NewAssociations

NEWS, ANALYSIS, OPINION FOR THE PSYCHOANALYTIC COMMUNITY | **ISSUE** 5 **SPRING** 2011

BRITISH PSYCHOANALYTIC COUNCIL

Time for realignment

By Julian Lousada and Malcolm Allen

Second Citizen: Truly, the souls of men are full of dread: Ye cannot reason almost with a man that looks not heavily and full of fear.

Third Citizen: Before the times of change, still is it so: By a divine instinct men's minds mistrust ensuing dangers.

SECTIONS OF OUR profession are currently experiencing a tide of uncertainty and anxiety not unlike what was felt by the London citizens in *Richard III* after the death of King Edward. Already grappling with the precarious position of our discipline, we now face jolting new challenges for psychoanalytically-informed work within the mental health sector.

The pushing through of £20 billion worth of 'efficiency savings' in the NHS and the reckless moves towards GP commissioning from 'any willing provider' risk a return, as a leading BMA spokesperson recently warned, to the 'grim and unfair days of the 1930s and 40s' leaving a 'tattered safety net'. Large numbers of psychotherapy posts are being lost or down-graded. Highly valued psychotherapy services are disappearing. The Cassel Families Unit will close at the end of the month, as will the National CAMHS Support Service. Many voluntary sector projects are threatened by cuts to local authority funding. The cries of pain from the front-line grow louder every day and are heard in many of these pages. The effects of all this will reverberate throughout the entire economy of the profession – the private sector too will not be immune.

This is the backcloth for two recently announced Government policies that will each have additional repercussions for the position of psychotherapists. First is the Government's new mental health strategy, *No health without mental health*, which contains much to be supported. Its aspiration for 'parity of esteem' between mental health and physical health provision, its cross-government approach, the focus on early intervention and recovery and the commitment to reduce mental health stigma are all welcome ambitions.

But whether the strategy's objectives can be delivered within the framework of what Vince Cable has labelled a 'Maoist' approach to re-organisation must be a huge question. The document states that 'any efficiencies in mental health services need to be carefully thought through so that false economies and greater costs elsewhere in the health and social care system are avoided.' But this ultimately depends on local decision making, and many primary care trusts and local authorities are already making ruinous cuts in mental health services.

A key dimension of the strategy is the next phase of the IAPT programme, backed by the high-profile announcement of £400 million extra funding, unfortunately followed by a bashful silence about some important details of the funding. When Professor David Richards, an eminent champion of the IAPT programme, asked some basic questions about these he was briskly dispatched from his position as a national advisor.

The need to widen the choice of therapies is reaffirmed, but only a limited amount of funding has been made available – so far for one year only – for training in the four therapies additional to CBT approved by IAPT. Regardless, the BPC is working with the DH and our partners to help build these therapies into IAPT services.

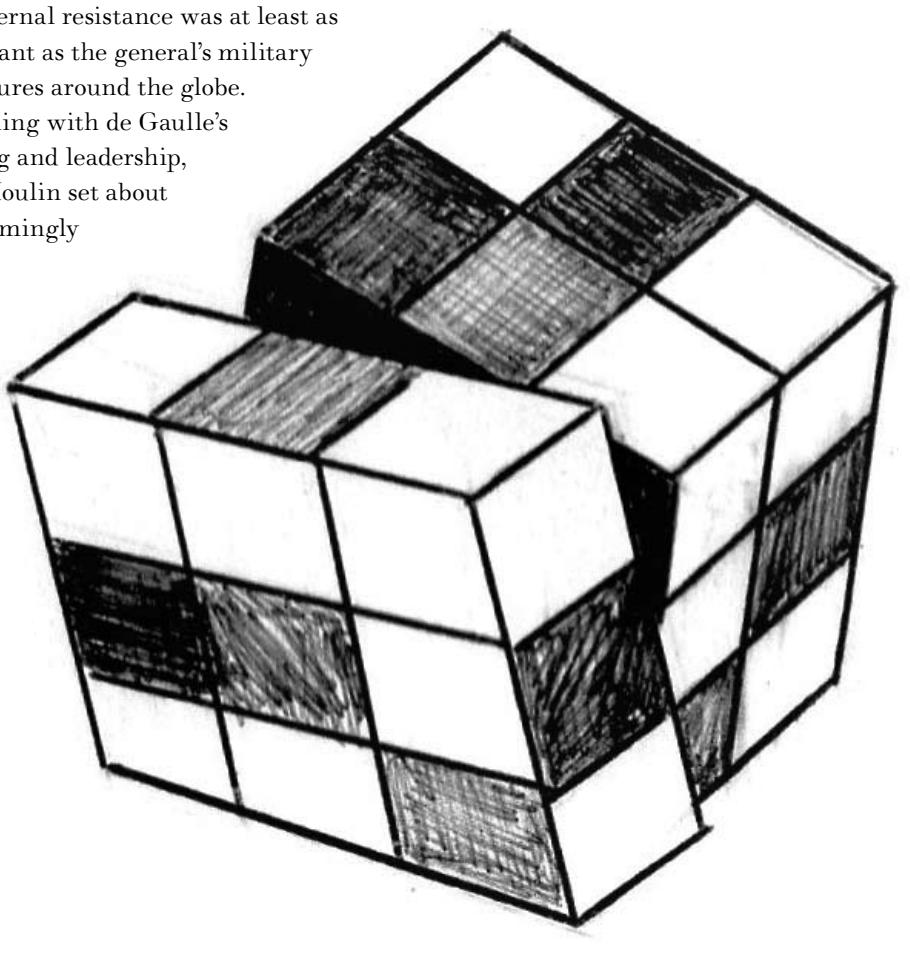
The second major policy statement, on health and social care regulation, has killed off previous proposals for statutory regulation of psychotherapy and counselling. For some, a victory against the state's threatened incursion into the hallowed ground of the consulting room, for others the fruit of a natural love affair between a modern day poujadism and the anti-regulatory zeal embraced by this government.

In its place the Government is proposing 'assured voluntary registration'. This is explored inside. The BPC continues to believe it is in the best interests of the profession to have in place the most robust and credible form of regulation to protect the public. We are now focused on making these current proposals work to arrive at maximum public protection, as well as to enhance the reputation and status of the profession.

'The effects will reverberate throughout the entire economy of the profession.'

We now face an accelerating pace of change to the environment and economy of psychoanalytically-informed work, and the emergence of a complex new force-field of threats and opportunities. The question is how to avoid positioning ourselves at the sidelines of these developments as spectators. One thing is clear. We can no longer afford the luxury of the organisational fragmentation that so enfeebles our capacity to respond to these events.

In the dark days of 1941, France's youngest ever *préfet* flew to London looking to persuade de Gaulle that the internal resistance was at least as important as the general's military adventures around the globe. Returning with de Gaulle's backing and leadership, Jean Moulin set about the seemingly impossible task of uniting eight fiercely independent resistance movements right across the political spectrum. And on 27 May 1943, meeting in occupied Paris, the National Council of the Resistance was formed. The operational effectiveness of the resistance was transformed overnight while later the Council's political programme of 1944 helped shape the future of post-liberation France.



No comparisons are made here with the horrors or the heroism of this period. But perhaps we can draw inspiration and learn some lessons from the foresight and resolution shown by Moulin and his comrades in taking the bold and determined steps we now need to take. For the profession faces some grave perils.

We publish inside proposals for the future strategic direction of the BPC which will be debated over the coming months. Underpinning the proposals is the desire to find new ways of relating to the wider psychoanalytic and psychodynamic community in our common task of fighting for the future of our profession. An immediate first step is to ask those organisations that already share or feel close to our aspirations but who are not part of the BPC to enter into urgent and focused discussions with us with a view to creating a decisive and purposeful realignment of psychoanalytic organisations in the short term.
We need our 27 May ■

Julian Lousada is Chair and Malcolm Allen is CEO of the BPC

What now for regulation?

By Malcolm Allen

THERE SHOULD BE A phrase for when the banality of a pronouncement belies the consequential nature of its subject. When the Bolsheviks dissolved Russia's newly-elected Constituent Assembly, the closure was executed by the anarchist sailor Zheleznyakov telling the assembled delegates: 'The guard is tired. I propose that you close the meeting and let everybody go home.'

The Government brought to a close more than 40 years of speculation and debate over the regulation of psychotherapy and counselling in similar fashion. The announcement was made in the oblique prose of clause 4.11 of Command Paper 8008[1]:
'For the overwhelming majority of occupational and professional groups which are not currently subject to statutory regulation and which are generally not considered to present a high level of risk to the public, but where recommendations that regulation should be introduced have been made (including those groups recommended by the HPC for statutory regulation in the past, but not yet registered), the assumption will be that assured voluntary registration would be the preferred option.'

Psychotherapy or counselling are not referred to specifically here, though they are mentioned in a footnote (14) at the end of the paper, which lists those groups of 1.3 million professionals which this clause is describing. The use of the passive verb, so cherished by governments, in the phrase '*where recommendations that regulation should be introduced have been made*' delightfully glosses over the fact that the recommendations were made by none other than the Government of the day, albeit a different one.

So what is 'assured voluntary registration'? It can mean one of two things.

First, the CHRE (Council for Healthcare Regulatory Excellence) – now to be called the Professional Standards Authority for Health and Social Care – has been given powers to accredit the voluntary registers of others, e.g., professional bodies.

4.5 The CHRE will set standards against which the governance, procedures, registration criteria and performance of voluntary registers can be judged to establish whether they are sufficient to provide assurance to the public and employers about the training, skills and conduct of their registrants.'

Alternatively, the nine health statutory regulators, including the Health Professions Council (HPC), have been given powers to establish voluntary registers for those professions who are not statutorily regulated. Thus, the HPC will have the powers, not to accredit other registers, but to set up its own voluntary register for psychotherapy and counselling.

What next?

CHRE will start to devise its criteria and systems for accreditation. One question will be whether CHRE will wish to accredit a multiplicity of registers from different professional bodies, or whether they will insist on a single register per profession. This seems unlikely but such questions are still to be worked through. If it were to accredit several registers from a profession, it is almost certain to impose some constraints (e.g., registers not below a certain number).

The BPC will argue that the accreditation of a small number of different registers for psychotherapy and counselling is the only realistic and sensible way to accommodate a profession that does not share common definitions, standards or accreditation criteria.

We also understand that HPC is considering the option of establishing its own register for psychotherapy and counselling.

The main professional bodies in the Psychological Professions Alliance Group (PPAG)[2] have recently met. We are requesting an early meeting with CHRE to discuss their likely approach to the accreditation of voluntary registers at the same time as seeking to influence what approach they may take.

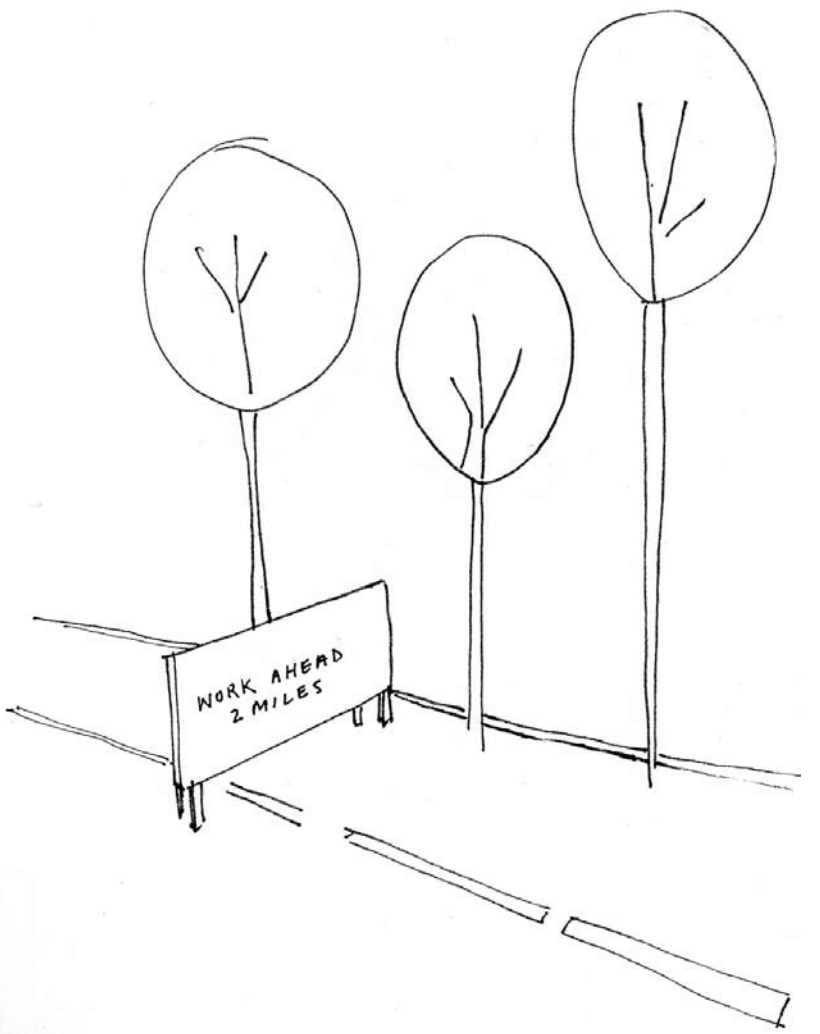
PPAG is also writing to HPC to say that while we are exploring with CHRE the main option of a system based on the accreditation of existing voluntary registers, it would be helpful if HPC did not pursue for the moment the setting up of its own voluntary register. Such a move might serve to muddy the water of the dialogue we now need to have with CHRE.

