NewAssociations

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BRITISH PSYCHOANALYTIC COUNCIL

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# The social unconscious and the herd

*By Lene Auestad*

WE ARE LIVING in dark times. Right-wing populist movements are spreading and gaining in power throughout Europe and beyond. These are shocking and frightening days.

One of the foremost promises in Donald Trump's electoral campaign was that he would erect a wall on the border with Mexico and have Mexico pay for it. Hungary did raise a fence with barbed wire last autumn on its border to Serbia and Croatia. While refugees were drowning in the Mediterranean last spring and the party voted to deny access to Syrian refugees, the politician of the populist right-wing Progress Party in Norway, Per Sandberg, sported a t-shirt with a picture of an anchor displaying the text 'good journey – sea adventure'.

What can psychoanalytic thinking contribute to understanding such phenomena? What constitutes its fruitfulness and what are its limitations? I would like to argue that psychoanalytic thinking is indeed invaluable when it comes to grasping what is at stake in such political movements, and that it is a tragedy that its insights have been lost from mainstream social science, indeed are avoided by it. At the same time I would like to caution against a too uncritical reliance on some of its individualist assumptions when confronted with social phenomena.

In witnessing these contemporary manifestations, of shutting out, humiliating and mocking a threatening other – an imagined other in so far as the subject who does it is concerned, but with real consequences of suffering and ultimately death for those who are targeted, what are the questions we would want to ask? Perhaps, what fears or fantasies are played on in the rhetoric of the politicians who enforce these agendas, would be a highly relevant question to ask, and one that psychoanalysis is supremely equipped to explore, and (therefore) often left out in debates today.

Or: why this individual, rather than another, could be asked of the leader or of the follower of a right-wing populist, nationalist movement; another question to which psychoanalysis could contribute. A further question, why is this particular category of people being targeted today, is one that is better answered by current social conditions, by relations of power. In other words, the fantasies involved in prejudices against 'others', in social stigmatisation and denigration, in ideas of what constitutes the qualities of the 'us' and the 'them' are remarkably constant – though the targets vary in time and in space.

Rather than understanding the current political mood of increasing nationalism and ethnocentrism, of idealisation of what the nation-state has defined as falling within the boundaries of the 'we', and the denigration of those defined as 'others' as exemplifying pathology in contrast to a perceived normality, I propose to see these tendencies as qualities of the social unconscious of these societies. The point is not that characterising certain extremists as mad or ill in some ways is entirely wrong; it may indeed often be fitting. The point is rather that focusing one's attention here may distract from a more serious issue – the spread of attitudes previously thought of as extremist in the general population. When that happens traits that used to be seen as 'abnormal' become normal in the sense of being common, and their general social acceptance makes them recede from view. To paraphrase Adorno et. al., personality patterns that have been dismissed as pathological because they diverge from the manifest trends or dominant ideas in a society have turned out to be but exaggerations of what was almost universal below the surface. Thus what is pathological today may, with changes in social conditions, become the dominant trend of tomorrow.

Similarly, the fascist leader, as described in 'Freudian Theory and the Pattern of Fascist Propaganda', is distinguished from the followers in expressing more freely the drives which incite the member of the crowd to follow, in being less inhibited in voicing what is latent in them, thereby allowing them the vicarious gratification of merging with this passion.

Authoritarian populist movements construe immigrants, refugees, asylum seekers, black people, Roma and Muslims as enemies, threats to one's community and one's 'way of life'. The 'other' is depicted in dehumanising terms as diseases, insects or vermin that threaten to destroy the body politic. In other words, as fundamental anxieties to do with the destruction of one's self, or attacks on one's body, which are exploited for the political purposes of reinforcing a nation-state as an imagined closed unit which successfully expels 'foreign bodies', pollutants or difference.

**'What is pathological today may become the dominant trend of tomorrow.'**

In one sense, psychoanalysis is in a unique position when it comes to understanding and interpreting such discourses, due to the unconscious meanings they draw upon and exploit. Though this is complicated when we reflect on the fact that these meanings are socially embedded in everyday practices, in social norms and standards for what and whom counts, and who is not worthy of attention or reflection. Since the analysts or psychoanalytically informed theorists are part of the same society in which these meanings are embedded, and in which many of the same things are taken for granted and remain unquestioned; and since they take part in the same social unconscious, they are not necessarily in a better position than anyone else to spot dehumanising practices of which they are part. I have elsewhere described how we can refer to condensation and displacement, and other characteristics of primary process logic, as unfolding in public space when people are portrayed as masses and become mere objects of discourse, and when groups are depicted as inwardly homogenous entities that are rigidly distinct. For instance, white middle-class people in this society habitually displace racism onto white working-class people and perceive it as a quality belonging over there. This is allowed for because it is a shared social structure of displacement, supported and not questioned by social practices. Thus knowledge and experience of unconscious dynamics as such, though important, is in itself insufficient without genuine and equal encounters with social positions, environments and practices.

The new nationalisms' answer to a felt need for belonging, significance and security is an imagined unit which has the features of an 'I' made 'we', replacing individual narcissism with group narcissism. Togetherness is allowed for in so far as the members of the in-group are imagined as being all the same, and

