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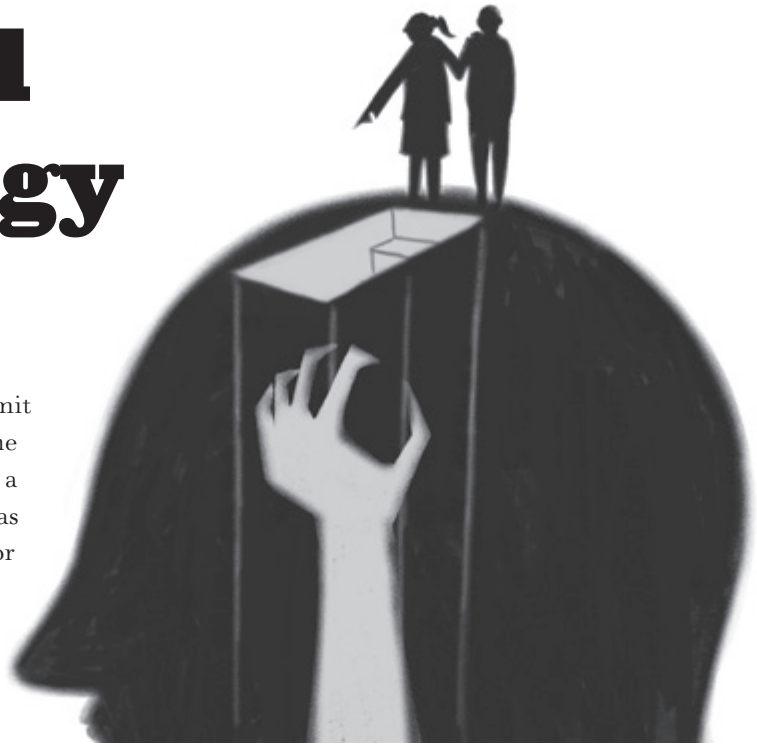
‘Anxiety means: the soul demands’ – Jung’s reformulation of psychotherapy beyond the treatment of pathology

Katerina Sarafidou



One of Jung’s most substantial contributions to the practice of psychotherapy was the addition of a modality that aimed not just at the removal of symptoms but at the higher psychological development of the personality, which he termed individuation. This new approach was part of a wider shift in the understanding of psychotherapy in the early 20th century from a pure medical treatment of pathology, to facilitating the experience of a specific type of interiority and singularity that led to the emancipation of individual subjectivity from societal norms, traditional moral conditioning and familial authorities. The aspiration was the autonomy of personal life and the construction of identities imbued with renewed meaning and purpose.

This expansion of the remit of psychotherapy from the treatment of disorders to a life- enhancing process has important implications for the relationship between analyst and patient, but also for the nature of psychotherapy, which now becomes the vehicle

for self-knowledge and self-education. For Jung, this self-education had not just personal relevance but was the only way to achieve cultural regeneration and could serve as a bulwark against mass-mindedness and against conflict between nations. Writing during World War I, he suggested that 'the psychology of the individual is reflected in the psychology of the nation… Only a change in the attitude of the individual can initiate change in the psychology of the nation' (1916a, p.4).

Jung's approach was grounded in his understanding of the nature of the psyche as prospective. This means that products of the unconscious such as dreams, fantasies and symptoms were not necessarily related to wish fulfilments or products of early infantile predispositions. They were attempts to resolve moral conflicts in the present and to prepare the way to the future. Neurotic symptoms were a purposeful attempt of the self-regulating psychic system to restore balance. The focus of psychotherapy was not to reveal a retrospective cause of neurosis but to restore the flow of the stream of life by establishing a connection between conscious and unconscious parts of the psyche.

The method serving the new aim of psychotherapy was called 'active imagination'. Unlike Freud, Jung never wrote dedicated papers on technique. This is likely because he describes a highly subjective process that does not lend itself to fixed rules and rational measurements. It involves an attitude of openness, receptivity and careful observation of the natural happenings of the psyche, paying attention to the non-rational activity of the deeper layers of the psyche which are creative, imagistic, paradoxical, ambiguous and autonomous (and in the latter sense objective, i.e. experienced as 'other' to the conscious 'I').

This practice involved engaging in a waking state with creative fantasies and images that emerge from the depths of the psyche and trying to dialogue with them. Engagement with these images had a structuring and healing effect in the person's internal life. Jung's aim was not to interpret these fantasies or the mental states of his patients, but to bring about an effective synthesis of this material and an integration into conscious functioning, which could then lead to a transformation of life. He states: 'My aim is to bring about a psychic state in which my patient begins to experiment with his own nature – a state of fluidity, change, and growth where nothing is eternally fixed and hopelessly petrified…. The creative activity of imagination frees man from his bondage to the "nothing but" and raises him to the status of one who plays' (1931, para. 98).

The therapeutic task was the attainment of full knowledge of the heights and depths of one's own nature, and this could never be achieved through purely rational means: it required the cooperation of non-rational elements and processes of the psyche. According to Jung, the disconnection of the Western mind from imagistic consciousness and the repression of irrationalism as a psychological factor led to the outbreak of irrationalism reflected in the War.

The role of the analyst is not one of an expert, but rather a guide who can teach the suffering patient to listen to their own nature and accompany them in 'their descent into the hell of self-knowledge' (Sarafidou, 2023, p. 15). The analytic work 'is less a question of treatment, than of developing the creative possibilities latent in the patient himself' (Jung, 1931, para. 82).

Individuation is not a spontaneous occurrence but a moral achievement. It requires a preparedness to tear down previous ideals and cherished convictions and to remould one's values. It is a voluntary sacrifice of a previous sense of security and the withdrawal of projections that allows one to come to grips with all those aspects of the unconscious psyche that were previously excluded and rejected. This was the only effective protection against war. As Jung states: '…when do men fall on their brothers with mighty weapons and bloody acts? They do such if they do not know that their brother is themselves… . They should sacrifice the hero in themselves, and because they do not know this, they kill their courageous brother' (2009, p. 153).

For Jung, the process of individuation becomes evident only in the transformation of human relationships and ultimately in the reshaping of society. As Jung's soul puts it: 'Anxiety means: the soul demands. A remedy has befell men: not wisdom, not virtue, not belief. But growth' (Jung 2020, p. 272). The way of life is not exclusion of any part of humanity, but transformation.

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The Israel-Gaza Conflict and the BPC

Lee Smith

I have recently found myself, as Chair of the BPC, in the midst of a uniquely heated and polarised debate about the conflict in Israel and Gaza. Many of our registrants have felt it important to draw attention to the slaughter and kidnapping of innocent Israeli civilians in October 2023 and the ensuing humanitarian crisis in Gaza. Many others have organised to condemn Israel's disproportionate actions in seeking to defend itself. This group, Clinicians for Gaza, contacted the BPC to ask us to promote its activities, which we did in the April e-newsletter.

Following this, a small but impassioned number of responses were received, expressing disbelief at the way this information was communicated. On such a significant matter the BPC, it was said, should have taken a far more robust position, expressing outrage at the suffering being inflicted on innocent Palestinians. Instead, the BPC had chosen to remain silent, to stifle discussion, making itself complicit against the cause of justice. All of these comments were fed back to the BPC Board.

Others, however, claimed that the events of October 2023 were so abhorrent that there was nothing to be said or thought about in relation to them. They must be condemned, and those who had perpetrated them were inhuman. By extension, publishing anything from the Clinicians for Gaza group was tantamount to condoning these atrocities.

That there can be no perspective here, that it is felt there is nothing to be said from 'the other side', is of course a position we will all be familiar with – a position from which there can be no dialogue because there is nothing to be thought about. Can an organisation with a membership as diverse as the BPC hold a space for thinking without this being immediately condemned as a failure to act?

My intention here is not to give a view on the conflict in Israel and Gaza. Neither is it to defend the position the BPC adopted, or to 'call out' the people who chose to contact the BPC. That they went to the trouble of organising to make their views known is testament to the levels of engagement and passion in our profession. I do though want to address important questions these events raise for the BPC about how we engage with divisive and emotive subjects, and about what we have to offer.

The Purpose of the BPC

The objects of the BPC as set out in its Articles of Association are 'the maintenance and regulation of professional standards' and 'to advance education in and of psychoanalytic and psychodynamic psychotherapy and counselling'.

"Is there a collective voice, and if so how is this to be arrived at? And what should be prioritised?"

In recent years, partly motivated by the spectre of statutory regulation, the BPC has focused its efforts and resources on consolidating its regulatory role. The BPC is now a registered charity and a Professional Standards Authority voluntary regulator. For some, this emphasis has come at the cost of speaking on behalf of the profession. The board's view has been that it is only by putting in place a robust regulatory framework, a system for identifying and remedying problems within our profession, that we can have a voice that will carry authority and credibility. Even then there remain questions about who the BPC is speaking on behalf of. Is there a collective voice, and if so how is this to be arrived at? And what should be prioritised? Making the case for psychoanalytically informed practice to be included in NICE guidelines on depression and anxiety is one thing. Representing the view of the profession when confronted with a humanitarian catastrophe is quite another.

The difficulties we as a profession have with debating are well documented

(see Tuckett, 2023). Basic Assumption rather than work group functioning characterises internal debate but also impinges on what psychoanalysis has to offer the wider world. Nor are we immune from the polarisation and heatedness characteristic of much social media discourse. But if we lose the ability to create and hold space for thinking and feeling of all kinds, we risk losing the essence of what our profession has to offer.