The BPC will be working with other professional bodies and the CHRE to ensure that we put in place a robust and credible system of voluntary registration that will serve the demands of public protection as well as provide a sound regulatory framework for practitioners ■

Notes

1. 'Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers', Cm 8008, Department of Health, February 2011

2. PPPAG's members are: British Psychoanalytic Council, United Kingdom Council for Psychotherapy, British Association for Counselling and Psychotherapy, British Association for Behavioural and Cognitive Psychotherapies, and British Psychological Society.



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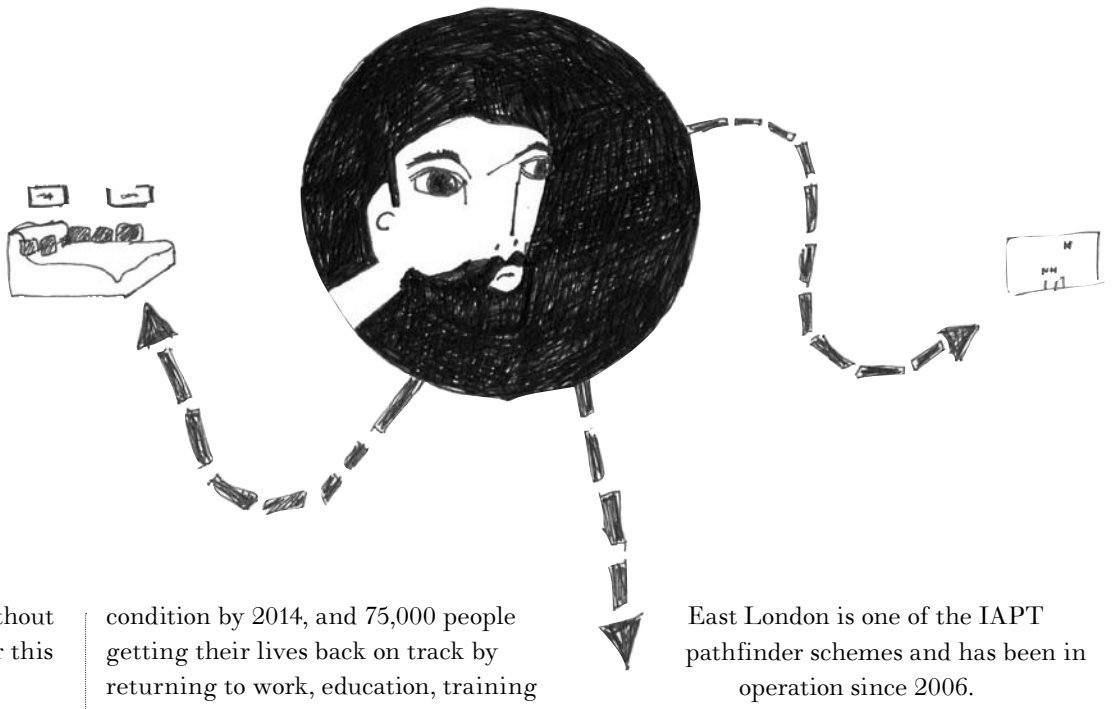
‘Your guess is as good as mine’



By Mark Gould

News that millions more people are to get fast access to an extended range of psychological therapies was somewhat tarnished by concerns over money.

David Richards, a long time campaigner for wider access to therapies and professor of mental health research at Exeter University, was only voicing the concerns of many including BPC chief executive Malcolm Allen when he publicly questioned (in an interview on *The Guardian*’s website) whether the £400 million earmarked by the Department of Health (DH) to extend access to talking therapies was new money or siphoned off from elsewhere in the NHS.

He also wanted guarantees that, if it is new money, it will be spent on training new therapists and not used to plug other gaps in the NHS. The DH took exception and he was summarily sacked as National Advisor to the flagship Improving Access to Psychological Therapies (IAPT) programme,

The government stress they are investing new money, but many therapists involved in IAPT say they have been led to believe that it would have to be found from the £20 billion that is currently being required as an efficiency saving in the NHS, and would be used to fund developments in the NHS such as setting up the new GP consortia, training midwives, cancer drugs and other priorities such as IAPT that the government identified in the 2010 Comprehensive Spending Review.

In response to David Richards’ sacking the board of the British Association for Behavioural and Cognitive Psychotherapies (BABCP), of which he was a past president, issued a statement alleging that the cash is not new to the NHS even if it is new money for psychological therapies.

‘There is clear evidence from across England that the funding allocated over the past three years for developing the first phase of the IAPT has already been given up as efficiency savings by PCTs as they seek to balance their budgets,’ they said. ‘We have the possibility, then, that the new money is not only really old money: it is in fact old IAPT money to be used to develop a service but also without any safeguard that it will be used for this purpose.’

Commenting on Professor Richards’ departure a DH spokesperson said he had done some great work for the psychological therapies programme, ‘but regrettably the way in which he made his comments about funding damaged confidence in the programme and was incompatible with his position as an adviser to it.

‘As a result, the Department ended his formal involvement with the talking therapies scheme. In accepting this decision, the professor has offered his continued support for the programme.’

And in response to questions about funding he added: ‘This is new money. The NHS has already been notified of PCT allocation for 2011-12, which included additional funding for increasing access to talking therapies. We will continue to increase the funding we give to PCTs to support talking therapies. This will amount to an additional £400 million over the spending review period on top of the annual allocation of £173m from the first phase of the programme which will continue. The NHS Operating Framework 2011-12 mandates an annual expansion of IAPT services in line with this commitment.’

When asked if he thought the cash was new money West Sussex GP Amit Bhargava, the GP lead for South East Coast Strategic Health Authority IAPT, said: ‘Your guess is as good as mine. There are issues as to whether the £400m is new money or being recycled.’

Whatever the exact origin or freshness of the funds, money will have to be spent on ensuring a wider choice of therapies than the ubiquitous CBT which is, according to government figures, available to 70% of the population. The government wants GPs to offer universal access to five National Institute for Clinical Excellence (NICE) recommended therapies: CBT, counselling for depression, interpersonal psychotherapy, couples therapy and dynamic interpersonal psychotherapy.

The government says that extending psychological therapies to all those with mental health problems will result in one million people recovering from their condition by 2014, and 75,000 people getting their lives back on track by returning to work, education, training or volunteering. It will also create over £700 million of savings to the public sector in healthcare, tax and welfare gains.

New GP commissioning consortia will be required to offer talking therapies to patients with ‘medically unexplained symptoms’ such as chronic pain, bowel problems or even chronic fatigue syndrome, people with long term conditions, children and teenagers, the elderly, and people with major psychiatric disorders such as schizophrenia and bipolar disorder.

‘We have the possibility, then, that the new money is in fact old IAPT money.’

Dr Bhargava, who is also the NHS Alliance clinical lead on practice based commissioning, says fledgling GP consortia are fully aware of the need to develop and extend access to therapies, but it will be a challenge: ‘I think there needs to be a full assessment of available skills because the current workforce is not trained either to take on these new clients, nor are they trained to offer these extended skills and different therapies. There is a will to do it but it will mean up-skilling for some therapists or bringing in new workers. Some therapists will be happy to re-train but it will need a thorough assessment.’

He also wants training for medical and nursing students and qualified clinicians to include greater emphasis on psychological wellbeing and therapeutics. ‘I think emotional wellbeing needs to be embedded in medical training not just in medical schools, but for older, hardened physicians and surgeons who see everything in terms of a bio-medical model rather than a psycho-social and get hard wired.’

What does seem remarkable is the success of therapies in improving wellbeing. Newham Primary Care Trust (PCT) in East London is one of the IAPT pathfinder schemes and has been in operation since 2006.

According to independent analysis some 55% of IAPT users in Newham reported ‘significant improvement’ in Generalised Anxiety Disorder (GAD) symptoms some four months after treatment, and 137 people were supported to return to work.

Newham is an area of high unemployment and deprivation with the fourth highest Jarman index and the tenth highest MINI (mental health need index) score in the country, and the lowest male and female life expectancy in the UK. Over 60% of the borough’s population come from black and minority ethnic (BME) communities and it has the highest number of refugees of any borough in London.

Epidemiological studies would suggest the IAPT scheme might receive some 2,400 referrals for a borough-wide CBT service. While the pilot has had teething problems with staff, it’s a measure of the work still to do in identifying suitable patients that in the last year only 1121 patients were referred to IAPT.

Dr Sim-Roy Chowdhury, the IAPT lead for Newham, said that the IAPT teams have been successful in raising their profile with the BME community by carrying out targeted visits to high street sari shops and restaurants, community and religious groups and third sector organisations and employers.

Some 50% of GP surgeries have in-house therapy teams but access continues to be a problem, particularly for patients in hospitals. However, surveys show users are happy with the quality of the service and choice of therapies. Dr Chowdhury said: ‘The key for the service users is the quality of the service. A major problem has been the waiting time to see a therapist. We have driven down waiting times in primary care but there is still a problem with accessing therapies in hospital settings’ ■

Journalist Mark Gould writes for The Times, The Guardian, and the Health Service Journal.

NHS Special

The challenge for mental health care

By Andy Bell

The NHS in England has been asked to cut its costs by some £15 billion over the next five years to withstand the financial pressures being faced across the public sector. Mental health care, which accounts for one pound in every eight of NHS spending, will not be immune from making its share of these savings.

In previous times of financial difficulty in the NHS, mental health services have in fact taken a disproportionate share of the pain. Five years ago, over-spending in many acute hospital trusts was paid for by primary care trusts (PCTs) 'raiding' mental health trust budgets. And while public spending on mental health services has risen almost every year since 1999, in many years it has not grown at the same speed as the NHS as a whole.

Anecdotal evidence of new and forthcoming cuts in mental health services is beginning to emerge from across the country. Little systematic evidence of the nature or impact of such cuts has as yet come to light. But we do know that commissioners and providers of mental health services face difficult decisions about resource allocation and prioritisation of limited funds. Only a minority of GPs, who are now taking over responsibility for most NHS commissioning, are confident in their ability to commission mental health care according to a survey conducted by the charity Rethink.

Beyond the NHS, the impact of spending cuts is more immediate and in places dramatic. Local authorities across the country are reducing a range of services, many of which will have a direct impact on people with mental health problems and, directly or indirectly, the NHS. Numerous local authorities, for example, are cutting back services funded through the Supporting People programme, a funding stream that offers practical help to people to maintain independence and stay in their own homes. Many of the beneficiaries of Supporting People have mental health and substance use problems. Withdrawing such support could increase people's vulnerability and end up costing the public purse considerably more over time.

In its recent mental health strategy, *No health without mental health*, the Government set out a guiding policy principle of 'parity of esteem' for mental health with physical health. As the NHS undergoes another major change in its commissioning arrangements, with consortia of GPs taking over from primary care trusts and the regional strategic health authorities facing abolition, ensuring that parity of esteem happens in practice will be a challenge. Many GP consortia will need advice and support to commission for mental health in their localities, not least from the people who have mental health problems and use (or do not use) their services.

There are, of course, ways in which mental health services can achieve better value for money, making more efficient use of resources while also improving the quality of care they offer. Hospital admissions and lengths of stay vary widely from one area of the country to another. An Audit Commission report last year identified six-fold variations in admissions and a fifteen-fold variation in lengths of stay between trusts, while the National Audit Office in 2007 concluded that one hospital admission in five could have been avoided. Out-of-area placements, which affect some 10,000 people a year, carry a large cost for many PCTs as well as disrupting people's links to their communities. Building up, rather than cutting back, effective community services may help to reduce some of these variations, as may improved commissioning and management arrangements.

Secure mental health services could also be made more efficient and cost-effective. Secure services cost £1.2 billion, some one-fifth of the specialist mental health services budget, providing about 8,000 beds across England. Yet admissions to secure hospital from prison are subject to long delays and patients spend long periods in secure hospital with little provision available to help them to step down to less restrictive, and expensive, settings.

'Commissioners and providers of mental health services face difficult decisions.'

