bisexual people. I imagine that some readers will wonder why this was necessary. The ban on acceptance of gay and lesbian candidates for psychoanalytic training on the grounds of their sexual orientation is surely a thing of the past? All member organisations are now bound by the Equality Act, and have signed up to the Position Statement that the BPC adopted in 2012, which stated that:

> The British Psychoanalytic Council opposes discrimination on the basis of sexual orientation. It does not accept that a homosexual orientation is evidence of disturbance of the mind or in development.

Might this be another symptom of the unstoppable march of political correctness, which will lead to an intrusive policing of psychoanalytic training organisations?

So why do we need for a task group for this purpose? It has frequently been pointed out that the members of the psychoanalytic community in the UK are an exclusive group – white, middle-class and often financially secure – and that this is reflected in the profession's dominant values and assumptions. One of the consequences of this exclusivity has been a lack of curiosity about the impact of social differences in the therapeutic setting. A previous issue of *New Associations* (Issue 12, 2013) that dealt with issues of culture and ethnicity argued that the psychological impact of cultural difference has always been conspicuously overlooked as a serious subject of study in psychoanalytic and psychotherapy training, and resistance to changing this continues. However, the absence of familiarity with the LGBT (lesbian, gay, bisexual, transgender) community is of a different order, because of the position that psychoanalysis has taken on sexual diversity until relatively recently. Since psychoanalysis became established in Britain, gay men and lesbians who applied to train were refused entry, except in a very few instances where individuals were 'very discreet'.[1] This bar to training was not an expression of an interviewer's personal bias, but arose from the theoretical understanding that a homosexual orientation was evidence of pathology or arrested development. Heterosexuality was not simply seen as the norm, but as an expression of psychological health. Homosexual acts were considered, after all, criminal until 1967.

Nowadays, society has come a long way towards an acceptance of sexual diversity, but although attitudes of most members of the BPC have moved on, training programmes in psychoanalytic theory tend to be conservative. It is still not clear how much serious questioning of these earlier attitudes has taken place, and what views are being reflected in the teaching. And, because of the years of exclusion, recent gay and lesbian recruits are not yet making an impact at senior levels. Members of the task group suspect that few clinicians engaged in interviewing candidates or supervising and analysing trainees have any idea how deep the lingering suspicion about psychoanalysis runs in the LGBT community.

Research into the attitudes of psychotherapists – members of the BPC in 2001 and a wider cohort in 2009[2] – indicated that a substantial percentage of respondents believed that a patient's sexual orientation could usefully be changed to heterosexuality if he or she reported unhappiness at finding themselves gay, lesbian or bisexual. Only this year, after discussion with all the main bodies involved in providing counselling and psychotherapy to the public, the Department of Health has found it necessary to launch a Memorandum of Understanding, signed by all providers, warning the public about the dangers of 'Conversion Therapy' – offering to 'restore' a patient to heterosexual functioning.[3] This document points out that there is no evidence that such therapy works, but plenty of evidence that it increases the patient's unhappiness. For all these reasons the BPC Executive felt that something further needed to be done to create a greater sense of openness and awareness of the issues involved in dealing with sexual diversity including, perhaps, explicit recognition of the suffering that the psychoanalytic stance has caused in the past.

'Heterosexuality was seen as an expression of psychological health.'

The psychoanalytic community in the USA went through a bitter struggle in the 1970s about the way psychoanalysis theorised sexual orientation, far beyond anything that we have experienced in the UK. Not only were their psychoanalytic theorists among the most conservative on the subject – Bergler, Rado, Ovesey, Socarides for example – but the gay and lesbian community in the US, which had become a highly effective organised political force after the Stonewall Riots in 1969, mounted a strenuous opposition to their views.[4] But when the American Psychiatric Association voted in December 1973 to remove homosexuality from the psychiatric disorders listed in the DSMIII, some psychoanalytic members fought against this change, and forced a referendum of the entire membership of the APA. Although the decision was upheld by a majority of 58%, the rebels continued to argue against it, and gay and lesbian candidates were still being refused admission to train in most psychoanalytic institutes throughout the 1980s.

Finally, in 1991, in response to a lawsuit, the American Psychoanalytic Association adopted an Equal Opportunities policy on admissions to training and issued its historic Position Statement, updating it the following year to cover recruitment of teaching staff and training analysts. APsaA also set up a system of committees to identify and address bias affecting gay and lesbian issues in their member institutions.[5]

Although this was a painful process, it forced a wide discussion of a kind that has never occurred in the UK, except, perhaps, for a brief moment when Charles Socarides, the American psychoanalyst who never abandoned his view that homosexuality was a borderline condition, was invited by the Association for Psychoanalytic Psychotherapy in the NHS to give the annual lecture in 1995. This provoked an effective protest and a Letter of Concern, signed by a substantial number of clinicians seeking to engage a debate of the kind that had happened in the US. But until recently British psychoanalysis and psychotherapy have made no collective statement of a change in policy like APsaA's Position Statement. ■

Helen Morgan is...

Continues over the page

Editorial

This is my editorial

By Gary Fereday

I'VE BEEN ASKED to write some thoughts as a gay man on my training as a psychotherapist in one of the BPC's Member Institutions. Why, you might ask? Well, perhaps in telling my story that will become clear. This type of training isn't easy – nor should it be. It should and it did make me examine who I am, to think about the phantasies and realities of myself, and that has at times been painful. The school I trained with was excellent in so many ways – academically and clinically top notch, sympathetic and boundaried in its pastoral care and in every sense the 'Transferential Mother' to us trainees!

Finally you might note this piece is anonymous – and I debated long and hard about that. How can I say I want to hear your views if I won't say who I am? It's a fair question. Ask yourself why I make this choice though. It's fear. Fear of possible consequences for my career, repercussions based on prejudice or even hostility from colleagues. You might doubt that this would happen, but I know from others that even in 2015 discrimination is alive and kicking, and I have to be conscious of that. I have a role in tackling the fear, but if you don't think you have a role too in tackling the overt and covert examples of prejudice helping to perpetuate that fear, then I guess 'homosexuality' in the end doesn't belong to all of us after all ■

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

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

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

For insertion of advertising materials contact
mail@bpc.org.uk

Managing Editor Gary Fereday
Editor Leanne Stelmaszczyk
Production Janice Cormie
Illustrations Leanne Stelmaszczyk
Printer Thames Print

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

Deadlines: The next issue of *New Associations* will be published in October 2015. The deadline for article proposals is 1 August 2015. Contributions and letters to the Editor should reach us no later than 20 September 2015.

ISSN 2042-9096

Psychoanalytic Psychotherapy NOW

Psychoanalytic Psychotherapy NOW review tbc

By Carlin Armfelt

I WAS ONLY half-listening, in a slightly agnostic way, during a hot Sunday morning sermon when the priest began to talk of St Peter and St Paul. While Paul thought it important to look outwards and evangelise, Peter was happier to look inward. My thoughts drifted to the differences between Al Qaeda and Isis that were brought up at this year's PP Now conference.

Whereas Al Qaeda was searching for the caliphate, argued PP Now keynote speaker Professor Vamik D. Volkan, Isis believed that there was no need to search because Isis (the Islamic State of Iraq and Syria) was the caliphate.

Among other differences between the two fundamentalist groups, the conference heard, were the gap between Al Qaeda's belief in the need to eradicate non-Muslims to protect large-group identity and the Isis choice of more extreme 'purification', by also killing those 'wrong' Muslims. And then there were similar eradications at other times by Christians and other religions.

Perhaps the best sign of a good conference is when the events and the papers given at the conference surface in the mind in a wide variety of ways – including in the middle of a hot, morning sermon. And I wanted to share my experience as a trainee and a disabled person, of attending this year's PP Now.

As a trainee member of the British Psychoanalytic Council, I was attending my first PP Now conference. On arrival at the Holiday Inn hotel in London's Kensington, I couldn't see posters directing people to the conference. Yet conference members' own more benign large-group identity was apparent.

PP Now attendees, I suspected, were not the men with coloured polo shirts and brown leather man-bags or binoculars, nor the women in coloured dresses and sunglasses who all milled around in the foyer. These, I assumed were tourists. I followed people going to the first floor who looked like they might be therapists… somehow quieter and more loose-knit and anticipatory.

I had been apprehensive about attending PP Now because, for me, it did involve a lot of 'firsts'. The conference was the first I had attended without the decidedly schizoid cover of being a journalist. Conferences were something that I was used to attending but always as an outsider. I was someone at a conference who was there to 'cover' it, whether it were the Conservative party, the TUC, the British Medical Association or anything else.

This was also the first time that I would be at a conference I wanted to attend as opposed to being paid to attend, and my first psychoanalytic conference. But at least at surface-level, the point-of-anxiety was that it was the first conference that I was attending as a disabled person on a wheelchair. While I had been disabled for many years, the process of reality-testing still occasionally happens whenever I do something that I have not done since before I became a wheelchair-user.

In advance, I had wondered what attending PP Now would, at a very concrete level, be from a different perspective – a conference at waistband viewpoint. The answer is that there are difficulties when negotiating a tall forest of people, and seeking to avoid running over people's heels, etc., but it was do-able. Gaining entry to many morning and afternoon 'break out' sessions meant that the helpful and friendly people had to unlock the closed, narrow double doors. I could not operate the self service coffee machines one handed and on too high surfaces – others helped of course. A sense of difference was no longer being provided by journalism and was now provided by impairment.

I am used to disability and my wheelchair emerging in one form or another within the patients' transference and my countertransference. At the conference, I was the one wheelchair-user and aware of the loneliness of difference – being somehow not approachable. Yet I was also conscious that difference, and a sense of difference, comes in many forms.

And differences disappeared with the interest of the talks. Vamik Volkan's keynote talk, 'A psychological look at terrorism', had focused on the psychology of 'encapsulated' religious fundamentalism. The speech looked at fusion of individual- and large-group identities and how people can exhibit extreme sadism and masochism under the impact of large-group identity.

Volkan developed a strong theme stemming from individual identity. Large group identity, the audience heard, is a necessary part of individual identity but there is a risk of prejudice when that group perceives itself as under threat.

Winnicottian transitional phenomena enables groups who perceive themselves under perpetual threat to turn away from outside reality. Unlike infants who can effectively block out outside reality, said Professor Volkan, adult, extreme religious fundamentalists continually perceive the environment as threatening. This can prompt to the need to strike out at all threatening objects…

Islamic fundamentalists groups had chosen glories, chosen traumas and remembered shames around which to unite, said Volkan. These range from the shame of the killing of the fourth Caliph – a cousin and son-in-law of Mohamed - to the 1924-collapse of the Ottoman Empire.

I found myself thinking of the psychoanalytic work of Lord John Alderdice, a key negotiator of Northern Ireland's Good Friday Agreement, on the chosen glories and traumas in Northern Ireland's politico/religious landscape. I also thought of the still-stoked traumas of Scotland's 1715 Jacobite and 1745 Bonnie Prince Charlie uprisings.

Outside the conference hall, PP Now lunch and tea breaks were a chance to bump into colleagues, meet old friends and make new acquaintances. Psychotherapists, counsellors and analysts from around the UK were present, it seemed. A psychoanalytic psychotherapy trainee based in Edinburgh and I discussed the difficulties of finding training patients. A Jungian analyst described her wheelchair-accessible consulting room.

Meanwhile the breakout sessions that I attended, both morning and afternoon sessions, were riveting.

In a session on 'Emotional poverty' Graham Music and Sue Gerhardt looked at how neoliberal capitalism affect mental health and emotional relationships. Unless there is trauma, a lack of attunement, poor attachment and in particular insecure attachment, said Music, infants are altruistic. Between ages three and six months, infants choose 'goodies' over 'baddies'. And toddlers given rewards for being helpful are less likely to help the next time round. For a toddler, I heard, being helpful is a reward in itself. Being securely attached, Music explained, makes humans less selfish.

Emotional poverty, Sue Gerhardt said, is basically a lack of emotional resources – internal resources that are built primarily through early life experiences. Gerhardt saw emotional poverty as the equivalent to financial poverty. Gerhardt's session covered the effect on individuals when parents cannot hear the music of a child's communications, through the growing materialisation and 'mean-mindedness' of the 1990s. David Cameron can speak out about his love for his disabled father and his grief about his disabled son, but this doesn't involve a wider empathy outside the individual family, Sue Gerhardt said.

Thinking back to the PP Now conference, I enjoyed the choice of sessions. I had opted in advance to attend 'Poverty and the psychological impact on money', but on the day, I felt that, as a disabled trainee, I was familiar with this topic. With relish, I chose a different session on 'Antisocial personality disorder – new directions'.

This session was by Gill McGauley and Jessica Yakeley, who showcased recent development and research findings on the applications of Metallization Based Treatment (MBT) with individuals with ASPD and histories of violence. Incidence ASPD stood at 2.3% of the general population but 70% of the prison population, said Yakeley, many of whom have depression and anxiety. Yakeley argued that MBT was effective with some men who have antisocial personality disorder – so long as they are not too psychopathic. Those who present with depression and anxiety tend to be more treatable.

Towards the end of the afternoon, I gave up pretending to scrawl notes that in any case, were illegible. After the enjoyable conference summary chaired by Julian Lousada and Helen Morgan, it was time to relax into the awards ceremony. On returning home that night, my feelings were firstly, how enjoyable it was and that I was really glad to have attended. But I hope that the time will come when there will be more disabled people within the profession – or certainly more visible ones attending conferences ■

Psychoanalytic Psychotherapy NOW

Psychoanalysis, altruism, neoliberalism, and emotional poverty

By Graham Music

WE ARE LIVING in troubled and troubling times. In the UK in the last 35 years the social fabric has dramatically changed, the Bevanite settlement and welfare state has been profoundly (possibly irreversibly) pulled apart. Since the end of the cold war we have seen the seemingly relentless march of neoliberalism and untamed capitalism, the spread of globalisation, and rising inequality. The world many psychotherapists grew up in and expected to continue is on the retreat, and many of us feel the need to find a response which articulates our core beliefs and hopes.

I believe psychoanalysis, and psychology generally, has a potentially important role to play with profound points to make, and that we can challenge a range of preconceptions that have gained weight in society at large. In order for this to happen, though, we do need to distance ourselves from versions of human nature that play into the hands of neoliberal individualism, and we also must resist the uses that are made of psychotherapy to support an overly individualistic and 'blame the victim' ideology.

A starting point is the rise of a dominant view of human nature as competitive, individualistic, and aggressive, a view all too close to Freud's of course. This echoes age-old debates about human nature, whether in philosophy (e.g. Rousseau v Hobbes) or in psychoanalysis (Freud/Klein v Winnicott/Kohut for example). Research that I have become interested in has shown clearly that even very young infants are born with prosocial and proto-moral capacities (Hamlin et al. 2007; Bloom 2010), showing overt preference for characters who act well and kindly as early as three months. Toddlers by 14 to 16 months are genuinely altruistic and helpful (Tomasello 2009), and in experimental situations pick up cues about others' needs and respond helpfully when that is needed. Children who have had good care tend to be cooperative, capable of reciprocity and generosity. This gets turned off in the face of stress, fear and anxiety (Music 2014).

What most of us know clinically of course is that trauma, stress and anxiety undermine empathy, altruism and compassion. I have worked with maltreated kids and adults for decades, and now working with forensic patients at the Portman Clinic, and it is clearly no coincidence that those who can act in the nastiest, most selfish and scary ways are the very people who have often suffered the most terrible abuse and trauma.

We have known for decades that abuse turns off prosocial tendencies as early as toddlerhood (Main and George, 1985), and that secure attachment is profoundly linked with kindness, generosity, empathy and cooperation (Mikulincer et al., 2005). Indeed, the very brain areas central to empathy and cooperation tend to be more offline following trauma and abuse (McCrory et al., 2011), whereas more primitive brain regions such as the amygdala become more dominant. This research fits well with psychoanalytic ideas about the dominance of persecutory or paranoid-schizoid states in fear, stress and anxiety.

Why does this matter? Increasingly we are peddled a view of human beings as naturally selfish and individualistic, and that a moral and social sense can only be instilled by society and the adult world. Dawkins was as guilty of this as anyone, writing in The Selfish Gene (Dawkins, 2006), 'If you wish, as I do, to build a society in which individuals cooperate generously and unselfishly towards a common good, you can expect little help from biological nature. Let us try to teach generosity and altruism, because we are born selfish.' Since Thatcher this has become a dominant strand in neoliberal ideology. Yet of course a very competitive dog-eat-dog world is one which breeds these very selfish individualistic traits. As social psychology has long shown us, when stressed, anxious or in a crazy rush we become less nice and helpful (Darley and Batson 1973), whereas when the world feels good or beneficent we tend to act more generously and benignly (Isen and Levin 1972). It might be that the current economic world is creating the dominance of this version of human nature, and giving less space for more humane altruistic ways of being to thrive and flourish.