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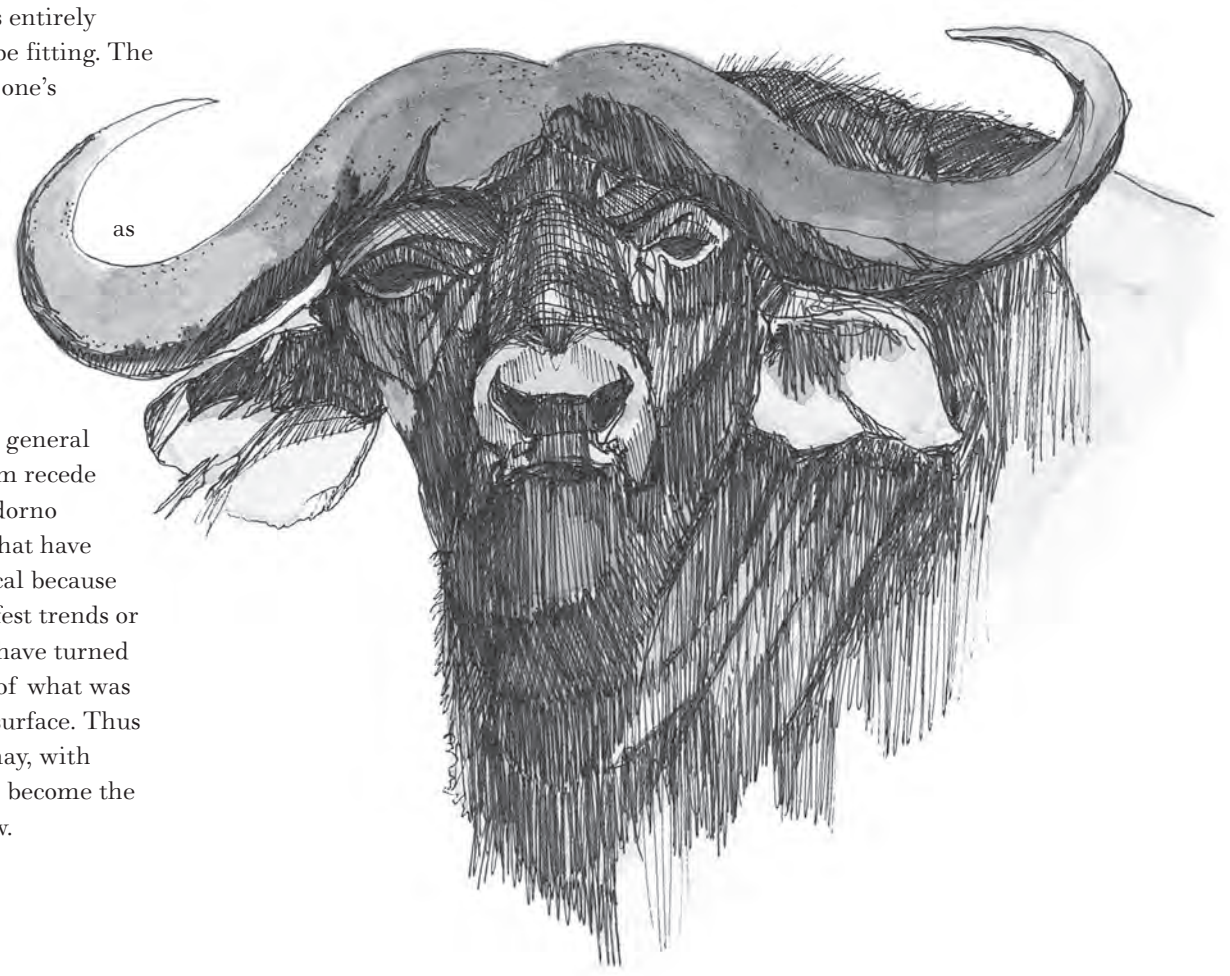

Editorial

# A precarious balance

*By Gary Fereday*

THIS EDITION of *New Associations* carries its usual diverse range of articles designed to provoke thought and debate. The articles are varied in their themes but there is a challenge posed as to how psychoanalysis, with its focus on the individual and the inner world, can and should relate better to the outer world and societal factors that affect individuals.

Lene Auestad argues that not only has psychoanalytic thinking been lost from mainstream social science, but is even avoided by it. This should be of huge concern to all of us who believe our profession has something important to say to policy makers, academics and professionals from other disciplines.

We face huge challenges as a global society: on the political right we have a US presidential candidate appearing to stoke up fear of 'others', with talk of building walls to keep the 'other' out; on the left we have North Korea aggressively parading its missile technology, presumably to mask the dire economic reality of day-to-day life of its citizens; and (surely dwarfing other concerns) we have climate change scientists gathering data that suggests our world is warming up at an even faster rate than we thought; so fast we may no longer be able to do anything about it.

Richard Sherry, in a challenging article, asks us to think how we address the profession's often indifference to these societal issues; 'to transform the very privileged training we have received to better apply these to the real world problems.' A theme of course that *New Associations* returns to regularly – how do we articulate a voice for the profession in the wider political debate and policy making arena? How do we get to Lene Auestad's position where our psychoanalytic stance, with its focus on reflection, is seen as a much needed insight when Britain's education system is moving in the opposite direction, focusing on efficiency and less thought?

**'How well do we understand the intersection between the individual, the group, a system and society?'**

With relatively limited resources (we are a profession that is small in numbers) the BPC is working hard to respond to the challenges of articulating a voice for the profession. To do this we have to work closely with our member institutions and our registrants. The willingness of individuals to give so much time and expertise freely is quite humbling particularly when, as Elizabeth Cotton's article highlights, so many are facing challenges in day-to-day clinical practice with increasingly precarious working conditions and the steady decline of effective teamwork.

As well as taking the profession's messages to policy makers and politicians, a key role for the BPC is to support registrants in their day-to-day clinical work. One area we are increasingly recognising is the issue of our ageing profession and retirement. This provokes very real anxieties for many of our registrants, and Gill Barratt, Georgina Hardie, Judith Philo and Ruth Pitman thoughtfully explore this sensitive issue in their joint article.

We are currently developing a range of 'good practice' guides that are likely to cover a range of issues that includes dealing with retirement as well as other concerns such as: clinical records and data protection; implications of the Equalities Act; and child protection.

In many ways the BPC's diverse work mirrors the complexity and diversity of articles in this edition, many of which reflect on the theme of precarity. The precarious balance we have to strike to ensure that we simultaneously support and critically review the potential that psychoanalytic thinking can add to wider societal issues, as well as support individual registrants in the complex job of working with their clients, results in a rich and dynamic mix of possibilities and objectives. In the realm of pathology and psychological understanding, our profession charts its course considerably, but how well do we understand that external intersection between the individual, the group, a system and society? ■

*Gary Fereday is Chief Executive of the BPC.*

## Social unconscious

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the emergence of a dissimilar other evokes all the rage which reveals the limits of these bonds. These ideologies transform the liberal individual, an isolated competitor seen as driven only by egoistic motives, into a herd-animal sticking close to its kin though equally ruthless towards a perceived outsider. 'Our contempt for weakness' is common to both of them – this is to point to how features which now appear on the political scene in their extreme cruelty have already been fostered in the society we share – of competitiveness, egocentrism, coldness towards self and others, and with contempt for many of the qualities that make us human.

To refer again to Adorno's essay on fascist propaganda, he describes how fascism plays on unconscious forces in such a way as to perpetuate the follower's dependence. It expropriates the unconscious for social control rather than aiming to make the subjects conscious of their unconscious. As a contrast, it is inherent of the practice of psychoanalysis that it takes a stand against instrumentalisation. In these times where effectiveness and usefulness are worshipped, with few people pausing to ask: usefulness for what ends, the psychoanalytic stance of promoting reflection, wherever that may lead, is a much needed alternative position, when even the education system is moving in the direction of more efficiency and less thought. This stance is worth defending, and it is worth questioning how it can be extended so as to provide more safe spaces for thought ■

*Lene Auestad holds a PhD in Philosophy from The University of Oslo. She is editor of* Psychoanalysis and Politics: Exclusion and the Politics of Representation *(Karnac, 2012),* Nationalism and the Body Politic: Psychoanalysis and the Growth of Ethnocentrism and Xenophobia *(Karnac 2013) and a book on Hannah Arendt in Norwegian (Akademika, 2011). Her monograph* Respect, Plurality, and Prejudice: A Psychoanalytical and Philosophical Enquiry into the Dynamics of Social Exclusion and Discrimination *was published by Karnac in 2015. She founded and runs the international and interdisciplinary conference series Psychoanalysis and Politics, www.psa-pol.org*

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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 1200 words) please contact Leanne Stelmaszczyk: leanne@bpc.org.uk

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The Surviving Work Survey

# Start where you are

*By Elizabeth Cotton*

TALKING ABOUT working in mental health is not as easy as it sounds. Despite being of the dialogic persuasion many people working in mental health are reluctant to raise concerns about wages, progression and the downgrading of therapeutic services.