In our professional lives, the question of when to speak and when to remain silent is hotly disputed. We are clear about the need for analytic neutrality and we routinely hold our silence when confronted with the worst of human suffering. Whether and when to break our silence, whether and when to interpret, is not about better or worse practice. It is about sensitivity and the need above all to protect a capacity for thinking in the face of unbearable pain.

I know, having spoken to many registrants, that remaining silent about the Israel-Gaza conflict is not a matter of indifference. For many, maintaining their silence has been a hard-won choice, reflective of intense personal turmoil. We know from the consulting room, though, how easily silence can be misunderstood. The brevity of the information carried in the newsletter certainly belied the passionate discussion that took place within the BPC. What the BPC can attempt to do is to hold a position that reflects the diversity of opinion among our registrants and, when the time is right, to foster further dialogue and thinking.

I have found myself following the terrible events in Israel and Gaza on a daily basis, looking at the history, trying to make sense of what is happening. On a recent podcast, Ari Shavit, an Israeli journalist and author, described this conflict as being about 'history, identity, and soul and feelings, and humiliation and anger and fear' (Klein, 2024). What I understood from this person to whom I had looked to make sense of what is happening was that perhaps they too are looking for help, and perhaps it is even to us that they are looking. As a professional community, perhaps we would do well to value more highly our own contribution to the search for a solution on a level at which we are uniquely qualified, of 'identity, and soul and feelings, and humiliation and anger and fear'.

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We welcome your ideas for articles, reviews and letters to the Editor. In particular we are looking for reviews of cultural events, books and films with psychoanalytic interest. If you would like to propose a topic for a longer article (up to 2,000 words), please contact Helen Morgan at helen.morgan@bpc.org.uk.

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Editorial

A 'Matricial Space'

Helen Morgan

In his contribution to this edition of *New Associations*, 'Ethics: the larger picture', David Black refers to Chetrit-Vatine's concept of the 'matricial space'. Beside echoes with Winnicott's 'transitional space' and that of the 'transcendent function' within my own Jungian tradition, I was reminded of the Social Dreaming Matrices first 'discovered' by Gordon Lawrence and with which I have been involved over many years. Here, great care is taken to establish a container so that the sharing of dreams and associations can lead to new thinking about the social and political context in which we exist. What may emerge from such places can be remarkable and creative but is dependent upon a form of containment that often remains unnoticed, but which requires an active attention from whoever is responsible for holding the space.

"great care is taken to establish a container so that the sharing of dreams and associations can lead to new thinking about the social and political context in which we exist'

There are a number of articles in this edition which describe different spaces where analytic thinking is required to find expression in less familiar shapes. There is a helpful description by Devika Dhar of the work of APPCIOs, a BPC Member Institution that supports the work of organisations rooted in the Therapeutic Community tradition. Several articles consider what sort of spaces are needed to work with those suffering from dementia, trauma and 'personality disorder'. The research report by Jane Johnson and Julia Ryde offers important thoughts on how power relations can play out within the analytic structures.

Concerning the nature of the 'space' that is our theoretical base, I hope those trained within a mostly psychodynamic framework might find the articles by Katerina Sarafidou and Andrew Howe of interest in their consideration of how a Jungian perspective brings a different sort of creativity.

"Several articles consider what sort of spaces are needed to work with those suffering from dementia, trauma and 'personality disorder'"

A stark reminder of what can happen when the matricial space is absent or damaged or corrupted in some way is starkly present in the powerful piece by Anna Motz who calls on us to 'Think the Unthinkable' as she describes her work with mothers who have killed their children. There is a strongly articulated plea within the piece for us to stay looking

and listening to events that are regarded by society as so abhorrent, and consider what spaces such women require that move away from the reactive and punitive to something more holding and helpful.

"consider what spaces such women require that move away from the reactive and punitive to something more holding and helpful"

More than ever, it seems, we have much need in society for spaces that can hold different realities alongside each other and allow the possibility for communication and new thinking. In a small way I believe this is what *New Associations* aims to be and, although it can look passive, I am learning how much ongoing work and active attention is required by the editorial board who are responsible for holding the space. I am coming to believe there is an important distinction between the establishment of a 'quiet' place and a 'silent' one. 'Quiet' in that our views should not dominate the issue but remain a background presence in order to facilitate conversation and hopefully new thinking. Paradoxically the protection of such a space can, at time, require a certain ferocity.

"there is an important distinction between the establishment of a 'quiet' place and a 'silent' one"

The BPC as a registering organisation has to hold a similar – although also different – sort of space and Lee Smith writes in this edition about where he finds himself in terms of his role as chair of the BPC in relation to the terrible events taking place in Israel and Gaza. No doubt readers will respond differently to what he has to say, but I hope it helps to further understanding of the work he and the BPC board are doing on what sort of space the BPC should be offering at a time where there are strong pressures arguing different realities, each passionately held.

At *New Associations*, we as an editorial board continue to think about and discuss our role and how we can ensure that New Associations remains a 'matricial space' from which new thinking, new understandings might emerge.

Ethics

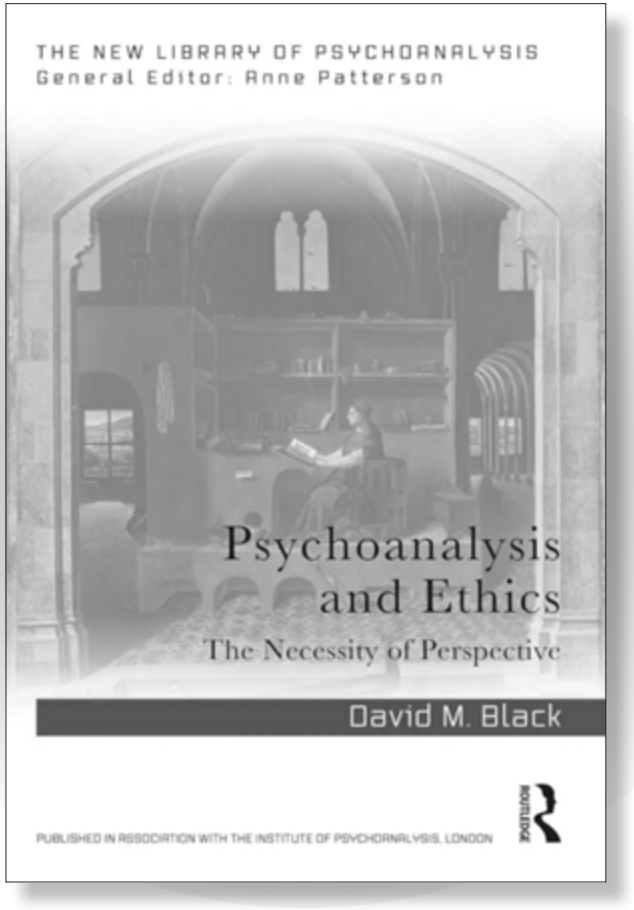
Ethics: the larger picture

David M. Black

The issue of 'ethics' has become ever more central in the past few decades, both in the wider spheres of politics and ecology, and in more restricted fields such as that of psychoanalytic thinking. In America, Donna Orange and others have spoken of an 'ethical turn' in psychoanalytic thought; in Britain, this is still confined to individual thinkers, but Alessandra Lemma, for example, in an impressive book entitled *First Principles* (2023), has recently confronted the issues head-on.

"The issue of 'ethics' has become ever more central in the past few decades"

I shall attempt here to outline the larger context, in which the necessity for this 'turn' has developed. As I conceive it, though several issues are now approaching dangerous crisis-points (the list is, alas, familiar: climate-change, authoritarianism, hypercapitalism, nuclear weapons…), they have a common root stretching back through at least two centuries. This common root is 'materialism', the metaphysical assumption that the ultimate reality is matter, what can be measured and counted. This assumption is both cause and consequence of the rise of science and of a scientific understanding of the world, rendered ever more impressive by the triumphs of medicine, productivity, armaments and technology. It has led too to the decline of religious thinking, in which the existence of the world was meaningful. Religious thinking has 'declined' in two senses: religions have been increasingly side-lined or rejected by educated people as they come to adopt the assumptions of science, and much of religion has itself declined into literal-minded understanding: fundamentalism in Christianity, Zionism in Judaism, extremism in Islam, Hindutva in Hinduism.



The price of this complicated set of developments has been the loss of a central place for ethics. The philosopher Alasdair MacIntyre described it well in *After Virtue* (1981). If the world is ultimately nothing but matter, and if the history of the cosmos and of evolution is merely an account of random events – Darwin asserted emphatically that evolution has no goals – then the notion of intrinsic value becomes meaningless: 'values' can only be instrumental. Friedrich Nietzsche (1844-1900) is an iconic figure in this history. His awareness of the crisis of meaning was so painful that he conceived a solution: an *Übermensch*, a Superman, so vital that he would 'laugh above abysses', create his own values, and be un-depressed by the meaninglessness of the world in which he finds himself. Nietzsche imagined the everlasting recurrence of this futile history – the inevitable outcome, he thought, if atoms were indestructible and time were infinite. Even this, however, would not daunt the heroic *Übermensch*. To the psychoanalyst, Nietzsche's solution can only look like an example of a familiar psychological defence, namely, manic denial. He was unable to stay with the despair evoked in him by the world he believed he was confronted with. (He finally went mad, and was looked after for his last eleven years by his sister.)

The problem Nietzsche was essentially aware of, the 'death of God', the replacement of religion by materialism, was inadequately addressed by philosophy in the following century. Freud's psychoanalysis, which accepted the assumptions of science, struggled to find a basis for ethics. In *Civilization and its Discontents*, Freud wrote that ethics derives essentially from a re-purposing of the death-drive. So much does man long 'to satisfy his aggressiveness on the other…to use him sexually without his consent, to seize his possessions,' and so forth that the only way to manage these urges has been to internalise them; ethics is the product of the death-drive, acting in the service of the superego against the ego's unbounded selfishness.