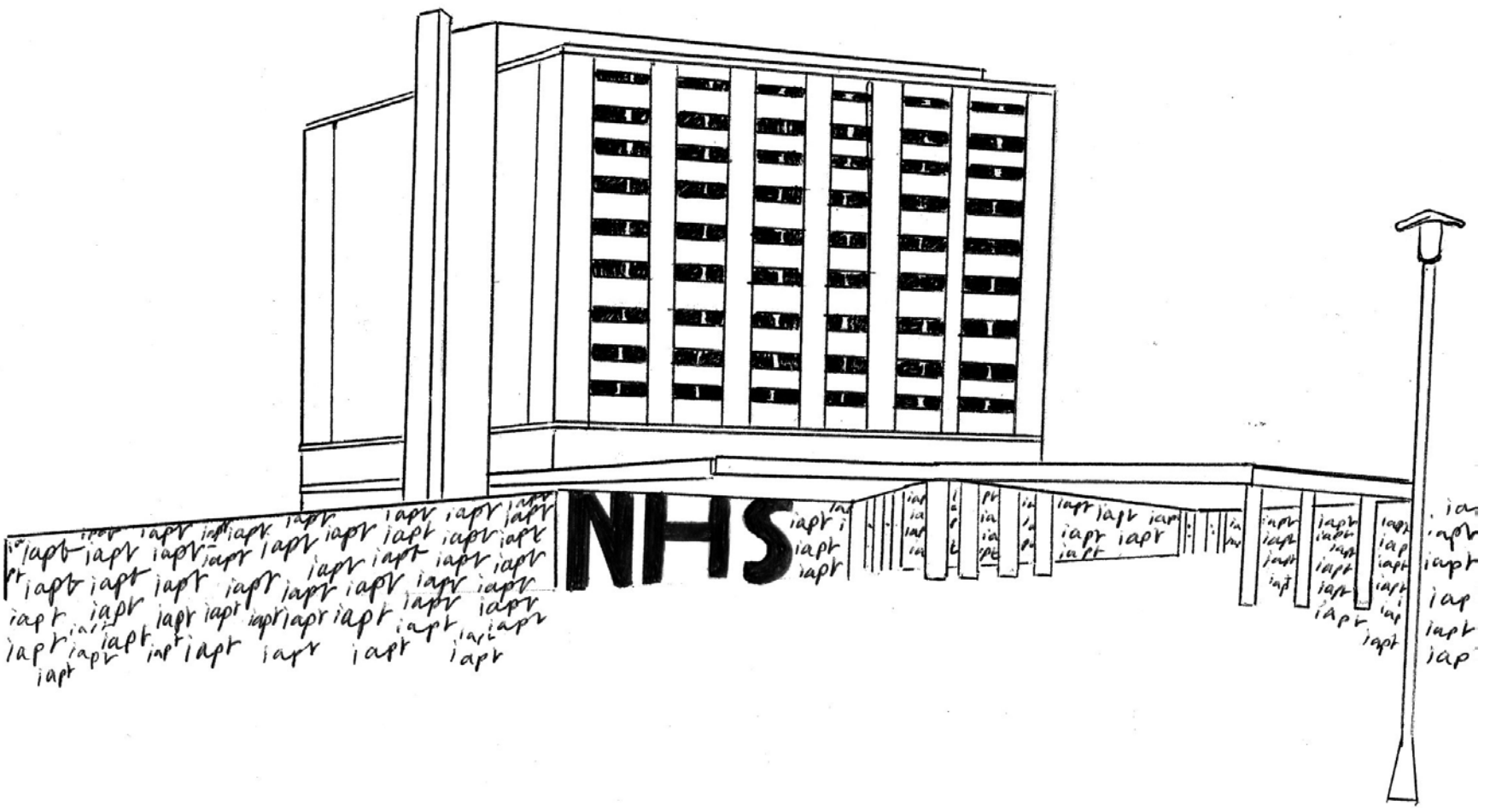
A major focus for improved value for money in the NHS is to break down the barriers that currently exist between physical and mental health. People with long-term physical conditions experience high levels of mental ill health, while those with mental health diagnoses have far worse physical health than average. There is a strong association, for example, between mental ill health and physical health problems such as diabetes, arthritis or cardiovascular disease. Depression has been associated with a fourfold increase in the risk of heart disease, even when other risk factors like smoking are controlled for. The presence of co-morbid mental health problems can lead to poorer quality of care for the physical condition, decreased adherence to treatment, increased health service costs and poorer outcomes. The size of the financial impact of co-morbidity can be significant – in the case of diabetes, the costs to the health service of each person with co-morbid depression is up to 4.5 times greater than a person with diabetes alone.

In addition to the presence of distinct mental health problems in people with long-term conditions, there is often a psychological component to physical illness which can be addressed using standard mental health interventions such as cognitive-behavioural therapy (CBT). There is evidence that addressing mental health and psychological needs can produce sustained reductions in admissions to hospital for people with a range of long-term conditions, including angina, diabetes and irritable bowel syndrome. The savings associated with avoided admissions can be considerable. And every year, the NHS spends some £3 billion on largely ineffective interventions for people with 'medically unexplained symptoms', many of which have a psychological dimension that could be addressed through psychological therapy.

Mental health care can therefore offer a great deal to the rest of the NHS to cut back on costs while improving people's health. One of the biggest costs to the NHS is staff sickness. Mental ill health among the NHS workforce costs some £1.3 billion a year, more than half of it in reduced productivity among people coming into work unwell. Simple, straightforward steps to improve health at work in the NHS and to help supervisors and managers to respond appropriately when people become unwell can cut these costs dramatically.

Improving efficiency in mental health provision is therefore an important response to the financial scarcity faced by the NHS and its partners. And there are further gains to be made from making more radical changes to the support we offer to people who have or are at risk of mental health problems. The objectives of *No health without mental health* present opportunities to make these bigger changes, working on four different levels, based on good evidence of effectiveness and cost-effectiveness.

First, the prevention of mental ill health should be as much of a public health priority as the prevention of physical illness. Parenting support for people with young children costs an average of £1,200 per child and is known to be effective in reducing the risk of emotional and conduct problems in later life. The lifetime cost of conduct problems in childhood, by contrast, is some £225,000. Directors of public health in each local authority area, working through health and wellbeing boards to pull together a range of partners, have great potential to improve mental health among their populations. If mental health is to have 'parity of esteem' with physical health, prevention and promotion work with families, schools, neighbourhoods and communities can offer excellent value for public money.



Second, we need to intervene more quickly when people become unwell. Intervening early not only reduces the burden of ill health a person experiences but also decreases the damage to their life chances. Fewer than a quarter of people with depression or anxiety seek or receive treatment. The extension of psychological therapies in the NHS over the past five years has begun to bring down waiting times in many areas for people with depression, albeit in some localities – despite government guidance – at the expense of existing psychological therapy services. Early intervention in psychosis (EIP) teams, mandated in the previous Government's National Service Framework for Mental Health, help to speed up access to treatment but also appear to improve employment prospects and outcomes. Some early intervention teams are now at risk as health services seek to cut their costs. Disinvesting in early intervention services because of financial expediency would represent a major loss for the NHS.

The principles of early intervention can be applied successfully beyond EIP. Diversion services for people who come into contact with the police and the courts can identify those with mental health problems, learning disabilities and substance misuse and put them in contact with health and care services. Existing diversion arrangements are patchy and many fail to fulfil their potential. Few offer round-the-clock support or advice. Fewer still work effectively with children and young people or the services they need. Opportunities to divert people with mental health problems from prisons to their communities, and from neglect to care and treatment, are being missed daily. The Government has now committed to developing diversion and liaison services across England; a welcome investment that if achieved should cut the costs of crime and justice considerably.

Third, mental health services need to change fundamentally the way they relate to the people who use them. The role of mental health services should be to support people to live the lives they want. Clinical care and managing the symptoms of mental illness are important factors in Recovery but Recovery is just as much about having an ordinary life. While 80% of people using mental health services want to work, for example, only 20% are in paid work or education.

There is clear evidence about how to support people with mental health problems into employment. The Individual Placement and Support (IPS) approach is characterised by immediate job search rather than lengthy job preparation or training, with time-unlimited support once a person begins work combined with benefits advice and integrated with health care. IPS is both less expensive for the NHS than traditional vocational services, such as sheltered work, and by being more effective reduces the costs of health care – as people who succeed in gaining employment require fewer hospital admissions.

Some mental health services in England have already taken steps towards a Recovery focus. South West London and St George's Mental Health Trust pioneered the development of a User Employment Programme. It uses the IPS approach to support people into mainstream, open employment and has also opened up employment within the trust to many more people with experience of mental illness. Other mental health trusts, as well as voluntary and private sector providers, are now beginning to use IPS and refocusing their services on Recovery. The Centre is now working with the NHS Confederation to support the development of Recovery focused services across the UK.

People who use mental health services frequently describe being disempowered in the care and treatment they receive. While mental health services are often ahead of the rest of the NHS in terms of listening to users' views both in their own care and in overall service planning, for many individuals services are experienced as coercive and controlling. Disproportionate numbers of people from Black and minority ethnic communities are admitted to hospital, detained under the Mental Health Act and kept in secure units. Race inequality in mental health care has persisted despite a concerted effort through the Delivering Race Equality programme to address the issue since 2005.

'Investment in mental health has a lot to offer to the taxpayer.'

Finally, efforts to improve mental health care, intervene early and promote wellbeing will be limited in their effect on society as a whole if we do not also address the continued stigma of mental illness and the discrimination that stems from it. Stigma and discrimination cast a long shadow over the lives of people with mental health problems. Millions of people every year do not seek support for mental ill health for fear they will be rejected and disadvantaged – at work, at school, even within their own families – if they acknowledge that they need help. People who use mental health services frequently report discrimination and harassment as everyday experiences or they fear that seeking work will lead only to disappointment because of their history of illness.

Action to tackle stigma and discrimination can therefore provide excellent value for public money. The Time to Change programme, funded by the Big Lottery Fund and Comic Relief, has begun to bring about a discernible change in public attitudes towards people with mental health problems. That progress needs to be sustained, as the cultural change we need to bring about will be the work of more than a generation.

Mental health services have changed dramatically over recent decades. In the last ten years, the development of community services, the rapid growth of secure care and the more recent expansion in psychological therapy provision have been enabled by significant overall funding increases to add-on new services to old, without necessarily reforming the latter.

The challenge now is to keep on changing service responses for the better in an environment of scarcity. We can no longer improve people's experiences of mental health care by adding new services or staff without the loss of existing provision. The next big steps for mental health care will be to shift investment 'upstream' towards prevention and early intervention while offering support to those with mental health problems to recover their lives, on their own terms. Mental health support for children and for older people did not enjoy the same level of investment and improvement as services for working age adults and both need to be developed to offer better quality and coverage.

The risk we face is that these radical changes will be impeded by short-sighted, politically expedient cuts to mental health care budgets. Investment and reinvestment in mental health has a lot to offer to the taxpayer. The NHS as a whole will achieve better value for money by bridging the divide between physical and mental health and by investing in prevention, recovery and early intervention. The Government's mental health strategy offers a vision for improved outcomes for the next five years: it is now up to all of us together to make that vision into a reality across the country ■

Andy Bell is deputy chief executive of the Centre for Mental Health.

A fully-referenced version of this article is available on the BPC website at www.psychoanalytic-council.org

NHS Special

CAMHS in a Big Society

By Ricky Emanuel

Major fears exist around the implications of government cuts, and the new mental health strategy, for child and adolescent mental health services.

There were many difficulties with the last Government in various policy areas, but credit must be given where it is due, and so it is important to recognise how forward thinking and innovative they were in the area of children's services in general and CAMHS in particular.

We saw an unprecedented growth in CAMHS services under the last administration, and CAMHS itself was high on the political agenda. It began with the Children's National Service Framework (NSF) where there was a specific CAMHS module which worked to produce a blueprint for CAMHS services, including a definition of comprehensive CAMHS. At the same time, and with some difficulty, Every Child Matters was published by the Department for Children, Schools and Families (DCSF). This dual track strategy, where the Department of Health led on one hand and the newly established DCSF led on the other, reflected a fundamental split in Government about who should lead on children's health and mental health.

Be that as it may, arising from the NSF were four proxy indicators which were tied to increased funding in a public service agreement. This was the first time this had happened in CAMHS, and although people have different views on the value of top-down targets, there is no doubt that the funding matched to targets led to an improvement in CAMHS services. The targets included developing a comprehensive CAMHS service for children with disabilities (non-existent in most areas before this), 24-hour cover by CAMHS (very patchy before this), a service for 16-17 year olds (increasing the age range for CAMHS), and putting in place arrangements for funding complex packages of care across agencies for the most vulnerable children, particularly looked after children.

Several other initiatives followed, including specific funding for targeted mental health interventions in schools (TAMHS), a comprehensive review of CAMHS, and the inclusion of disorders treated by CAMHS in NICE guidance (a mixed blessing, although psychoanalytic child psychotherapy did get onto the radar of NICE in the children with depression guidelines. This has led to NICE now funding the biggest RCT ever undertaken in this country, the IMPACT study,[1] looking at short term psychoanalytic psychotherapy against CBT and specialist clinical care in children with moderate to severe depression. This is the one breath of fresh air in these turgid times).

There were a number of other initiatives where the importance of CAMHS was recognised and often funding followed. These included initiatives to reduce social exclusion and anti-social behaviour, to improve the mental health of looked after children, Sure Start with an emphasis on early intervention with under fours and their parents, including working with post natal depression and its impact on babies and children, etc. A comprehensive mapping of CAMHS services was undertaken each year to monitor the progress in CAMHS, and an NSF implementation review was also undertaken showing progress in most areas of CAMHS services. A national CAMHS support service was also set up with a network of regional development advisors to help develop CAMHS services throughout the country.