Despite the crisis in mental health being openly discussed, it appears that the people delivering those services are not talking to each other about how this public crisis might also be becoming a deeply personal one.

Nobody knows how many people work in the UK's mental health services or the conditions under which they work. This year's Mental Health Taskforce report bleakly reported that the data on who and how we work in mental health is not known.

Depressing pockets of data have surfaced. That 50% of us are depressed (BPS Wellbeing Survey) and that 64% of us don't think that the therapy we offer is intensive enough to do any good (BPC/UKCP report 2015). The 'pervasive culture of fear' within the NHS compounds this lack of information about mental health systems into a disorienting sense of impending catastrophe.

The job of containment becomes harder to do when we're exposed to precarious working conditions – the stuff of monsters under the professional bed setting us up for a sectoral panic attack. People, when did we become so scared?

The Surviving Work Survey was set up last December to find out what is happening with work in mental health. The first phase involves an anonymous online survey for anyone working in mental health – and we're now starting to carry out follow up interviews to look more closely at people's experiences of working life and how it affects our own states of mind.

This is what we have found so far, based on nearly a thousand responses:

**We're not earning enough**

The top issue for survey participants so far is how to earn a crust. Wages and the lack of a secure income was the number one issue of concern. 40% are working part time and 25% earn money from outside of mental health. 14% work unwaged as honoraries with an average loss of income of £200 per week. The vast majority estimated that 10% of their working hours were unpaid.

**Precarious work is growing**

A second tier of workers is developing rapidly in mental health. This includes the Psychological Wellbeing Practitioners who provide the main bulk of IAPT services, the hundreds of honoraries working for free in the NHS, the people manning the mental health call centres, the clinicians carrying out disability welfare assessments and the ones working in social care and support services who have been unable to secure clinical jobs.

**'The lack of a secure income is the number one concern.'**

The use of honoraries and unwaged labour to deliver NHS services, including IAPT, is widespread. Despite their fears of blacklisting the group most willing to be interviewed were IAPT workers – perhaps exposing the lack of opportunity this group has to talk about their working lives.

There is a growing number of people working for Private Employment Agencies – but only one respondent was willing to have an anonymous follow-up interview. Respondents were extremely nervous about naming their private employers despite the survey being completely anonymous.

Many people said that the one thing that would improve their working life would be to retire.

**What happened to teamworking?**

Ours is not a sector which appears to be well managed. Everyone reported problems of unmanageable caseloads and work intensification. Compounded by staff shortage and short term contracts, the vast majority of people said that they were not functioning within their teams.

Many people reported that the NHS obsession with cuts, targets and unrealistic caseloads really forced us into a command and control system. Do it now rather than 'what can we realistically do?'

Concerns aren't being raised for fear of victimisation. Only 4% have raised concerns about patient safety – this goes up to 47% raising concerns about working conditions and wages.

We had only two reported cases of management responding to these concerns. Something is very wrong with our lack of capacity to negotiate changes in the way that we work with patients.

Despite the emphasis on relationships and group dynamics within our tradition there is very little evidence that we're able to find a way of working collaboratively within our teams. At best we're working without a real understanding of our sector, at worst feeding what Sally Weintrobe calls Noah's-Arkism – a split between the growing number of precarious workers and the shrinking number of directly employed, permanent clinicians.

In our psychoanalytically-minded society there is a growing split between the established and the disestablished – we see it every day in our services but we now need to allow ourselves to see it in our profession.

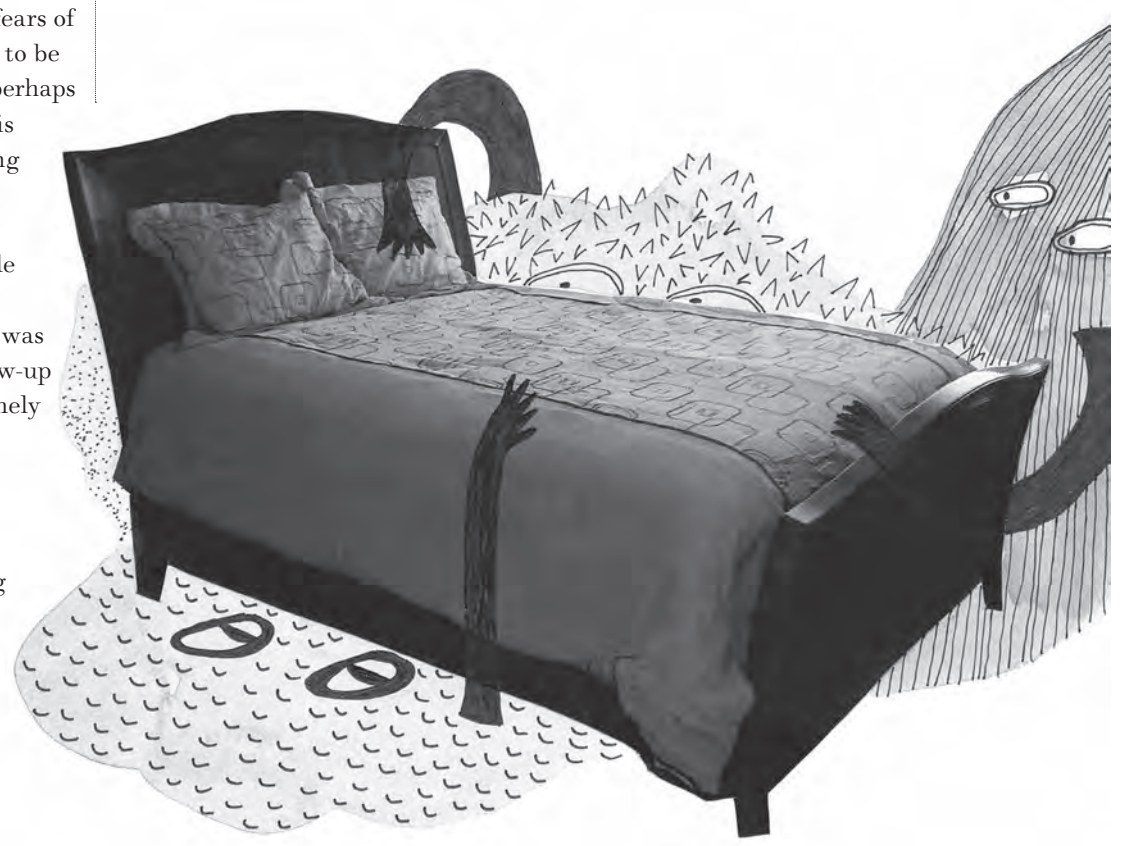
If we can start where we actually are, rather than where we'd like to be, we stand a chance of talking honestly with each other about the future of our profession. At some point we have to organise and speak about what is going on in our professional minds. This cannot be done blindly or alone. A kind of professional first aid – where caring for our patients is based on a care for ourselves and the people we work with. At some point this will mean negotiating wages and challenging targets, something that a fragmented and isolated bunch of workers cannot do.