Freud was describing something, undoubtedly, but his account begs the question: on what grounds does the superego perceive that exploiting others is wrong? The superego results from the internalising of others' values: on what basis do they stand? The argument leads to an endless regress. More recent analysts, for example Viviane Chetrit-Vatine, have sought an origin for ethics in the first relationship of the baby to the mother. Chetrit-Vatine (2004) speaks of the 'matricial space', the psychological space that the mother offers the baby to allow him his psychological growth. 'Matricial' derives from the French 'matrice', the womb: matricial space is like a psychological womb, in which the 'true self' can come into being. It is essentially ethical in its nature, though inevitably always given distinctive tensions by the mother's personality and history. In itself, however, it is both ordinary and wonderful, offered by the 'ordinary devoted mother' who recognises the baby's need for love and safety; she subdues her own desires to the baby's need. The phrases in quotes are from Winnicott, a key figure in the move towards the new thinking.

A similarly matricial space is offered by the psychoanalyst. Chetrit-Vatine is influenced by the French philosopher Emmanuel Levinas (1906-1995), whose account of the origin of the power of ethics in the experience of 'seeing the face of the Other' – by which he meant not the physical face, but something more like the vulnerable human reality of the Other – gave us the first really innovative account of the origin of ethics since Nietzsche's tragic collapse. Levinas, a phenomenologist in the tradition of Heidegger, was a Jew whose family of origin all perished in the Holocaust. He devoted his life to understanding the place of ethics, which he declared to be 'first philosophy' (1984), something known and recognised with an immediacy prior to the sort of knowledge ('ontology') that is given by the natural sciences.

What I have written here is of course an extremely abridged summary of an extremely complex history, and much in it many would disagree with. But it's an attempt to indicate an area of questioning that is becoming ever more important, as we see the decline of ethical seriousness in public life, the increasing use of lies by politicians and business leaders, the irresponsible abuse of power by billionaires, and the increasing development of silos and echo-chambers caused by the use of algorithms in the media. All these things are causes of anxiety; they impact on all of us and on mental health, and are necessarily an important concern for psychotherapists. They call ever more insistently for a new understanding of the place and importance of ethics.

David M. Black is a Fellow of the British Psychoanalytical Society. He has written widely on matters to do with ethics and religion. His most recent publication is Psychoanalysis and Ethics: The Necessity of Perspective (2024).

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Practice

More than symptoms: why hallucinations matter

Andrew Howe

Before you begin reading this article, take a moment to engage in some free association with the word 'hallucinations'. What came up for you? I would be willing to bet that 'psychosis' or even 'madness', despite the connotations of the term, would be in there somewhere. Hallucinations as an experience are seen as pathological. However, this has not always been the case. The analytic world, particularly at its origins, is no stranger to hallucinations. I invite you to consider hallucinations in the hope we might progress them from symptoms to meaningful human experiences.

Hallucinations are defined as sensory perceptions of any modality occurring without external stimulus. Pinpointing their emergence as a conscious experience is challenging. Talking to spirits and experiencing visions has been a part of many civilisations, cultures and religions. For example, Mesopotamian medical tablets note that dead spirits could converse with people and enter their bodies via the ears to cause illness, and Plato heard a voice advising him against specific actions. As Christianity developed in the Western world into the Middle Ages and beyond, experiences of hearing voices continued. There was, however, a notable difference in the response to these based on gender. Women who heard the voice of God were often determined to be mad or even demonic, whereas men were often seen as prophetic. A prime example of this is the persecution of women as witches in the 15th century. The birth of scientific thinking in the 17th century and biological sciences combined with gradual improvements in treatment for those with mental illness contributed to hallucinations being consigned to pathology.

In the present day, I suggest that hallucinations are firmly pathologised

and devoided of any meaning. Even the recent benefits of hallucinogens in treating many different mental health illnesses do not often delve into the meaning of the experiences themselves. I argue that this needs to change; we are missing out on the potential of material, likely from an unconscious source, that may benefit personal growth. This idea is not novel, and the analytic world has much to contribute.

You may note my hesitance to use the term 'psychoanalytic' in this article. My reason for this is that a large part of what follows will rely on the theories of Carl Jung. Jung was a psychiatrist before his development into a psychotherapist and psychologist. After his medical training, he worked under Bleuler at the Burgholzli Hospital in Zurich. Here, he would live an almost monastic life of dedication to his work. Bleuler would coin the term 'schizophrenia' and would direct those who wanted to consider the psychology of the condition to Jung. Large parts of Jung's writing and the seeds of later cornerstones of his work, such as archetypes, would all have their origins in this time when Jung worked daily with hallucinations. Despite this, in the psychiatric and analytic world, Jung's contributions to ideas about schizophrenia and psychosis remain comparatively unsung.

Jung considered hallucinations to be part of the psychotic experience but not exclusively so. Perhaps his religious and mythological background, as well as his personal experiences, developed /this belief. Of particular importance was his version of complex theory, where he explains that hallucinations as an experience are due to unconscious affect-laden complexes (Jung, 1907). The hallucination, then, gives voice to the unconscious. If one tries to interact with the voice, understand it or classify it, one gets a direct expression of unconscious material. Indeed, this is often a more overt experience than a complicated interpretation of a dream or finding meaning in day-to-day actions.

What about schizophrenia and psychosis? In Jung's theories, he noted that hallucinations and complexes could be expressed differently based on factors such as ego strength. For those with weaker ego strength, he expected complexes to lean towards psychosis, and for those with more robust egos, he expected them to lean towards 'hysterical illness' (Jung, 1908). The negative definition of hysteria notwithstanding, what Jung does here allows for hallucinations to be experienced in many different situations and, in his later writings, these are not all pathological. This idea is supported by recent work which notes hallucinations to be prevalent in personality disorder, PTSD and in the general population. I have often used the term illness and pathology in this article; I ask the reader to consider the power of removing something from the grasp of pathology. In living memory for some of us, homosexuality, for example, was defined as an illness. One can see the power of not confining something to an illness. It stops becoming something we must eliminate, treat or cut out.

However, we run into a problem: service users and healthcare workers usually all wish to eradicate hallucinations, and medication is the evidence-based treatment of choice. As an NHS psychiatrist, I encounter patients in distressing, complex states; and their hallucinations could be considered a part of an illness. In my practice, I attempt to explore hallucinations as they are happening, as Jung would advise. This has led to conversations with God, Satan and all manner of people via the patient as an intermediary. I recall being denigrated and insulted by the Devil because I was a doctor. This interaction allowed me to fully understand one patient's unconscious anger at doctors and nurses following repeated traumatic events with her physical health. Exploring this further as symptoms improved confirmed suspicions and led to a referral for trauma-focused therapy, something that would have otherwise been missed. To this date, thankfully, this patient has not relapsed in terms of their psychosis, perhaps because we understood the underlying cause.

While not all of us will meet people during acute psychotic episodes, we can still work with the psychotic content afterwards. Indeed, this is where Jung suggested the most fruitful psychological work could occur. I suggest we need to be open to talking and thinking about hallucinations. Furthermore, as analysts or psychodynamic therapists, whatever our particular theoretical leanings, we need to be willing to look for the unconscious in the experience, be creative and add hallucinations to our metaphorical tool kit. Given the prevalence of hallucinations mentioned above, many of our clients may be having hallucinations but be reticent to bring these to sessions, perhaps for fear of rejection or a myriad of other reasons. I ask that we be open to hallucinations and be willing to explore them wherever it takes us.

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For those wanting to read more about the Jungian theory, the unconscious and hallucinations or the psychotic process, I would suggest reading *The Collected Works of C. G. Jung, Volume 3*.

Practice

Thinking the Unthinkable

Anna Motz

A 19-year-old who murdered her newborn son hours after giving birth has been jailed for at least 12 years.

A trial heard Paris Mayo, then 15, suffocated the boy, Stanley, by stuffing cotton wool into his throat.

Mayo delivered him alone at her family home in Ross-on-Wye, in March 2019, while her parents were upstairs.

"Killing your baby son was a truly dreadful thing to do," said the judge, Mr Justice Garnham, passing a life sentence.

Mayo, who denies murder, claimed she did not know she was pregnant, and the baby was not moving or breathing after birth.

Mayo told paramedics that she did not know she was pregnant and thought she had just put on weight, adding that the baby had 'fallen out of her'.

(BBC News, 'Paris Mayo Jailed for Murder of her Newborn Son', 26th June, 2023)

Can psychoanalytic thinking help us to make sense of this crime, which seems to go against all that we hold dear in terms of the idea of motherhood and the innocence of babies? What could drive an ordinary young woman, with no criminal history, to kill her own baby? As a forensic psychotherapist, working for many years with women who have inflicted fatal violence on others, including their children, I have had to enter the realm of what is, to many, an unthinkable state of mind, in which the only solution to deep despair or rage is to attack another, or oneself.

For an adolescent who has become pregnant accidentally, or whose family would not approve of her having sex, the prospect of childbirth may be horrifying, to the extent that she cannot acknowledge the fact of pregnancy even to herself. Hysterical denial of pregnancy is more

common than would be assumed, and results in situations where termination is no longer possible and a mother might give birth alone, only learning that she is pregnant when her labour begins. Killing a baby within its first 24 hours of life is termed neonaticide; within the first year of life, infanticide; in childhood, filicide. An unthinkable crime to many, it is essential to understand its causes, the social and psychological factors which give rise to it, and how we, as a society, can prevent it. A recent study reveals that the lives of mothers who committed neonaticide, infanticide or filicide were characterised by poverty, abusive relationships, poor family and lack of social support, but doesn't allude to the unconscious fears and phantasies that underlie the killings (Milia and Noonan, 2022).