Funding for the training of child psychotherapists was increased; so in London 15 fully funded posts were commissioned a year, including the cost of analysis. In other parts of the country training in child psychotherapy grew, with a new training school, the Northern School, opening successfully. The new workforce strategy announced by the Government may leave it to local Trusts to decide on workforce needs, which could severely impact on national funding for child psychotherapists and other disciplines.

Much of the above is now under severe threat. In order to understand this it is necessary to explain how CAMHS is funded. Local PCTs fund a large section of CAMHS services, and originally the extra money given for the development of CAMHS came in a ringfenced manner to the PCTs. This was in addition to their base budgets. Since there were performance indicators specific to CAMHS, including the four proxy measures mentioned above, PCTs had to report on these, and their overall performance was affected by how they fared on these indicators. This extra money, called the CAMHS grant, suddenly was transferred to the local authority as the power of the DCSF grew at the expense of the Department of Health. The Every Child Matters agenda began to swamp the NSF agenda and the local authority became increasingly important as the lead agency for children's services.

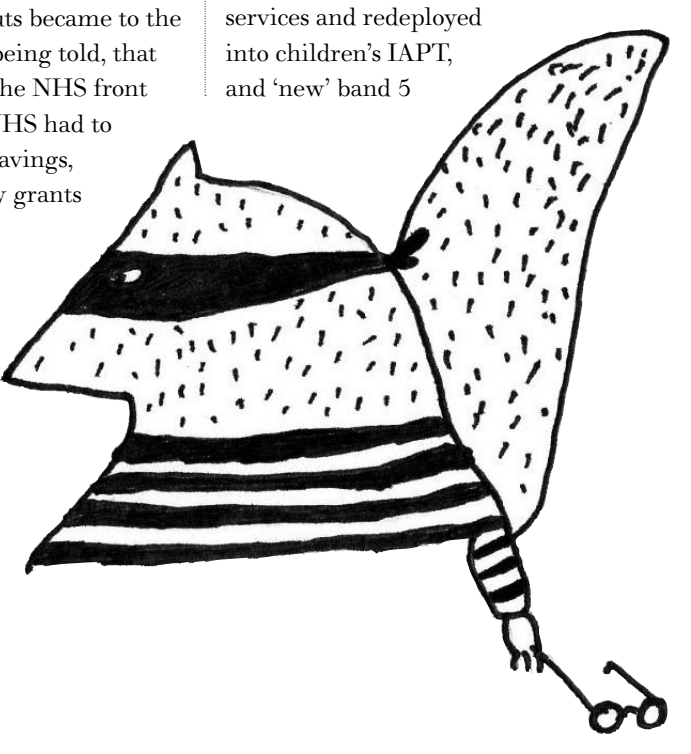
Many of us worried about this trend, knowing that the priorities of the local authority were necessarily different from those of health but there had been a definite shift in the balance of power. Joint commissioning structures were encouraged to ensure that the priorities of health and the local authority could be addressed jointly in commissioning CAMHS services. There could at least be some checks and balances in place if commissioning was undertaken jointly. At this point the CAMHS grant to the local authority was ringfenced. This has gradually become eroded and has now disappeared altogether. The CAMHS grant was incorporated into what was called the area based grant, but the CAMHS element was again ringfenced. Many services were commissioned from this area based grant, usually for CAMHS services in schools, for looked after children and children with disabilities, children centre services for under fives, youth offending team services, etc. These were in addition to the core services commissioned from the PCT core budgets for CAMHS.

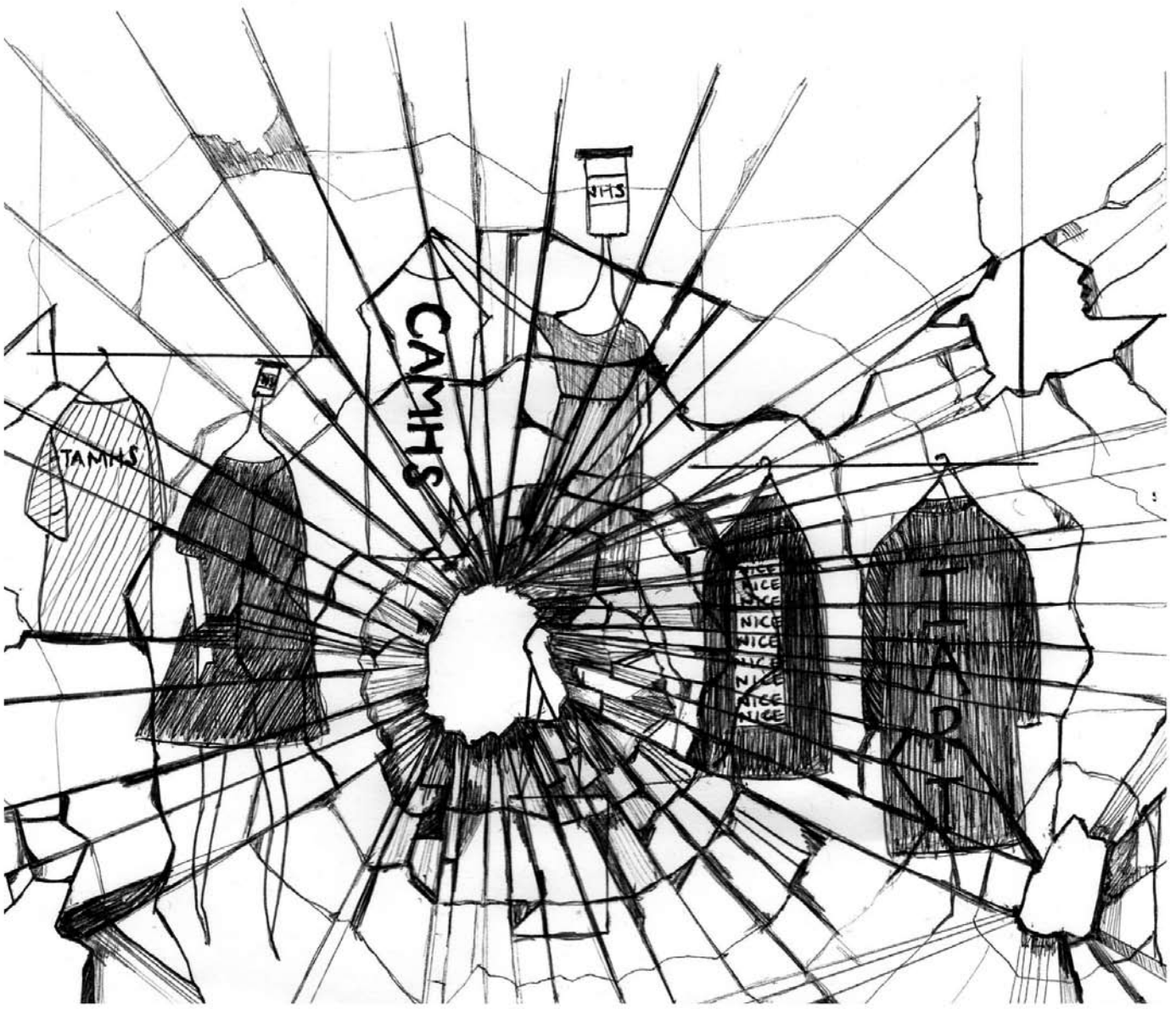
'Despite the motherhood and apple pie rhetoric, the reality is very different.'

Then came the coalition! Although both parties in the coalition promised in their manifestos not to reorganise the health service, within a month of coming into power a white paper, *Liberating the NHS*, was published. This heralds the biggest reorganisation of the NHS in its history. This white paper could not have been developed in a month and so clearly there were lies being told in the election manifestos. The issue of cuts became to the fore, but with another lie being told, that there would be no cuts to the NHS front line services. Instead the NHS had to find £20bn of 'efficiency' savings, and any ringfencing of any grants to local authorities were to be lifted. This 'allowed' the local authorities to make their own decisions about how to spend their money. However, their budgets have been severely cut, on average by about 25-30%. A new grant, the Early Intervention grant, much heralded in the new mental health strategy just published called *No health without mental health*, replaces the old area based grant and is not ringfenced. However, there are statutory services which have to be provided from this grant, especially the 'Aiming high' services which included short breaks for disabled children introduced by the last government. All the other funding streams have been merged into this much reduced grant. This includes all the money for TAMHS and early intervention services provided by Sure Start. (The last government had started to mess about with Sure Start, trying to enhance its child care functions to enable mothers to work, but many of the mental health aspects of Sure Start had been preserved through the area based grant.) So where does this leave us now?

Despite the motherhood and apple pie rhetoric in the new mental health strategy that nobody on the ground can argue with, the reality is very different. Despite the fanfare about the increase in IAPT services, including an IAPT for children, the reality is that the funding for this has to come from existing services. Robbing Peter to pay Paul. This has led to the sacking of the national advisor of IAPT by the government when he dared to raise questions about this. Existing services already are feeling the enormous pressure placed on them by the need to make 'efficiency savings', so that many services in mental health are being severely reduced. If they then have to find extra money for IAPT from their existing services the crisis becomes more acute.

Children's IAPT was promised to be more wide angled than adult IAPT, recognising the complex networks children live in. This included a promise of a wider range of treatment modalities being offered. Instead, CAMHS is to be 're-engineered' (minister Paul Burstow's phrase in his press release about Children's IAPT) to rid itself of treatments which are not approved by NICE. The only treatments to be offered by children's IAPT are CBT and behaviourally-based parenting training programmes for conduct disorders. The resources are to come from CAMHS services. In some parts of the country Band 7 posts from CAMHS have been removed from the CAMHS services and redeployed into children's IAPT, and 'new' band 5





posts have been offered to CAMHS in their place. Band 5 is below the training grade for all core CAMHS professions. Whilst outcome monitoring is something that I have no difficulty with at all if it is applied sensitively and thoughtfully, the new children's IAPT has to use session-by-session outcome monitoring tools. This has been promulgated by a section of the CAMHS community but has never found favour with the wider CAMHS constituency. Now it is policy in children's IAPT. This makes no sense to use with many types of interventions, including all the psychoanalytic modalities.

A further very serious trend happening around the country is that services which were previously funded by the area based grant via the local authority are being savagely cut, as ringfences are removed and local authorities under extreme financial pressure try to deliver their core services. These are NHS services for some of the most deprived and needy children in the country, and often delivered in non-stigmatising accessible environments like schools, children's centres, youth clubs, etc. CAMHS were encouraged and funded to provide services like this which now have had their funding seriously cut. This includes core frontline services in Tier 2 and 3 CAMHS. But keep reminding yourself there are no cuts in the NHS. The government told us this. It amazes me why people have been so taken in by this and are not protesting more.

Another trend emerging as providers try to find the 'efficiency savings' forced from them, along with the loss of the area based grant, is that many posts in CAMHS services are being 'deleted' and a re-organisation is taking place. People are having to apply for their own posts again but at a banding one down from the one they were in. Also there are fewer posts to apply for. Those people not getting posts are being made redundant.

'Initiatives developed by the last government are fuel for the bonfire of the quangos.'

The initiatives developed by the last government are fuel for the bonfire of the quangos. The CAMHS mapping has been abolished. The national CAMHS support service and the regional development workers have been abolished and all posts made redundant. The Department of Children, Schools and Families is now the Department for Education. The new mental health strategy has the gall to mention the national CAMHS support service as a resource to turn to in implementing the new strategy. When I read this I contacted the head of the service, whom I knew from my time on the various government groups I was on, asking if this meant they had been saved from abolition. No such luck; they disappear from 31st March.

Much has been made about the shift of power to GPs from the abolition of the PCTs. Working as I do in a children's commissioning team in a PCT advising on the commissioning of CAMHS from a clinical perspective, I cannot see how GPs will be able to commission CAMHS or mental health services with any competency. If, as is likely, they sub-contract this to the local authority or private sector, who will be able to provide the checks and balances onto the local authority to ensure true joint commissioning takes place which takes account of both local authority and health priorities? The whole choice agenda becomes window dressing as the choice of services, which were provided in a variety of settings, are systematically being dismantled across the country. The voluntary sector or big society cannot fill this gap. What has taken years to build up takes minutes to smash up and this is what I am afraid is happening, despite 'there is no health without mental health', or 'there are no cuts to the front line services in the NHS'. Thank goodness people are wising up to what is going on and many professional organisations are coming out vociferously against these developments. I would hope the BPC join them ■

1. Improving Mood with Psychoanalytic and Cognitive Therapies. www.impacttrial.org.uk

Ricky Emanuel is an Adult Psychotherapist, a Consultant Child and Adolescent Psychotherapist at the Royal Free Hospital, and clinical lead for Camden CAMHS

NHS Special

Attacks from below the radar

By John Keene

The squeezing of mental health services is unwelcome news for patients and practitioners alike. John Keene reports from the service provision front line.