**'If we can start where we actually are, we stand a chance of talking honestly about the future of our profession.'**

To do this, we need to go back to our roots. To start realistically, to talk, and stand up to the internal and external voices that say we can't change. To contain the anxieties that are flooding our consulting rooms, and take some time to think about how we work. We have been humbled by the care and concern respondents have shown to mental health services where how we manage work is both a professional and personal issue of ethics of care. But can we really care for others when we care so little about each other? ■

*If you work in mental health – particularly if you work for IAPT, a private contractor or a private employment agency or are working in an NHS service for free – help us map what's happening in our sector by completing our anonymous Surviving Work Survey at www.survivingwork.org/surviving-work-survey*

*Elizabeth Cotton is a senior lecturer at Middlesex University, associate at the Tavistock Institute for Human Relations, and member of the Chartered Institute for Personnel and Development, OPUS and ISPSO.*



Retirement

# Can we bear to think about retirement?

*By Gill Barratt, Georgina Hardie, Judith Philo, Ruth Pitman*

THE PROFESSIONAL Endings Group of BPF (British Psychotherapy Foundation), are pleased to have been invited to contribute to this edition of *New Associations*. Over the last 23 years the BPC has forged partnerships with many training organizations and established a community to define and support professional practice and standards. The ideas of partnership and community, including support, are themes that the authors of this article wish to emphasise. We include a registrant's experience of preparing for their retirement.

### Beginnings

The Professional Endings Group, originally called The Retirement Group, is still in its teens, 13 years to date. It began when a small group of people started a conversation about how to open a regular forum where the important and difficult subject of retirement could be discussed. In June 2003 the event *Opening the Door to the Third Age* was the outcome. Three members shared their experience of planning for and embarking on their retirement. Lively discussion followed on the merits, or otherwise, of the subject. Some were determined to continue working until they dropped, a view which continues to be voiced occasionally; how far an organization should be involved in what many people believe is an individual and private matter was also raised. The Retirement Group felt confident in the value of a termly meeting where members could meet with similarly minded others to explore mutual concerns on the subject in an atmosphere of informality and trust.

### The Group development and changes

In the early years, a fairly consistent group of 15 to 20 people came together to explore the issues that the prospect of retiring raises, from practical, financial ones, timing and management of the process for patient and therapist, to ethical and psychological dimensions and the thorny subject of age. Present legislation no longer makes age a compulsory requirement to retire, leaving individuals room to reflect on how far this is a factor in their decision making. Sometimes, as a variation to the theme, a speaker with specialist experience was invited. Once or twice a retired member returned to speak about 'life after retirement'. A special visitor was Diana Athill, whose compellingly frank account of life in her nineties, and the courageous changes she made in her living arrangements, aroused the respect of a large and responsive gathering.

As attendance at meetings dwindled the committee decided that a change of name, to The Professional Endings Group, offered a way to broaden the thinking of group meetings. Our thinking was influenced by the prospect of a proposal to merge the British Association of Psychotherapists with the Lincoln Clinic and the London Centre for Psychotherapy, all of which organizations had their own distinctive character and history. Also the prospect of retirement begins long before its actuality; we experience many types of endings before we retire; we felt that the original name limited the scope of the group meetings. The merger occurred three years ago. Now, in a difficult period of transition, the present challenge is to find ways of reconciling our experience of that loss with potentially new opportunities and possibilities.

### Change is difficult

We know this, as working with resistance and psychological defences is a fundamental aspect of our work as clinicians. What we hope to facilitate in the lives of the people who we work with is growth, a capacity to live life fully as a separate being capable of making long term satisfying relationships, and also to manage their losses and bereavements. We give weight to the process of assessment, make formulations as to short or long term work, beginnings and endings. As therapists we have had long hard years concentrating on our psychoanalytic training, which may also have been alongside other work responsibilities and training in other disciplines. Becoming, being a therapist has so much meaning for our identity, our sense of worth, our need to make reparation to others. It also carries a rite of passage when we qualify, a public presentation of a certificate, a celebration shared. *What does retirement offer us?*

Retirement is a major life threshold accompanied by a multitude of complex choices, and whatever the circumstances, it is a very personal decision, each individual choosing their own path. There is however a lack of tradition associated with this rite of passage. Our psychoanalytic forebears, concerned with innovation, independence and a need to establish theories and methods, did not retire. In consequence, the subject of retirement does not receive the kind of attention from organizations or practitioners that qualifying does. This leaves many practitioners in private practice in limbo, a word perhaps lightly used in modern life but meaning a place of abandonment.

A similarly evocative word is 'termination', an abstract theoretical term for the end of treatment.

These powerful words can stir deeply painful emotions if we relate them to ourselves. They may not be commonly used, but they represent a level of anxiety that links to an extreme reluctance to face the subject of retirement from a profession in which so much of a sense of self and worth are invested. When people do put feelings into words they speak of 'falling off a cliff', remark on the loneliness of closing the consulting room door and walking away with no witness to this moment of finality, or that they 'love their work', implying that not to work is unimaginable.

In recent years we were pleased that the Professional Endings Group has become included in first the BAP's and now the BPF's AGM agenda as an aspect of organizational life. However, individuals prefer not to be named. How to speculate on this? At AGMs the emphasis is on achievements, prospects, growth. Honorary fellowships are awarded to some 'elders' in recognition of their work, rightly, but a narrative for 'ordinary' members is missing. This might feel like being invisible, and after the arduous process of deciding to retire from clinical work and doing so it may feel too much to be publicly named.

**'Retirement does not receive the kind of attention that qualifying does.'**

Sometimes there is no choice, life can be unpredictable. Some preparation or acknowledgement of our own expectation of ending is realistic, and grasping the nettle can be emboldening.

### Ways and means

There is more than one way to prepare for retirement. A successful development from the original Retirement Group was the establishment of a Retirement Course by three members of the then BAP, and three fortnightly Saturdays were designed to provide opportunities for free discussion:

1. Contemplating change and loss: The meaning of work and retirement.
2. The process of retirement.
3. What comes next? Creativity and adaptation.

The course ran for five years, was well attended and has been written up in the *British Journal of Psychotherapy*.

Sometimes we may be more engaged in the process of working towards retirement than we think we are. The establishment of registration and regulatory bodies like BPC and UKCP has meant that the profession now recognises standards of practice, and training organizations have ethical committees that review concerns. Two related principles are recognised as a foundation to practice which are: fitness to practise; and duty of care to the patient and to oneself. These two principles are in effect renewed in the annual undertaking of recording CPD (Continuous Professional Development). At its best, CPD represents the growth of the

individual as a valuable and ongoing life process. Paradoxically this process deserves closer attention the more experienced we become and as we age.