"An unthinkable crime to many, it is essential to understand its causes, the social and psychological factors which give rise to it"

Aggression exists in even 'ordinary mothers' whose unthinkable and unspeakable thoughts and feelings towards infants are hard for society to accept. Such feelings are far more common than imagined, as anthropologist Katherine Mason shows in her research into mothers' intrusive thoughts. Even for those who do not go on to harm their babies, the intensity and frequency of these violent thoughts reveals how maternal aggression is often suppressed, only to re-surface as 'alien' thoughts, intruding from without. Mason gives an example:

The Blender

A woman enters the kitchen warily, a three-week-old bundle in her arms. The bundle is asleep, but the woman knows that might not last. She creeps over the threshold, the linoleum cold under her bare feet. She will be fast. The cup of water is right there. She will just creep in and grab it before anything can happen. But there are so many weapons here. The blender—the baby would fit in…

"Did you hear what I told you?" she is telling me. She would reach through the phone if she could, shake me, to make me understand. "I said I thought about putting my baby in the blender." (Mason, 2022: 117)

As Estela Welldon first revealed, maternal violence is a reality, one that is fiercely resisted in the public imagination. For a woman with a history of narcissistic or neglectful parenting, caring for a tiny creature with unknown needs and unmet desires, childbirth can be devastating. The infant may seem unfathomable and impossible to satiate – a persecutory being, its cries and frustration are proof to the mother that she is a failure, unable to soothe or satisfy this infant. Far from the idealized image of 'Madonna and Child' the new baby can place intolerable pressures on a mother, and this new coupling can be far from idyllic. To acknowledge this is to invite shame and disapproval.

For many women, pregnancy is a time of hope that includes a projection of unfulfilled longings invested in their unborn baby, who is imagined to be a healing force, offering ultimate satisfaction, a triumph in the procreative power of the mother, evidence of goodness. Their fantasy is that the baby will offer the experience of being loved and nurtured; the birth of an actual baby can be a terrible shock, shattering these fantasies. A pregnant woman deprived or abused in her own life may especially hope for a baby to fulfil her need for love and bestow a sense of self-worth upon her. During pregnancy, the fullness in her body, the interest it generates, and the power of her feelings can offer an unexpected sense of being seen, noticed and attended to. It may also be a kind of suspended animation, hoping for a happy ending – for a second chance at enjoying, through their babies, the kind of childhood they had longed for. At an unconscious level, becoming pregnant involves identification with their own mother and her body as well with the unborn child, and offers a forum for revenge. Attacks on the baby reflect both homicidal and suicidal feelings.

Some women are scared by unusual sensations and afraid of what is growing within them, especially those to whom containment, support and guidance is unknown. Dinora Pines describes how the birth of a child can be a terrible disappointment and shock, dispelling the fantasies of ideal care, nurture and love for a deprived mother, re-activating earlier pain and a sense of rage. Sometimes this shock and anger is projected onto the baby, whose tiny mind and body become targets for sustained attack. While the aim of the assaults is to project unwanted impulses onto a living creature, rather than kill them, the baby does not always survive.

The strongly held belief in the sanctity of motherhood and the hope that even for the most damaged and deprived women, becoming a mother 'will be the making of

them', can blind people to the fact that for some women, pregnancy and childbirth can be a traumatic reawakening of early experiences, and may in some instances unleash intense emotions, including violent ones. The medical and criminal justice systems can be slow to recognize the real meaning and motivation of the women's actions and the extent to which they can reasonably be held responsible for them.

"The medical and criminal justice systems can be slow to recognize the real meaning and motivation of the women's actions"

I worked with Lily, a 28-year-old woman who was charged with and pleaded guilty to infanticide following the death of her six-month-old daughter, Tamara, whom she had suffocated. My role was to work with Lily to help her understand what had led her to this point, how to make sense of the complex and dark forces within her, and finally, how to live with this. In forensic psychotherapy a central task is to discern the underlying and often unconsciously forged meaning of the offence. Psychoanalytically, the underlying meaning of the crime must be deciphered in the light of desires, fears and wishes, not yet accessible to the perpetrator, who maintains that they acted without thought, or under coercion. In so doing, there is serious risk that therapy will destabilize the defences, leading to a crisis or breakdown, perhaps even leading the mother's death. The fusion of homicidal and suicidal impulses means the mother may take her own life as easily as that of her child, with whom she identifies.

Lily's history was typical of women I have met in secure services, prisons and probation hostels, and included sexual and physical abuse, as well as chronic neglect. Her mother was a drug-addict who frequently self-harmed, which Lily witnessed. Teachers commented on how sad, neglected and scared she seemed, often coming to school hungry. She became involved with gangs at 12 and left school at 16. After dropping out, Lily lived rough, where she met her violent partner, to whom she became, in her own words 'addicted'. She used drugs and self-harm to distract herself from feelings of emptiness and fear. At 18 she became pregnant. Lily did not conceal the pregnancy, seeing it as proof that she could have something 'good'. By the time she gave birth, three weeks early, her partner had left her for a new relationship, though still wanted contact with his daughter.

Socially isolated, Lily despaired, neglecting Tamara as she turned to drugs. Care proceedings began, and Tamara went into foster care. Shortly before she was six months old, Lily had contact with Tamara in her home, with her mother supervising the visit. On the day, her mother left them to go to the shops, unaware of risk. When she returned, Lily was lying in bed with Tamara, whom she had suffocated. She seemed dissociated, singing to her and cuddling her lifeless body.

Lily delayed talking to me in any detail about the day of Tamara's death. She referred to it only as 'the incident', giving little sense that she appreciated the emotional gravity of what she had done, or even saw her child as a human being in her own right. By contrast, she talked readily about her feelings of rage and desperation about her partner leaving her, which triggered overwhelming associations with childhood abandonments. So angry was she at him, and so closely did she identify the two together, that she became convinced the baby could not be allowed to live.

Therapy took place weekly in a secure unit and lasted three years. Lily presented like a small girl, speaking in strangled, soft tones, as if she too had been suffocated. Eventually she disclosed her experience of maternal abuse as well as details of the offence, describing how the break-up of her marriage had reawakened a sense of abandonment and rage, and how she felt that if she couldn't have her baby, no-one could. She related to her daughter not as a subjective creature, but as an extension of herself, to be disposed of at will. Her neglect of Tamara had been extreme, mirroring her own self-neglect. Her plan had been to kill her baby, and then herself.

For women like Lily, murderous violence is an act of communication, an expression of overwhelming pain, their damaged ego and psyche obscuring any loving impulse. As a psychotherapist what is striking is how the heat of that anger and trauma can lead to an almost complete detachment in sessions, with the woman hard to see as someone capable of that unthinkable crime, and so unwilling or unable to engage with its reality. While therapy eventually helped her to

understand her crime, and to mourn Tamara as a separate human being, the pain of what she had done never left her.

The social context of pregnancy, childbirth and childrearing is a crucial concern and the isolation, fear and stigma of unwanted or unplanned pregnancies are forces that can drive a woman to kill in desperation, without apparent awareness of the consequences. Serving time in prison for this crime may seem just, but will not protect future unwanted babies, nor help the mother to recover. Psychotherapeutic work with mothers who have killed can be effective, but the irrevocable nature of their offences carries a lifelong weight of guilt and shame, meaning that therapy requires caution and acute sensitivity.

The consequences of not being able to face and respond to women's fears, histories, and unconscious wishes are profound. We need to acknowledge the traumatic realities of their lives, and to interrogate our own biases, values and preconceptions. Only by being able to think the unthinkable can we hope to protect both mothers and their children.

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Practice

Power in theory and practice: clinician research drawing on peer reading group discussions

Jane Johnson and Julia Ryde

The question for contemporary practice is not whether to engage with power dynamics, but rather, to what degree is it possible to notice and acknowledge the implications of obvious and felt expressions of power? This is the question we were left with after clinician research we conducted drawing on peer reading group discussions organised in the British Jungian Analytic Association. These discussions had the specific aim of developing a critical, evaluative approach to theory. They were set up as part of wider work within the BJAA to engage with racism as a power system manifesting in a largely white psychoanalytic profession (Morgan, 2021). Four key theoretical concepts were chosen for discussion on the basis that each was problematic if used unquestioningly.

We analysed four discussions, using transcripts of recordings made with the permission of the sixteen Jungian analysts who participated (including ourselves). The four concepts were: The Primitive; Inner and Outer Worlds; Contrasexuality (Jung's idea of femininity in men and masculinity in women); and Participation Mystique (a concept Jung took from the writings of the anthropologist Levy-Bruhl on 'primitive mentality'). The discussions were informed by clinical material and by papers chosen for their critique of the concepts from the point of view of binary and hierarchical divisions found in Western and European thought. We drew out three main themes from the discussions after working across the four transcripts using thematic analysis (Braun & Clarke 2012). The first, 'Work of Analysis', identified ways the analysts described, defined, and expressed concern about, particular practices in the consulting room. The second, 'Frames of Reference', identified where participants used, held onto, and questioned identifiable and implied frames of reference, including theoretical concepts. The third, 'Power Dynamics', identified where the discussions concerned power and demonstrated power dynamics in relationships, knowledge, and groupings. We were struck by the number of times we used the broad term 'power dynamics' to describe what we observed or felt was being expressed. This applied across all three themes and provided a link between them. What we mean by power here is a process that influences and asserts difference in relations, capabilities or status, rather than as a possession of an individual or group. The range of connected meanings in the term 'power dynamics' were obvious in some ways, but less obviously, and to a much greater extent, were the felt effects of more or less unconscious power dynamics. This is significant to the question of how, and whether or not, we can choose to engage with power.