The dominant ideology increasingly has shown a disdain for much that we value in psychoanalysis, particularly dependency, vulnerability and softness, the qualities that often have (somewhat sexistly) come under the umbrella of being 'maternal'. Much contemporary thinking is in thrall to a particular version of phallic machismo which is dangerously near Rosenfeld's description of the mafia gangs (Rosenfeld, 1987). In this the poor are despised and blamed as 'scroungers' and lazy, the wealthy are feted for their justly rewarded endeavour, and the weak are exhorted to 'man up' and stand on their own two feet.

In this individualistic Weltanschauung any proper social analysis disappears. Poverty is the responsibility of the poor, individuals need to look after themselves, the strongest survive and thrive in a Spencerian perversion of Darwin's in fact much more socially aware ideas. One of the worst sequelae of this is the idea that so-called 'job-seekers' will be made to undertake a course of CBT or mindfulness to make them 'fit for work', with the implication being that somehow it is their unfitness that is the problem, rather than the way society is currently configured, with fewer jobs, foreshortened career structures, rising inequality, a rise of zero-hours contracts, etc.

The very basis of psychotherapy of course is to help people to feel more hopeful, to develop capacities to mentalize, empathise, to take back projections and see others more as they are. Many of us have noted how in psychotherapy over time, as people feel more at ease, they also become more generous, prosocial and even, to use a non-psychoanalytic word, kind (Music 2011; Music 2012). Indeed, just being empathised and attuned with has been shown to make people more prosocial and altruistic, not only in adults but even in babies (Carpenter et al. 2013). Yet these systems in our brains, and in our autonomic nervous systems, go offline under stress, or in fear and anxiety, and our social engagement systems turn off as we prepare to meet threat (Porges 2011). Thus, much that we are aspire to in psychotherapy works against the dominant ideology.

Indeed, it might even be argued that capitalism and materialism have a vested interest in poor mental health. People who have more extrinsic motivation, as defined by Kasser (2003), tend to value consumer goods, status, and how they are seen. They also tend to have poorer mental health and much more likelihood of a psychiatric diagnosis. They are much

more likely to believe that purchasing material goods is the road to happiness and the way out of despair, depression or emotional pain. In other words, they make far better consumers than those with intrinsic motivation who value relationships, good experiences, or having a sense of vocation or community, for example. It is no coincidence I think that we have seen a marked rise in narcissism, at least in the US (Twenge and Campbell, 2009), in recent years, as well as a decline in empathy (Konrath et al., 2011). We also know that as inequality rises, not only do health (Marmot, 2005) and mental health outcomes get worse (Wilkinson and Pickett, 2009), but we see a decline in altruism and empathy, and the worst culprits being those with the most privilege (Piff et al. 2012). Just being primed to think about money and financial words makes people less caring and more selfish, indeed more likely to become the Dawkins version of human nature (Vohs et al., 2006).

Of course altruism, at least that kind motivated by empathy (Batson, 2011), i.e. intrinsically motivated altruism, is threatened both by stress, fear and anxiety, and is also turned off by the offer of extrinsic rewards. Indeed, even Tomasello's altruistic toddlers stopped being motivated to help once they were offered concrete rewards for helping (Warneken and Tomasello 2008). Maybe the new breed of public sector managers and commissioners should take note. Most of us want to work because our hearts are in it, not for the extrinsic rewards, which might even turn us away from the tasks.

We as psychotherapists can have a voice to combat these arguments, and also to resist the individualising and blaming agendas that are rife. We know that inequality, poverty and poor early experiences all massively increase the likelihood of later mental and indeed physical health issues (Felitti 2002). We need to help individuals of course, and not blame them, but we also cannot lose sight of the fact that social change is needed.

Allied to this worry about individualising, we also need to resist the process of commodification of wellbeing, into which psychotherapy can be dragged alongside the self-help industry, wellbeing, CBT and mindfulness apps, and other forms of commodification. While these can all be very helpful, this also smacks of the kind of fetishism that Marx (1867) writes about - one that disguises the social relations behind the processes - as well as the fetishism that Freud wrote about, in which something important becomes perverted. Neoliberalism has this capacity to encapsulate, hide and make shiny the radical edge of therapeutic thinking. Its genius is to hoover everything up in its path, ingest it and convert (pervert) it for its own uses.

Much therapeutic work of course is aiming to develop capacities that we sometimes describe as 'containment' (Bion, 1962), emotional holding (Winnicott, 1996), 'mentalizing' (Fonagy, 2002), mindsight (Siegel, 2010), mindfulness (Williams and Penman, 2011), mind-mindedness (Meins et al., 2012). These all describe versions of how we can be in touch with our own and other's thoughts and feelings, without which emotional wealth/capital (as opposed to poverty), altruism and genuine mutual care and cooperation are not possible. Many children and adults never develop such abilities. When in a near constant state of heightened arousal, anxiety or fear their capacities remain off-line. Consumerism, high levels of competition, of distrust, and the quest for status and money also turn these off.

This argues for a model of human development assuming an inbuilt human propensity for relationships from birth onwards, what Trevarthen (2001) called being born with a 'companion in meaning making'. Bråten (2006) described infants as born 'alterocentric' as opposed to the 'egocentric' Piaget, Emde (2009) 'we-go' not 'ego'. Of course selfishness vies with cooperativeness and indeed is adaptive in certain situations, and for good reason can become exaggerated at times of stress and tension.

To finish with a quote from Carol Gilligan: 'More than ever, we need psychoanalysis with its method of free association to undo the dissociations that currently threaten not only our happiness but also our survival. But we need a psychoanalysis freed from its truncated Oedipus story, a psychoanalysis that recognizes trauma, not nature, as the force that turns love incestuous and anger murderous; a psychoanalysis that is at once psychological and political — that… encourages us to take the risk of opting for love and freedom' (Gilligan 2013) ■

Graham Music is...

References

Batson, C.D. 2011. Altruism in humans. Oxford: Oxford Univ Pr.

Bion, W.R. 1962. Learning from experience. London: Heinemann.

Bloom, P. 2010. The moral life of babies. The New York Times.

Bråten, S. ed. 2006. Intersubjective Communication and Emotion in Early Ontogeny. New Ed. Cambridge University Press.

Carpenter, M. et al. 2013. Being Mimicked Increases Prosocial Behavior in 18-Month-Old Infants. Child Development.

Darley, J.M. and Batson, C.D. 1973. ' From Jerusalem to Jericho': A study of situational and dispositional variables in helping behavior. Journal of Personality and Social Psychology 27(1), pp. 100–108.

Dawkins, R. 2006. The selfish gene. Oxford University Press, USA.

Emde, R.N. 2009. From ego to 'we-go': Neurobiology and questions for psychoanalysis: Commentary on papers by Trevarthen, Gallese, and Ammaniti & Trentini. Psychoanalytic Dialogues 19(5), pp. 556–564.

Felitti, V.J. 2002. The relation between adverse childhood experiences and adult health: Turning gold into lead. Editor's Comments 6(1), p. 44.

Fonagy, P. 2002. Affect regulation, mentalization, and the development of the self. New York: Other Press.

Gilligan, C. 2013. Joining the resistance. John Wiley & Sons.

Hamlin, J.K. et al. 2007. Social evaluation by preverbal infants. Nature 450(7169), pp. 557–559.

Isen, A.M. and Levin, P.F. 1972. Effect of feeling good on helping: Cookies and kindness. Journal of Personality and Social Psychology 21(3), pp. 384–388.

Kasser, T. 2003. The high price of materialism. Cambridge, Mass: The MIT Press.

Konrath, S.H. et al. 2011. Changes in dispositional empathy in American college students over time: A meta-analysis. Personality and Social Psychology Review 15(2), pp. 180–198.

Main, M. and George, C. 1985. Responses of abused and disadvantaged toddlers to distress in agemates: A study in the day care setting. Developmental psychology 21(3), pp. 407–412.

Marmot, M. 2005. Status Syndrome: How Your Social Standing Directly Affects Your Health. London: Bloomsbury.

Marx, K. 1867. The fetishism of commodities and the secret thereof. Capital: A Critique of Political Economy 1, pp. 71–83.

McCrory, E. et al. 2011. The impact of childhood maltreatment: a review of neurobiological and genetic factors. Frontiers in Psychiatry 2.

Meins, E. et al. 2012. Mind-Mindedness as a Multidimensional Construct: Appropriate and Nonattuned Mind-Related Comments Independently Predict Infant–Mother Attachment in a Socially Diverse Sample. Infancy 17(4), pp. 393–415.

Mikulincer, M. et al. 2005. Attachment, caregiving, and altruism: Boosting attachment security increases compassion and helping. Journal of Personality and Social Psychology 89(5), pp. 817–839.

Music, G. 2011. Trauma, helpfulness and selfishness: the effect of abuse and neglect on altruistic, moral and pro-social capacities. Journal of Child Psychotherapy 37(2), pp. 113–128.

Music, G. 2012. Selfless genes, altruism and trauma: research and clinical implications. British Journal of Psychotherapy 28(2), pp. 154–171.

Music, G. 2014. The Good Life: Wellbeing and the new Science of Altruism, Selfishness and Immorality. London: Routledge.

Piff, P.K. et al. 2012. Higher social class predicts increased unethical behavior. Proceedings of the National Academy of Sciences 109(11), pp. 4086–4091.

Porges, S.W. 2011. The polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, and self-regulation. New York: Norton.

Rosenfeld, H.A. 1987. Impasse and interpretation: therapeutic and anti-therapeutic factors in the psycho-analytic treatment of psychotic, borderline, and neurotic patients. Oxford: Routledge.

Siegel, D. 2010. Mindsight: Transform Your Brain with the New Science of Kindness. Oneworld Publications.

Tomasello, M. 2009. Why We Cooperate. Cambridge, Mass: MIT Press.

Trevarthen, C. 2001. Intrinsic motives for companionship in understanding: Their origin, development, and significance for infant mental health. Infant Mental Health Journal 22(1-2), pp. 95–131.

Twenge, J.M. and Campbell, W.K. 2009. The narcissism epidemic: Living in the age of entitlement. New York: Atria.

Vohs, K.D. et al. 2006. The psychological consequences of money. science 314(5802), pp. 1154–1156.

Warneken, F. and Tomasello, M. 2008. Extrinsic rewards undermine altruistic tendencies in 20-month-olds. Developmental psychology 44(6), pp. 1785–1788.

Wilkinson, R. and Pickett, K. 2009. The Spirit Level: Why More Equal Societies Almost Always Do Better. London: Allen Lane.

Williams, P.M. and Penman, D.D. 2011. Mindfulness: A practical guide to finding peace in a frantic world. Piatkus.

Winnicott, D.W. 1996. The maturational processes and the facilitating environment: Studies in the theory of emotional development. London: Karnac.

Psychoanalytic Psychotherapy NOW

The privatisation of madness

By Elizabeth Cotton

Elizabeth Cotton considers the case of precarious work in mental health.

I'VE BEEN WANTING to talk about money for a long time, mainly because I don't have enough of it. When that opportunity came up to present along with David Graeber about money at the BPC, we seized it and asked the question how we might organise ourselves into a better position to think about, talk about and negotiate money within our profession.

Like many people working in mental health, this is not my first career. Coming from a union background I am dogged by an anger about how hard it is to raise the subject of wages. My political position is influenced by working as an adult educator and organiser for 15 years and is sufficiently digested to be mercifully short. I believe that adult education and psychoanalysis are both emancipatory projects and, whichever way you cut it, growth means facing up to both internal and external oppression.

Moving between these two worlds of activism and psychoanalysis is increasingly straightforward, held together in our minds by some bearded blokes including the educator Paulo Freire who understood the deep developmental stream from which these two crafts come. Activists and psychotherapists clearly share some important tools - dialogic methods, seeing the world as it is, building our sense of ourselves as agents in the world, a reliance on collectivism and the bitter pill of dependency.

Working within a context of economic crisis helps to re-establish these connections, with professional audiences ready and willing to think about the basics. Increasingly people working in mental health are on the political frontline of welfare cuts and social justice - and many define themselves as activists. All that's happening now is that crisis is drawing out the essentials of what we do, with the exception of an honest debate about money.

So why is it so hard to talk about money? One of the reasons is that we have superegos like tanks: huge, defensive and aggressive. Despite everything we know from Freud, we can retreat into a world of magic solutions and magic ideological wands and nurture a deep need to take the moral high ground. There's nothing wrong with being right, but we are dogged by punitive and often sadistic states of mind which blunt our humanity to ourselves and each other and with it our need for such things as wages and decent jobs. The love between us is powerful - but we make massive demands and judgements on each other and find it very hard to respond to each other's material needs. We work in situations where all of us at points work for free, made to feel the guilt and shame of not being able to articulate a need for cash.

As work gets more traumatic in health and social care we defend ourselves by splitting the working world into the thems and us-es. This next bit might smart because it's an internal conversation that many of us dedicated open-minded and thoughtful folk fall into.

Splitting divides our profession between women who married rich men and can afford psychoanalytic training, experienced NHS clinicians who have retreated into private practice taking with them the last generation of pensions and all the world's resources with them; versus the chippy lefties, community mental health workers, NHS whistleblowers etc. etc. who couldn't get over their own needs and trauma enough to become real psychoanalysts and are left stewing in their own righteousness.

This is very a very depressing thought for the anarchosyndicalist-feminists amongst us to live with.

One of the ways in which we might find a more humane perspective which respects our political, professional and personal needs might be to understand the context within which we do it using an employment relations perspective.

In June the CQC produced a sobering report about the crisis in mental health services (http://www.cqc.org.uk/content/right-here-right-now-mental-health-crisis-care-review). Chaotic commissioning and sustained cuts in mental health services leading to the profound conclusion that if you reach a crisis in your life and you need some compassion or care you should head to the nearest police station rather than A&E.

In the same week the Guardian's ClockOff survey came out measuring the stress levels of public sector workers (http://www.theguardian.com/society/2015/jun/10/stress-working-public-services-survey). People working in health are the most stressed out public servants, with 61% reporting that they are stressed all or most of the time.

These reports are not about failures of individual compassion or positive thinking; rather it highlights the impact of precarious work on our states of mind. Mental health has always been the poor cousin of public services, affecting not just those of us using those services but also those of us providing them. Working in mental health has become a text book definition of precarity.

The debate about precarious work is a defining one in the field of employment relations, making the research link between between nationally set cuts and targets, privatization of services and growth of externalised labour, the use of command and control management, work intensification and bullying cultures. The confusion and ignorance about the employment relations system of psychotherapists is very much about the continuous privatization and restructuring of the NHS and the 2013 shift of commissioning powers to local level. However, it also exposes a range of employment relations problems faced by psychotherapists, including the growth of contract and agency labour, the use of unwaged labour, the insecurity of 'permanent' psychotherapists in the NHS, and the retreat into private practice. We will look at each problem in turn.

The advent of agencies is nothing new in healthcare, but with the massive rise in demand for mental health services, NHS cuts, and waiting lists of between six and 18 months, we are now seeing the creation and expansion of private contractors and employment agencies for therapists. Because of the intense insecurity of agency work and the fear of blacklisting of individual therapists, nobody wants to talk about this growth of third parties in mental health and, as a result, not much is known about them.

The growth of contract and agency labour is part of a national campaign to downgrade mental health services. Under the NHS's Improving Access to Psychological Therapies (IAPT) programme the main bulk of services are low intensity 'wellbeing' programmes, based on a diluted model of Cognitive Behavioural Therapy (CBT). This service is delivered by Psychological Wellbeing Practitioners, a formalized and standardized role with intense targets of eight to ten satisfied clients a day. Under this system, if a patient does not pick up the phone for an initial assessment within the allotted 15-minute time period, they are referred back to their GP, presumably to wait for a further six months.

This model of 'wellbeing', to be clear, can under no description be considered as therapy. Although most of the people working as PWPs are highly qualified their job is not to provide a space where patients can actually say what is on their mind. The work is scripted, manualized and always leads to one compulsory outcome, which is that everyone feels well. Computer says no. PWPs who offer more support, mainly through giving more time and going off script, are forced to keep this secret from employers because

it breaks their contract of employment, leaving them to carry the full ethical and clinical consequences of their interventions.