Whilst retirement is a process of relinquishment and mourning, it also carries a prospective potential that offers new opportunities for the future. There is an important distinction to make between retirement from clinical work and retirement from the world of psychotherapy. Some people choose to make a complete ending and then pursue further studies or interests, develop creative activities, or travel. Others continue to contribute to the profession through teaching and supervision which is enriched by their years of clinical experience. Yet others maintain an interest in the field through links with past colleagues, attendance at professional meetings and, as members of committees, contribute to the work of the organization.

If we are familiar enough with an idea we can allow it a place in our imagination, in our thinking, and give voice to it. Like seeds, ideas need time to germinate; if possible it is helpful to have options from which to choose.

Before concluding here is an illustration of one person's experience.

### Preparing for retirement

*Retirement is very much a personal as well as a professional decision. Training as a psychotherapist, building a private practice, working in institutional settings and coming to endings of work – all that has been very much my personal as well as my professional life. I have recently decided that I am going to retire, and this has taken much time and hard thinking, including thinking with others and talking about my feelings. As psychotherapists we are wonderfully good at listening to other people, our patients, and talking about their feelings, but we are extremely bad at talking about our own to each other apart from to our closest friends. Of course our patients know us as a real other person, but we are skilled (rightly), when with them, at keeping our personal stories and feelings to ourselves, and we continue to do that in professional settings such as scientific meetings. The nearest we get to it is in talking about our countertransference, but that is still mainly about the ways in which patients communicate their feelings to us, rather than our own feelings.*

*This is second time round for me, though this time I feel that I am free to choose, to try to decide what is right for me.*

*The first time I had little choice. My husband, also a psychotherapist, was diagnosed with a terminal cancer not long after I qualified. Nonetheless, I built up a small practice and worked as a psychotherapist with parents in a families unit in an NHS hospital. He decided that he didn't want his patients to experience him become increasingly ill, at worst, to die on them; also he wanted some time for himself before he died. We felt that we needed to leave London, which meant that I too would have to stop work. We gave our patients a year's notice. It was a huge wrench. But the ending of my work and the anger and distress of patients who didn't feel that they were ready to end their treatment was mixed with anxieties about my husband's illness and treatment. Inevitably my main focus was on him and on finding a way, with him and our family, to live with his diagnosis and bear and face the uncertainty about how long he still had.*

**'There is a distinction to make between retirement from clinical work and from the world of psychotherapy.'**

*We moved to a small coastal town and I struggled there after his death to build a new practice, finally concluding that this was an uphill struggle; I felt isolated from family, old friends and familiar colleagues. I decided to return to London to work and was lucky to be offered some consulting work with fostering agencies and social services cases while gradually rebuilding some private work. I remarried.*

*A year ago my new husband was diagnosed with cancer and had major surgery which doctors were sure was completely successful. At first I thought I was facing the same thing again and my initial thought was that I should stop working. But the prognosis was good and he was completely supportive of whatever I wanted to do. Even so, I found myself wondering about my priorities. When my first husband died I told myself that I would no longer do anything I didn't want to do – impossible really, but not a bad guiding principle. I am now fourteen years older. My enthusiasm is undiminished and I feel I am working as well as I ever have, enjoying the stimulus and encouragement of good supervision. But if I were to take on new patients I could be committing myself to working into my eighties. I am conscious that life isn't forever and I want to make more flexible space for other things now.*

*I began going to the Professional Endings Group, a bit half-heartedly at first. Surely retirement was a private decision. I gradually began to realise, however much or little I was making use of the group, that my work and my decision to retire are not just private matters between me and my patients.*

*In the BPF we are also in the middle of the painful transition of the amalgamation of our original training organisations and trying to muddle through the painful process of those endings and losses and to make some sort of sense of our new incarnation. We are a part of that new professional family and there are mutual obligations. For instance, it is possible that patients might need help in future after their therapy ends. The BPF should be able to advise and refer them if they need this, and I would want there to be a record kept of my patients in case this should happen. I would also like to feel that I could maintain a real and active link with colleagues in retirement.*

*We all as psychotherapists and analysts have different circumstances and different ideas about how to approach retirement. I am beginning the process of letting my patients know, and there will be a lot of work and quite a long journey for us as we work towards the endings of their treatment. It has been helpful this time to talk to others and to hear about their different thoughts and experiences.*
**Georgina Hardie**

### In conclusion

The subject of retirement deserves attention from the beginning of professional life, as it is an inevitable conclusion to it. Keeping it in mind as we develop our professional capacities allows for the idea to become an integrated part in understanding our responsibilities, not only to our patients, but to ourselves. Retirement is also an organizational matter. As this gains recognition, there can be greater clarity about what arrangements and responsibilities are shared between us. Bringing retirement out of the shadows means that it can be marked as a personal event and also one within the professional community.

The Professional Endings Group aims to provide a mindful space for discussion. Where different stories are told and shared, as each person takes their own time and way. A valuable body of knowledge and experience has been established that can now be shared and drawn on. In writing the article together we have reencountered some of the difficulties that the subject of retirement arouses in everyone. We can also confirm that we have each benefited from using the group as we undertook our own process ■

### Selected reading

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Opinion

# It's time to get out of our heads

*By Johnathan Sunley*

*Why psychotherapists should not make a fetish of the brain*

IN THE LAST ISSUE of *New Associations*, the author of the article 'Where will the future be found?' issued a 'rallying call' urging her fellow psychotherapists to pay more attention to the discoveries being made by neuroscience (*New Associations* 19, Autumn 2015). Colleagues who aren't so impressed by the importance of the brain, she writes, generally display two types of reaction. One she terms Arrogant (psychoanalysis knows everything already), the other Weary (neuroscience is just too difficult).

As a psychotherapist I find myself unable to share her enthusiasm about the insides of our heads, and in this article I want to make a case – one that I hope is neither Arrogant nor Weary – against the view that this is where the future of our profession lies. I am aware that in our culture it practically goes without saying that you and I are in one sense or other the products of our brains. The fact that, notwithstanding, barely a day goes by without some expert appearing in the media to say precisely this (see, for example, the much-hyped recent TV series 'The Brain' presented by neuroscientist David Eagleman), might itself arouse our analytic interest. What kind of supposedly obvious truth is it that has to be asserted over and over again to such numbing effect?

But my greater concern with what philosopher and former professor of medicine Ray Tallis calls 'neuromania' is the impact I think it is having on our minds in another way. This edition of *New Associations* has the theme 'Precarious States of Mind'. Mental illness is said to be at unprecedentedly high levels in the UK, and one explanation often given for this is that we are living in times of unprecedented social and economic uncertainty. Why wouldn't we all be chronically anxious and vulnerable occasionally to deeper disturbance?