We observed that many of these felt experiences were expressed in areas of professional authority in relation to theoretical knowledge and clinical experience, where analysts used their expertise in the discussions in different ways. There was also power at play in the asymmetry of the analytic relationship and the framing of it with reference to theoretical ideas rooted in systems of power. There was power as a process in social constructions that operate within analyst and patient, often unconsciously imported into the work.

Our experience of looking at what happens when key concepts are critiqued, itself an expression of power, revealed the importance of engaging with power, but also the difficulty of doing so.

The artwork *Cold Dark Matter: An Exploded View* by Cornelia Parker was one of the associations that came to mind as we worked together to consider the discussion transcripts, line by line, 'observing' and 'interpreting' to produce codes. Parker arranged for a garden shed and its contents to be blown up by the Army and then suspended the remaining objects. Describing this process, she says:

I chose the garden shed because it's the place where you store things you can't quite throw away … In the gallery as I suspended the objects one by one, they began to lose their aura of death and appeared reanimated … The shed looked as if it was re-exploding or perhaps coming back together again. (Parker 2022)

The artwork held much of the tensions and expressions of what we found we were working with and gave us a way of thinking about both the process of critiquing foundational theory and the challenge of

holding in mind the range of interconnecting and shifting systems of power.

The participants in the discussions experienced anxiety, a shake-up and exposure of their ways of thinking and working. 'What do we do, and do we do it right?' captures this in the Work of Analysis theme. In Frames of Reference, a participant expressed concern about, 'Using this word [primitive] without even thinking about it.' In relation to the theme of Power Dynamics another describes how 'It felt pretty free until you hit up against a power system'.

While there was a willingness to engage with critiquing of key concepts, and an openness to the conflicts this evoked, we found that a deeper reading of the discussions revealed the extent to which power dynamics are intrinsic to both the difficulty and benefits of challenging unconsidered ways of working in analysis. Cornelia Parker's artwork captures what needs to be tolerated when confronting the dynamics of power. Her idea that 'the shed looked as if it was re-exploding or perhaps coming back together again' speaks to the act of critiquing the foundations of analytic work: engaging with dynamics that both blow apart and bind together established notions underpinning analytic work. In relation to this dynamic Paul Hoggett writes that uncritical thought is not simply passive but active in maintaining and 'clinging' to established beliefs. Conversely:

> To think critically one must therefore be able to use aggression to break through the limitations of one's own assumptions or to challenge the 'squatting rights' of the colonizer within one's own internal world. (Hoggett, 1992, p.29)

Blowing apart the analytic shed can be experienced as an act of violence. We are being asked to tolerate the possibilities of further blowing apart or a coming back together. With this comes the question of whether concepts resume their 'aura of death', with no change, or whether there can be a 'reanimation' of the cornerstones of analytic work.

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See full article ''Power Dynamics in Discussions of Contemporary Jungian Theory and Practice' by Jane Johnson and Julia Ryde, *Journal of Analytical Psychology*, 69(3), 2024, The Society of Analytical Psychology. Publisher: John Wiley & Sons.

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Profession

The Tavistock Trauma Service

Jo Stubley

Freud (1920) described trauma as a breach in the psychic shield, caused by an external event that was sudden and provoked the experience of helplessness, causing the mind to be flooded and overwhelmed. The traumatic neurosis is marked by the compulsion to repeat because remembering is not possible. Freud (1895) spoke of 'pathological reminiscences'; trauma being defined in relation to remembering and as an event that causes dissociation. Both definitions support a model of trauma we recognise – traumatic experience challenges the limits of language, fragments the psyche and ruptures meaning.

The world is facing a climate crisis, causing the mass migration of people. The conflict in Israel and Gaza has led to increasing polarisations and prejudices that threaten world and societal stability. The impact of the Covid pandemic on social structures is ongoing whilst neoliberal capitalism leaves its destructive mark on communities with growing inequalities and social and economic injustice. For those of us in the National Health Service, the rise of bureaucracy, potential mergers and increasing risk aversion demonstrate failures at a senior level to contain the survival anxieties that are linked to chronic underfunding in a system that is falling apart.

In this context, attempting to offer a psychotherapy outpatient service to individuals who have experienced complex trauma is challenging. The Tavistock Trauma Service grew out of a workshop begun by Caroline Garland in 1987 and was initially mainly for people who had experienced a significant adult trauma. We have grown into a substantial service that is half of what used to be called the adult department in the Tavistock Clinic. The Tavistock itself has struggled, and one might suggest the organisation shows signs of being traumatised.

"attempting to offer a psychotherapy outpatient service to individuals who have experienced complex trauma is challenging"

Most patients we see have experienced early relational trauma including neglect, physical, sexual and emotional abuse, frequently compounded by various adult traumas, such as sexual assaults, interpersonal domestic violence, and accidents. Many have had very difficult, even re-traumatising experiences in mental health services, and have spent long periods attempting to access therapy and have often been told they are 'unsuitable' or given repeated brief interventions. They are likely to have unstable external realities causing instability in their lives.

We recognise these external realities and endeavour to work ethically and in a trauma-informed way alongside our patients without causing moral injury for the staff. Many of our patients are not psychoanalytic patients in the traditional sense, but we use our psychoanalytic framework to inform, develop and contain the work. We attempt to meet the patient where they are, and this forms the basis for the co-construction of a personalised treatment plan within the initial four session consultation. This is not an assessment, in fact we do not gatekeep the service. Most referrals are accepted if it looks possible to hold the therapy in our outpatient setting. The consultation is to determine if the therapist and patient feel they can work together and to decide what aspects of the service might be beneficial to them.

Patients can be offered up to 18 months of once weekly individual therapy with the same therapist who does the consultation. Whilst being aware that for many therapists working in the NHS,, 18 months may sound like a luxury, the painful reality that is acknowledged by the team and to our patients is that this is rarely sufficient for the extent of their difficulties. This is a potential space for moral injury as staff struggle with the guilt of not being able to offer more, while holding an awareness of a long waiting list of people. We are seriously underfunded and for many years only survived through the incredible work and good will of many trained psychotherapists and analysts who came to us in an honorary capacity. We have now formalised this arrangement to begin offering a two-year trauma course from autumn 2024 which includes a clinical placement in the team.

Several years ago, we noticed a significant increase in referrals of adults who had experienced child sexual abuse (CSA). This led to us setting up a separate arm of the service specifically for Non-Recent CSA. We have learnt how vital it is to have different kinds of groups that can either run alongside the individual work or take place before or after it. The groups include men's and women's groups for NRCSA, art therapy, gardening groups, trauma yoga groups, trauma-focused mentalisation groups and psychoeducation groups. This increases the length of the therapeutic journey and allows us to attend to aspects of the patient that may not be available in individual work.

This links with our patient involvement work. We have two peer supporters/ experts by experience, ex-patients of the service, who offer welcome calls to new patients and provide a drop-in group for those awaiting their consultation. They have co-facilitated psychoeducation groups and the Next Chapter group on endings. Patients nearing the end of their treatment can join the Trauma Service panel which meets monthly with staff to inform, support and develop the service. Membership of the panel can continue for one year.

To survive and grow the service, we have had to be innovative, often on a shoestring and drawing on the enormous goodwill in the team. We can struggle with having enough time to meet and reflect but see it as central to the work, valuing our own connections as a model for containing the painful and, at times unbearable, nature of the experiences our patients bring. We often balance precariously in our attendance to the external world and inner psychic lives of our patients, just as we can sometimes feel that trauma-informed work pulls us away from a psychoanalytic stance or vice versa. Holding these tensions creatively together allows the work to continue.

Jo Stubley is a consultant medical psychotherapist and psychoanalyst who is also trained in trauma-focused therapies. She has been the lead clinician of the Tavistock Trauma Service since 2008 and is co-editor with Linda Young of Complex Trauma: the Tavistock Model *(2022). jstubley@tavi-port.nhs.uk*

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Profession

APPCIOS: The Association for Psychodynamic Practice and Counselling in Organisational Settings

Devika Dhar

APPCIOS has been a Member Institution of the BPC since 2011. Our modality is 'psychodynamic organisational therapy' and we represent an application of psychoanalytic practice based on traditions of the psychoanalytic therapeutic community.

Psychoanalytic therapeutic communities have a distinguished history. In their heyday they were known as training grounds for psychoanalytic practitioners and were an important part of what used to constitute the psychoanalytic diaspora. Many veteran psychoanalytic psychotherapists began their careers working in such communities, going on to consult to them.

The development of therapeutic communities had many influences, including education, psychiatry, group analysis and philosophy. After WW2 a good deal of government funded research went into psychiatry and education, in an attempt to address the high levels of trauma and distress affecting large numbers of veterans as well as the civilian population. Bion's work in groups was part of the broad response to this crisis. The Northfield Experiments that took place in Hollymoor Hospital, Northfield, Birmingham, were hugely significant in the development of group psychotherapy and in the therapeutic community movement. Here patients were encouraged to think and work things out for themselves and face the difficulties of their debilitating condition.