To add insult to injury, tucked away in the 2015 Budget (https://www.gov.uk/government/publications/budget-2015-documents) is the proposal that IAPT services should be introduced to 350 job centres in the UK. The 'psychologization' of poverty where unemployed people are forced by precarious PWPs to internalise a global economic and social crisis. In this scenario its hard to imagine who needs the most help, the client or the clinician.

A growing percentage of IAPT services are provided by contractors and labour agencies who are literally buying up the growing NHS waiting lists. As with all externalised employment relations, it is not just the contract of employment that gets passed over to third parties, it is also the responsibilities of employers. Many people working in the NHS via agencies receive no training or supervision, raising questions about the duty of care to clients and employees.

The second employment relations problem in psychotherapy relates to internships, or the widespread use of honorary psychotherapists. The most important part of your training as a psychotherapist, along with your own personal therapy, is to carry out clinical work. In order to train as an adult psychotherapist and become an accredited member of a professional body you have to work part-time - usually on to three days a week for between four and eight years. The problem is that the trainee is not paid. There is currently no comprehensive data on how many psychotherapists work unwaged as honoraries, but with 6,000 psychotherapists being trained every year a conservative estimate is that 2,000 full time jobs in mental health are covered by unwaged workers. This includes a substantial percentage of the psychotherapists working for the NHS, the big third sector providers such as Mind, and many local mental health charities providing clinical and wellbeing services in the UK.

The professional bodies are complicit in this system of unwaged work, leading to the curious situation that the bodies charged with building a sustainable profession are currently not able to do that. If there is a political cause worth fighting for it is to make the demand for our professional bodies to organise a platform to negotiate wages.

As a result this is a profession open primarily to people from families rich enough to support them. There are some who work full time and do the training on top, but there is a real risk that (as in other fields such as the media and the arts) the great majority of practising therapists will be people from affluent backgrounds. That is not to say that rich people make worse therapists than poor people, but it does raise important questions about class and power, both clinically and within the profession.

The third employment relations problem relates to therapists employed directly by the NHS. In most cases the days of 'permanent' contracts are over, with cuts in funding and increasingly short funding cycles meaning many of the jobs are fixed and short term. Most NHS services are understaffed, particularly in Child and Adolescent Mental Health Services (CAMHS), leading to an emerging gold rush for private contractors and agencies. The insecurity of NHS workers has profound implications for 'workplace fear' and creating cultures where clinicians are reluctant to raise concerns about patient care. Despite the important debate going on now about raising concerns (https://theconversation.com/nhs-guardians-wont-help-whistleblowers-unless-theyre-protected-from-bullying-too-37543) in the NHS, the reality is that precarious workers are unlikely to speak up for fear of victimization and job loss.

As a result, many experienced psychotherapists have retreated to private practice, unable and unwilling to navigate a broken system. Many make enough money to survive, but only having spent most of their working lives in the NHS, leaving their pensions intact. This generation of psychotherapists will retire within the next five to ten years, leaving behind a whole generation of self-employed psychotherapists, many of them working within social enterprises and charities, who will never earn enough to cover the basics of pensions or sick pay. It is not to say that private practice does not offer massively needed services - it does - and a careful assessment and referral can make the difference between life and death. But it increasingly means that services are accessed only by those that can afford it.

The current economic argument for mental health services is based on the unacceptable working conditions of thousands of mental health workers. From Psychological Wellbeing Practitioners, to IAPT workers in job centres (https://www.indymedia.org.uk/en/2015/06/520756.html), to the clinicians employed by Maximus and Atos to carry out welfare assessments, working in mental health poses significant health risks to both clients and clinicians. As long as psychotherapists are working quietly and diligently under precarious conditions, the NHS as an employer will never respect the people who work for it. In a context of deteriorating mental health services, the fact that psychotherapists are an unorganised and silenced group of public servants is a matter for both professional and personal ethical concern ■

Elizabeth Cotton is...

Psychoanalytic Psychotherapy NOW

Shame and its role in violence

By Jean Knox

IN OUR CONSUMER society, wealth and possessions reassure their owner of his or her value, success and status in society. Consumer societies thus increasingly reward the pursuit of ruthless self-interest – as a glance at chief executive pay packets confirms - and disadvantage and poverty are treated as shameful. Those who are more vulnerable or powerless in our society can easily come to feel as though it is their inadequacy that has made them fail to climb the ladder to power and success, and to reach a position where they are invulnerable.

So I wonder if the idea that losing face or backing down that Paul Kassman [Need Ref] suggests is so unthinkable in a gang lifestyle may partly result from the 'systematic shaming' by the more successful groups in our society of ethnic or demographic groups that are disadvantaged, whether through poverty, lack of education, unemployment, poor health, ethnicity or other characteristics that become the focus for discrimination.

James Gilligan, an American psychiatrist, has highlighted the link between shame and violence, based on his therapeutic work with prisoners in Massachusetts. Gilligan suggests that violence is mostly an attempt to restore self-esteem and so can be directly linked to shame. But everyone experiences feelings of shame at one time, and to some degree, but not everyone becomes violent. Gilligan suggests that while shame is a necessary condition several other preconditions have to be in place.

One of these is that the individual perceives himself as not having sufficient nonviolent means by which to save or restore his self-esteem, for example skills or achievements, a sense of standing in the community or just material status. Gilligan suggests that the violent criminals with whom he worked for the most part lacked all of these: most were uneducated or even illiterate, unskilled or unemployed, poor or even homeless, or members of disadvantaged ethnic or demographic groups. He does not argue that one has to be poor or discriminated against to become violent, but I think that it does not help to belong to a group that is marginalized or despised by the rest of society. It is this sense of exclusion and marginalization that leads to the sense of disengagement from what society has to offer in terms of education, employment and social status.

The Boston bomber brothers offer an extreme example - they were not part of a gang culture, but Masha Gessen argues that, among many other factors, social exclusion and marginalization were critical in turning them into violent terrorists. The elder brother, Tamerlan, was once considered an Olympic boxing prospect, but was denied the opportunity to compete at nationals because he was not a US citizen. As immigrants, they were shut out of the American dream.

As Margaret Heffernan has pointed out there is plenty of research that shows that an individual or group who feel excluded or ostracized from society start to feel worthless and that their lives are meaningless:
ostracism makes individuals feel they lack purpose, have less control over their lives, are less good moral beings and lack self-worth (Heffernan, Wilful Blindness, 2011).

If we want to argue that enlightened legislation has eliminated discrimination, we only need to look at the impressive research and publications that describe the huge range of inequality that persists in our society and the discrimination that accompanies it. Books by Wilkinson and Pickett (The Spirit Level, 2009), Danny Dorling (So you think you know about Britain, and Injustice, 2011), Owen Jones (Chavs: the demonization of the working class, 2011), and Nobel-prize winner Joseph Stiglitz (The Price of Inequality, 2012 and The Great Divide, 2015) identify a raft of overt and implicit discrimination in relation to education and employment.

For example, in relation to racial discrimination, Stiglitz quotes research showing that in the US, a white man with a criminal record is more likely to be considered for a job than a black man with no criminal past, when they are matched on qualifications and other criteria.

Danny Dorling also produces some unexpected but memorable statistics to illustrate this kind of implicit discrimination. Such as the fact that

- • the majority of children who live above the fourth floor of tower blocks in England are black or Asian, while on the lower four floors the majority of children and their parents are white.
- • children from the top socio-economic class are 30 times more likely to become doctors than those from the lowest socio-economic class.
- • in Kensington and Chelsea, the life expectancy from birth is 11 years longer for women and 13 for men than in Glasgow City, a divide last seen in the early 1920s.

Dorling writes:

> We know we have returned to inequalities as great as those last seen around 1918 because we can compare the gaps in life expectancies between areas then and now, because we can measure the gaps in income and wealth and see that both before and after they have paid tax, the rich are again so very rich that in terms of social inequality we are all back to the Edwardian era of great socio-economic injustice.

Owen Jones makes the point that 'demonizing people at the bottom has been a convenient way of justifying an unequal society throughout the ages' and that:
Social problems like poverty and unemployment were once understood as injustices that sprang from flaws within capitalism, which, at the very least, had to be addressed. Yet today they have become understood as the consequences of personal behaviour, individual defects and even choice.

The plight of some working-class people is commonly portrayed as a 'poverty of ambition' on their part. It is their individual characteristics, rather than a deeply unequal society rigged in favour of the privileged, that is held responsible.

This has sometimes turned into a particularly nasty form of social Darwinism. Newcastle psychiatrist Bruce Charlton wrote:
Poor people have a lower average IQ than wealthier people… and this means that a much smaller percentage of working-class people than professional-class people will be able to reach the normal entrance requirements of the most selective universities.

The second factor that Gilligan suggests turns shame to violence is that the degree of shame and humiliation the person is experiencing is so intense that it is overwhelming, to the point that it threatens the cohesion and viability of the self. This is almost always the case with interpersonal trauma. As Lowenstein and Welzant (2010) argue, a central feature of 'bullying, child abuse, rape, torture and sadism, is the deliberate humiliation of the victim' who has been rendered powerless and helpless, a kind of death of the self. Donald Nathanson (2010) describes a 'compass of shame', of which one feature is that 'the one who is shamed wishes to attack back, to make the bully, the perpetrator, feel the shame that the victim experiences'. This is a vicious cycle, which is presumably amplified in a gang culture.

As Paul Kassman puts it:

- For most teenagers full of adolescent insecurities, the idea of losing face is hard to accept. Grafted on to a gang lifestyle, where your rep and your gang's rep are at stake, the idea of losing face or backing down is unthinkable.

and

- 'Representing' or 'repping' your estate, means letting no challenge, however small, go unanswered, and marking out your territory through street crime.

This is not just relating through projection but also through projective identification. As Jessica Benjamin (2004) puts it so well:

I'VE BEEN ASKED to write some thoughts as a gay man on my training as a psychotherapist in one of the BPC's Member Institutions. Why, you might ask? Well, perhaps in telling my story that will become clear. This type of training isn't easy – nor should it be. It should and it did make me examine who I am, to think about the phantasies and realities of myself, and that has at times been painful. The school I trained with was excellent in so many ways – academically and clinically top notch, sympathetic and boundaried in its pastoral care and in every sense the 'Transferential Mother' to us trainees!

Finally you might note this piece is anonymous – and I debated long and hard about that. How can I say I want to hear your views if I won't say who I am? It's a fair question. Ask yourself why I make this choice though. It's fear. Fear of possible consequences for my career, repercussions based on prejudice or even hostility from colleagues. You might doubt that this would happen, but I know from others that even in 2015 discrimination is alive and kicking, and I have to be conscious of that. I have a role in tackling the fear, but if you don't think you have a role too in tackling the overt and covert examples of prejudice helping

In the doer/done-to mode, being the one who is actively hurtful feels involuntary, a position of helplessness. In any true sense of the word, our sense of self as subject is eviscerated when we are with our 'victim', who is also experienced as a victimizing object.

I think the victim as victimizing object describes the fragility of the temporary position of power - the fact that gang members feel themselves to be constantly at risk of being the humiliated victim and so constantly need to seize the role of powerful attacker.

Another factor that may turn shame into violence is when the individual has lost the capacity for the emotion that inhibits violence toward others, namely guilt and remorse.

There is some interesting neuroscience research on this. Jean Decety and colleagues have found (Decety & Meyer 2009) that adolescents with conduct disorder lack the capacity to distinguish self from other (an important aspect of mentalization). Neuroimaging studies suggest that they strongly 'feel with' someone in pain, in the sense that their own pain matrix is highly activated (including the anterior cingulate cortex, insula, somatosensory cortex and amygdala), the emotional contagion aspect of empathy. But compared with a control group who showed activation of the areas that regulate emotion and monitor whose feelings belong to whom (medial prefrontal cortex, lateral orbitofrontal cortex, and right temporoparietal junction), in the conduct disorder group, these areas are not activated—they cannot down regulate their own distress, which becomes transformed into aggression toward the person in pain. They lack an ability to differentiate the other person's distress from their own, and to maintain separate perspectives on self and other.

Once again, this echoes Jessica Benjamin's description of the victim as victimizing object. The gang member who is temporarily in control is actually experiencing the same pain and terror that their victim feels through the activation of the same pain networks, and presumably this may intensify the degree of violence towards the victim who is seen as the cause of his, the attacker's distress. Research has shown that guilt involves the activation of the orbito-frontal cortex. Moral cognition and social emotion-processing broadly recruit a fronto-temporo-subcortical network, supporting empathy, perspective-taking, self-processing, and reward-processing. It is these areas that Decety and colleagues have shown are not being activated in conduct disorder adolescents, and this does seem as though it has some relevance for understanding aggression and violence.

A fourth precondition that enormously increases the chance that shame will lead to violence
exists when the individual has been socialized into the male gender role that, in a patriarchal culture, means he has been taught that there are many circumstances and situations in which one has to be violent in order to maintain one's masculinity.
For men in a patriarchy, there are many situations in which violence is honoured and nonviolence is shamed. Such men experience the wish to be loved and taken care of by others as the state of being passive and dependent, as opposed to being self-reliant and taking care of oneself, or being active and autonomous. When men socialized into a gang lifestyle find themselves wanting to be loved and taken care of by others, they feel shame, which drives them to react by becoming active and aggressive, independent and ambitious. If they do not perceive themselves as having nonviolent means for becoming independent and being able to take care of themselves (such as skills, education, and employment), the activity and aggressiveness stimulated by shame can easily turn into violent and sadistic behaviour.

Which brings us full circle back to exclusion and marginalization of the individual and of whole communities from the advantages society can offer as a major contributing factor to the toxic experience of shame and hence to violence. ■

Jean Knox is....

Psychoanalytic Psychotherapy NOW

Treating the untreatable?

By Jessica Yakeley and Gill McGauley

Using Mentalization Based Treatment for antisocial personality disorder in the community.

IN THE LAST DECADE, the historical antipathy of psychiatrists and other mental health professionals in treating personality disorders has been effectively challenged by the development of specific psychological therapies and the subsequent development in the UK and other countries of dedicated mental health services for personality disorders. However, the focus has been on developing treatments for patients with borderline personality disorder, and there remains a lack of service provision for individuals with other personality disorders, including antisocial personality disorder (ASPD). ASPD is a complex condition carrying high rates of comorbidity and mortality for individual sufferers as well as harmful consequences for their families and society. Despite the publication of NICE guidelines for ASPD (NICE, 2009) the evidence base and provision of effective treatments for patients with this costly disorder remain inadequate, and the belief amongst psychiatrists and other professionals that the condition is untreatable remains widespread. Many clinicians remain wary of treating people with ASPD due to the difficulties of engaging in them in a treatment process, issues of risk, substance misuse and a widespread belief that their personality difficulties are unamenable to therapeutic change. The few treatment programmes that do exist are derived mostly from a CBT model, delivered in the Criminal Justice System rather than in the NHS, and driven by a public protection agenda, focussing on the reduction of risk rather than improving the health of individuals with ASPD.

ASPD, attachment and mentalisation

Our interest in ASPD focuses on understanding the aetiology and development of the condition, drawing particularly on attachment theory and the concept of mentalisation, and how this understanding may inform effective treatment. There is an increasing body of empirical evidence suggesting that some violent offenders with a diagnosis of ASPD have disordered attachment systems and an impaired capacity to mentalise. Some studies have shown an over-representation of insecure attachment in violent offenders and forensic patients compared to other clinical and non-clinical populations (van IJzendoorn 1997; Frodi 2001; Levinson, 2004; Bogaerts, 2005). These research findings support clinicians' experience of listening to their patients' narratives and clinical studies, both of which confirm that offenders in prison or secure forensic institutions are more likely to have experienced separations, abuse and neglect from their early caregivers compared to individuals in the general population (Coid 1992; Pert et al 2004; Weeks 1998).

Bateman and Fonagy (2008) propose that a substantial group of patients who fulfil diagnostic criteria for ASPD have experienced significant trauma and disruptions to their attachment system in childhood, which has interfered with their neurobiological development and the development of psychological defences. This compromises their capacity to mentalise and lowers their threshold for emotional reactivity. Mentalisation is the capacity to reflect and to think about mental states, including thoughts, beliefs, desires and affects. It includes the ability to distinguish one's own mental states from others, and to be able to interpret the actions and behaviour of oneself and others as meaningful and based on intentional mental states (Allen 2008). Children who experience significant childhood abuse, neglect, or violence, however, will be unable to feel safe about what others think of them, which may lead to a poorly developed capacity to mentalise, deficits in empathy, and a difficulty in distinguishing one's own mental states from others.