Although there may be something in this argument, what I want to focus on here are the implications for our psychological health of materialism, not as a synonym of sorts for consumerism, but in its original philosophical sense. This is the doctrine that the world is ultimately made up out of hard bits of stuff known as 'matter', and that living organisms like plants, animals and humans are made of this too. Materialism underpins the claim that we are basically our brains. Yet I believe that if anything in the early twenty-first century can be said to be driving us out of minds, it is the view that 'I' am somehow to be found in a few pounds of neural tissue enclosed in a fragile casing atop a wobbly stem that joins me to the rest of my body. Such a sense of self is bound to feel precarious.

**'Materialism underpins the claim that we are basically our brains.'**

How did we come to think like this? Psychoanalysts of all people ought to be curious when they hear about a part of the body being endowed with special significance. Yet the well-nigh magical powers that neuroscience attributes to the brain attract little comment from them. Perhaps this is understandable. The same Freud who wrote a paper on fetishism began his career as a neuroanatomist and, for all that he frequently cautioned against confusing either the conscious or unconscious mind with the brain, never lost his fascination with the field of study he had given up, famously writing in 1920: 'Biology is truly a land of unlimited possibilities.'

Almost a hundred years later it seems to me that neuroscience and its champions are convinced we have finally reached the promised land foreseen by Freud. Maybe there isn't a 'God spot' in the brain quite as some research suggested. There might not be a chocolate-craving zone either (this too has been pinpointed in imaging studies). But it has long been accepted that there are parts of the brain associated with language and vision. And now thanks to the latest brain-scanning techniques we can demonstrate that the hippocampus is 'for' memory just as the amygdala is 'for' emotion. In other words: we have the technology. We also have the kudos. So give us the funding to finish the job and in a few years, perhaps a decade, we'll be able to tell you who you really are down to the last neural network.

There are many difficulties with this outlook. Some of these concern the techniques currently in use for measuring brain activity. We may think of fMRI scans, for example, as taking a kind of snapshot of a brain engaged in (say) deciding something. That is certainly how the results of experiments based on them are often presented. In actual fact, such scans only make it possible to detect levels of blood flow across the brain – and don't take pictures of anything.

But let us suppose all technical and methodological challenges of this kind could be overcome. What then? At best we would still only have a detailed map of the neural correlates associated with the experience of remembering or eating chocolate or getting angry. We would not be a single step nearer to understanding what these experiences feel like to the person having them – nor where they come from.

In philosophy this has been known for some time now as the 'hard problem' of consciousness (the 'easy' one being to specify structures and processes in the brain that in some way support such experiences). Various solutions to this problem have been put forward and one that has proved surprisingly popular holds that we aren't really conscious at all – that subjective experience is an illusion. 'Are zombies possible?' asks Daniel Dennett in his book *Consciousness Explained*. According to this eminent philosopher and cognitive scientist, 'They're not just possible, they're actual. We're all zombies.'

It may not be often that we meet someone in our consulting room who maintains they belong to the living dead. But I'm sure we all have patients who to a lesser or greater degree cannot bear having feelings and who will do anything they can to be rid of them. Generally this involves the use of defences like repression, splitting and projection. But belief systems also play their part – as in the case of a patient of mine who tried to persuade me that he was really a hologram. I am not saying that everyone who is a hardline materialist with respect to the 'hard problem' needs to go on the couch in order to understand why they endorse the fantasy of a feeling-free

world. But I was struck reading in the recent obituaries for Marvin Minsky, who is seen as one of the fathers of artificial intelligence and who argued that human minds are simply 'meat machines', that he had been bullied in childhood.

If you aren't philosophically-speaking a materialist, however, then what are you? Does that make you a dualist, i.e. someone who holds there must be a second sort of stuff around to account for subjective experience – be that soul, spirit or something else? Or perhaps you think the problem is just too hard for humans at our current stage of evolution to solve and are therefore content to be called a mysterian? Psychotherapists may not care much for the label itself but otherwise 'mysterianism' might be the philosophical position they feel closest to. For ours is a profession that makes a virtue out of not knowing.

Some scientists may think they know better – or at least more. And no doubt that can cause us to feel envy towards them. But what we seem to overlook is how, over the course of the twentieth century, the kind of old-fashioned scientific materialism that Freud was steeped in took a pounding from physicists who really knew their stuff – and who came to the conclusion that, at the sub-atomic level, 'stuff' as such can only be said to exist when it is observed and thus depends for its existence on the minds of observers. What modern physics has shown is that the more we try to grasp matter the more it slips through our fingers. Or as Gertrude Stein said in a completely different context: there's no there there.

Many philosophers and scientists at work today regard materialism not as a proven fact about the way things are but as a dogma or even superstition that limits our understanding of the world. Rather than succumbing to this superstition, isn't it time for psychoanalysis to be more confident in sharing with these and other disciplines what it has come to find out about 'psychical reality'? The term itself might have been coined by Freud but I think that the paradigm-busting potential of it is still to be realised.

And yet the unconscious fantasy I referred to earlier of 'me' being my brain in my head is clearly a powerful one – despite the fact that it contributes to our feeling so unstable. Can psychoanalysis throw any light on this? In his paper 'Mind and its relation to the psyche-soma', Winnicott states that a healthy brain is certainly necessary for the normal functioning of what he prefers to call the psyche rather than the mind. But because the psyche is no more and no less than the 'imaginative elaboration' of the soma (his term for the body), it is indistinguishable from it – from the entirety of it. In his words: 'The psyche is not, however, felt by the individual to be localized in the brain, or indeed to be localized anywhere'. That only happens, writes Winnicott, when something goes amiss in development – which it invariably does. To try and cope with this setback a person may well go into his head, meaning not just that he becomes a bit detached from himself and other people but that he starts to think of himself as somehow originating or being situated there.

**'Isn't it time for psychoanalysis to be more confident in sharing what it has found out about "psychical reality"?'**

Why the head, though? Why not the hand or foot? Obviously these feature in our fantasies too. But special about the head, says Winnicott, is that it is a part of the body we are very much aware of but cannot see. This gives it the feel of an enemy, one that we may seek to control from within. He also thinks that the enormous pressure it comes under during birth ensures that the head always has a unique importance for the unconscious.

In his book *The Claustrum* Meltzer acknowledges this importance but provides a different explanation for it. For him it is the richness of the 'head-breast' that distinguishes it from other compartments of the internal mother's body as a place we may wish to inhabit at the expense of our own minds. We load it with things we long for like knowledge and creativity and then imagine these are there for the taking. The problem is that this is all a projection on our part, one that gives rise to a pathology that Meltzer terms the 'Delusion of Clarity of Insight'.