Of the innovative initiatives to set up therapeutic communities, many were short lived. Some like the Cassel Hospital, set up as a therapeutic community in 1946, and the Henderson Hospital's Democratic Therapeutic Community established in 1947, endured longer.

Attempts were made to introduce a more developmental approach into mainstream comprehensive schooling. Research in education built on the tradition of educationists Froebel, Montessori, and the philosopher John Dewey. These schools were found to help children suffering from trauma. Children were encouraged to think and their experience of learning was taken into consideration. In some part the approach was influenced by psychoanalytic theory on the development of the self.

A concept underpinning all therapeutic communities is that the individual is seen in the context of their environment, particularly in relation to the culture of the organization or institution they are in. The unconscious mind of the individual

has an impact on the organization that cares for them through projection, projective identification and re-enactment. The unconscious minds of the staff that work for the organization shape the culture, including the defensive practices, of the organization.

"A concept underpinning all therapeutic communities is that the individual is seen in the context of their environment"

This two way unconscious process, of the patient being impacted by the culture of the institution and the staff of the institution and institution as a whole developing defensive practices in order to bear the work with the patient, needs to be attended to as it can hinder or help the recovery of the patient and the task of the organization.

Since the 1980s, the grounding belief in the importance of social community has been eroded by a culture of competitive individualism and economic cost. Social care and health care has increasingly become driven by budgets and outcomes, and this has gradually become a hostile environment for the survival of therapeutic communities.

APPCIOS works to maintain the tradition of working with the community in the mind of the individual. We recognize the importance of attending to the interface between what individuals unconsciously bring to the organisation, and how individuals are changed by the organization.

We live in a climate of austerity that tends to prioritise standardisation over relational and nuanced thinking. Creating a therapeutic environment can be hard enough to achieve within a consulting room with only two participants; it is many times more complicated when, instead of a single therapist and a single patient, a staff group works to create a therapeutic environment for a group of vulnerable clients.

The training that therapeutic community staff groups have traditionally received has taken many different forms. The model we use in APPCIOS is based on the experience of its founder members and the trainings that they evolved in residential settings over many years. It would take longer than the space available here to describe in detail how we have adapted this training to other organisations, but if you are interested, a brief outline of our core training can be found on this webpage: psychodynamicthinking.info/pot-training

APPCIOS's psychodynamic organisational therapists are trained to apply psychoanalytic thinking to their working context, to facilitate the creation and maintenance of a therapeutic environment. They work in a variety of professional roles, within a wide spectrum of organisations that provide services for vulnerable client groups of all ages. These include residential care homes, schools, prisons, fostering agencies, charities supporting homeless people, youth work with victims of knife crime and with survivors of child sexual exploitation, and many others.

A large part of our work consists in helping our members to develop their own trainings within these diverse organisations. These bespoke trainings aim to enhance the skills of staff and managers, and provide them with the support to offer in-depth therapeutic understanding and emotional availability to very disturbed and traumatised clients, who might never enter a consulting room. Graduates of these trainings can themselves become members of APPCIOS, top up their basic training to register with the BPC, and go on to set up further trainings in other organisations.

APPCIOS is shaped by the people who are our members and who participate in and deliver our discussions, seminars and conferences. Perhaps, the most significant aspect that draws people to APPCIOS is the capacity or willingness to think about the unconscious processes and defences within organisations.

Perhaps most importantly, APPCIOS aspires to be a therapeutic community in its own right. We offer an interactive Community Website open to anyone interested in psychodynamic thinking, through which we facilitate free discussion groups, conferences and thinking spaces.

Do come and see it for yourself at psychodynamicthinking.info, and if you want to know more about us, do take out a free account. We'd be glad to welcome you to our free events and discussion groups.

Devika Dhar is an Edinburgh based Psychotherapist (UKCP adults and children) and a Psychodynamic Organisational Therapist (APPCIOS). She is on the management committee for APPCIOS. She is a tutor in Infant Observation and Institutional Processes on HDS's MSc in Psychoanalytic Observation. She facilitates Infant Observation registered by APPCIOS. She delivers training with Trudy Darien on Race from a Psychodynamic Perspective. She works as a counsellor for care experienced young people with The Promise at Bright-Lights and has a psychotherapy private practice with First Psychology.

Practice

Transference-focused psychotherapy: a personal view

Jonathan Radcliffe

I first encountered transference-focused psychotherapy (TFP) in 2013, when therapists from the Personality Disorder Institute in New York came over to teach a group of psychotherapists and psychologists at South London and Maudsley NHS Trust (SLaM). TFP is a form of psychodynamic psychotherapy, adapted to meet the challenges of working with patients with a personality disorder. Such was our enthusiasm that we commissioned training of a core group of us in SLaM. We later formed TFP-UK and have gone on to provide training collaborations with colleagues in the International Society of TFP.

After completing my TFP training, the psychological therapy service I headed-up was disbanded, a casualty of NHS organisational change. From this troubling experience some good came when I was given the opportunity to form a new personality disorder (PD) service and my suggestion of offering both Mentalisation Based Therapy and TFP was agreed to. Lewisham PD service is one of two UK PD services that offer both of these. Dialectical Behaviour Therapy is offered in the Community Mental Health Teams and once-weekly therapies such as Cognitive Analytic Therapy and psychodynamic psychotherapy are provided in primary care, representing a range of therapies.

"Personality disorder is highly prevalent, has high suicide rates and is hugely impactful on people"

Personality disorder is highly prevalent, has high suicide rates and is hugely impactful on people. Patients commonly also have co-morbid disorders and their PD may also be misdiagnosed, for example as a depressive disorder, anxiety disorder, bipolar affective disorder, ADHD, autism or complex PTSD. Solely addressing trauma does not in itself address underlying personality difficulties.

Otto Kernberg developed TFP, following his directorship at the Menninger Clinic in Kansas in the 1960s, where a study found that patients with significant personality pathology did not respond well to classical psychoanalysis. Kernberg and his colleagues developed and refined TFP over several decades drawing on clinical experience and empirical findings. Their aim was to find a way to create the conditions to be able to carry out a psychoanalytic explorative approach whilst addressing the acting-out and splitting-based defences of patients with moderate and severe PD that can undermine psychotherapy. Kernberg's ideas about the features of PD are now reflected in ICD-11 and the DSM-5 Alternative Model of PD. These identify the core dimensions of PD as problematic self and interpersonal functioning and take a dimensional approach that better reflects the nature of PD – providing greater clinical utility than the traditional categorical approach of 'below threshold' or 'meets threshold' and which does not differentiate dimensions or severity.

TFP has much in common with mainstream psychoanalytic psychotherapy but has significant differences. The object relations theory behind TFP will be familiar to many BPC members. It draws strongly on the British Kleinian tradition,

as well as North American approaches including ego psychology. The idea of a manualised treatment will be alien to those who prefer working wholly freely and intuitively, but I find having a clear and systematic method helpful, and skill, creativity and nuance are needed. The manual provides principals guiding how and when to interpret (not too soon), asking patients questions to gain clarity, and detailed guidance on setting up a treatment frame, including how and when to place limits on acting-out behaviour. This framework allows clinicians to carry out the essential psychoanalytic work of exploring and interpreting unconscious conflicts that uncontrolled acting-out makes difficult or impossible.

The first step is a structural interview to assess psychic structure, and this includes a comprehensive survey of problems; functioning in social, romantic and work-life domains; the degree of integration vs diffusion of representation of self and other; the expression of aggression; level of moral functioning; treatment; and developmental history. Whereas a diagnosis may be less important for milder pathology, diagnosing combined with psycho-education help explain the nature of difficulties, the nature and size of the treatment task and the commitment needed. Accurate diagnosing informs decision-making and avoids the danger of unrealistically short treatments. Clinical and theoretical frameworks and empirical evidence can be applied to specific presentations. It can also be a relief for patients to hear their diagnosis combined with a plan to address their problems.

“Accurate diagnosing informs decision-making and avoids the danger of unrealistically short treatments”

If TFP is indicated, the therapist negotiates an individualised contract, explaining the need for each aspect. They establish what the patient wants to change and negotiate aims relating to functioning at work, in social and romantic relationships. Minimum contracted conditions include attending every session on time, not engaging in self-harm or other self-destructive behaviour, finding work, seeing friends and dating at some point if working on a romantic relationship is one of the aims. The patient is responsible for contacting crisis services if in danger, which frees the therapist to think and explore. The therapist explains that the patient should try to say what comes into their mind at any moment, and talk about the problems that brought them to therapy. Only once the contract is agreed can therapy proceed. Acting-out breaches of the contract are normal and expected, and these are explored and interpreted, but having a pre-agreement makes setting limits easier and more effective.

Therapy then involves the fundamental psychoanalytic techniques of interpretation, transference analysis, the use of the counter-transference and adopting a position of neutrality in relation to patients’ conflicts. However, the TFP therapist is not neutral when interpretations fail to prevent significant acting-out which would undermine therapy were it to continue. Ultimately the therapist may end therapy if the patient continues breaching the contract. TFP interpretations proceed from surface to depth, and are preceded by asking clarifying questions, and drawing attention to contradictory aspects of the verbal and non-verbal communication that indicate the presence of splitting-based defences. The aim is to systematically explore the playing-out of object relations in life and in the transference, with a focus on addressing the predominance of the paranoid schizoid position, leading to a more integrated psychic structure, improved relationships and a more satisfying life.

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Our next TFP-UK and SLaM one-year weekly online introductory course starts in October 2024 consisting of a weekly online seminar. For more information, or further references, visit tfpintroductorycourseuk.co.uk or contact Jonathan.Radcliffe@slam.nhs.uk.