Mentalisation, aggression and violence

A person with a limited capacity to mentalise is unable to tolerate negative emotions and impulses such as anger, hatred, and a wish to hurt others. Instead, these individuals may become highly aroused and overwhelmed with negative affects. People with ASPD are often particularly sensitive to any real or perceived threats to their self-worth or 'respect', which generate shame and humiliation which are particularly difficult emotional states to bear. These unbearable feelings cannot be managed by normal representational means within the mind, but are experienced very concretely as feelings that need to be expelled through violence. The expression of aggression is further potentiated by the reduced capacity of the individual to mentalise – if he is unable to see others as having mental states as different from himself, this reduces the inhibition of his aggression and violence towards others as he is unable to empathize or appreciate another person's suffering.

Therefore the capacity to mentalise is thought to be a critical mediating mechanism between insecure attachment states of mind and interpersonal violence (Fonagy et al, 1997). Individuals with an impaired capacity to mentalise, whether this is a context dependent failure of mentalisation or a pervasive deficit, are more likely to be violent. This proposed pathway linking insecure attachment states of mind, mentalisation and violent behaviour is supported by some empirical research. Levinson and Fonagy (2004) report poorer mentalization in a violent group of prisoners whose offences were of inter-personal violence, compared with prisoners who had committed non-violent offences. They propose that the violent act may occur when a person with poor mentalization is in conflict and therefore resorts to physical action against the other.

Piloting MBT for ASPD

Mentalisation-based treatment (MBT) is a psychodynamic treatment based on mentalisation principles that was originally developed for the treatment of borderline personality disorder (Bateman & Fonagy 2004; 2006). Randomised controlled trials have shown that MBT is effective in reducing self-harm and hospital admissions. MBT originally arose out of a psychoanalytic model, drawing from the theories of analysts such as Winnicott and Bion, but it also incorporates a relational approach, where the person's mind and his relationship with other minds are the foci of therapy. In recent years there has been increasing interest in using MBT in forensic settings in the treatment of violent offenders. In 2009 Jessica Yakeley and Andrew Williams at the Portman Clinic spotted a 'gap in the market' when they realized that men were presenting asking for help with their aggressive impulses but were unable to find a service to treat them. In response, these clinicians initiated a pilot community-treatment programme adapting MBT for ASPD in conjunction with Professor Anthony Bateman and his personality disorder service at St Anne's Hospital in North London.

The ASPD-MBT treatment programme comprises an initial assessment, followed by weekly group psychotherapy sessions facilitated by two therapists (JY and AW) and monthly individual psychotherapy sessions with one of the therapists, for 18 months. The mainstay of treatment is group therapy and the monthly sessions are used primarily to support the patient's ongoing participation in the group. One of the overall aims of treatment is to facilitate the patient in his interpersonal functioning by stimulating attachment bonds whilst encouraging him to examine the mental states he experiences in relation to others. This process may be more effective in group treatment, as this offers more opportunities to understand other peoples' minds and is less arousing than individual therapy.

During the initial assessment the therapists meet with the patient several times, and these sessions include explicit psycho-education about the patient's diagnosis and the treatment to be offered. Crisis management and psychiatric review form an important part of treatment. In line with NICE guidelines for ASPD, psychotropic medication is prescribed for co-morbid conditions such as depression, but not for the traits of ASPD per se, such as irritability or poor impulse control.

The patients who initially entered the treatment pilot were all men who fulfilled the diagnosis of ASPD, but also had some motivation for treatment and had presented voluntarily to their GPs or mental health services requesting help with their aggression. All had a history of violence and most had previous criminal convictions for violent acts, including patients who have been convicted of murder and were serving the end of their life sentence in the community. The majority of patients continued to be involved in more minor incidents of aggressive behaviour in their everyday life such as disputes with neighbours, pub fights and road rage. Most patients came from deprived working class backgrounds, and all had experienced various forms of serious abuse and neglect from their parents and parental figures, some spending time in care. Unsurprisingly, all of the patients reported difficulties in their close interpersonal relationships with partners and family. In general, the younger patients found it more difficult to accept responsibility for their aggression or the long-term nature of their difficulties, and tended to drop out of treatment early on. Consequently the group comprised men whose ages ranged between mid-thirties and mid-fifties, most of whom had presented to health services with depression and anxiety, the diagnosis of ASPD emerging later.

As many individuals with a diagnosis of ASPD find it difficult to admit responsibility for their difficulties and accept therapeutic intervention, engaging such patients in treatment proved to be a major challenge. This necessitated the therapists taking an assertive approach to engagement, including telephoning the patient after any missed sessions. These challenges have meant that the treatment programme was initially slow to establish, with many patients failing to attend the initial assessment following referral or leaving during the assessment phase. However, over time, the programme gradually became established and approximately two thirds of those initially accepted engaged and stayed in treatment.

In MBT-ASPD the content of the group therapy sessions is steered by the therapists towards encouraging the patients to talk about recent violent incidents, and to focus on what is happening in the patient's mind, increasing awareness of his thoughts and feelings, particularly those around shame, that precede the violent act. However, because individuals with ASPD find it difficult to empathise with other people's affective states, interventions aimed at consideration of their effects on others, or 'victim empathy', are often counterproductive and are avoided, at least in the early stages of treatment.

Group sessions are often lively, with the patients' feelings of anger easily activated when they describe emotive topics. At this point their mentalization fails, and the therapists need to actively intervene to deflect attention away from the angry member until his state of arousal diminishes. The other members are encouraged to examine what just occurred in the group to make that person angry. At times, the therapists need to offer their thoughts if the patients are unable to reflect on the situation. In exploring their motivations for violence shame is something that all of the patients identify with, and threats to their self-esteem (being 'disrespected') are a common trigger for violence. Therapists have also found that they need to be careful about expecting patients to examine their feelings as they often feel stupid or unable to put feelings into words, and are hypersensitive to being criticised or corrected.

Antisocial individuals experience relationships in terms of power and control, and issues of dominance and hierarchy have pervaded the group's discussions and functioning. Rules and boundaries, which are important in any group treatment, may become a central feature in groups for ASPD individuals. Based on their own early attachment experiences of maltreatment these patients have a distrust of parental figures and authority, and will rebel against whatever rules are imposed, including those of the group, but may have their own strict code of conduct. Boundary violations are therefore to be anticipated. For example, although we advised against meeting each other outside of the group, as this could lead to people feeling left out, misunderstandings or even confrontations between group members, unsurprisingly this advice was ignored. Some group members did make contact, for example meeting socially, or lending each other money, which inevitably did not always go well. It was only through direct experience of some of the consequences that the therapists had warned about that the group members understood the rationale of this particular boundary. In the mentalisation model they had moved into a non-mentalising teleological mode of thinking where they could only understand something when acted out. In teleological mode, where individuals have temporarily lost aspects of their capacity to understand the minds of others, actions really do speak louder than words. As therapists, we realized that we must be prepared to tolerate expression of anti-authoritarian attitudes and act as a parental figure against which the patients could rebel, until such attitudes could be safely explored and understood within the group. The aim is to nurture a culture of trust, openness and honesty in the context of attachment relationships with the other group members by first helping the patient explore his own code of conduct and interactions with others within and outside of the group, and identify the affects and states of mind which lead to violence. Developing a sense of responsibility and awareness of appropriate boundaries in relation to others is an important task of treatment, although this may be difficult in patients who have grown up within, and may continue to live in, a criminal sub-culture. In this pilot, on-going assessment of risk was monitored through the content of each group session and the monthly individual sessions. Additionally patients completed the self-report Overt Aggression Scale (OAS) (Coccaro et al, 1991) at the end of group sessions, in which they rated the frequency of their thoughts of and acts of violence towards others and self over the past two weeks. The OAS is also useful for monitoring the serious risk of suicidality in these patients; a risk which is often overlooked compared to the more obvious risk of violence towards others. Patients with ASPD often find it shameful to admit to feelings of depression, let alone suicidality, in front of others and instead maintain a front of aggressive bravado within the group.

The results of our pilot using the OAS as an outcome measure showed that the patients' reported levels of violence externally decreased quite quickly within several months of starting treatment, whilst their feelings of irritability remained more constant (McGauley et al, 2011). This suggests that the patients appeared to be fairly quickly contained by entering therapy and more able to control their violence, but that the process of mentalisation and encouraging them to reflect on their internal states, particularly negative feelings, is arduous and makes them feel more internally agitated. In our experience, new members are initially wary of disagreeing with other patients in the group, and any irritability is directed towards the therapists, who are unconsciously perceived as safer targets for their aggression. As the group members get to know each other, however, they begin to feel safer in challenging each other which, at times, has led to verbal disputes and patients storming out, but returning to subsequent sessions in which the antecedents to the patients' anger can be examined.

Developing MBT-ASPD services within the National Offender Personality Disorder Pathway

In 2012 the Portman MBT-ASPD team approached Nick Benefield and Nick Joseph, the architects of the National Offender Personality Disorder (PD) Pathway, with a funding proposal to further develop and research the MBT-ASPD service. The Offender PD Pathway, co-commissioned by NHS England and the Ministry of Justice, is the sequel to the Dangerous and Severe Personality Disorder (DSPD) programme (Home Office & Department of Health 2002) which was decommissioned in 2011 in favour of a reconfigured national strategy for managing high-risk personality disordered offenders based on a 'whole systems pathway' across the Criminal Justice System and National Health Service (Joseph & Benefield, 2012). This new strategy is informed by a developmental model of personality disorder and the recognition of the centrality of attachment experiences in the historical and current lives of offenders. It promotes education of the workforce about personality disorder towards the goal of creating more therapeutic environments in prisons and forensic institutions, as well as prioritising the development of specialized services for the management and treatment of neglected groups of personality disordered offenders. The importance of meaningful service user involvement in the development and delivery of services is also emphasized.

Following a tendering process, the Tavistock and Portman NHS Foundation Trust were commissioned in 2013 by NHS England and granted funding for Jessica Yakeley to develop and implement 13 new MBT community treatment services nationally. These are for offenders with a diagnosis of ASPD who are currently under statutory supervision of the National Probation Service and part of the Offender PD Pathway. The services are equitably spread across England and Wales, with sites in Liverpool, Preston, Leeds, Lincoln, Nottingham, Staffordshire, Bristol, Exeter, Wales, and four sites in London. Treatment is delivered within probation premises and consists of weekly group therapy with monthly individual sessions for one year. The MBT team in each site includes three MBT therapists, an assistant psychologist, a psychiatrist, a probation officer and an ex-offender service user. All members of the team are trained in MBT and receive on-going supervision from the Anna Freud Centre, led by Anthony Bateman. The evaluation and research of the services is being led by Professor Peter Fonagy at University College London and an application for funding from the National Institute of Health Research (NIHR) to conduct an RCT across all the sites is in progress.

These treatment services commenced in April 2014 and predictably have faced numerous challenges in their implementation. The most challenging is the government's restructuring and partial privatization of the probation services as part of the 'Transformation Rehabilitation' (TR) programme for how offenders are managed in the community, which went live in February 2015. TR has led to widespread demoralization amongst probation officers, with high staff turnover, high rates of sick leave and many probation officers leaving the profession; so it has not been a good time to introduce and promote a new service. The reorganisation has also adversely affected the system at a practical level, with access to data systems and buildings being disrupted. This wider turbulence in the organization has impacted on

Continues over the page

Psychoanalytic Psychotherapy NOW

A genocidal imagination?

By Philip Spencer

THE CRIME of genocide has a particular status in international law and global ethics. It was first defined in the Genocide Convention, agreed by the United Nations in December 1948, some 24 hours before the Universal Declaration of Human Rights, and there is a sense in which the two together can be seen to form the normative basis of the post war settlement. The Convention talks of genocide as 'an odious scourge' from which it is necessary to liberate humanity. The International Tribunal set up to deal with perpetrators of the genocide in Rwanda in 1994, where some 800,000 people were killed in a matter of months, with a killing rate three times faster than that of the Holocaust, called genocide the 'crime of crimes'.

Despite the Convention, however, genocide has recurred at an alarming rate, with very little effective effort made by the international community to halt or prevent its recurrence. It has taken place in every decade and on every continent: in (to give only a few examples) Indonesia in 1965, East Pakistan (now Bangladesh) in 1971, Cambodia between 1974 and 78, Guatemala between 1981 and 1983, Iraq (against the Kurds) in 1987-8, Bosnia (against Muslims) between 1991 and 1995, Rwanda in 1994, Kosovo against Albanaans in 1998-9, Sri Lanka in 2009. Many would argue it is taking place today in Darfur, in the DR, in Burma, in Syria, in Iraq against Yezidis, and more generally in the Middle East against Christians.

There is therefore a prima facie case for thinking that the issue of genocide might loom quite large among society's ills and that psychoanalysis might have something useful to say about how we might think about it. Before looking at this, however, it is important to be clear about what genocide is (and what it is not). The Convention defines it as set of 'acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such'. The acts are also defined: killing; causing serious bodily or mental harm; deliberately inflicting conditions of life calculated to bring about physical destruction; imposing measures intended to prevent births; and forcibly transferring children of the group to another group. What connects them and was particularly important to Raphael Lemkin, the originator of the concept and the man who did far more than anyone to persuade the international community to adopt the Convention, is the idea of group destruction as a fundamental assault on humanity. Lemkin conceived of humanity as inherently and essentially diverse. Genocide was, in his view, a fundamentally destructive project to alter or re-engineer humanity by eliminating one or more of its constituent elements.

The scale of the destructive project of genocide is therefore considerable. It is about more than killing large numbers of people (though it almost involves huge loss of life), or the pain and suffering involved in any of the acts specified in the Convention. It requires the resources of a modern state to achieve its implementation, the mobilisation of large numbers of people prepared to carry out the task, effective organisation and control over land and space. Modern states have control over the latter, as they are sovereign bodies with a monopoly on the means of violence and coercion inside internationally recognised borders. They have several key apparatuses - including armies, police, bureaucracies at central and local level. And they have leaders with acknowledged authority, who can direct these apparatuses to carry out their plans and intentions.

A key question then is how and why the intention to commit genocide arises. What kind of imagination is required to conceive of genocide in the first place, to imagine a world in which a designated group has been removed (in whole or in part)? What, from a psychoanalytic perspective, might shape the fantasies held by genocidal elites when they come to imagine that it is both possible and desirable to use the apparatus of a modern state to destroy a group of fellow citizens?

This not to ignore the question of mass participation in the apparatuses of destruction, those formally set up to carry out the killing (such as armies and police) and those set up less formally often for such purposes, such as paramilitary forces. Considerable debate has raged for some time about what motivates 'ordinary' men and women, but this has largely been dominated by social psychology rather than psychoanalysis and has focused, especially since the pioneering work of Stanley Milgram in the 1960s and Philip Zimbardo in the 1980s, on situational explanations, rather than the internal world that has more been the object of psychoanalytic enquiry.

One significant piece of evidence about the genocidal imagination is available to us in the form of a recorded interview of a speech made by the SS Heinrich Himmler in 1943, in Poznan in Poland, to top officials in the Nazi state who had been charged with and carried out the mass killing of Jews in the Holocaust. In this speech, Himmler openly acknowledged what had been done and took and sought to share full responsibility for it. At the same time he insisted on the need to keep it a secret. He also described those who had carried out the killing as people who had remained 'decent' throughout an act, in what he called 'a glorious chapter' in their shared history.

The great Holocaust historian Saul Friedlander has suggested that this speech poses a major challenge to historians, partly because of the way Himmler used apparently recognisable moral terms . How can one imagine the world from Himmler's perspective (or indeed that of his audience)? Friedlander talks of our being 'blocked at the level of self-awareness.'

Perhaps psychoanalysis, as he suggests, can offer some insight here (and Friedlander himself uses Freud's notion of the uncanny in very interesting ways). But we might also be able to unpack some of what is going on here by thinking about what is being said not only about the other (the targeted group) but about the self, about how these might be related, and about some of the tensions or contradictions in what is being expressed.

The picture Himmler paints of Jews for his audience is of a threatening and harmful foreign body (a 'bacillus') that has to be destroyed before it can destroy the self. It corrupts by its very presence and there is an acute anxiety about contamination. But the image is more than pseudo-medical or biological. There is something about strength and weakness here that appears quite contradictory. Jews are said to be both sub-human, and inferior and contemptible; but they are also extremely powerful and dangerous.

The perpetrator group is, on the other hand, strong and powerful, but it is also acutely vulnerable. It is confident, able to do the most difficult things yet fearful and anxious. It looks forward to, and is building a glorious future, yet this is imperilled in the moment in an alarming way. There seems to be some tension then between a defensive posture and a euphoric one. It may be no accident that the decision to exterminate the Jews appears to have been taken (although there is a lot of debate between historians about this) at the moment when the Nazis seemed on the verge of total victory (in the summer of 1941). It is as if they imagine that there are no restrictions on what they can now do, no boundaries they cannot cross. But this sense of omnipotence is not secure and perhaps this is because what has to be attacked is not so much outside as within, split off and projected. It cannot be destroyed without more and more violence, which is needed to reassure the self that it is intact; the violence therefore has to keep being repeated and escalated to greater and greater levels.