Are neuroscientists particularly prone to this delusion? Perhaps only slightly more than the rest of us. Writing in an era when leucotomies were still considered a legitimate treatment option, Winnicott did not completely condemn the surgeons who performed these operations, accepting that they were 'caught up in the mental patient's false localization of the mind in the head, with its sequel, the equating of mind and brain.' Nowadays leucotomies are rare but pharmacological approaches to mental illness tend to be regarded as more effective than psychotherapeutic ones and largely, I suspect, for the same reason: it is the brain that counts and pills entering the inside of the head through the mouth are thought to have direct access to this most precious of organs.

If we seem to be living in precarious times then I would argue that this is

*Continues on page 11*

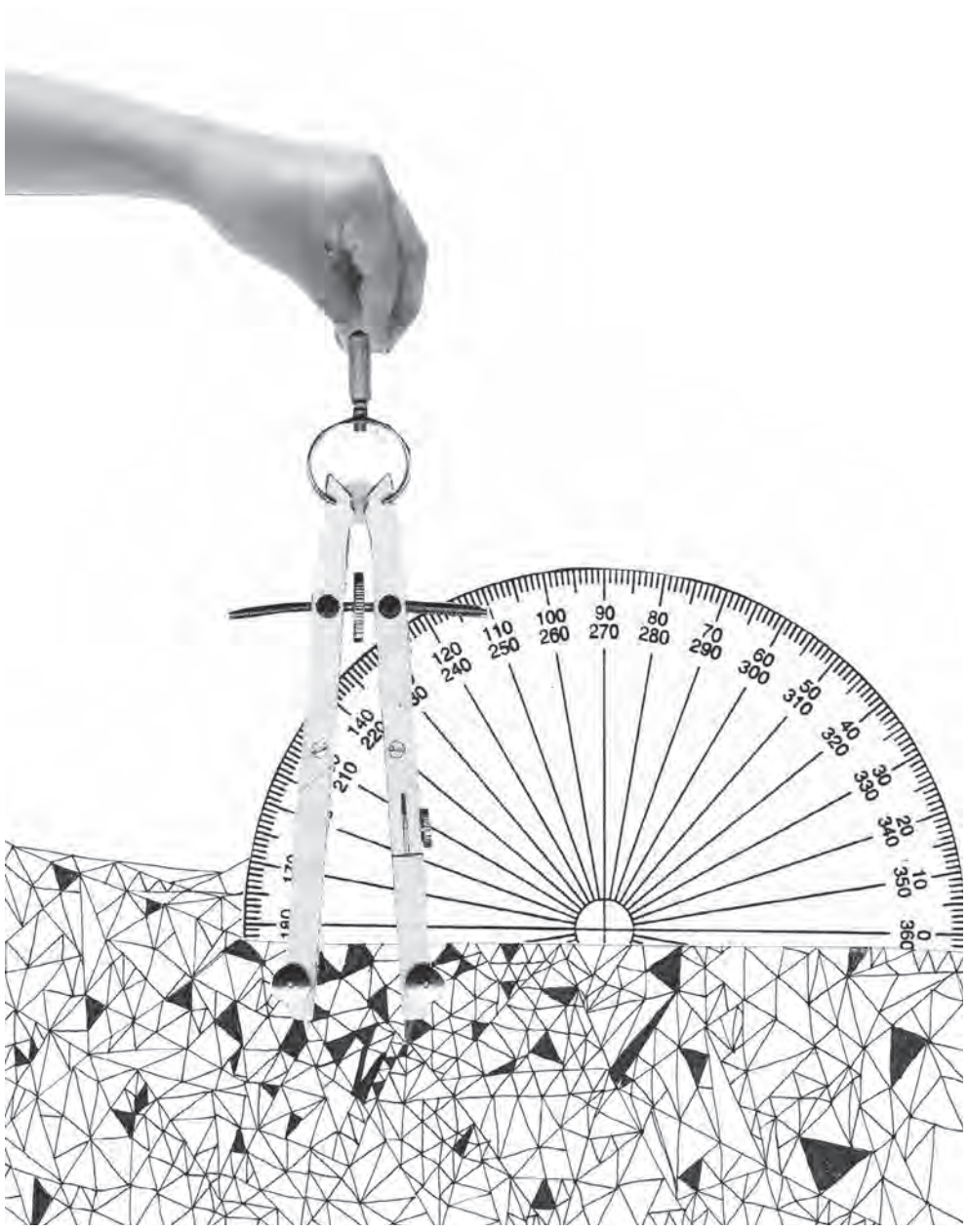
# Recalibrating our models

*By Ruth Schmidt Neven*

*Time-limited psychodynamic psychotherapy with children and adolescents: towards a paradigm shift*

IT IS EXCITING to know that the BPC is spearheading what is described as 'a renewal of our profession' and creating opportunities for discussion in a forum such as *New Associations* in which we can engage with difficult and challenging issues. The need for a re-examination of what our profession has to offer and the imperative for renewal is nowhere more urgent than in the field of child and adolescent mental health. The new century has prompted a reassessment and re-evaluation of many of the accepted and traditional frameworks with respect to our understanding of the social, health, economic, political and environmental issues with which we are concerned. For psychotherapists who work with children, adolescents and their parents these issues of social change are at the tipping point, since it is within the family context and the rearing of the next generation that the demands and challenges for change are largely generated.

My forthcoming book *Time-limited psychodynamic psychotherapy with children and adolescents: An interactive approach* represents the outcome of a lifetime of clinical work with children, adolescents, parents and families in a wide variety of settings and across three continents: the United Kingdom, South Africa, and now Australia. In the book I discuss some of the reasons that have led to the marginalising of psychoanalytic and psychodynamic treatments for children and adolescents that are due not only to the contemporary cost-cutting economic climate, but also to the reluctance of many practitioners to fully engage with the changing social and emotional landscape in which they practice. Within child psychotherapy training as well as adult psychoanalytic training, sacrosanct doctrines tend to prevail in which there is an adherence to the theories and life works of many remarkable pioneers who have made enormous contributions to our understanding of human psychology. There is a problem however when these theories, so illuminating in their time, become embedded and repeated as articles of faith in the various training schools. These embedded articles of faith make it hard to overturn rigid views about how psychotherapy for children and adolescents should be practised, with the result that what was once innovative becomes stagnated into doctrine.



This comes particularly to the fore when we consider how psychoanalytic psychotherapy with children and young people is almost always defined in relation to long term work. The 'true gold' of child psychotherapy that takes place over years may be fascinating for clinicians interested in the complexity of psychopathology, but does it actually ensure that the patient gets better? Jonathan Shedler, who has championed the contribution of psychodynamic psychotherapy, refers to what he describes as the endless preoccupation amongst psychotherapists about what 'really' constitutes psychotherapeutic treatment with respect to the patient lying on the couch or the frequency of sessions. As he pithily reminds us, 'psychoanalysis is an interpersonal process, not an anatomical position.'