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Mental Health

Analytic witnessing in dementia care

Phil McEvoy

It's nice to think somebody's listening to me instead of saying "oh shut up"' (Alsawy et al., 2020 p156)

Julie, who has Lewy Body Dementia, reflects upon her experience of what good communication is. She is making an appeal to have her voice heard and attended to, rather than dismissed. However, a closer reading also points to Julie's unconscious desire to be connected to a good object who can bear witness to the emotional reality of her experience.

There are an estimated 800,000 to 950,000 people like Julie living with Alzheimer's Disease or another form of dementia in the United Kingdom, which has now overtaken heart disease as the most common cause of death (The Office for National Statistics, 2023). As the neurological decline associated with dementia increases, the capacity to deal with practical challenges and negotiate the emotional landscape, in time present and time past, fades. In benign relational environments in which their needs are met, people with a dementia may live well despite their disabilities, whereas in unsafe environments, their vulnerabilities are hugely exacerbated.

Societal discourses about dementia are generally split into two camps. In the 'bad' camp, dementia is portrayed as a tragedy in which people are divested of self-identity and personal agency as they become increasingly vulnerable. These narratives are often linked to the image of a 'demographic tsunami' of dementia in commentaries about the ageing population. In the 'good' camp, the strengths of people living with a dementia are emphasised

to challenge their stigmatisation and the negative focus on disability. This is exemplified by the mantra 'see the person, not the dementia' (Alzheimer's Society, 2018), often quoted by professionals in the field, which can sometimes take the form of a utopian ideal. Like all split positions, the discourses of the 'bad' and 'good' camps tend to be self-reinforcing in their mindsets, as they fail to address the varied experiences of those affected by dementia in different ways.

A more authentic analytic witnessing requires us to recognise the helplessness and confusion often experienced by people with dementia and their care partners, without being paralysed by impotence. In their edited book on psychodynamic approaches to dementia, Evans, Garner and Darnley-Smith (2020) highlight the directions this may take.

- Recognising the importance of attachment relationships to people with a dementia and the sense of connection that comes from emotional contact with another mind.
- Resisting the tendency to drift into primary process thinking and non-mentalising states of mind.
- Understanding the specific grief responses to dementia that may complicate the task of mourning; anticipatory grief, ambiguous loss and disenfranchised grief.
- Maintaining boundaries and establishing containing spaces is important to allow uncertainties to be tolerated and the limitations of what can be done acknowledged.

These issues come to the fore in the process of dying with dementia, as the pressure to withdraw from emotional contact with the person with dementia becomes more pronounced. However, in the context of an atmosphere of forbearance, life-enhancing meaning and connection can be sustained. Jehanne Gheith, a practising social worker in hospice care, with a psychoanalytically informed ear, recently cited a moving example to illustrate this point:

I watched Miss Agnes light up for her husband even when she could no longer speak. He told stories about her as a young woman, reminding her of who she was... He was the keeper of a past she could no longer communicate, but one which she still resonated with, smiling at the jokes, looking sad at the difficult parts – even when she was largely uncommunicative. (Gheith, 2023, p.347)

As they prepared to say goodbye, Miss Agnes and her husband communicated gratitude for the life they had shared together. Many people with the complications of severe dementia are not so fortunate, as they die in much more confusing and chaotic circumstances, without the witness of such a loving and attentive presence. They are rarely supported in such a containing environment as the hospice, at the time of their impending death. It is a confusing time for their care partners, as their sense of what is theirs and not theirs to hold on to comes under fierce attack. This can be a lonely place to be if it seems that traumatic experiences are unacknowledged and met by societal indifference. Masur and Wertheimer (2022) have drawn attention to the role that the privatisation of dependency plays in exacerbating these trends in the post-pandemic era. Those who are most involved in the day-to-day care of people affected by dementia in a professional capacity are given little status, poor remuneration and almost no opportunities to reflect on their practice. If we are not to assume the role of passive bystanders, greater attention to dementia care within our psychodynamic institutions and training centres is warranted.

Analytic witnessing requires us to challenge the tendency to place people affected by dementia at the margins of our societal concerns. Practically speaking, this involves holding people affected by dementia in mind. Our response may range from finding creative ways of allowing people with dementia and their care partners to utilise their strengths, to the provision of backup support that they require when they cannot care for themselves. For example, by conducting reflective practice groups for professionals in the field of dementia care or involving ourselves in counselling and support services for people directly and indirectly affected by dementia. These measures can be more complex than they appear, as they can expose us to the painful countertransference that accompanies unrepresented states of mind. In part, this stems from our own fears of annihilation and the guilt we experience when we find it hard to tolerate the absolute dependence of others (Winnicott, 1949).

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Dear Editor,

It took a very long time for the psychoanalytic world to begin to address racism within our profession in the UK.

But truly what could be more racist than the avoidance of facing the reality of the genocide in Gaza and avoidance of speaking out about this catastrophe openly within our organisations? Having dialogue and not being censored. Of course we are fearful, fearful of causing upset, fearful of causing hurt, fearful of being cancelled, fearful of losing status, but nothing like the fear for one's life, for the lives of one's family and for the future on one's homeland.

The attempt to annihilate Palestinians is happening today, and has been happening since 1948.* There is nowhere that is safe for Palestinians. Their homeland has been taken over and the current aim of Netanyahu appears to be to kill whoever and whatever remains so that there is no Palestine for Palestinians.

Surely this warrants our serious and urgent attention.

A friend pointed me in the direction of the history of the Deutsche Psychoanalytische Gesellschaft, "the genocide of Jewish people led to a fundamental collapse of psychoanalysis in Germany. … It took years and the work of generations of analysts to alleviate the burden of our Nazi legacy in order to be able to work through shame and guilt … to reclaim psychoanalysis proper …"

Our profession appears to be avoiding speaking about the reality of the genocide of Palestinian people and the impact this is having within our profession today.

Silence is the real crime (Segal1987). And turning a blind eye is collusion. As Steiner (1979) points out in his paper, everyone knows.

*See the documentary, *Blue Box* (2021), for historical context prior to 1948.

Jackie Charbit-Middleton

Film Review

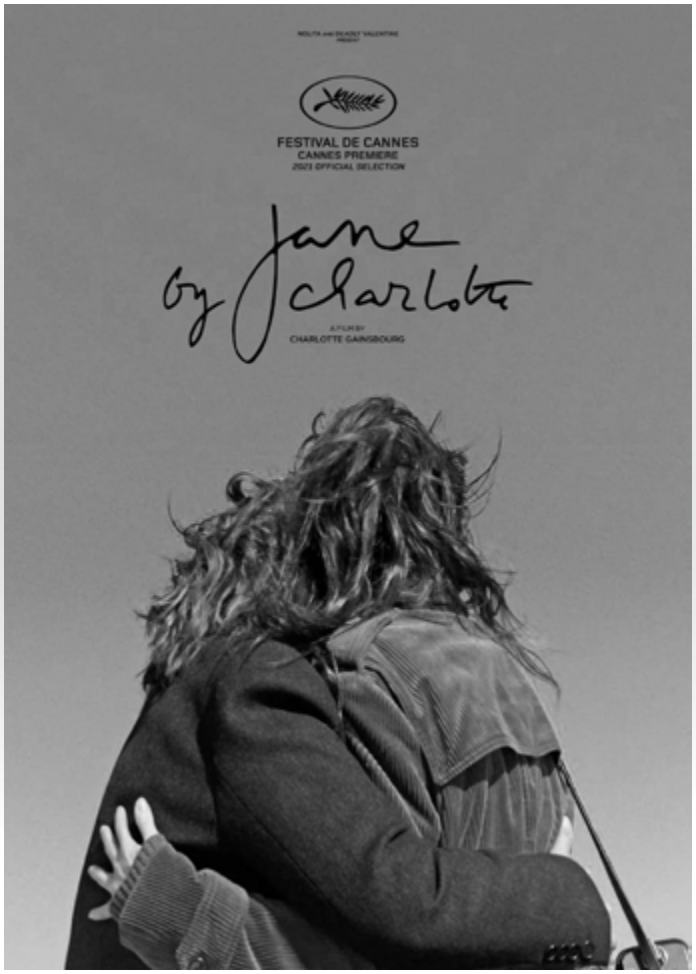
Jane by Charlotte

Film review by Leila Dubois-Barnes

This documentary film was written and directed by Charlotte Gainsbourg and is about her celebrated mother, 'the most French of British artists Jane Birkin' (Le Monde, 2023). Cutting through their shyness, mother and daughter discuss transmission, filial love, motherhood, ageing, sickness and loss. There is no script, the only rehearsal is when duetting the well-known song, *Je t'aime moi non plus* (1969), written by the late Serge Gainsbourg, Charlotte's father. Subtly provocative and unsettling in Gainsbourg-Birkin fashion, the aesthetic dimension of the film is magical.

The fast unsteady motions that open the film signal the atmosphere of a concert about to begin. Jane makes her entry on stage singing. Graciously she engages with the Japanese audience and honours the memory of Serge – introducing in the process the absent father. The applause is immediately followed by panting sounds. Charlotte's? We see bits of urban scenes with an electro-rock soundtrack and hear the distinctive murmuring voice of Charlotte. This creates a sharp dissonance with the melodious overture of the philharmonic orchestra. These moments of quiet backstage and of exciting fast-paced scenes with intermittent taking flights, are a keynote of the rhythms and the mood of the film. Jo, Charlotte's daughter, gracefully comes and goes amidst reveries and the tensions derived from the enigmatic 'beautiful' mother and 'intimidating' daughter. 'Isn't it a bit gloomy?' wonders Jane. 'No, not all, it's actually very pretty,' replies Charlotte, mindful of the aesthetic value of realness.