Somewhat below the radar, the provision of mental health services by qualified and experienced mental health workers has come under threat, as the degrading of frontline mental health services proceeds apace to achieve a reduction in service of 30% over the next five years.

The idea that these Cinderella services can find these as efficiency savings is widely regarded as impossible. Much of the provision has already been cut to help meet overspends in acute hospital trusts, and treatment services for the mentally troubled have been underfunded for many years, leading to significant reductions in the treatments offered. That is, except for the recent injection of IAPT money, which has inevitably been used in places to replace rather than augment existing provision. Protecting frontline service is of no priority, as the loss of posts and services has been accelerated to meet cuts required by the end of March 2011. Two significant ways of meeting 'efficiency savings' are to stop providing the service, or to use less qualified or unqualified staff.

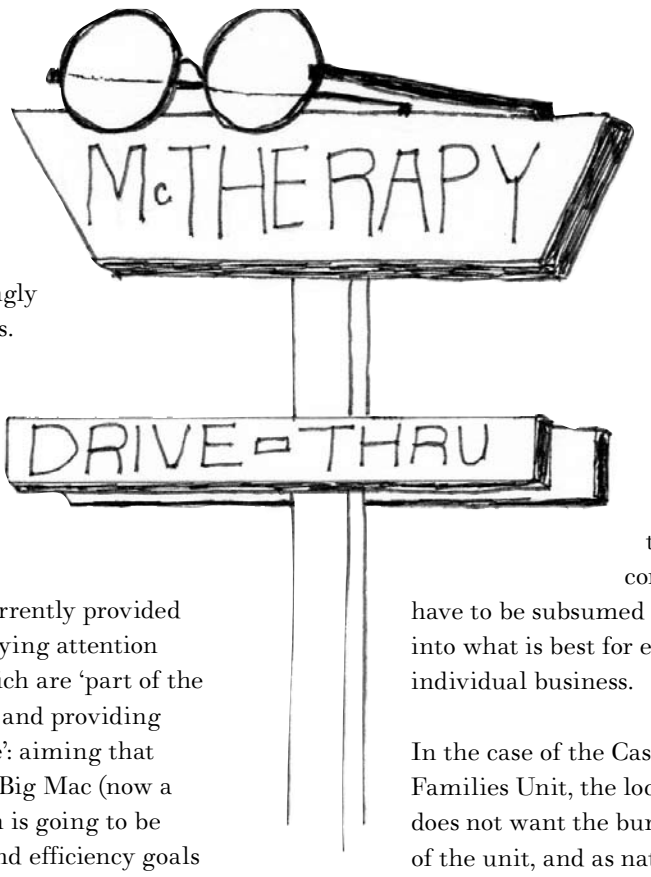
Psychotherapy posts, whether medical or non-medical consultant posts, family therapy, or psychoanalytic psychotherapy, are all vulnerable to review on account of cost alone. I have heard from one Trust that when 8c and 8d (consultant grade) psychotherapy posts become vacant they are either disappearing or being re-advertised as 8a posts, and that psychotherapists are being given two years on their current grading before being regraded to the top of the band below (i.e. forced to leave or take a pay cut).

Child psychotherapy trained art therapist and social worker grade 8a vacancies in CAMHS clinics in one Home Counties Trust are being replaced by adult trained Community Psychiatric Nurses on Band 6. Elsewhere, the recruitment of graduate mental health workers without clinical training is replacing expensive qualified and experienced staff. Graduate worker posts have traditionally been a step on the training path for psychotherapists who gain experience as nursing assistants, care workers, or group workers, accepting little money in exchange for study time to pursue their professional mental health training as clinical psychologists or psychotherapists. Trusts frequently are reneging on this implicit bargain by refusing study leave for any course not strictly required for their lowly banding as unqualified staff.

The idea of patients as consumers and of treatment as an objectively conceived 'product' has eclipsed the understanding that the quality of relationships between individuals is the key to mental health of the population – crucial both in the therapeutic relationship and in the availability of a containing, stable network of trusted colleagues caring for disturbed families and individuals. These keys to the effectiveness of mental health provision are made extraordinarily difficult by the attack on collaboration and its replacement by competition between fragmented rival 'providers'.

People, whether patients or professionals, are objectified and treated as interchangeable and indistinguishable, and patients' suffering is similarly reduced to diagnostic classifications. Budgetary and accounting goals push mental health Trusts towards offering only very time-limited brief interventions, which can quickly result in 'case closed' decisions if patients or families fail to engage immediately, or short-term acute provision when things go badly wrong.

This is in spite of the weight of research evidence of the greater cost-effectiveness over time of longer interventions for complex cases and co-morbidity. In the current climate evidence base has no relevance, as cost cutting is the prime determiner of decisions. Psychotherapeutic treatment by suitably experienced practitioners is being rapidly removed from NHS provision. The additional social and governmental costs arising from breaking up established networks of colleagues and service provision in terms of increased acute referrals to social services, A&E, the police and ultimately the prisons will not appear immediately, and not on individual Trusts' balance sheets, where the survival of their 'business' is clearly the most proximal priority for many, regardless of the betrayal of trust owed to patients and communities. Consultancy periods for closing services seem not figure strongly in current discussions.



Samples of talk at senior levels in a range of Trusts include 'raising the drawbridge', that is, no longer making currently provided services available; paying attention only to functions which are 'part of the core business model'; and providing a 'McDonalds service': aiming that wherever you go the Big Mac (now a 'little Mac') provision is going to be the same. Business and efficiency goals have not been merely added to clinical goals; in many places they have replaced them. Clinical decisions about admission and discharge are now being taken by commissioners and not clinicians, and patients complain that commissioners have spent all their money on other patients, which is why there is no money for the treatment they and their doctors believe to be necessary. And in this competitive market place, which is being so misguidedly promoted at present, senior clinicians are required to spend increasing amounts of their time on business, promoting their business's activity.

'Psychotherapy posts are all vulnerable to review on account of cost alone.'

The consequences of short term demands are illustrated by a closure in which I was involved a couple of years ago, which demonstrates the prevailing logic. The Direct Access Psychotherapy Service in Watford, which provided both CBT and psychoanalytic assessments and psychotherapy (meeting all the IAPT aims), was closed to save £500k in order to help fund the overspend in the Acute Hospitals Trust. There the Trust agreed that it was an important part of service provision which met government targets and was very well regarded by its users, but they could only reconsider it when funding became available. There was little or no acceptance that the trust necessary for clinicians to work effectively as groups and parts of networks of care is built up slowly through experience, and that such a level of sophisticated responsiveness and effective service cannot be quickly recreated once destroyed. The present system of commissioning, which is about to be realigned, yet again creates a dog-eat-dog situation focussed on local areas where treatment concerns have to be subsumed into what is best for each individual business.

In the case of the Cassel Families Unit, the local Trust does not want the burden of the unit, and as national funding has not been agreed it will close at the end of the month. For units serving more local areas (such as Northgate Clinic, a residential medium term therapeutic unit for adolescents), the commissioners appreciate the service, but are unwilling to purchase even small block contracts as it is in their interest to spot-purchase only when they require a bed, while the provider Trusts have little incentive to underwrite expensive medium term provision. The idea that satisfactory alternative resources can always be provided in the community seems pure wishful thinking at a time when the substantial contribution of Social Services to much jointly funded provision is being dramatically reduced because of cuts to Social Services budgets. As the Cassel's research amply demonstrates, these services are very cost efficient, and also reduce chronic suffering; however, there is no incentive it seems for provider Trusts to take such global budgetary factors into account. Their 'bottom line' approach is simply to close units if adequate funding is not in place from the beginning of April.

There is little organised opposition to the continued privatisation, fragmentation and destruction of mental health provision, and there is a widespread feeling of tiredness, gloom and a sense of inevitability. As elsewhere in society there has been a loss of any belief in collective power. The threat of yet more disturbed untreated patients 'on the streets' at risk to themselves, their families and to others should not be underestimated as a way of getting the attention of local and national politicians ■

John Keene is a training psychoanalyst of the British Psychoanalytical Society, an NHS trained psychotherapist, and an organisational consultant working in NHS units in two NHS Trusts

Policy in an era of change

By Ian McPherson

With the National Mental Health Development Unit closing at the end of March, its Director, Dr Ian McPherson, reflects on the implications for supporting the delivery of No Health without Mental Health *and the potential opportunities for groups within the psychotherapeutic community.*

What was the role of the National Mental Health Development Unit?

The National Mental Health Development Unit (NMHDU) was established in April 2009 with funding from both DH and the NHS to provide national support for improving mental health and mental health services by putting policy into practice and best practice into policy.

NMHDU has done this by commissioning or providing:

- Specialist expertise in priority areas of policy and delivery
- Effective knowledge transfer on research, evidence and good practice
- Translation of national policies into practical deliverables
- Coordination of national activity to help regional and local implementation.

NMHDU's main programmes[1] have included

- Improving Access to Psychological Therapies (IAPT)
- Effective Mental Health Commissioning
- Mental Health Care Pathways
- Equalities in Mental Health
- Social Inclusion and Social Justice
- Well-Being and Public Mental Health
- Personalisation in Mental Health

While much has been achieved through these programmes, *No health without mental health*, the Government's mental health strategy published in February, makes it clear that the areas we have worked on remain central themes for policy implementation, and a great deal still needs to be done to establish these in the rapidly changing systems across government and all agencies responsible for promoting better mental health and mental health services.

Why then is NMHDU closing?

The answer lies in a mixture of reorganisation and financial pressures. In the light of the NHS White Paper, DH has determined that it is no longer its role to support policy implementation in the way that NMHDU has done. It is considered that this function, to the extent that it still needs to be carried out nationally, should transfer to the new NHS Commissioning Board. However, it had also been determined that DH could no longer fund these functions, other than some transitional support for IAPT.

What will this mean for national support for mental health policy implementation?

The NHS Commissioning Board does not come into operation until 2012, and it is not clear where mental health will feature on its agenda at a time of major reconfiguration with an emphasis on local determination and financial savings.

While some work will be commissioned on a transitional basis in 2011 by DH in conjunction with the SHAs, the pressure to maintain the focus on improving mental health and mental health services will fall back to the mental health community. Evidence of a willingness to take on aspects of this has been demonstrated in the *Call to Action* published alongside *No health without mental health* to which many organisations have signed up. However, each of these organisations will also be under pressure, and the commitment that exists now will need to be harnessed by the mental health sector if the momentum of what has been achieved with the support of NMHDU is to be sustained and developed in the increasingly difficult financial climate.

What are the implications for the psychotherapeutic community?

NMHDU's demise may not seem a major issue for the psychotherapeutic community. To the extent that they may have been aware of NMHDU's existence, this would have been likely to be through IAPT which the Government has clearly indicated will continue in *Talking therapies: a four-year plan of action*, This in itself is likely to produce very mixed feelings among those from the psychodynamic and psychoanalytic sector of psychotherapy, some of whom may wish that IAPT was departing along with its parent body.

There are those in the psychotherapeutic community who, despite reservations about aspects of IAPT, have significantly shaped its direction and ensured that NICE-approved therapies developed from within the psychodynamic and psychoanalytic sector are now a core component of the Talking Therapies Programme. Therefore, this does not seem the time for the sector to pull back and hope that IAPT might wither on the rather shaky vine that is the NHS in 2011. Rather it needs to seize the opportunity to consolidate what has been achieved and use the current uncertainties in the system to influence the direction that is taken under Talking Therapies, particularly as it focuses on the needs of children and young people, older adults, those with physical health problems or presentations, and those with more severe and enduring mental health conditions.

'This does not seem the time to hope that IAPT might wither on the shaky vine that is the NHS.'

No health without mental health presents opportunities not just in relation to the Talking Therapies programme, but also across mental health policy. This strategy is the first to take an explicitly developmental perspective, reflecting the importance of early experience on the likelihood of having mental health problems in adult life. From a psychodynamic and psychoanalytic perspective, the analysis in the strategy and related documents of this and what needs to be done, in both addressing these problems at an earlier stage in life and in trying to help promote mental health and well-being, may not seem particularly sophisticated. However, there is a real opportunity to bring forward examples of good practice which are informed by psychodynamic and psychoanalytic thinking and demonstrate how these and similar approaches may offer more robust models to deliver the outcomes that the strategy aspires to.

There will be those who argue that it is too risky getting involved in supporting the delivery of this strategy, in that the end results may not be what the sector wishes to see, and that its reputation could be tarnished by association with an increasingly politicised debate about how to progress mental health policy implementation in a system going through massive reconfiguration in a financially challenged environment. These risks have to be acknowledged but balanced against the risk of the sector missing the opportunity to shape the debate and remaining on the margins of mental health as it moves into the next era of change.

In a culture which encourages competition and, despite the rhetoric, seems to judge only on cost and not on value, it is easy to see the climate as hostile and want to retreat into our comfort zones. However, unless the case for psychodynamic and psychoanalytic perspectives continue to be articulated in ways that acknowledge the predominant political narratives, and the realities of diminished resources to those who will be determining the way in which services are commissioned and provided, the chances of these approaches having any significant place within the NHS and wider public sector seem remote.