These are of course only some initial thoughts about what might be involved in the genocidal imagination. This might be an atypical case or it might, by virtue of its very radicalism (because in this case the project was one of total destruction), highlight some fundamental elements. But what it suggests is that it may be possible to think along these lines about a genocidal state of mind from within, despite the horror and shock it rightly and necessarily provokes. We might need to do so more than we are currently, if we are to respond more effectively to a crime which is committed both against an acutely vulnerable group and against humanity itself, and which continues to so haunt us today ■

Philip Spencer is...

Treating the untreatable?

continued from previous page

the rate of recruitment of offenders into MBT treatment groups, which has been slower than anticipated. Moreover, the pool of offenders from which we are recruiting is potentially even more difficult to engage in treatment than the wider population of people with ASPD. To be eligible for these MBT treatment services, the offender has to be being managed by the National Probation Service: the part of the old probation services that has remained state funded and which manages the highest risk offenders. Offenders assessed as being low to medium risk are now managed by the private sector via the newly established Community Rehabilitation Companies (CRCs). Efforts to boost recruitment have included changing our entry criteria so that MBT treatment may not always be completely voluntary for the offender, as originally planned, but may be made part of the offender's licence condition or sentence plan. This 'assisted compliance' marks a shift in our thinking which has challenged how we conceptualise the benefits or not of treatments that are, at least in part, mandatory. Other related difficulties encountered in the implementation of the project have been how to negotiate complex issues of information and clinical governance, such as confidentiality, information sharing and recording information between two organisations with very different cultures and ethos – the NHS and the Criminal Justice System – exposing tensions as to whether our primary aim is to reduce risk to others or to improve health outcomes for offenders.

These difficulties notwithstanding, all sites are now operational and treatment groups have commenced. Half of the sites have also recruited ex-offender service users or 'experts by experience' to help in the recruitment and retention of offenders in treatment. We ensure that all the teams meet regularly to discuss clinical and service issues and to learn from each other. The excitement and enthusiasm of the members of the MBT teams in developing these much needed treatment services has been heartening. The services are becoming more established and welcome within the probation service, as well as in prisons where we are recruiting many of our participants before their release. Although it is early days and the services have yet to be properly embedded and evaluated, preliminary reports suggest some positive outcomes, such as decreased rates of recalls locally. Most importantly we have been able – for the moment at least – to take advantage of an opportunity to offer therapeutic input, informed by psychodynamic and psychoanalytic principles, for a neglected population which historically has found it very difficult to access treatment of any kind ■

Girls are....

References

Allen, J.G., Fonagy, P., Bateman, A. (2008). Mentalizing in clinical practice. American Psychiatric Press.

Bateman, A. W. & Fonagy, P. (2004). Mentalization-based understanding of borderline personality disorder. In Psychotherapy for Borderline Personality Disorder, mentalization-based treatment, Oxford University Press, Oxford.

Bateman, A. W. & Fonagy, P. (2006). The structure of mentalization based treatment. In Mentalization-Based Treatment for Borderline Personality Disorder, A. Bateman & P. Fonagy, eds., Oxford University Press, Oxford, pp. 37-59.

Bateman, A. W. & Fonagy, P. (2008) 8-year follow-up of patients treated for borderline personality disorder: mentalization-based treatment versus treatment as usual. American Journal of Psychiatry 165 (5): 631-38.

Bogaerts, S., Vanheule, S., Declerq, F. (2005). Recalled parental bonding, adult attachment style and personality disorders in child molesters: a comparative study. Journal of Forensic Psychiatry and Psychology 16: 445-58.

Coccaro, E. F., Harvey, P D., Kupsaw-Lawrence, E., Herbert, J L., Bernstein, D P. (1991). Development of neuropharmacologically based behavioral assessments of impulsive aggressive behaviour. Journal of Neuropsychiatry & Clinical Neurosciences. 3(2): S44-51, 1991.

Coid, J, (1992). DSM-III diagnosis in criminal psychopaths: a way forward. Criminal Behaviour and Mental Health 2: 78-94.

Frodi, A., Dernevik, M., Sepa, A., Philipson, J., & Bragesjo, M. (2001), Current attachment representations of incarcerated offenders varying in degree of psychopathy. Attachment and Human Development 3(3): 269-83.

Fonagy, P., Target, M., Steele, M., Steele, H., Leigh, T., Levinson, A., & Kennedy, R. (1997) "Morality, Disruptive Behaviour, Borderline Pd, Crime and Their Relationships to Security of Attachment," in Attachment and Psychopathology, L. Atkinson & K. J. Zucker, eds., The Guilford Press, New York.

Home Office & Department of Health (2002). Managing Dangerous People with Severe Personality Disorder: Proposals for Policy Development. HMSO.

Joseph, N., Benefield, N. (2012). A joint offender personality disorder pathway strategy: An outline summary. Criminal Behaviour & Mental Health 22: 210-17,

Levinson, A. & Fonagy, P. (2004). Offending and attachment: the relationship between interpersonal awareness and offending in a prison population with psychiatric disorder. Canadian Journal of Psychoanalysis 12: 225-51

McGauley G, Yakeley J, Williams A, and Bateman A. Attachment, Mentalization and Antisocial Personality Disorder; the possible contribution of Mentalization-Based Treatment. European Journal of Psychotherapy and Counselling. 2011; vol 13. No 4: 1-23 . http://dx.doi.org/10.1080/13642537.2011.629118

National Institute for Health and Clinical Excellence (NICE) (2009). Antisocial Personality Disorder: Treatment, Management and Prevention. NICE Clinical Guideline 77, Full Guideline. National Collaborating Centre for Mental Health, Commissioned by the National Institute for Health and Clinical Excellence.

Pert, L., Ferriter, M., & Saul, C. (2004) "Parental loss before the age of 16 years: a comparative study of patients with personality disorder and patients with schizophrenia in a high secure hospital's population", Psychol. Psychother., vol. 77, no. Pt 3, pp. 403-407.

van IJzendoorn, M. H., Feldbrugge, J. T., Derks, F. C., de Ruiter, C., Verhagen, M. F., Philipse, M. W., van der Staak, C. P., & Riksen-Walraven, J. M. (1997). Attachment representations of personality-disordered criminal offenders. American Journal of Orthopsychiatry 67(3): 449-59.

Weeks, R., Widom, C.S. (1998). Self-report of early childhood victimization among incarcerated adult male felons. Journal of Interpersonal Violence 13: 346-61.

Psychoanalytic Psychotherapy NOW

Female violence and intimate relationships

By Anna Motz

Finding the hidden aggression in toxic couples

We need to acknowledge and understand the often overlooked reality of female violence in the context of destructive, perverse and violent partnerships, or 'toxic couples'. This violence can be understood as a reflection of unconscious forces, often in direct contradiction to what the woman consciously wants. Such violence, that the woman directs against her partner, her children or her own body, is often hidden from view, enacted in secret in the private domain of the home, and in in unseen places on the bodies or on victims who can not or will not speak about it, out of fear or shame. Its hidden, clandestine nature is mirrored in the common societal response: a denial of such violence altogether that perpetuates the mythology of female passivity. To ignore female violence is to deny female agency and to fail to protect those children and adults who are at risk.

Intimate partner violence is a major public health problem, and the understanding and research offered by attachment theory and forensic psychotherapy offer effective models for its assessment and treatment. While the criminal statistics point to the fact that men are more likely than women to perpetrate violence against women (Wykes, 2009), recent literature shows that the problem of female-perpetrated violence is greatly under-documented across cultures, with one in five men reporting having experienced interpersonal violence (Damarais et al., 2012).

I have assessed and worked with partners in abusive relationships, using a psychotherapeutic approach, focussing on those couples whose attraction is based on malignant forces, often unconscious, but always compelling. These perverse couplings can be highly addictive and the bond between the pair appears to be based on a shared need to engage in abusive practices. The role of both partners in the dangerous and compelling patterns of interacting that underpin violent and sado-masochistic relationships requires analysis, and their respective contributions disentangled. As Joanna Rosenthall describes, 'It is not unusual to see couples who repeatedly enact hate-filled scenarios with each other, which often cause pain in their most vulnerable area, and yet these couples are unable to part.' At times the perverse activity of the couple extends to their own children, or those of others, viewed largely as objects to be used for their own gratification. This can take the form of sexual, emotional or physical abuse, in which children are wholly objectified.

The mythology of domestic violence is that it consists of a male perpetrator acting against a victim (often female). In contrast, within a toxic relationship it is the interaction of the two individuals that creates this destructive force, even when one partner is the principal enactor of the violence. As I have argued, here and elsewhere, it is often overlooked that the woman can be the primary aggressor, using her partner as an object onto which to project her own feelings of disgust, humiliation and unworthiness. He in turn becomes the 'poison container', filled with shame and a sense of degradation. Sometimes women unconsciously locate their own aggressive impulses into their partners, and this frees them temporarily from awareness of their own violent wishes towards others.

The nature of the bond between women who have been sexually abused and their abuser can be seen as a malignant attachment – this is clearly the case in incestuous relationships, where a child or adolescent has been forced or seduced into a sexual relationship with a parent or sibling. When these abusive relationships are re-created in later life, women as well as men can inflict serious levels of harm on one another, and on children within their household. The consequences of incest are profound for both male and female children, but the stigma of female sex offending makes it particularly difficult for boys to disclose their abuse, especially if their perpetrator was their mother. As in other cases of child abuse a woman who has been abused early in life may later perpetrate a similar violation against another, vulnerable, person, often a child. This reflects the psychic defence of identification with the aggressor (A. Freud, 1936); she attempts to rid herself of shameful and unwanted feelings by treating the child as the degraded object of adult desire, and target of rage, or 'poison container' as she once was.

In the following clinical illustration the female perpetrator, herself the subject of sexual and physical degradation and trauma in her own early life, later re-enacted physical and emotional abuse in relation to her male partner, and emotionally deprived her children. She was also capable of showing great love and care to them, which surprised her, but offered some hope in her capacity for change.

Initial Referral and Background
M, a 38-year-old woman, was referred to the forensic service initially because of child protection concerns, and readily agreed to engage in treatment, describing how hard she found it to control feelings of depression and aggression. During the course of assessment for psychotherapy she also revealed a long history of violence towards her partner, beginning during her first pregnancy. Generally, intimate partner violence begins in pregnancy with the male assaulting the female, and her unborn child, but in this case she had herself started to 'lash out' at him, and her self-harm had intensified. She was able to describe how alienated and invaded she had felt by the baby growing inside her, and how terrified she was of giving birth to an alien. Her fear and growing violence towards herself and others offered clear evidence that the image of pregnancy as a time of peace, contentment and fulfilment was far from accurate, particularly in the case of this woman, with her own profound disturbance about her own mothering, capacity to mother, and hatred of her female body itself. In her own childhood her mother had been physically and emotionally violent towards her.

Countertransference issues
It was clear that there was a risk of becoming another 'toxic couple' with M, and having the therapy become a hostage to her assaults on the work. She and I needed to find a way of collaborating and enabling the therapeutic space to be one in which thoughtful exploration could take place, rather than an intense, fraught environment that relied on actions rather than emotional engagement. She arrived at sessions in a highly guarded fashion, and sometimes argued with her husband - who always accompanied and waited for her - on the way in, as though discharging difficult feelings before meeting with me. This put me in the position akin to a child, watching parents fight, and feeling helpless, collusive and frightened. She walked robotically to the room and held herself stiffly, showing me she was 'on guard'.

In the room, I often found myself warding off indirect threats in the form of attacks on the work itself, or through elaborated fantasies of what she would like to inflict on other professionals, and on people who let her down. Although she saw me as 'good' I was aware how quickly, and dramatically, this could switch. In this state of paranoid-schizoid functioning it was impossible for her to hold the awareness of mixed feelings in mind, or to forgive me my imperfections. At times I felt I became a hostage, frightened to miss a session or show any kind of weakness or failure; gradually I was able to discuss this with her, making links between this experience and her own projected fear of vulnerability.

At times I felt battered by her, and almost scared to speak, but when I suggested to her that she was communicating her wish to silence me, alongside her hope that I would be able to bear her anger and threats, she softened and became accessible to exploring her own fears of vulnerability, shame, and abandonment. I felt that I needed to summon up all my strength and courage to confront the power of her intimidation, and aggressive and destructive feelings conveyed through a real threat of violence in the room. It seemed essential that I could bear and articulate this, but it was, at times, difficult for me to keep this thought

alive. The unconscious wish for me to stay strong and thoughtful was in sharp contrast to her conscious challenges to me. At times I felt in identification with her husband, and the children, who had both relied on and feared her.

During the sessions M frequently described her vicious assaults on herself, including cutting herself internally. She was able to think about how she had herself identified with her abuser, treating her body with contempt and retaining a sense of suspicion about herself. We were able to consider how she had internalised him, attacking her body through brutal acts of self-harm. I felt that I was unconsciously invited to both participate in and become witness to this savage self-treatment.

She began to disclose more about her physical and verbal attacks on her husband, who seemed to tolerate these in what seemed a form of masochistic surrender. She did not harm her children physically, but she found it difficult to show them love or tenderness, and regretted this. When she eventually made the link between her own parents' violent interactions, her mother's abuse of her, and her own treatment of her family, she seemed to become less wedded to her own aggression, and more in touch with her wish to engage in loving interactions. Over the course of the therapy she gradually reduced her violent assaults on her husband, and she self-harmed less frequently and with less destructive methods. She found herself more able to engage in play with the children, and to tolerate their need for her, bringing dreams of childhood games into the sessions with me.
By the ending of the work she felt less frightening, and less frightened, but still retreated into her world of violent fantasies at times of stress. Interestingly, she controlled the timing of the ending, and chose to leave just short of the 18 months agreed. I noted my sense of sadness that this complex and difficult work was ending, in contrast to the apprehension with which I had begun.

Concluding Comments: The Impact of Intimate Partner Violence on Young Minds

In my clinical experience over the past 24 years I have been struck by how adult forensic patients, both male and female, vividly report their early fear and horror as they saw one parent brutalise another, and, how some describe their rage that the victimised parent repeatedly protected and forgave their aggressor. Many these patients have repeated the patterns of their parents' violence in their own relationships, while others feel that they are still too affected by this exposure to form any partnerships at all, choosing to remain in a frozen state of isolation and apparent self-reliance. Using perversions, including the violence and threats, can be a means of securing a false sense of confidence in one's capacity to manage the threats posed by intimate relationships. The need to control the other is a central feature of perversion, offering the promise that the object will not threaten the individual, either through abandonment or engulfment (Glasser, 1979.) Giving pain felt far safer than facing the risk of receiving it, and returning to a place of humiliation and fear. It was essential for this work that I was not pulled into a sado-masochistic relationship but remained able to think with M about the feelings that underlay her violence. The links between her past experience as victim, and current role as perpetrator needed to be made explicit, within a containing therapeutic relationship, so that she could begin to integrate these unacceptable aspects of herself including shame, helplessness and vulnerability, rather than project them into her partner, whom she would then attack.

Viewing domestic violence as simply an expression of the male wish for power and control is reductive and inaccurate, as Dutton and Nicholls (2005) describe: 'A case is made for a paradigm having developed among family violence activists and researchers that precludes the notion of female violence, trivializes injuries to males and maintains a monolithic view of a complex social problem' (2005:680).

Anna Motz is...

References

Desmarais, S. L., Reeves, K. A., Nicholls, T. L., Telford, R. P., & Fiebert, M. S. (2012) Prevalence of physical violence in intimate relationships. Partner Abuse, 3(2)
Dutton, D. G., & Nicholls, T. L. (2005). The gender paradigm in domestic violence research and theory: Part1, The conflict of theory and data. Aggression and Violent Behavior, 10(6), 680-71

Motz, A. (2008) The Psychology of Female Violence; Crimes Against the Body, Second Edition. (Hove: Brunner Routledge)

Motz, A. (2014) Toxic couples: The Psychology of Domestic Violence (Hove: Brunner-Routledge)

Rosenthall, J., 'Perversion As Protection', in Clulow, c. (ed), Sex, Attachment and Couple Psychotherapy: Psychoanalytic Perspectives (London: Karnac Books, 2009)

Welldon E.V. (2012) 'The Malignant Bonding', in Therapeutic Milieu Under Fire, Adlam et al. (eds.) (London: Jessica Kingsley Press)

Wykes M. and Welsh K. (2009) Violence, Gender and Justice. London: Sage.