On the seashore, on a train, in Tokyo or on a roof top in New York, Charlotte films sensitively with simplicity. Time is ebbing away. She is holding the camera, perhaps a transitional object, and artfully places the dual unity of life and death, light and darkness, presence-absence in the conception of her project. There are moving intimate images of



bygone days and of loved ones projected here and there. Present and past blend with ordinary living, just as humour 'so British' (as the French would say) offers refreshing interludes between the emotional storms that are inevitably being created when two people come together. The aesthetic turmoil that is aroused by the manifest beauty of the object, namely the mother, is harmoniously negotiated, if not sublimated (Meltzer, 1988). 'The intention,' said Charlotte to Jane by way of introduction, 'is to look at you like I have never dared looking at you…the camera is basically an excuse'. It is about looking, touching, and being touched, and us to-ing and fro-ing alongside, in and out, attending to our own reverie and fantasies.

Depending on the area of experiencing, through various angles, perspectives, and location, we get to have a close-up look at 'parts' of the mother: her skin, hands, or face. Jane, in all her casual self, engages so naturally and elegantly with the camera, that one wonders if the object itself isn't imbued with special qualities – that of embodying different parts of the mother, public and private alike. The beauty of a woman self-aware, well into her seventies, who has survived the loss of a daughter (Kate) and suffered from cancer, who is so exposed to overwhelming emotions and exposes herself to the camera in all her nakedness, is simply a profoundly humbling experience. 'At some point you don't recognize yourself' said Jane over Bach's *Above and below B Minor*, conveying a sense of foreboding.

Under the clouds of mortality, Jo runs in the wilderness. Here and there we see a tear discreetly wiped away. We learn that mother and daughter were estranged after Kate's passing.

Throughout, there are scenes equated with reciprocity and receptivity. Homes have a significant place. In Jane's home in Brittany or Serge's in Paris, Charlotte's camera captures the stillness of a room or a view. Here and there memories 'of other lives' embedded in ordinary objects are seized with the same intensity and details. Time is suspended. Jane's interior is spacious and welcoming – the 'mess is a kind of a mild illness'. Serge's is darker and obscured. It is remarkably preserved in its original state. 'It's like Pompei,' Jane exclaims.

The lively creative union between the parents and the knowledge of the father permeates the film. In an early scene, in a tranquil, leafy Japanese garden, Charlotte is not yet holding the camera. Instead, she looks up (to the cameraman?) for clues. 'When you were fourteen,' Jane recalls, 'I was dying to see you naked… I asked you to touch your breast… I found you so beautiful'. As we lean forward, to catch the drift of any fleeting nuances of Jane's self-disclosing 'tactile' fantasy, Charlotte appears unfazed. We are surprised to even find ourselves in the position of peeping through a keyhole in disbelief witnessing yet another intimate intercourse à deux. Aside from it being not unusual for the Gainsbourg family to be seen sharing beds – as in the video of the song 'Lemon Incest' (featuring Charlotte with her shirtless father), there is a sense of the shadow of the object – the father is alive in the mother and daughter's mind and that knowledge generates life, love, and an infinite creativity capacity to be in the world. In fact, the language between Jane and Charlotte is French, the language of the father. Interestingly both admit that each was made to feel particularly special by her father.

The film ends on the seashore. From a distance, Charlotte is filming. In a whisper she tells her mother how much she loves her: 'The more I look at you, the more I love you...' In the final scene, mother and daughter unite in an embrace – two bodies becoming one.

If there was to be a film exemplifying the concept of the good breast as a supremely good object, the recognition of the parents' intercourse as a supremely creative act and the recognition of the inevitability of time and death, *Jane by Charlotte* could be that film (Money-Kyrle, 1971). Jane passed away last summer. In this moving tribute, Charlotte honours the memory of her parents thanking each of them individually for having loved the other so much.

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Jane by Charlotte (2021). Directed by Charlotte Gainsbourg. Jane Birkin, Charlotte Gainsbourg, Jo Attal, 1h28mns, DVD, Jour de Fête Distribution. www.imdb.com/title/tt14851374/

Words in italic are quotes from the film, translated by me.

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Film Review

Poor Things

Film review by Lorena Muñoz-Alonso

In Mary Shelley's novel *Frankenstein* (1818), the first time we hear the creature talk he is fluent, poetic even, as he makes his plea for sympathy in the face of abjection – and issues a murderous threat. When we first meet Bella, the heroine of *Poor Things*, she is energetically banging a piano with both hands and feet, her walk unsteady and her speech limited to 'ba, ba, ba', which could be 'ba ba' for 'daddy' or 'baba' for 'bye-bye', quite possibly both. For inescapable reasons, Yorgos Lanthimos' eighth feature film, an adaptation of Alasdair Gray's 1992 eponymous novel, has often been compared to *Frankenstein*. And indeed, both star maverick yet troubled scientists who bring inanimate matter back to life, as well as the creatures that result from their morally dubious endeavours. But both works are, well, very different beasts. While Frankenstein can be seen as an almost existentialist meditation on manic omnipotence and the links between rejection and violence, *Poor Things* takes us straight into the world of parenting and early development, of infantile sexuality and of processes of individuation. Because Bella Baxter is not a gargantuan monster made of discrete limbs and organs cobbled up together from trips to morgues and abattoirs, but an infant in the body of an adult – or a baby's brain in the body of its mother, to be specific.

The first part of *Poor Things*, which covers the period of Bella's first psychic years, plunged me back into the infant observation I conducted as part of my psychoanalytic training. Emma Stone's performance as a baby is phenomenal and precise. In one scene Bella is at the table, banging things about as she waits for her meal. Food is served on her plate and for a moment she seems confused as to what to do, her eyes oscillating between the room and a more introspective gaze. She then looks at the adult in front of her, Godwin Baxter, who's eating his food with cutlery and a neutral smile. She plucks some courage and picks a morsel of food and puts it in her mouth, chewing slowly with a puzzled look before deciding she doesn't like the taste, her face a grimace of disgust as she spits it out. Bella's walk is very wobbly to begin with but gets better as she ages, as does her capacity for thought and speech. But this is never rushed, the writing and the performance allowing for the gradual pace of human development, and Stone nails these nuances. One wonders what this film could have looked like in the hands of a less skilful and committed actor.

As Bella grows in mental age she also develops a voracious sexual appetite, unbound by the moral codes of a society she isn't acquainted with. She names sexual intercourse 'furious jumping' and engages in it with abandon, wondering why people don't do it all the time. This aspect of her journey hasn't sat right with many commentators who see her sexual exploits more as a form of exploitation and who can't seem to separate the notion of infantile sexuality with paedophilic concerns. Up until the moment when Bella ends up in the purview of a Parisian brothel, which did grate on me, what I saw was an ingenious depiction of the infant's discovery of her body and of the sensual pleasures associated with touching her genitals, first in bed, then by rubbing objects, leading to a fully interpersonal erotic dimension. Although the time span depicted remains undated in the film (and its art and costume design are a beautiful yet undatable melange of Victorian steampunk and art deco), Gray's novel situates its plot more conclusively between 1881 and 1911. My first association was that this was also the period during which Freud researched, wrote and published his *Three Essays on the Theory of Sexuality* (the first edition came out in 1905) where he first outlined his concept of infantile sexuality, causing a furore whose flames can be still fanned today, it seems.

But it's also true that there is an inherent vulnerability to Bella. She has no mother, for starters. In a very concrete and disturbing way, she is her own mother, living in the body that her mother disposed of in her suicide. Yet she does have a father: Godwin, whom she affectionately calls 'God' for short. Godwin is certainly a demi-god, able to give life to her without the need of intercourse, gestation or birth. But unlike the rather less sympathetic Victor Frankenstein, unable to feel love or compassion for his unflattering creation, Godwin becomes a father figure to Bella. One imagines her beauty and charm couldn't have hurt this positive rapport, but Godwin does look after her with the utmost care and devotion, doting on her every developmental milestone with glee, and although everyone expects he has created Bella as a sexual companion, he has not done so. Although physically affectionate and responsive to her kisses and cuddles, he sets firm boundaries and doesn't sleep in the same bed as her, which she demands after her bedtime story. It's not difficult to see Godwin as a good object for Bella who, despite her traumatic background story, is able to develop a healthy attitude to men and to sex.

"Emma Stone's performance as a baby is phenomenal and precise"

Godwin's motivations for Bella's inception, besides scientific glory, seem rather driven by an unconscious wish for reparation. After all, Godwin is a lab rat and a medical novelty himself, subject to cruel tampering at the hands of his doctor/butcher father. Godwin has been disfigured and damaged for life, and although there's a significant portion of identification with the aggressor and of repetition compulsion in his choice of profession and in the experiments he conducts, the love and kindness he feels towards Bella foster a new and much healthier dynamic. He seems to be doing unto Bella what he wished would have been done unto him, rather that re-enacting the damage. More importantly, he allows her to flee the nest and discover the world when it's clear that her wish for emancipation is too strong to be contained by his desire to (over)protect her. 'You hold me too tight. Kiss me and set me forth, otherwise my insides will turn rotten with hate,' says Bella, still a bit wobbly on her feet but her intelligence by now shining through. And although it breaks his heart, he lets her go, hiding emergency money in the seam of her skirt in case she needs it. Drinking port for breakfast to numb the pain of her absence, Godwin says to an alarmed assistant: 'She is a being of free will. She will be fine.' And she is.

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