No health without mental health appearing at the same time as the closure of NMHDU may seem ill timed but it does create real opportunities to support the 'policy into practice into policy' cycle. Groups within the psychodynamic and psychoanalytic sector will need to decide quickly whether they wish to form strategic alliances, both with each other and with other parts of the mental health community, in working with DH and the wider government system to take these opportunities, or leave others to fill this vacuum ■

1. Details of NMHDU's activities can be found on www.nmhdu.org.uk. This website will be maintained for at least the next 12 months.

Dr Ian McPherson will cease to be Director of NMHDU on 31 March 2011, but will be taking up the role of Chief Executive of the Mental Health Providers Forum, which represents the main voluntary sector organisations in mental health, from April 2011. He is also a Non Executive Director of the Tavistock and Portman NHS Foundation Trust.

A new strategy for the BPC

Proposals from the Future Strategy Work Group

A SPECIAL WORK GROUP was commissioned by the BPC's Executive and Council to get to grips with the strategic challenges faced by our profession and its institutions. These have been well rehearsed elsewhere. The group has now outlined a series of issues and propositions that need debate and resolution over the coming months. If agreed, they will provide the co-ordinates of a clear strategic direction for the BPC and its member institutions.

The group has taken into account the implications of the Government's recent Command Paper,[1] and specifically the implications that the Government will not be pursuing statutory regulation for psychotherapy.

The specific issues have been informed by three overarching and interwoven strategic aims:
1. To support and sustain a viable psychoanalytic/dynamic professional community
2. To build an effective professional organisation serving the professional needs of that community
3. To maintain and expand the availability and attractiveness of psychoanalytic/dynamic therapy to a UK population with increasingly diverse needs.

A document proposing a strategic direction for the BPC for the next four to five years has now been approved by Council, and three conferences in the coming months will examine the issues described in more depth:
• A Strategy Conference – to look at some of the issues and propositions below, together with the structure and activities of the BPC
• A Search Conference to focus on advocacy
• A Training the Future Profession Conference.

The group invites BPC registrants to comment on these matters, either within their own Member Institutions or directly to Helen Morgan, the Chair of the work group, at helenmorgan@phonecoop.coop

1. Redefining and realigning the profession

In addition to the long-term challenges faced by psychoanalytic psychotherapy, we now face a set of urgent problems within public mental health provision in the UK. We now need to continue the expansion strategy set in train by the Strategy Conference of May 2008 and to follow through more completely the logic of those decisions. Secondly, like-minded psychoanalytic organisations need to achieve a greater organisational unity to overcome a level of fragmentation that we can no longer afford.

These objectives require us to be clearer about what we mean by 'the profession'. The task of redefining and realigning the profession go hand in hand.

A continuing expansion strategy built upon a rigorous clarity about the nature of the profession is necessary not just to enhance the position and profile of psychoanalytic psychotherapy, but also for the scientific and theoretical renewal of the profession.

Propositions to be dealt with by the Strategy Conference:

• Develop a robust formulation of the theoretical basis and boundaries that define the BPC

At the moment, the definition of the profession, or at least the membership of the BPC, rests on an overly simplistic, and arguably reductionist, appeal to a concept of 'frequency'. The equation 'high standards equal high frequency' does not do justice to what is a more complex set of considerations.

We need to formulate a theoretically rigorous basis for the definition of the profession and its boundaries. For example, an article by Jonathan Shedler which includes a section called 'Distinctive features of psychodynamic technique'[2] might serve as a useful starting point for such an exploration.

Such a redefinition would hopefully provide the basis for the mutually respectful bringing together of different modalities within the psychoanalytic/dynamic community – building a recognition across the board of the value and integrity of the various modalities and their different roles.

Making new associations

There are now a number of different ways that organisations and individuals can have a relationship with the BPC.

Linking with the BPC in one of these ways is a means by which you can help create a viable blueprint for the future of psychoanalytic and psychodynamic psychotherapy.

Training accreditation and registration through a BPC member institution

We are now able to accredit a wide range of psychoanalytic and psychodynamic trainings.
We have already developed criteria for accrediting the following types of qualifying trainings:

- Psychoanalysis
- Jungian analysis
- Psychoanalytic psychotherapy
- Psychodynamic psychotherapy
- Psychodynamic counselling
- Couples psychoanalytic psychotherapy
- Group analysis
- Psychodynamic group psychotherapy
- Psychodynamic counselling in institutional settings

Where such trainings are not undertaken by an existing member institution, then either the organisation can apply for BPC membership or arrange to get the training course 'adopted' by an existing member institution. Widening the basis for organisations to become member institutions of the BPC is one of the proposals for the new strategy.

Graduates from such accredited courses are then eligible to become registrants of the BPC. Where we have accredited a training, we are also able to approve arrangements whereby those people who have qualified from the course prior to accreditation can also become registrants.

We have also developed criteria for accrediting courses that do not lead to BPC registration.

So far, these include:

- Application of psychodynamic principles
- Dynamic interpersonal therapy

Affiliate member institutions

This category is open to organisations which support the growth of psychoanalytically-informed work in the UK and broadly support the policy aims and objectives of the BPC. It will enable organisations of different types, which may not be eligible or may not wish to become full Member Institutions for a variety of reasons, to have a formal association with the organisation.

An organisation pays an annual fee, which will be £250 per year until 31 March 2012. It can send one non-voting observer to BPC Council meetings (normally three times a year) and to the AGM.

The BPC will send copies of *New Associations* to up to 50 individual members of the organisation. We can also arrange to send copies to a greater number of individual members for an enhanced fee (currently £3 per additional member).

We will also explore ways in which the BPC and the affiliate member institution can work together for mutual benefit as well as for the benefit of the wider psychoanalytic and psychodynamic community.

Individual affiliate members

The BPC Council has approved the principle of introducing a form of individual affiliation to the BPC.
We have yet to work through the detail of this, in particular putting in place a range of tangible benefits that will make the scheme worthwhile for the individual concerned.

But this will allow a whole range of individuals, including practitioners but also academics and those working in ancillary professions, who support the overall project of the BPC to have some form of association with us.
So, watch this space for details ■

• Agree the principle of accepting high quality psychodynamic organisations (whose members train and work at lower frequencies) as BPC member institutions

This is a logical step from the decisions of the 2008 Strategy Conference. Some benefits would be:

- a bigger pool of registrants, so that the BPC can speak with a stronger voice
- greater regional representation
- diversity of approaches to meet the needs of varying patient populations
- to provide more favourable circumstances in order to progress the equalities and diversity agenda – as below.

• Develop a credible action plan that will start to properly address the long-standing issues of equality and diversity within the profession

These sorts of issues have often been discussed within the MIs and other forums across the community. Useful ground work has been done. It is now crucial to begin to draw that work together and to formulate a purposeful, credible and realistic action plan for the BPC that will start to make a difference.

• Develop a credible action plan to make the BPC a truly national organisation rooted in the nations and regions

Propositions now agreed by February BPC Council:

• Begin urgent and purposeful discussions with like-minded psychoanalytic/dynamic organisations with a view to achieving greater organisational cohesion in the short term

• Develop an appropriate relationship with bodies such as UKCP and BACP which also represent psychoanalytic/psychodynamic practitioners

This is about maintaining a productive dialogue and, where appropriate, collaborative activity with these organisations. We will promote the BPC as a resource to all psychoanalytic/dynamic practitioners.

• Develop a scheme to enable and encourage individual and group affiliates, especially from relevant fields such as psychiatry, Government, NHS, universities, etc.

The BPC has already established the category of Affiliate Member Institute, and a small number of organisations have become AMIs. We have now agreed to establish a category of individual affiliates for those individuals who wish to associate themselves with the 'political' project of the BPC, promoting psychoanalytic/dynamic work, but who cannot or do not wish to be registrants of the BPC.

• Agree as a strategic objective to give high priority to communicating effectively to our own registrants the importance of the BPC's strategic mission and objectives

2. Advocacy

The BPC was originally set up to perform the function of regulation in anticipation of statutory regulation. More recently there has been a developing need for the BPC to take on the role of promoting the profession in an increasingly difficult climate. Many MIs are already attempting to take on this task on a local basis but they often struggle to do so without the necessary expertise or resources. We believe this is a task often better undertaken by the BPC as a central body which can consider the needs nationally, act on behalf of the psychoanalytic community as a whole, and/or co-ordinate the initiatives of individual registrants or MIs.

As this requires combining forces and increased resources, it is planned to organise a Search Conference to look at how to strengthen the position of psychoanalytic/dynamic therapies within the UK.

3. Training the future profession

There is a lot of thinking still to do about the future of training within our member institutions, and the work group has identified four areas of concern:

- Further development of BPC accreditation standards for training (especially if the BPC takes on 'assured voluntary registration' under the CHRE)
- 'Gaps in the map' – working with regional groups and individuals to help ensure comprehensive training provision across the UK
- Helping MIs (where they wish) to work together to make the various training programmes more 'interoperable' – recognition of experience from previous trainings (analogous to APEL arrangements in FE and HE), avoiding over-duplication, greater modularisation, sharing resources, etc.
- Helping MIs (where they wish) to think about how to make the structure and content of our trainings fit for purpose in the 21st century – to help challenge current practice and nurture creative innovation and renewal.

A special Training Conference will start to tackle these large questions.

4. Structures and activities of the BPC

These issues and propositions will inform the future structure of the BPC, as well as what we decide as priorities for present and future activities. The decision of the Government not to pursue statutory regulation for psychotherapy and counselling clearly has a significant impact on these issues.

Broad questions to be looked at by the Strategy Conference are:

- Does the BPC wish to pursue a role within the 'assured voluntary registration' framework as set out in the Government's Command Paper?
- If the BPC does wish to undertake this role (strengthening its regulatory function), does this sit comfortably with expanding its role as the voice of the profession (advocacy, etc.)?
- What activities should we set as priorities and over what sort of time scale?
- Should the BPC continue to be an organisation of organisations or become an individual membership organisation?
- How do we structure the various relationships (with our member institutions, other organisations and individuals) we seek to build?

Members of the Future Strategy Work Group are Helen Morgan (Chair), Alexa Walker (Vice-chair) David Black, Warren Colman, Andrew Cooper, Susie Godsil, Sally Griffin, Jane Polden and Harvey Taylor ■

Notes

1. Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers', Cm 8008, Department of Health, February 2011.

2. Shedler, J (2010). The Efficacy of Psychodynamic Psychotherapy, *American Psychologist*, 65 (2), 98-109. See link: http://www.apa.org/pubs/journals/releases/amp-65-2-shedler.pdf

Media technology and romantic love

By Carol Leader

The ability to creatively use media in the services of romantic love demands psychological and emotional readiness. 'Media and the Inner World' recently looked at the ways in which love and technology interact.

THE LAST TEN YEARS have seen a phenomenal growth in the advances of modern communication technologies and the emergence of such giants as Facebook, Twitter and Linkedin alongside their siblings Skype, email and texting. This is having what appears to be an unstoppable impact on the way the youth of today relate as human beings, and has become a subject for contemporary academic research.

John Storey, Professor of Cultural Studies at the University of Sunderland, is currently investigating the kinds of media interactions that 18–24 year olds make use of when pursuing their romantic relationships. I suggest that the ability to creatively use any type of media in the services of romantic love demands psychological and emotional readiness, or we end up eating the menu rather than enjoying the real meal.

What comes to mind is a patient of mine in her 40s who has never had a long term romantic relationship and who, although successful in her work life, spent her spare time reading romantic novels, staying in a world of fantasy and putting off a conscious adult engagement with the world. She then started to discover that the novels didn't mediate her real love and passion, they were suppressing it.

Erickson's theory of psychosocial development

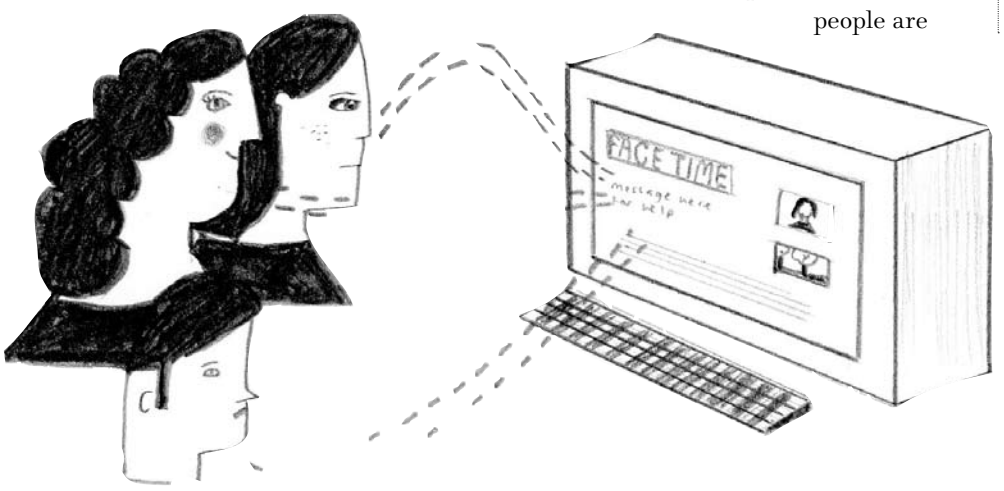
The age range of Storey's research subjects covers the early years of what the psychoanalyst Erikson calls the *Young Adult Stage* of psychosocial development. The vital questions that emerge during this stage are about *intimacy* versus *isolation*: 'Am I loved and wanted? Shall I share my life with someone or live alone?' The *virtue* to be grasped during this stage is *Love*.