Psychoanalytic Psychotherapy NOW

Bullying in couple relationships

By Joanna Rosenthall

BULLYING IS any kind of oppression in which by means of power, violence, cruelty and perversity, one side forcibly tyrannises and subjugates another. Clinicians seeing couples will be familiar with seeing cruelty enacted in front of them, and can't help being aware of the challenge to maintain thinking and thoughtfulness when faced with bullying and sado-masochistic interactions.

Some basic thoughts:

- Bullying, like cruelty, is part of the human condition.
- Bullying and cruelty can become extreme when there's no love to temper them.
- Bullying and cruelty are a common occurrence in relationships and could be said to be ordinary.
- The more vulnerability there is, the more room there is for cruelty to take hold, either as perpetrator or victim.
- Anxiety about identity often arouses an acute intolerance of difference either in the self or the other.
- Bullying always takes place within a relationship.
- It's important to know about our own capacity for cruelty so that we can address it in others, without shock or condemnation.

Seeing an individual, you might want to consider why someone takes up a victim or a bully role, but with a couple the important difference is that there are two people. You can't have a bully without a victim or a victim without a bully. It's not enough to understand each person and their motivation for being cruel or masochistic. When a couple come for help, the couple relationship is the entity coming for help. As a couple psychotherapist, one is primarily aiming to understand the psychic system operating between them, as well as understanding their valency for bullying-type relationships, whichever position they have a tendency to take up.

In couples, there seems to be an intensifying of raw feeling, impulses and behaviours in which cruelty is lived out as well as a relaxing of inhibitions, all of which allows for a reliving of early, primitive feelings of both love and hate. This might be partly due to the fact that the couple relationship is also a physical relationship, as is that between mother and baby.

In addition to this added intensity, we also have to take into account that inflicting pain on others or wielding power can be pleasurable and exciting. It is observable that the dominance of the bad self over the rest of the personality often has an excited or addictive quality, and that this quality can invest cruel, bullying behaviour with a life and momentum of its own. This excitement suggests sado-masochism and not simply aggression.

Being in a couple relationship presents the partners with a dilemma of maintaining enough of a sense of separateness and individuality and, at the same time, of each partner also experiencing enough intimacy. This dilemma has been eloquently and vividly described as a universal, primitive dilemma for us all in Glasser's (1979) description of the core complex. Like the infant, each partner needs intimacy and closeness but, at the same time, closeness brings with it terrors of annihilation and merger. If separate, the individuals have their own thoughts, feelings and desires, but too separate and they're cut off and desolate, unable to get the nourishment they need from intimacy with an other. If overly close, then the individuals are no longer isolated, but the new threat is one of suffocation and claustrophobia. A couple needs to find a way of allowing enough of each person's individuality at the same time as allowing for enough of an intimacy and a shared enterprise. These terrors are especially strong for an individual whose mind is relatively unformed and undeveloped.

This very dilemma, that's so relevant for couple relationships, has been captured beautifully by the German philosopher Schopenhauer, who told the story of the porcupines at night. They are cold and huddle together for warmth and to ensure survival, but as they get very close, they prick each other with their quills and must move further apart. However, when they do they get cold again…

Of course it's not as simple as the porcupines' dilemma, because each individual in the couple is also different in their needs for intimacy and separateness, and in addition these needs change day by day and also over time. There's never a perfect position for both people. What's needed therefore is a flexibility and a capacity to bear disappointment for when you don't get the intimacy you need at the time when you most want it. Most couples struggle with this; they may argue, even fight about who is going to get their way, who's right and who's wrong. All of this is ordinary. What's problematic is when a bully/victim quality enters the relationship.

There's plenty of evidence that partners unconsciously 'choose' each other on the basis of finding someone who will receive one's own unbearable parts. Each partner is a willing recipient of the other's projections. A couple relationship can be conceived of as 'a mutual transference relationship' (Ruszczynski, 1993). An everyday saying - 'opposites attract' - captures this more simply. Initially, each person is relieved of unmanageable parts of their own experience, leading to a wonderful feeling of acceptance and love. Freud himself likened it to delusion (1930a, p.56), and without doubt that there is a repudiation of reality. There is probably a shared phantasy that these difficult parts of the self need never be faced again, which might explain the experience of elation.

Falling in love has a parallel with the passionate first love between mother and baby. After infancy there continues to be a longing for a primitive state of fusion, where all needs are taken care of and no frustration is experienced. Falling in love can temporarily 'provide it.' The desire for the ideal, and the phantasy that it exists, is a primitive and powerful psychological force that very often drives the early stages of a relationship.

This produces a painful paradox: the individuals are now in close daily contact with those very aspects of themselves that they can least manage. The projected parts, now located in the other, cannot be forgotten as they tend to be frequently enacted in everyday life, although now experienced as emanating from the other and not within the self.

McDougall (1986) describes individuals who cannot manage to apprehend the facts and details of their lives and resort to externalising inner conflicts by various means, for example by relying on substances like drugs or food, or else on other people. She describes a 'transitional theatre' in which the individual plays a part and chooses others to enact parts that cannot be borne psychically. 'The wish behind such complicated dramas is to try and make sense of what the small child of the past, who is still writing the scripts, found too confusing to understand' (p.65). These individuals join together and find a way of being that she calls 'action symptoms', which binds together psychic experiences that cannot be borne or known about. An example of this is a

bully-victim interaction. In a couple both partners derive relief from externalising unresolved mental pain. At the same time, this defensive strategy tends to mean that the relationship can only take place in a restricted zone, which may look deeply unhappy, even hate-filled, to the observer. The couples, too, often come and express with incredulity that things are so awful, they just can't understand why they are still together.

Imagine a toddler who was left unexpectedly by his mother. When he realized she wasn't returning immediately, he screamed loudly and threw himself on the floor, sobbing uncontrollably for a long time; it was almost impossible to reassure or comfort him. He was simply expressing an outburst of uncontrollable rage and pain, wanting the pain to be removed, evacuating something that couldn't be borne.

Adults who have not achieved the capacity to bear pain demonstrate an intolerance of separation and difference that can lead to refusal to accept another's viewpoint, at one end of the spectrum, through to impairment of reality testing, psychosis, suicide and even murder, at the other.

When individuals don't achieve this development, the experience is a repeated traumatic one which Bion described as the looming presence of 'nameless dread', and Meltzer (1973) described as 'the bedlam of infantile anxieties.' The individual is then only able to deal with these states by wishing them out of awareness, sometimes through phantasies of being able to evacuate them, as if they were a physical product like faeces or urine, or else by binding them up by using an object, like a partner, or a substance like alcohol, in a particular way.

When two individuals, both of them unable to bear mental pain, come together to form a couple system, the level of primitive experience can feel un-survivable, and therefore they have to find a way together of binding it up, or defending against it, even if it means forming a very unsatisfying kind of relationship with a sado-masochistic quality.

There may be lots of different kinds of violence and aggression that are fuelled by different states of mind. I've definitely noticed the two different kinds that Glasser outlines (Glasser, 1979a, 1998) in the couples I see.

One seems to have a purer form, or do I mean a more primitive form. It appears to be borne out of desperation to survive; the threat might be experienced as either abandonment or smothering or as a direct assault. It has a desperate intense quality as if life depended on it. Its aim is to get rid of the threat. When it's expressed it feels shocking and frightening to experience so much uninhibited rage in the consulting room. In Glasser's terms this is self-preservative aggression, and its purpose is to eliminate the other who is perceived as life-threatening.

However, when the object that is perceived as threatening is also the object depended upon for survival, this poses a dilemma, either for the child or the adult. How can the child survive if it can't get rid of the mother? Some people find a solution, which is to libidinise the aggression (Campbell, 2005). The aggression no longer has the aim of getting rid of the object but instead of controlling the object in a libidinally gratifying way. The aggression is then infused with cruelty, and the interaction mirrors this and becomes sado-masochistic. This kind of rage and violence seeks to control the other, and the aim is to cause the object to suffer.

Ruszczynski makes the point in one of his papers that both forms of aggression aim for domination and control; however, 'in self-preservative aggression it is utilized to negate danger, whilst in sadism it plays a central role in entrapping and engaging the object' (Ruszczynski, p30).

In the consulting room I'm not sure that I ever see one kind without the other. It's likely that the first often turns into the second, because couples who are functioning at this primitive level often form a shared sado-masochistic defense in order to manage their vulnerability and in order to keep certain realities at bay, especially those that involve a disavowal of the differences between the sexes and the generations.

Individuals in this situation potentially experience life as a series of traumas and try to form a relationship with each other which will remove the pain, even though it has been replaced with a cruel, sometimes violent relationship. In Bonner's words: 'the Other exists as a soothing function, not a real person' (2006, p.155).

This kind of relating is fuelled by 'psychological perversion' (Bonner, 2006), meaning 'not the more obvious quest for excitement by aberrant means, but as a person's last effort to protect himself from anticipated psychological breakdown, in which excitement serves as a smokescreen hiding the internal terror' (p. 1549). As a result of this desperate quest for survival, neither of them are able to experience each other as the people they really are, but instead only as players in an already fixed, repetitive and defensive scenario. This kind of relationship may be a compliant one, or it may be almost constant excited, sado-masochistic fighting, but what is essential about it is that it is a ritualised enactment which enables both parties to escape the raw emotional, 'nameless dread' experience which threatens to overwhelm them.

The tragedy of couples stuck in this scene is that when they sought help for this from each other, they found someone who enforces the early trauma, that no-one is there to help, leaving them desperate, raging and in despair and as a last resort, using a repetitive cruel arguing as possibly the only available method of managing their shared vulnerability ■

Joanna Rosenthall is...

References

Bonner, S., (2006), A Servant's bargain: Perversion as survival, in: International Journal of Psychoanalysis, 2006;87:1549-67.

Campbell, D., 'Perversion – sadism and survival,' in Budd, S & Rusbridger, R., Introducing Psychoanalysis.' Pp.231-246

Freud, S., (1920) 'Beyond the Pleasure Principle,' S.E., 18: 1-64

Glasser, M., (1979). 'Aggression and Sadism in the perversions.' in I. Rosen (Ed.) Sexual Deviation. Oxford: Oxford University Press.

McDougall, J. (1986), Theatres of the Mind. London: Free Association Books.

Ruszczynski, S., (1993,) Thinking about and Working with Couples, in Psychotherapy with Couples, ed: S. Ruszczynski.

Psychoanalytic Psychotherapy NOW

Forensic psychotherapy: the psychodynamic understanding of perversion, violence and criminality

By Estela V. Welldon

Using Mentalization Based Treatment for antisocial personality disorder in the community.

FORENSIC PSYCHOTHERAPY's aim is the psychodynamic understanding of the offender and his consequent treatment, regardless of the seriousness of the offence. It involves the understanding of the unconscious as well as the conscious motivations of the criminal mind, and of particular offence behaviour. It does not seek to condone the crime or to excuse the criminal. On the contrary, the object is to help the offender to acknowledge his responsibility for his acts and thereby to save the offender and society from the perpetration of further crimes. One of the problems in achieving this object is that the offender attacks, through his actions, the outside world - society - which is immediately affected. Hence, concerns are rarely focused on the internal world of the offender. It is time to re-focus our concerns, at least in part. The more we understand about the criminal mind the more we can take positive preventive action. This, in turn, could lead to better management and the implementation of more cost-effective treatment of patients.

The forensic patient is unable to think before the action occurs because he is not mentally equipped to make the necessary links (Bion 1959). His thinking process is not functioning in his particular area of perversity which is often encapsulated from the rest of his personality. This therefore is the work of therapy, but at times the patient's tendency to make sadistic attacks on his own capacity for thought and reflection is projected and directed against the therapist's capacity to think and reflect, and it is then that the therapist feels confused, numbed and unable to make any useful interpretations. Such patients fear transformation, since it is felt to endanger their lives.

Acting-out behaviour, which is a constant trait in their personalities, is a substitute for verbal expression. Patients react, but these actions are devoid of any reflection. After all, that acting-out has a meaning, just like a dream, and instead of feeling hurt or annoyed at being 'got at' it needs the right interpretation. That alone, though, is not enough; even if it hits the spot and makes a strong impact, the impact will be short-lived because the compulsion to repeat is stronger than a quick insight into unconscious motivations. It requires 'working through' with more interpretations at different times; eventually no further acting-outs of that sort will appear.

Obviously, persistent acting-out indicates a deeper unresolved conflict that needs to be worked through from different angles. Acting-out is also a challenge to the system of boundaries, which has to be rigorous and strict with these patients. It is essential to take care of the analytic frame and to keep boundaries in respecting rules and regulations. The analytic frame is there to give a sense of safety and containment. Only when patients experience the setting as adequate will they feel (Winnicott) 'allowed' a process of playing and thinking. In their early childhoods, they were deprived of the elements of safety and containment, since their mothers failed to provide the holding that would later have allowed both safety and playing. That is why they are prone to act out, trying to break the analytic frame, such is the dread of feeling betrayed yet again by the significant other. This is a stagnant position where playing does not exist. It is here that transferential interpretations make a unique contribution since they will lead to a process of thinking. We should keep in mind Winnicott's axiom that 'Playing is the precursor of thinking.'

These patients are involved in actions against society and against themselves in extremely destructive ways, usually of either a sexual or a social character, involving perversions or serious antisocial behaviour. Sometimes this is well concealed; at other times, violence is openly expressed. Their actions towards others are characterized by a strong element of dehumanization; they are unable to consider others as full, separate/individuated human beings but just as a part of themselves, without much consideration about using or abusing them. There is a strong element of sexualization but without the habitual quality of care and love. These individuals as babies were treated as fetishes by their carers and as such experienced a total lack of control; they were at the mercy of the adults around them who were responsible for their maturity during their developmental process. This, obviously, was carried out in severe faulty ways, which as adults they tend to repeat in a compulsive way, unaware of why they are doing what they are doing. They have to keep a most tyrannical control of all circumstances and situations. At times they are drawn to most odd, bizarre scenarios, which they feel compelled to design and fulfil.

Furthermore, though the pervert knows that his action is wrong, he is unable to interpolate a thought about the consequences of his action for himself or others. He proceeds to act on the impulse because of some basic aspects attached to the 'bizarre', perverse action, which I shall attempt to underline. First, he acts impulsively because that particular action is the only one that provides him with immediate sexual gratification and release from unbearable anxiety. Second, in carrying out his 'bizarre' perverse action he is completely unaware of the associated symbolism; in other words, he is as baffled by his actions as are all other witnesses. There are specific feelings that are expressed by these patients in different ways from those expected with other patient populations. For example, shame is usually associated with being a witness to domestic violence, whereas remorse is frequently experienced afterwards by the perpetrators. Shame is focused on the witness's feelings of powerlessness and impotence, and it has a powerful impact, especially on the children involved.

This different set of feelings encountered in victims and perpetrators is of enormous significance, since shame appears in children in an almost automatic way. At times we experience a sense of inexplicability about children feeling shame, but its manifestation becomes obvious when we think how powerless and weak children felt in stopping their parents fighting or inflicting harm on each other and on others, including their own children.

Although shame and remorse share a sense of impotence, remorse is forever associated with a sense of irrevocability, even if associated with the need to reparation; what has been destroyed is something very valuable, and the act of destruction can never be reversed or remedied. Remorse only appears after a period of reflection and is usually associated with the capacity to think, previously cancelled out or obliterated. How often have I heard perpetrators, especially women whose children have been taken into care because of their own violence, saying with unbearable psychic pain: 'If only could I turn back the clock.'

Remorse is therefore comparable to grief, in that it is focused on the past and on the fact that something has been destroyed and lost. It relies on care and concern for what we value and necessarily involves an internal authority who is judging from within. The attitude of mind called up by the experience of remorse is focused not on action but on reflection, on contemplation on the damage done.

The remorseful individual gains release from his or her emotion by reliving a structurally analogous scene to that of the initial trauma. In Freudian terms, this is exactly a repetition of the compulsion currently used in the definition of post-stress traumatic disorder. The word 'trauma' comes from the Greek 'to wound' or 'to pierce'. Freud referred to trauma as a process that involves the breaching of a protective shield, which normally functions as a protection of the mind (ego) from internal and external stimuli. In remorse, the guilty feelings occur after the acting-out; in other words, after the hostile impulses have been performed, the person will feel remorse. Actually, guilty feelings may prevent the acting-out of hostile tendencies and may become preventative because they have a sort of premonitory quality. The important thing, though, is that the unconscious makes no distinction between feelings of guilt that appeared before the event, and remorse that is experienced after the event.