In psychotherapy love is a central component, probably because it is not a Darwinian hard-wired emotion: the possibility of love only emerges through loving but unsentimental human relationships that foster specific brain development at a very young age. This is fundamental in developing a foundation for managing feelings that one day may lead to adult romantic relationships.

Freud and feelings

Sigmund Freud wrote that the goal of analysis was to be able to 'love and work', but he held an increasingly jaundiced view of the idealizing dimension of loving that is seen so clearly in romantic love. He saw it as ultimately regressive and defensive: an overvaluation of the other which was primarily a means of healing the narcissistic wounds left over from childhood.

Freud, I feel, is describing Romance with a capital 'R' as in The Romantic Movement – not the more ordinary experience that could be given a lower case 'r', but a regressive and merged state of mind connected with narcissistic objects. The idea of an



idealized, unavailable, mesmeric woman for whom the lover yearns brings to mind the unavailable, dark and uncanny object that the child introjects from an uncontaining narcissistic mother, primarily interested in her own performance as *Mother* rather than in the needs of her child.

Freud was hesitant to focus on the power of love or any of the emotions, claiming that it was 'not easy to deal *scientifically* with feelings' (my italics). Thus psychoanalytic mediation of ordinary romantic love saw it devalued and collapsed into infantile strivings, and love itself became equated with the sexual drive.

It took the rise of object relation theories to confirm the basic human need for a love relationship offering tenderness and romance. This has as its foundations the relationship between child and 'good enough' mother or primary carer that can later flower into active adult social and cultural pursuits.

The relational psychoanalyst Stephen Mitchell argues that a *lack* of romance in so-called mature love can in fact be the sign of defensiveness against the risks of excitement, danger and adventure that life naturally presents us with.

The rise of social networking

The film *The Social Network* tells of the spectacular rise of Mark Zukerberg's Facebook website that emerged out of university life in America in 2003. Interestingly Zuckerberg, as he appears in the film, comes over as someone who has great difficulties with relationships but demonstrates dazzling brilliance with computer technology. He reminded me of two different but highly successful older male patients of mine dominated by competitive anger and struggling with maintaining their relationships. Both needed analysis to explore their rage and then move towards a sense of tenderness towards themselves and others for which they both secretly yearned. As one of these patients said, 'Underneath my anger, I am crying.'

The meteoric rise of the whole field of media communications technology is something to be cautious about. Nevertheless it has brought a sense of collaboration, closeness and global connectiveness. Storey says that one unsuspected result of Skype, for example, is that young people are having a lot of face to face conversations in their romantic relationships, and this is something that is new.

Technology and the media

The archaeologist Timothy Taylor in *The Artificial Ape* persuasively argues that 'our relationship with technology and material culture is the critical point of distinction between us and animals.' He postulates that our early ancestors took control over their own evolution by developing technologies, media, which became the major element in the extraordinary growth of the human brain which cannot be merely put down to the process of natural selection and evolution.

Taylor imagines the story of a primitive human female around two million years ago – our ancestral mother – struggling with the weight of a young child and therefore vulnerable to attack from animals as she tries to keep up with her tribe. What can she do?

One of those transformational moments is about to occur which means that human culture will never be the same again: suddenly the woman grabs a piece of fur to create a rough sling to carry the weight of her child, and cradles it against herself in order to keep up with the rest of the group. Such initiative developments have allowed humans to dominate the planet, to successfully adapt to nearly all of its environments and to humanise the nature of our emotional relationships. Her spontaneous creativity is a distant link, I believe, to Zuckerberg and Facebook and with humans adaptively using media and technology to help us with our romantic relationships.

Love and why it matters

The psychotherapist Sue Gerhardt in *Why Love Matters* stresses that there is nothing automatic or inbuilt about the ability to relate to others. Before we learn to speak we need to have developed within ourselves an increasing skill in managing feelings. This relies largely on the quality of our pre-verbal social interactions that develop the post-natal brain.

Without ample mediation of our feelings by others when we are small, we run the risk of experiencing love as banal, meaningless or excitingly deathly. There is then the risk of developing addictive practices with media technologies and losing our sense of individual *agency*.

When all goes well enough in an analysis, patients may begin to look into the unknown with curiosity and not too much anger or anxiety. I see this as discovering a romantic relationship with life. It is a good moment when a person, obviously held and fashioned by their culture (how could it be otherwise), becomes free enough to have an inner world of reflective feeling. This allows their authentic self to experience spontaneity, sensuality and a sense of safety rather than paranoia. This is the person, I suggest, who can emotionally 'use' the technological mediation of love productively and creatively ■

Carol Leader is a psychoanalytic psychotherapist who also lectures and consults in business and the arts. Formerly an actor, writer and presenter, for the past two years she has been part of the advisory group of Media and the Inner World, an AHRC-funded research project.

This is a shortened version of a paper from the 'Psychoanalysis and Popular Culture' conference in February, hosted by Media and the Inner World.

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On The Frontline

‘Therapy improved my life’

By Rachel Thomas and Ann Byrne

‘Ms B, 45, arrived at the Women’s Therapy Centre looking destitute and burdened. I met a hunched woman, hidden under an oversized man’s overcoat, her dark curly hair trapped under a threadbare woollen hat.’

MS B* IS TYPICAL of many patients seen at the Women’s Therapy Centre. She was a refugee, driven from her country by rape, violence and torture. Her husband and children were dead and she had escaped to the UK via a family friend. Previously wealthy, she was living on benefits in hostel accommodation and was suffering from nightmares and flashbacks, recurrent depression and a plethora of psychosomatic symptoms. She spoke limited English and her initial sessions were conducted through an interpreter.

Ms B was the eldest of seven children born to a poor Black, African family. She was adopted by her childless maternal aunt at the age of six and had little contact with her family. She described a loving relationship with her Aunt who died when the patient was 14. She was then returned to a family from which she was estranged, and was quickly married to a wealthy man at the age of 15.

Her therapist’s initial countertransference was of despondency and doubt. Would a psychoanalytic approach be appropriate for this patient? Would it not be cruel to attempt to work psychically with someone with such concrete needs and deprivations?

The ethos of the Women’s Therapy Centre is that it is possible to work psychoanalytically with even the most traumatised and disturbed women, providing that appropriate clinical safeguards are in place. For some, this is via a supportive NHS network. For patients like Ms B, a crucial aspect was also the role of the Centre’s ‘Link Worker’ who provides parallel sessions for women in psychotherapy, offering practical advice and help. Her role is crucial to freeing the psychotherapists working with such damaged patients. Nonetheless, the analytic work needs to be applied and flexible:

On her third session Ms B came in agitated, demanding milk. She refused to sit down unless her therapist conceded. She was hungry and thirsty, she said, and could not think without milk. It appeared that she had not eaten a proper meal in two days. Her benefit money had not come through. A friend had offered to cook for her, but Ms B had felt too proud to take up the offer.

She was not provided with milk, but the receptionist made her tea and her therapist persuaded her to sit down. The session began with thinking about being too proud to ask for help. Ms B became tearful and talked of her shame about having to beg for food, having formerly been a woman who would have issued beneficence. She agreed that she would take up her friend’s offer. This enabled thinking to take place about her wish for concrete maternal care from her therapist, rather than that sessions might provide emotional understanding.

Her one-year therapy provided Ms B with an emotional language. Having arrived not wanting therapy, she began to find words (and in English) to describe her feelings. For such a traumatised woman, this was a notable achievement. In an endeavour to relate more directly, she took up English classes and began attending without an interpreter. It then became possible to link her more recent traumas with the traumatic early loss of first her family life and then her beloved Aunt.

The Women’s Therapy Centre has been offering individual and group psychotherapy to women since 1976. Its access policy ensures that psychotherapy is available to all women, regardless of financial or immigration status, sexual orientation, disability, cultural or social background, previous psychiatric history or age. The Centre has a particular commitment to offering psychotherapy to women who would not usually have access to it.

Over the years, the Centre has developed particular expertise in working with highly traumatised populations, including refugees/asylum seekers and women who have experienced extensive abuse, including domestic violence. The Centre preserves its philosophy of employing only female staff and working with female patients, but third position thinking is firmly adhered to via regular supervision and clinical discussion.

‘During recession, women can be particularly vulnerable.’

The Centre offers assessments and four-session psychoanalytic consultations, individual treatments ranging from 12-week to two-year contracts for highly complex cases. We offer group psychotherapy treatments, from focussed themed groups to longer-term general groups. Six-session community ‘psycho education’ groups and ‘taster sessions’ offer opportunities for women to find out about the Centre and directly experience a psychoanalytic way of thinking. A private referrals service operates for women able to pay a full fee. Patients pay fees on a sliding scale.

Whilst the Centre continues to preserve its diversity of clinical, teaching, research and supervisory work, it also faces increasingly challenging times. The government’s investment in IAPT, the implementation of the NICE guidelines, the global recession, all mean that the vital clinical service that the Women’s Therapy Centre offers is increasingly pressurised. The Centre and its staff are committed to surviving the current climate without compromising clinical standards, but we are simultaneously striving to be increasingly clinically creative in a turbulent external world. In recent years the Women’s Therapy Centre has lost funding: grants have been cut, funding has not increased in line with inflation, and fees are increasingly restricted.

During recession, women can be particularly vulnerable. As women already earn less than men and are more likely to live in poverty, any increase in poverty levels and reduction in levels of employment is likely to disproportionately affect women. Research also consistently indicates that high unemployment and economic recession increases domestic abuse.

The increase in demand for the Women’s Therapy Centre services coupled with the decrease in income means that we are unable to meet the high demand for therapy, even from women who urgently require support. Between 1 April 2009 and 31 March 2010, 400 women contacted the Centre but we were only able to offer assessments to 181.

Ms B completed her treatment and went on to join a group, where she continues to progress. Whilst a year’s treatment could only be a beginning for her, it was nonetheless one that enabled her to become less depressed, better integrated, more communicative literally and psychically, and to develop the beginnings of a symbolic and emotional language to describe her distress.

At the end of her contract Ms B wrote that she had been ‘helped with many, many problems’ and that ‘therapy improved my life’. Patients like Ms B are rarely deemed appropriate for psychoanalytic psychotherapy. As we enter our 35th year, the Women’s Therapy Centre will increasingly need the support of bodies such as the BPC as well as collaborations and partnerships in order to enable our way of working to continue to develop and flourish ■

Rachel Thomas is staff psychotherapist and Ann Byrne is Chief Executive at the Centre
www.womenstherapycentre.co.uk

* To protect confidentiality this patient is an amalgam of several patients seen at the Women’s Therapy Centre during 2010.