While incestuous parents as well as paedophiles involve themselves in child abuse and frequently have had a traumatic early childhood, their presenting problems and surrounding circumstances are quite different. Incestuous parents have been able to achieve a fully developed relationship with another adult and to have a family. In contrast, paedophiles target primarily under-age children, male or female, and they are not engaged in adult relationships.

Incest may be the outcome of a dysfunctional family dynamics, often including an external event such as a pathological bereavement. Paedophiles, on the other hand, do not present significant changes in their behaviour towards children related to external circumstances. Incestuous fathers shift from wife to offspring, whereas paedophiles may target women for their offspring. Furthermore, paedophiles have

intense fears of relating to their peer group—men and women. Their attitude towards the children involved is marked by intense externalization, rationalization, and justification of their actions, making themselves believe that initiation into sexuality by adults is a healthy process. Paedophiles also claim to be completely unaware of the serious long- and short-term consequences involved for the children they have abused, whereas incestuous parents are usually more aware of the long-term consequences produced by their actions, especially when they are taken into therapy.

Attitude towards treatment is also different. Incestuous parents are often more motivated, and frequently we see couples who come for treatment because of their incipient awareness of their need for understanding and professional help. In contrast, paedophiles rarely seek treatment voluntarily. In practical terms, risk assessment and dangerousness are quite different for both groups (so far as the two categories do not overlap, as sometimes could happen). Incestuous fathers, on the whole, do not present future danger to other children, while often paedophiles could, regardless of treatment and management, still offer future danger to children in general. Incest perpetrators have, if properly assessed and treated, a better prognosis than paedophiles.

I want to alert professionals to a particular pathology found during my clinical work with both victims and perpetrators of both sexes. This pathology at times links both categories of mothers alone with male paedophiles. Many single mothers who have children from either one or more partners find themselves on their own. It is not unusual for some men to leave the particular household after parenting one or more children because of the responsibilities associated with parenthood, and they go off to find another partner. The pattern may repeat itself many times. These women have been victims of sexual abuse themselves, are lacking in self-assertiveness, are depressed, have a low sense of self-esteem, feel despondent and valueless, and have very poor quality relationships or none.

Some of these women consider the children responsible for the absence of a man. They feel sexually abused by their partners, ostracized, unable to socialize, despondent, and depressed. Facing such predicaments, they fall into despair and start abusing their children, trying to obtain some comfort for their frustrated lives.

Other women continue their search for male companionship and, unable to meet them in the usual venues because of being house-bound, advertise in lonely hearts columns or through internet websites. They place adverts giving detailed and rich descriptions of their children, since they want to be open about what they consider to be handicaps in their domestic lives. In fact, these 'handicaps' will be quite a bait for male paedophiles, who readily answer such adverts and in no time make their way inside the domestic scene. Women in this position are taken by surprise. They can't believe their 'luck', because this man for the first time is so nice to the children. Women do not even mind whether they have sex or not, because they had lots of it before and it was very, very unsatisfactory. But they are delighted that he is so caring and nice to the children. A new relationship starts, and marriage follows. Eventually the incest or sexual assault or sexual abuse comes into the open, and often these men appear in reports as incest perpetrators because it happened inside the family, whereas they have been paedophiles from the beginning.

A confusion has been created, and as a result records may show inaccurate statistics.

I started in 1980 a group composed by both victims and perpetrators of sexual abuse. I owe most of my knowledge about these situations of sexual abuse from the interactions of the patients there. During group sessions when to my surprise I learnt from patients who had suffered from sexual abuse a rather coarse and unexpected classification of the abuse:

- A 'sadistic' one, in which the abuse took place after much seduction and grooming; and
- A 'benign' one, when the abuse was clearly violent, sadistic and unexpected.

This surprising classification, which reached general consensus among group members, had its own reasoning. In their own experiences, under the appearance of being rather soft and 'benign', the first one had created ambiguity, bewilderment, and a tremendous confusion, which they were left unable to disentangle from the abuser. The second one, instead, created a clear and raw sense of being really abused, and it was relatively easy to express alarm and anger and to rapidly push out forever the perpetrator.

Workers of all sorts involved in cases of incest frequently find it difficult to maintain a detached professional stance. They tend to take sides, usually becoming emotionally bound to the victims.

There is a strong tendency for the workers in incest cases to re-enact within their professional network the splits, denials and projections which are so characteristic of the experience of family members caught up in the dynamics of incest. In such circumstances, we professionals would do well to listen to one another, thus allowing healthy interactions in a different context. This could lead to better integration of professional workers dealing with members of a family involved in incest. So, in a sense, the patients could usefully become role models for the therapists. A crucial point about the discipline of forensic psychotherapy is that it is a team effort. It needs to be stated that this is not a heroic action by the psychotherapist alone.

Reviews

Boarding School Syndrome

(Routledge, £27.99) by Joy Schaverien. Reviewed by Annie Pesskin

Boarding School Syndrome is a thought-provoking new book by Joy Schaverien, an SAP Jungian training analyst, who has spent 25 years thinking about the ways in which being sent away to boarding school, particularly from an early age (seven or eight), can distort a child's emotional development. The book begins with a brief history of the boarding school as an institution, then moves into a detailed case study of a patient, Theo, whose therapy involved the rediscovery of traumatic memories through drawings of his boarding school days. In one particularly painful episode, Theo remembers a boy in his dormitory having a bad asthma attack. As the boy's laboured breathing became more and more frantic, Theo was torn between a wish to help him and a terror of the beating he would get if he got out of bed to help him. He didn't get out of bed. The boy didn't die. But the traumatic nature of this conflict stayed with him as a profound sense of guilt and an overwhelming experience of helplessness.

The helplessness of the little boy or girl, left in the care of complete strangers at a new boarding school, is a theme Schaverien elaborates in two later chapters – one on abandonment and the next on captivity. She uses extracts from memoirs by Roald Dahl and George Orwell to dramatize the ways in which the attachment system of the young child is severely disrupted by arrival at boarding school. In Roald Dahl's case, he remembers the headmaster's first smile as that of a shark eyeing up a little fish for his dinner – an image which captures two essential aspects of the traumatic situation arrival at boarding school presents – the passivity of the child who must submit to the fate his parents have consigned him to; and the profound sense of loneliness the child must endure separated from everything and everyone who is familiar to him.

Schaverien argues that coping with what is generally referred to as 'homesickness' requires acrobatics beyond the emotional skills of a seven- or eight-year-old child, and the consequence can be a cleaving of the personality into a prematurely-capable 'coper' and a helpless and terrified inner self whose capacity to trust in others is irrevocably eroded. Elaborating Winnicott's notion of a False Self to articulate this split, and Donald Kalsched's theory of the 'self-care system', she presents relevant case material to support her argument and argues, convincingly I think, that boarding school syndrome includes a cluster of symptoms involving 'encapsulation of self… that may last a lifetime.' The traumatised child inside the apparently independent and capable adult gets stuck there, with profound consequences for intimate relationships and a Winnicottian capacity to feel 'alive' as opposed to just 'living'.

There are other more subtle ways too that the boarding school child can remain 'stuck'. For example, an anecdote which occurred to my father (who was sent away at seven to board) when I mentioned I was writing this review was that of a man he regularly sees at his London club whose nickname is 'Rusty'. My father said he never called him by that name to his face, but that other people who had been at the same school as him also referred to him by this moniker. His name was Rusty because he had wet the bed so often that his bedsprings had begun to creak… Nearly 70 years on, this man was still known by the cruel nickname he had earned for a psychosomatic disturbance related to losing everything he held dear as a seven year old. I thought this was an interesting story for a number of reasons. First, through continuing to refer to this man as 'Rusty', all his peers were able to preserve and remember an important aspect of their own experience of emotional upheaval, while at the same time were able to project it into this man so he could carry it for them. Every time the moniker was used, 'Rusty' remained the mocked one, the wimp, the sissy, and the rest of them could feel satisfied by the feeling that the vulnerability was in him and therefore not in them.

Experiencing such total loss of the familiar as well as submitting to helpless captivity for a seven- or eight-year-old child must be classed as traumatic in the sense that it is more than the child is emotionally equipped to manage. The fact that many ex-boarders deny any traumatic consequences is in itself interesting. Are we psychotherapists therefore wrong to imagine every child is damaged by such an experience? What if the mechanism of projective identification buttresses some from experiencing the extent of their trauma by making a few sorry children the container for the traumatic feelings they don't want to feel?

Perhaps the story of Rusty illustrates a key way in which traumatic feelings can be projected out and then the container of them ostracized or ridiculed – in other words, bullied. From discussion with other clinicians, I notice that the patients who do come for help are often those who were badly bullied at boarding school. These patients were repeatedly subject to physical and emotional abuse at the hands of other children, normally for displaying signs of emotional disturbance, e.g. wetting the bed or crying themselves to sleep. They fulfilled an essential function for the group as a whole by being containers for the others' emotional 'rubbish'.

Boarding schools evolved to educate the sons of the land-owning classes, army personnel and the colonial administrators of the Empire. The Jesuits used to say that if you gave them the boy of seven, they would give you the man. What kind of man do boarding schools give you? If you explode attachments to family as young as seven, the child forms attachments to his peers. His school friends (assuming he isn't the bullied loner) feel like his family and it isn't hard to understand why the old boy network operates so effectively and endures for life, underpinned as it is by the strongest attachments human beings can make – to people who feel like family.

My father told me in passing two other facts. First, that on arriving at Oxford he had thought, 'grammar school boys were very exotic'; and that secondly, on leaving school his headmaster had told him, 'Chaps don't sleep with other chaps' sisters.' The implication being that they marry them instead. A 'chap' is someone like him, one of the In group; grammar school boys function as the Out group. Foreigners observing the English often remark on how class-bound they are. Nothing prepares a person better for English social apartheid than a boarding school from seven. Perhaps a first step towards building a fairer and more equal society in Britain would be to ban boarding schools. I'm in. Are you? ■

Annie Pesskin is...

Sexual diversity: a time of renewal for theory and practice generally?

Review of the BPC conference on Psychoanalysis and the challenge of sexual diversity, by Richard Jenkins

The BPC's professional stance on sexual diversity demands that the profession reframe its thinking about homosexuality. Does it signal a time for wider renewal?

How adequate is current thinking on homosexuality, in light of the profession's 2012 statement on sexual diversity? And do efforts to refresh theory in light of this renewed stance have implications for psychoanalytic thinking and practice generally? These were the questions raised and explored at a stimulating BPF event, Psychoanalysis and the challenge of sexual diversity.

To introduce the day, Juliet Newbigin traced the history of psychoanalytic thinking from Freud to the present day. She noted how the profession's stance had shifted from Freud's perspective of neutral observer to that of condemnatory social agent. Freud had stated that homosexuality was simply a 'variation of the sexual function' (Freud, 1935 /1960, p.43). For him, homosexuality originated in the universal bisexuality of the infant towards both parents, its persistence being explained by what he saw as a 'certain arrest of sexual development' in the journey through the Oedipal crisis towards (statistically) normative heterosexuality.

But for decades the psychoanalytic profession didn't think in neutral terms. In 1956 Bergler, based in the USA, wrote, '…homosexuals are essentially disagreeable people, regardless of their pleasant or unpleasant manner … [which contains] a mixture of superciliousness, false aggression, and whimpering … (Bergler, 1956, quoted in Lewes, 1995, p. 3).

The profession on both sides of the Atlantic has long disavowed this sort of attitude. But has it fully taken on board the psychological impact of such deeply ingrained homophobia? The United Nations human rights chief has said in a 2015 report that lesbians, gays, bisexuals and transgender people are victims of 'pervasive violent abuse, harassment and discrimination' in all regions of the world. Giorgio Giaccardi and Leezah Hertzmann grappled with just this. Giaccardi described from a Jungian standpoint the ways in which homophobic assumptions might distort the psychological development of those who experience same-sex attraction and the ways in which, from a teleological perspective, the psyche might develop through such defensive stages to a more integrated and stable position. Hertzmann, presenting a clinical example of work with a female couple, employed all of psychoanalysis' insights into the patients' inner world, but sensitively highlighted the ways in which such environmental homophobia can be recruited in super-ego development to impede the ability to accept and develop a loving relationship, including the ways in which this internalised homophobia might play out in the transference. David Richards also presented clinical material from a supervisory setting to explore an important transference issue, highlighted also by Hertzmann: that of the disclosure of therapist's sexual orientation. Can the therapist's reticence, so key to our neutral stance, repeat the traumatic silencing many lesbian and gay people consciously adopt as a strategy to get by?

What all of these various contributions highlighted was the need to take culture into account; first, in terms of responding to the contemporary lived experience of those with same-sex desire, and second, in reflecting on the adequacy and contingency of our theoretical formulations. Can we really read a comment like Berger's and not understand it as revealing more about the man, his time and place, than being anything to do with homosexuals? The point is highlighted if we delete 'homosexual' and replace it with any other category of minority community.

This need to think about culture surfaced in this event by repeated references to Lacanian thinking. Why? I suspect because Lacan takes culture into account as a psychological category in a way that

British object relations does not, with the latter's focus on the significance of the mother/child dyad as the key locus for psychological development.

French psychoanalysis, with its attention on the entry to the social sphere and initiation into its rules and taboos, provides a rich resource to consider how sexuality, gender and desire are culturally mediated categories. If, however, Lacan provides a way of thinking and talking about these things, his is not the only voice to which we might listen, and by no means one that we can engage with uncritically in this context.
Phil Goss, speaking from a Jungian perspective, explored one of the questions raised by reformed thinking about sexual desire, namely whether 'sexual difference' has any ongoing significance at all. Considering Lacan, but especially post-Jungian thinking on the contrasexual element within the psyche, Goss proposed that 'otherness' is a key component of developed sexuality however oriented. However, the experienced contrasexual within - symbolised according to Jung's (arche)typololgy of anima and animus – primarily reveals the capacity for relatedness itself rather than symbolising the search for a sexed and ultimately external object of desire.

Brid Greally also took up this question of sexual difference and explored it in light of Luce Irigaray, feminist critic of Lacan. Irigaray - for whom 'sexual difference is the question of our day' - critiques the construction of culture according to the economy of the phallic, all-knowing subject. Irigaray describes a feminine subjectivity famously symbolised by 'two lips touching'. In doing so she outlines a different economy, reclaiming bodily - and specifically feminine - knowing. There are dual consequences in this context: twoness no longer means that one must be subordinate to the other; and sexual similarity needn't entail psychological merging. Irigaray then offers a compelling theoretical alternative to heteronormative thinking about homosexuality which equates same-sex desire with narcissism and thinks only in terms of active/passive; male/female stereotypes.

I hope these snippets give a small sense of the incredible range of clinical and theoretical issues and formulations that arose in the course of just two days dedicated to thinking constructively about homosexuality and psychoanalysis today. The days left me feeling stimulated but also thoughtful.

One thought relates to the legacy and status of theory. In group discussions questions and anxieties were raised about whether the profession now had to jettison core psychoanalytic thinking about sex and gender. I don't know if they must be jettisoned, but my sense is they need to be reconfigured.

Freud's thinking about homosexual desire was a subset of his thinking about sexual desire understood as normatively heterosexual. To rethink the former demands a fresh look at the latter, including what we mean by 'theory'. Perhaps a hard case of that need is presented by how psychoanalysis might understand transgender issues. Are we even ready to go there?

Equally clear was the need for us to think more deeply and seriously about that other human perennial - our collective tendency to scape-goat those who differ from the cultural norm. I suspect if we could do that, we might unlock and bring alive much thinking on 'diversity', as well as gain insight into the repressed or 'shadow' aspects of those who identify with powerful cultural dominants, including the profession itself.

A not unconnected train of thought relates to the 'authority' of the profession to enunciate its views, and whether it can do so inclusively of those who are themselves lesbian or gay. Discussions about disclosure revealed that lesbian and gay practitioners feel reluctant to be open with colleagues, never mind patients.

Overall, however, I came away with a sense that these contributors were working at a clinical and theoretical leading edge, at least for psychoanalysis in the UK. Something had shifted I felt, and instead of feeling that psychoanalysis should somehow be able to 'explain' sexuality, there was a sense that contributors were affirming its enigmatic quality, its importance as a source of psychological growth and the inevitable variety of its expressions. In doing so, the event highlighted how much fresh thinking is happening – and how much is still needed.

Richard Jenkins trained at WPF Therapy and is a psychodynamic psychotherapist practising in central London at Southbank Counselling.