Diary

Until 2 April 2011
PSYCHOANALYSIS: THE UNCONSCIOUS IN EVERYDAY LIFE
Science Museum, London SW7
www.beyondthecouch.org.uk

MARCH

19 March 2011
WHEN MUMMY WANTS YOU TO DIE
Robens Room, Guy's Hospital,
Great Maze Pond, London, SE1
Speaker: Brett Kahr
Contact: 020 7378 2054
training@wpf.org.uk

19 March 2011
CHANGE IN PSYCHOTHERAPY AND OUR PRACTICE AS THERAPISTS
IGA, 1 Daleham Gardens, London NW3
Speakers: Andrew Samuels, Jane Campbell
Contact: 020 7431 2693
www.groupanalysis.org

19 March 2011
THE MURDER OF SANITY AND THE SANITY OF MURDER
Royal Geographical Society,
1 Kensington Gore, London SW7
Speakers: David Bell, Philip Lucas, Richard Rusbridger, Rob Hale
Contact: 020 7563 5016
www.beyondthecouch.org.uk

19 March 2011
HOW IMPORTANT IS THE PAST IN GROUP ANALYSIS?
The Red House, 78 Manchester Road,
Swinton, Manchester
Speaker: Harold Behr
Contact: 0161 728 1633
administrator@groupanalysisnorth.com

21 March 2011
CONTAINMENT AND THE THERAPEUTIC FRAME
Tavistock Centre, 120 Belsize Lane,
London NW3
Speaker: John Beveridge
Contact: www.confer.uk.com/
therapeutic_book.html

22 March 2011
ILLUMINATING CHILDHOOD
Freud Museum, 20 Maresfield Gardens,
London NW3
Speakers: Ellen Handler Spitz,
Andrea Sabbadini
Contact: 020 7435 2002
eventsandmedia@freud.org.uk

25-27 March 2011
INTRODUCTORY WEEKEND IN GROUP ANALYSIS
IGA, 1 Daleham Gardens, London NW3
Speakers: David Vincent, Cynthia Rogers, Seda Sengun
Contact: 020 7431 2693
www.groupanalysis.org

26 March 2011
DEPRESSION: A PSYCHOANALYTIC PERSPECTIVE
23 Magdalen Street, London SE1
Speaker: Stephen Crawford
Contact: 020 7378 2054
mayra.angulo@wpf.org.uk

31 March 2011
CONNECTING CONVERSATIONS WITH GRAYSON PERRY
Assembly Hall, Upper Street, London N1
Speakers: Grayson Perry, Valerie Sinason
www.connectingconversations.org

APRIL

1-3 April 2011
AGE MATTERS RESIDENTIAL CONFERENCE: Creativity, Ageing and Psychoanalysis
Rydal Hall, Ambleside, Cumbria
Speakers include Vic Sedlak, Graham Ingham, John Churcher, Tony Brown, Rachael Davenhill, Andrew Balfour, Susanna Abse
Contact: 020 7482 6413
www.agematters.org.uk

2 April 2011
THE I CHING: POINTS OF BALANCE AND CYCLES OF CHANGE
SAP, 1 Daleham Gardens, London NW3
Speakers: Peggy Jones, Ted Martin
Contact: 020 7419 8896
training@thesap.org.uk

2 April 2011
PORTMAN SYMPOSIUM: CONTEMPORARY PSYCHOANALYTIC IDEAS. Approaches to clinical work with perverse patients
Institute of Psychoanalysis,
112a Shirland Road, London W9
Speakers: Gigliola Fornari Spoto, David Morgan, Stephen Blumenthal, Heather Wood, Stanley Ruszczynski
Contact: 0208 938 2487
jdelafons@tavi-port.nhs.uk

2 April 2011
AGGRESSION, MOURNING AND THE SURVIVING OBJECT: D.W. WINNICOTT
Friends Meeting House,
91-93 Hartington Grove, Cambridge CB1
Speakers: Sarah Cooke, Martha Stevns
Contact: 020 7435 7696
training@thesap.org.uk

2 April 2011
SATISFYING MOTHER
Friends Meeting House, 43 St Giles,
Oxford OX1
Speakers: Mary Anne O'Donovan, Melissa Midgen
Contact: 020 7435 7696
training@thesap.org.uk

5 April 2011
OSCAR NEMON: MY FATHER AND FREUD
Freud Museum, 20 Maresfield Gardens,
London NW3
Speaker: Lady Aurelia Young
Contact: 020 7435 2002
eventsandmedia@freud.org.uk

8 April 2011
CIVILIZATION AND ITS DISCONTENTS
Royal Geographical Society,
1 Kensington Gore, London SW7
Speakers: David Bell, Gillian Beer
Contact: 020 7563 5016
www.beyondthecouch.org.uk

9 April 2011
CHANGE: GENDER AND SEXUALITY
IGA, 1 Daleham Gardens, London NW3
Speakers: Barbara Lloyd, Cherry Potter
Contact: 020 7431 2693
www.groupanalysis.org

14-17 April 2011
EPF CONFERENCE
Tivoli Congress Center, Copenhagen
Contact: www.epf-fep.eu
geber-reusch@t-online.de

16 April 2011
DISSOCIATIVE STATES AND CHILD ABUSE
Friend's House, Euston, London NW1
Speaker: Valerie Sinason
Contact: training@wpf.org.uk

28-30 April 2011
IAFP CONFERENCE: MURDER IN MIND
Apex International Hotel, Edinburgh
Speakers include James Gilligan, Schlomo Shoham, Cleo Van Velsen, Gwen Adshead, Barry Richards, Bandy X Lee, Anne R Douglas, Hubertus Adam
Contact: conference2011@forensicpsychotherapy.com

MAY

4 May 2011
PSYCHOANALYSIS AND POLITICS
Low Countries Room, Senate House,
University of London, WC1
Speakers: Stephen Frosh, Daniel Pick, Timothy Ashplant, Sally Alexander
Contact: 020 7862 8740
ihr.reception@sas.ac.uk

7 May 2011
BPC TRAINEES' CONFERENCE
Institute of Psychoanalysis, London W9
Contact: 020 7561 9240
mail@psychoanalytic-council.org

7-8 May 2011
IMPLICATIONS OF RESEARCH ON THE NEUROSCIENCE OF AFFECT, ATTACHMENT AND SOCIAL COGNITION
Cruciform Building, UCL, London WC1
Speakers include: Sarah-Jayne Blakemore, Anna Buchheim, Peter Fonagy, Andrew Gerber, Gyorgy Gergely, Jim Hopkins
Contact: n.harding@ucl.ac.uk
www.ucl.ac.uk/psychoanalysis/events

14 May 2011
THE ROLE AND FUNCTION OF MEANING IN CURRENT PSYCHOANALYTIC THINKING
The Governors Hall, St Thomas' Hospital,
Lambeth Palace Road, London SE1
Speaker: Margot Waddell
Contact: 020 7978 1545
clinic@lincoln-psychotherapy.org.uk

21 May 2011
IMAGINATION AND EARTH
SAP, 1 Daleham Gardens, London NW3
Speakers: Mary-Jayne Rust,
Anna Bravesmith
Contact: 020 7419 8896
training@thesap.org.uk

21 May 2011
WHEN CHAOS RULES: Psychotic and Disordered Relating in the Couple Dynamic
TCCR, 70 Warren Street, London W1
Speakers: Susanna Abse, Francis Grier, Stanley Ruszczynski, Joyce Lowenstein
Contact: 020 7380 1979, bscpc@tccr.org.uk

24 May 2011
APP AGM & ANNUAL LECTURE
Tavistock Centre, 120 Belsize Lane, NW3
Speaker: Peter Hobson
Contact: 020 7272 8681, www.app-nhs.org.uk

27-28 May 2011
SYNCHRONICITY CONFERENCE
BAP, 37 Mapesbury Avenue, London NW2
Speakers: Joe Cambray, Steven Flower, Hester Solomon, Warren Colman, Marilyn Mathew, Geraldine Godsil
Contact: 020 8452 9823
www.bap-psychotherapy.org

JUNE

11 June 2011
WHATEVER HAPPENED TO ACTION MAN'S GENITALIA?
Friends Meeting House,
91-93 Hartington Grove, Cambridge CB1
Speakers: Trevor Jameson, Daphne Lambert
Contact: 020 7435 7696
training@thesap.org.uk

11-12 June 2011
LACAN'S CHILDREN
Cruciform Building, UCL, London WC1
Speakers include: Lionel Bailly, Bernard Burgoyne, Françoise Hivernel, Amber Jacobs, Claire Meljac, Dany Nobus
Contact: 020 7679 5997
n.harding@ucl.ac.uk

18 June 2011
UNDERSTANDING AND TREATING BORDERLINE PERSONALITY DISORDER
Winchester University, King Alfred Campus, Hampshire
Speakers: Glen Gabbard, Paul Williams, Gwen Adshead
Contact: 07963 092 689 / 01794 511219
soep.conference@virginmedia.com

23-26 June
INTERNATIONAL NEUROPSYCHOANALYSIS CONGRESS: MINDING THE BODY
Berlin
Speakers: Wolf Singer, Bud Craig, Antonio Damasio, Peter Fonagy, Vittorio Gallese, Marianne Leuzinger-Bohleber, Jaak Panksepp, Mark Solms, Patrik Vuilleumier, Sigrid Weigel
Contact: admin@neuropsa.org
www.neuro-psa.org.uk

25 June 2011
AN INTRODUCTION TO JUNG'S CONCEPT OF INDIVIDUATION
SAP, 1 Daleham Gardens, London NW3
Speakers: Martin Schmidt, Anna Carey
Contact: 020 7419 8896
training@thesap.org.uk

25 June 2011
FUTURE: LOOKING INTO THE VOID
Friends Meeting House, 43 St Giles,
Oxford OX1
Speakers: Arthur Sherman, Barbara Levick
Contact: 020 7435 7696
training@thesap.org.uk

AUGUST

3-6 August 2011
IPA CONGRESS: SEXUALITY, DREAMS AND THE UNCONSCIOUS
World Trade Center, Mexico City
www.ipa.org.uk

24-28 August 2011
WORLD CONGRESS FOR PSYCHOTHERAPY
Sydney Convention & Exhibition Centre
www.wcp2011.org

Review

WALKING WITH FREUD

Radio 3, 21 November 2010
David Matthews and Anthony Cantle visit Leiden one hundred years on.
Produced by Rosie Boulton

One August day in 1910, in the Dutch town of Leiden, the 54-year-old Sigmund Freud met the famous composer Gustav Mahler for a one-off, four-hour consultation. Mahler was in crisis as a result of his wife having an affair, and a friend had advised him to speak with Freud. Mahler's reluctance to meet with Freud came in part from a fear that his creativity derived from his neurosis. After twice pulling out of previous appointments due to intense ambivalence, Mahler finally travelled to Holland to meet with Freud during Freud's summer holiday. They talked as they strolled around the locale.

In 'Walking with Freud' psychoanalyst Anthony Cantle and composer David Matthews retraced the steps their predecessors took a hundred years before, providing a treat for lovers of Freud's work and lovers of Mahler's music, a double treat for lovers of both. David Matthews identified strongly with Mahler, his passion for music and his pouring of emotions into it. Anthony Cantle did an excellent job of explaining the psychological factors affecting Mahler and his wife at that time. Each had suffered loss upon loss in childhood. Mahler was the oldest of 14, and eight of his siblings died in infancy, and two more later on, one through suicide. He and his wife were each a catch for the other. The great composer provided his wife with prestige and status. Alma was much younger, beautiful, and a highly talented composer herself. Mahler's condition of marriage was that Alma give up composing, as he considered that two composers in a marriage was one too many. This she agreed to, but it was a source of much resentment.

It was the death from diphtheria in 1907 of their beloved first child Anna, aged four, that was the start of the crisis. David Matthews pointed out that Mahler's cheerful letters suggested denial of his feelings about the devastating loss. Mahler was himself diagnosed with a serious heart problem. Alma did little to alleviate his distress. She dealt with her emotions by turning to drink, socialising, and later beginning an affair with a young architect, which apparently her husband knew about. Cantle described the likely relation between Alma and her lover as Alma taking control of her object for narcissistic purposes, providing feelings of excitement and triumph as a substitute for feelings of loss. In response to his wife's infidelity Mahler became distraught. He was described weeping on the floor of his composing shed. Cantle likened this to a child weeping, fearful of losing his mother. Additionally, Alma lost her sexual attraction for him. Alma was unrepentant; justifying her behaviour on the grounds that her husband had neglected her, which Cantle points out is not uncommon in this situation.

'Given Mahler's fragile state, Freud would have been cautious, gentle and kindly.'

In their discussion of Freud's likely approach Cantle suggested that, given Mahler's fragile state, Freud would have been cautious, gentle and kindly, his doctorly presence as much as his interpretations reassuring and containing Mahler. He reassured Mahler that the age gap with Alma was not the problem. Mahler felt much better after their talk, which led to a resurgence of love for Alma, inspiring him to write a highly expressive poem to her on the train journey home, emphasising his love for her and his need for her to love him. To her pleasure, he became more demonstratively affectionate, lavishing Christmas gifts upon her, and they resumed their sexual relationship, although she also continued the affair with her lover. That summer Mahler finished a long symphony, and in November the couple travelled to New York where he embarked on a hectic season of concerts and tours, conducting the New York Philharmonic orchestra. At Christmas he had a sore throat which developed into a bacterial infection, which was highly dangerous for someone with his heart condition, and he died before his next birthday.

Hearing an analyst and a composer retracing Freud and Mahler's steps created a sense of authenticity and emotional connectedness. These immensely influential, significant figures lived in Vienna at the fin de siècle, and of course Mahler's highly emotional music provided the backdrop for the programme. Anthony Cantle was no doubt conscious of the importance of this opportunity to cast psychoanalysis in a good light and correct some of the uninformed prejudices that abound. It is rare to hear an eminent practising psychotherapist describing his field in such an accessible programme, and Cantle conveyed both his humanity and deep understanding of mental life.

He explained several analytic concepts such as transference and the impact of childhood events on later relations in an accessible fashion. The difference between reassurance and containment was not made entirely clear, perhaps due to the editing. Cantle emphasised the importance of Freud not making interpretations to a fragile patient in a one-off consultation. One suspects that Mahler's surge of love for his wife following the consultation represented a putting to one side of his rage at her betrayal. Given this I was left wondering how Freud had dealt with the anger. It was fascinating hearing about Mahler's difficulties, and it will add another dimension to listening to his music in future. It is also very sad that he died so prematurely, depriving us of more great works. Unlike Freud, who fortunately lived long enough to write ten more volumes of the Standard Edition ■

Download the full text of Anthony Cantle's original presentation on this theme at www.psychoanalysis.org.uk/pdf/cantle2010.pdf

Anthony is presently working on another programme, with David Matthews and others, this time on Mahler's 5th Symphony Adagietto. This is to be broadcast this spring on BBC Radio Four.

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