Routledge Advert

Letters

Dear Editor,

Reading the spring issue of New Associations I was struck, not for the first time, by what a conservative and self limiting discourse psychoanalytic psychotherapy remains, in spite of brave efforts to modernise it. Indeed it is in the very attempts at progress that the conservatism reveals itself, remaining locked into 1950s preoccupations with 'normality', the dyad as the principle therapeutic unit, and culture as an external discourse separate from the inner world.

The discussion of sexuality seems largely conducted in terms of what might be designated as 'normal' or 'natural', seeking only to extend the limits of those terms. Only the introduction of 'Queer Theory' shows any inclination to problematise the whole notion of 'normality'. The article about couple therapy suggests it is still seen as adventurous to move beyond the psychoanalytic dyad, although this particular adventure was pioneered by family therapists over fifty years ago and is now well established.

The discussion of culture asks, 'How can the external reality of the trainee be kept in mind as much as much as the internal reality?' But it is precisely this external-internal split that is at the heart of the problem. The anonymous gay trainee writing a few pages earlier says, tellingly, 'Sexuality is also not confined to nice neat areas of our lives. My homosexuality is in my childhood, it's in my ambitions and dreams, it's in my body, my mind, my soul, it's in my whole life.' The same is true of culture. And the same is true of racism in both perpetrators and victims. In modern social theory the isolated individual with an internal world separated from the social world has been replaced by an individual who is socially constituted and self constituting through a social process within a social context. But the fields of cultural studies, postcolonial studies and subaltern studies seem still undiscovered by psychoanalytic psychotherapy. As usual, 'class' and its cultural implications remains an invisible elephant.

Without addressing these issues, psychoanalytic psychotherapy seems destined to remain significantly identified with and embedded within the dominant socio-political discourse even as it attempts to question it ■

Best wishes,

Dick Blackwell

Diary

AUGUST

18 August 2015

THE MAN WHO CLOSED THE ASYLUMS: FRANCO BASAGLIA & THE REVOLUTION IN MENTAL HEALTH CARE

John Foot
Freud Museum, London NW3
www.freud.org.uk/events

SEPTEMBER

5 September 2015

WHO DARES DREAM? DREAMS IN BRIEF DYNAMIC THERAPY

Anna Bravesmith
WPF Therapy, 23 Magdalen Street, London SE1 2EN
www.wpf.org.uk

11 September 2015

THINKING ABOUT THE FAMILY: A PSYCHOANALYTIC APPROACH

TCCR, 70 Warren Street, London W1
www.tccr.ac.uk/cpd

11 September 2015

HISTORICAL ABUSE: WHEN ADULTS ABUSE THE CHILDREN IN THEIR CARE - WHAT ONE RETROSPECTIVE STUDY HAS TAUGHT US

Francesca Hume, Birgit Kleeberg
Tavistock Centre, 120 Belsize Lane, London NW3
http://tavistockandportman.uk/training/conferences-and-events

18 September 2015

OLIVER JAMES: FROM WRITING FOR PROFESSIONAL PEERS TO REACHING A WIDE AUDIENCE

TCCR, 70 Warren Street, London W1
www.tccr.ac.uk/cpd

18-19 September

THE GREENING OF PSYCHOANALYSIS

Jan Abram, Litza Green, Gregorio Kohon, Michael Parsons, Rosine Jozef Perelberg, Jed Sekoff, Fernando Urribarri
Institute of Psychoanalysis, London W9
Contact marjory.goodall@iopa.org.uk

19-20 September

HOW JOHN BOWLBY REVOLUTIONISED OUR UNDERSTANDING OF HUMAN RELATIONSHIPS

Chair: Sir Richard Bowlby
Institute for Child Health, London, Freud Museum / Anna Freud Centre
www.thebowlbycentre.org.uk/cpd

25 September 2015

ECHOES OF THE NURSERY: SIBLING TRANFERENCES IN THE ADULT COUPLE RELATIONSHIP

TCCR, 70 Warren Street, London W1
www.tccr.ac.uk/cpd

26 September 2015

WHAT DOES INTERPRETATION PUT INTO WORDS?

Michael Parsons
Danson Room, Trinity College, Oxford OX1
www.britishpsychotherapyfoundation.org.uk

26 September 2015

AUDIENCES WITH AUTHORS: DISABLING PERVERSIONS

Alan Corbett with Brett Kahr
37 Mapesbury Road, London, NW2
www.britishpsychotherapyfoundation.org.uk

OCTOBER

3 October 2015

DYNAMICS OF PERSONAL IDENTITY IN THE DIGITAL AGE

Brid Greally,& Anne Power
Wessex Arts Centre, Alton College, Hants GU34 2LZ
admin@altoncounselling.org.uk

10 October 2015

BEYOND THE HEART OF DARKNESS: THE SHADOW RE-VISITED

Christopher Perry
Friends Meeting House, 91-93 Hartington Grove, Cambridge CB1 7UB
www.thesap.org.uk

17 October 2015

BETRAYAL AND THE COUPLE: AFFAIRS, PORNOGRAPHY AND THE INTERNET

Jenny Riddell
WPF Therapy, 23 Magdalen Street, London SE1 2EN
www.wpf.org.uk

17 October 2015

ENACTMENT: THE COMING OF AGE OF A CONCEPT

Caroline Polmear
Mansion House, Canynge Road, Clifton, Bristol
www.sipsychotherapy.org

17 October 2015

AUDIENCES WITH AUTHORS: MONEY AS EMOTIONAL CURRENCY

Anca Carrington
37 Mapesbury Road, London, NW2
www.britishpsychotherapyfoundation.org.uk

17 October 2015

SABINA SPIELREIN REVISITED

Coline Covington, Barbara Wharton
SAP, 1 Daleham Gardens, London NW3
www.thesap.org.uk

23 October 2015

UNDERSTANDING SHAME AND HUMILIATION IN COUPLE RELATIONSHIPS

TCCR, 70 Warren Street, London W1
www.tccr.ac.uk/cpd

23 October 2015

BROTHERS AND SISTERS: MYTH AND REALITY – CLINICAL IMPLICATIONS

Henry Abramovitch
SAP, 1 Daleham Gardens, London NW3
www.thesap.org.uk

23-25 October 2015

WORKING WITH OTHERS: PLEASURE, PAIN AND GAIN

Group Relations Conference
37 Mapesbury Road, London NW2
www.britishpsychotherapyfoundation.org.uk

24 October 2015

NICE WORK IF YOU CAN GET IT: EVIDENCE AND RESEARCH IN THE TALKING THERAPIES AS CULTUAL POLITICALLY INFLUENCED PRACTICES

Del Loewenthal
WPF Therapy, 23 Magdalen Street, London SE1
www.wpf.org.uk

29 October - 1 November 2015

EIGHTH PSYCHOANALYTIC FILM FESTIVAL (EPFF8)

Turning Points: Individuals, Groups, Societies
BAFTA, 195 Piccadilly, London W1
http://couchandscreen.org/epff8/films/

NOVEMBER

1 November 2015 - May 2016

EXHIBITION: ARTISTS & PSYCHOTHERAPISTS

AGIP, 1 Fairbridge Road, London N19
To exhibit, contact 07545 495 653, judithsymons@gmail.com
www.agip.org.uk

3 November 2015

MINDFULNESS: THE NEW PANACEA?

Carola Mathers
AJA Flat 3, 7 Eton Avenue London NW3
http://www.jungiananalysts.org.uk

6 November 2015

PUBERTY-SUPPRESSION: A TREATMENT IN ITS OWN RIGHT?

Bernadette Wren
SAP, 1 Daleham Gardens, London NW3
www.thesap.org.uk

6 November 2015

CONNECTING CONVERSATIONS: GEORGE FERGUSON WITH PAUL HOGGETT

Folk House, 40 Park Street, Bristol BS1
www.sipsychotherapy.org

7 November 2015

INTERPRETATION AS FREUDS SPECIFIC ACTION, AT KLEINS POINT OF URGENCY, AND BION'S CONTAINER-CONTAINED

Chris Mawson
The Barn, St Michael's Church, Church Square, Basingstoke RG2
www.britishpsychotherapyfoundation.org.uk

20-21 November 2015

ORGANIZATIONAL AND SOCIAL DYNAMICS: INTERNATIONAL PERSPECTIVES FROM GROUP RELATIONS, PSYCHOANALYSIS AND SYSTEMS THEORY

Stephen Frosh, Kay Souter
Ambassadors Hotel, 12 Upper Woburn Place, London WC1
www.opus.org.uk

20-22 November 2015

DONALD WINNICOTT CONFERENCE

Stefano Bolognine, Vincenzo Bonaminio, Andrea Brady, Matt Ffytche, Juliet Hopkins, Angela Joyce, Anne Karpf, Zeljko Loparic, Lynne Murray, Kenneth Robinson, Rene Roussillon, Kenneth Wright
Institute of Psychoanalysis, London W9
www.beyondthecouch.org.uk

27 November 2015

THE STUCK COUPLE: MANAGING DISAPPOINTMENT AND BLAME

TCCR, 70 Warren Street, London, W1
www.tccr.ac.uk/cpd

28 November 2015

GROUPS AND GANGS

Camila Batmanghelidjh, Kids Company, London Bubble Theatre Company
IGA, 1 Daleham Gardens, NW3
www.groupanalysis.org

Couple therapy and intergenerational change

By Amita Sehgal

The greatest tragedy of the family is the unlived lives of the parents.
C. G. Jung

JUNG CONVEYS the idea that children of unhappy parents are condemned to lead unhappy lives. He believed children were powerfully affected by the unconscious state of their parents which, in turn, informed their conscious interactions, and that family misunderstandings and conflicts had detrimental effects on their children. In *The Merchant of Venice*, Shakespeare comments, 'the sins of the father are to be laid upon the children'. The idea that the 'sins' of parents are visited upon the next generation, which emerges within general popular culture, resonates with the psychological view that destructive parental conflict has deleterious psychological effects upon children which can be passed on from one generation to the next. Two psychology researchers, Gordon Harold and Leslie Leve, have provided us with good research-based evidence verifying the intergenerational ill-effects of relationship difficulties on adult partners, on families and on children (Harold and Leve, 2012). This evidence makes a case for investing in the couple relationship as a way of promoting positive outcomes for children within a family context, and influencing the intergenerational transmission of factors that lead to future family breakdown. So, how can couple therapy help break the intergenerational cycle of disadvantage?

Jack attended the initial consultation on his own, without his wife Lucy. He asked me to help him separate from her. The marriage was over for him, he knew that now, but somehow he could not free himself from the strong grip that he felt Lucy had on him. When they first met, he had been bewitched by Lucy's beauty and charm and they had loved each other passionately. Then, after their daughter was born, Lucy seemed to change, becoming quieter and quieter as she gradually withdrew from Jack and their infant daughter and into herself. Jack explained he had tried hard to look after Lucy but she was out of his reach. Soon she began to take on lovers as he watched silently and helplessly from the sidelines. During the session Jack described Lucy as a whimsical woman who behaved callously towards him. He also portrayed her as an unreliable, neglectful mother who had left him to care singlehandedly for their now ten-year-old child.

This is a familiar scenario to couple psychotherapists, where individuals can approach us on their own and without their partners for help with marital difficulties. They convey a belief that couple psychotherapists can help them with problematic issues pertaining to their couple relationship without the need for their partner being involved. Generally, after a consultation such as the one described above, I try and arrange for a second consultation and suggest that it would be helpful if the absent partner attends too. I explored with Jack whether he wanted help for himself or whether he might like to bring his wife to a second consultation? Jack felt he had depicted his relationship accurately, his marriage to Lucy was over, and he needed me to help him extricate himself from it. He also felt that in inviting Lucy to the next session I was somehow prescribing the couple should stay together and not separate, and this made him anxious. Was he thinking that I thought it was always better to stay together for the sake of their child?

What kind of psychological relationship enables partners to function well, both as a couple and as parents to their children? In *Psychotherapy with Couples* (Ruszczynksi, 1993), Warren Colman described marriage as a 'psychological container' in which 'the relationship itself becomes the container, the creative outcome of the couple's union, to which both partners can relate. It is an image of something the couple are continually in the process of creating, sustaining and maintaining, while at the same time feeling that they exist within it – are contained by it' (Colman, 1993). This experience of feeling contained by the relationship is central to the couple's ability to parent their children.

In 1998, at the Tavistock Centre for Couple Relationships' 50th Anniversary Conference, Stan Ruszczynski, along with Mary Morgan and Philip Stokoe, presented the idea of the 'creative couple'. This concept applied Britton's idea of 'triangular

Lucy said she had never wanted children whereas Jack said he had wanted many. During Lucy's pregnancy, Jack seemed to form a close bond with their unborn baby and Lucy had felt edged out of Jack's mind. Lucy recounted how after their daughter's birth she felt Jack began to look after her as if she were an invalid and unable to look after their baby, how frustrated she felt at being unable to get through to him and how she eventually stopped trying and withdrew from him.

The story of Jack and Lucy illustrates how useful it can be to see the couple. By shifting from the focus on the individual to seeing the couple together I was led away from the possibility of being drawn into Jack's internal world to forming a fuller picture of the true complexity of their relationship. We now had an opportunity to address their shared experiences of growing up within their respective families, notably that each had a relationship with mothers where the roles were reversed and they had to care for illness or depression and that neither had experienced a well-functioning parental couple as both their fathers had gone missing.

The exploration of unconscious defences in the couple, as in any branch of psychoanalysis, takes time, but as internal representations of relationships begin to shift, change can be profound. In couple therapy the element of change comes from creating a forum in which partners can think about their joint history and not repeat it.

Cases like Jack and Lucy help us recognise the impact of unconscious beliefs on parenting practices, and alert us to the risk of intergenerational transmission of mental health difficulties like depression. We have evidence that couple therapy is an important alternative to medication in treating intergenerational transmission of mental health problems like depression, especially in preventing further relapses (Leff, Asen and Schwarzenbach, 2012), and Hewison, Clulow and Drake (2014) have recently provided us with an evidence-based manual for using couple therapy to treat depression. I think it is now time for an intergenerational transmission of what has been learnt through more than sixty years of research and clinical practice at TCCR, and other organisations like it, to acknowledge what we know: that psychotherapeutic work with couples, as Brett Kahr (2012) so fittingly describes, 'has the potential to make giant strides in the area of psychological development, offering us so many tools and insights that can help us facilitate a brighter future for our intimate partnerships, for the well-being of our children, for our nation's finances, and for our nation's health' ■

Amita Sehgal, MA, PhD, is a psychoanalytic couple psychotherapist, a Visiting Clinician and Lecturer at TCCR, and Collaborative Practitioner registered with Resolution.

** Jack and Lucy are pseudonyms for a couple whose histories and circumstances have been heavily disguised in order to protect their identities and to render them unrecognizable to themselves and to others who might know them.*

References

Balfour, A. (2012). 'Couple Therapy – Social Engineering or Psychological Treatment?' In: A. Balfour, M. Morgan and C. Vincent (Eds.), *How Couple Relationships Shape Our World. Clinical Practice, Research, and Policy Perspectives*. London: Karnac.

Britton, R. (1989). 'The missing link: parental sexuality in the Oedipus complex.' In J. Steiner (Ed.), *The Oedipus Complex Today: Cinical Implications*. London: Karnac.

Colman, W. (1993). 'Marriage as a psychological container.' In: S. Ruszczynski (Ed.), *Psychotherapy with Couples: Theory and Practice at the Tavistock Institute of Marital Studies*. London: Karnac.

Hewison, D., Clulow, C., & Drake, H. (2014). *Couple Therapy for Depression. A Clinician's Guide to Integrative Practice*. Oxford University Press.

Harold, G.T., and Leve, L.D. (2012). 'Parents as Partners: how the parental relationship affects children's psychological development.' In: A. Balfour, M. Morgan and C. Vincent (Eds.), *How Couple Relationships Shape Our World. Clinical Practice, Research, and Policy Perspectives*. London: Karnac.

Kahr, B. (2012). Foreword. In: A. Balfour, M. Morgan and C. Vincent (Eds.), *How Couple Relationships Shape Our World. Clinical Practice, Research, and Policy Perspectives*. London: Karnac.

Leff, J., Asen, Eia., and Schwarzenback, F. (2012). 'Depression, Couple Therapy, Research, and Government Policy.' In: A. Balfour, M. Morgan and C. Vincent (Eds.), *How Couple Relationships Shape Our World. Clinical Practice, Research, and Policy Perspectives*. London: Karnac.

Morgan, M. (2005). 'On being able to be a couple: the importance of a "creative couple" in psychic life.' In: F. Grier (Ed.), *Oedipus and the Couple*. London: Karnac.