### The need for a refreshed vision for psychodynamic work

One of the main arguments presented in my book is that by primarily identifying child psychotherapy with long term treatment we confuse method, objectives and outcome. The claim that it is the focus on long term work that sets child psychotherapy apart from other professions is further questioned, since it is akin to the surgeon claiming that their real skills only come to the fore in lengthy surgery. A further article of faith professed is that it is only through the experience of practising long-term psychotherapy that practitioners are enabled to carry out shorter term work.

I argue that time-limited psychotherapy for children and adolescents is not a shorter or watered down version of 'traditional' child psychotherapy. It requires more than a tweaking of established psychotherapeutic practice in order to accommodate a shorter time frame. Instead, in time-limited psychotherapy the problems presented by the child or young person are viewed as an opportunity to do the internal and external therapeutic work differently. By so doing, it promotes an integrative approach that must encompass the key people connected with the child or young person, namely their parents and significant others. In order to be effective, a time-limited psychotherapeutic approach addresses the total field that surrounds the child or young person, as well as, where necessary, other involved professionals. As Winnicott famously stated, 'there is no such thing as a baby,' and it follows therefore that there is no such thing as a child or adolescent without the parental and family context.

### How do we assess child and family mental health?

We need to consider not only the technical aspects of time-limited psychodynamic psychotherapy but also how, by changing the therapeutic model, we inevitably change and recalibrate many of the elements that are inherent in how we constitute mental health for children, young people, and their parents and families. A core theme is that we recognise the enormous value of the symptom through acknowledging how behaviour has meaning, rather than placing emphasis on pathology. Additionally, by including an active therapeutic approach to parents and caregivers we widen the therapeutic frame and reflect the world that people actually inhabit. This approach is the antithesis of a traditional therapeutic approach that is entirely focused on the child or young person separately, so that the parents are perceived as marginal to the therapeutic task. One may speculate that this kind of decontextualised practice and its accompanying rigidities have, even more than the old chestnut about lack of research rigour, served to undermine support for a psychodynamic way of working in the public service.

### The pathologising of childhood and adolescence: Why we need a psychodynamic approach more than ever

In current times we are bombarded with statistics citing the high prevalence of a variety of mental disorders in the child and adolescent population. This coincides with the paradox that at no previous time have so many children undergone a variety of assessments and tests and been given so many diagnoses with such disappointing outcomes. Prolific researcher Professor Sir Michael Rutter has made the point that improvements in child and adolescent psychological mental health have not kept pace with the improvements in physical health. He poses the question: 'Why has this been so?' and suggests, 'If we had a proper understanding of why society has been so spectacularly successful in making things psychologically worse for children and young people, we might have a better idea as to how we can make things better in the future' (Rutter 2002, p15).

However, it may not be so difficult to understand why we have made things worse for children and young people when we consider the increasing narrowing of the theoretical, clinical and research frameworks within which child and family mental health is constructed. This reflects the predominantly bio-medical approach to the construction of child and family health characterised by a focus on the identification of the problem within the child or young person, often to the exclusion of the

relational family and social context. Add to this the power of the drug industry in targeting psychopathology 'within' the child or young person and you have an explosion of diagnoses such as ADD (Attention Deficit Disorder), ADHD (Attention Deficit Hperactivity Disorder), and the grandly termed ODD (Oppositional Defiance Disorder). The true evidence for any of these disorders is pretty thin and contradictory. Given careful epidemiological examination these conditions would be unlikely to be prevalent in any more than 3% of the population at any given time.

Another motivation to write the book is to posit that Cognitive Behavioural Therapy (CBT) is not the only apparently evidence-based form of short term therapy. Whilst CBT may be a valid form of treatment option for a number of adult problems, its increasing usage in the assessment and treatment of children and adolescents should arouse our scrutiny and concern. The main reason for this is that cognitive behavioural therapies are concerned primarily with limiting the field of inquiry. In work with children and young people this takes the form of attempting to eliminate the symptom or presenting problem, particularly if this takes the form of challenging behaviour. This of course entirely denies the fact that the symptom or presenting problem is often the only means through which the child or young person can 'speak' the family and their experience. The symptom is an immeasurably rich and accurate communication. For example, at a time when we are confronted by the endless revelations of child sexual abuse hidden for decades, it is sobering to learn that these children and young people were not considered to be reliable witnesses to their own experience.

**'At no previous time have so many children been given so many diagnoses with such disappointing outcomes.'**

It is clear that individually lived life, whether of a child, adolescent or adult, cannot be separated from the relational, family, systemic and wider organisational social and political environment. The predominantly pathology-driven discourses described above cannot lead to positive outcomes in child and family mental health. In fact it becomes increasingly evident that narrow pathology-based diagnoses not only compromise the child or young person, but also compromise the ability of professionals to offer meaningful treatment and support. So what can psychodynamic therapy provide that can make a difference?

### Recalibrating the psychodynamic enterprise in time limited psychotherapy

First of all, I believe that we must tackle the thorny problem that is inherent in the use of the term *psychoanalytic*. Instead of being presented as a treatment mode, it appears to have become a generic term for various types of therapeutic engagement which, while they may include psychoanalytic principles, are not in themselves specifically psychoanalytic treatment.We may ask, 'what's in a name?' but the problem is that the 'order of words' quickly becomes 'the order of things' (Good and Kleinman, 1985). This leads to confusion about the difference between a treatment mode and a conceptual framework. In my book I identify the enormous value of the psychodynamic enterprise and how this is a critical component of time-limited psychodynamic psychotherapy. However, the psychodynamic enterprise as I describe it reflects a richness of approach that is not only predicated on an understanding of the individual, but also demonstrates the connections between the child and the parent, family systems, organisational life, culture and community.

In work with children and young people the conceptual framework must necessarily extend beyond the frame of the traditional psychoanalytic. A core theme that underpins the psychodynamic conceptualisation is the assumption of continuity of process and meaning and the unity of brain and mind. This acknowledges a line of continuity from the inner world of the child through to family relationships and connections with the outside world. Central to this integrated perspective is the recognition that all behaviour has meaning and is always a communication. Additionally, the fact that behaviour, rather than being perceived as rigid and fixed, is at all times perceived as dynamic and constantly changing gives impetus to a renewed and refreshed vision for understanding the problems of children young people and their parents within an emotional ecology.

### Shifting the paradigm from a focus on pathology to the dynamics of health and growth

I want to emphasise the need for an urgent paradigm shift from that of a focus on pathology to that of promoting the health and growth of children and young people. It is salutary in this respect to be reminded of the therapeutic legacy of the paediatrician psychoanalyst Donald Winnicott (1958b; 1964; 1965b), who through his clinical work and writings may be described as the real pioneer of time-limited psychodynamic psychotherapy with children, young people and their parents. Winnicott had already recalibrated the psychodynamic approach through his recognition of the inherent capacity for health, growth and self-healing in the child or young person who is in the full thrust of their development. Christopher Reeves (2003), child psychotherapist, refers to Winnicott's conviction of 'the natural capacities for growth and self-healing in the child, given the right environmental provision and less convinced of the indispensability of full-scale child analysis.' As Reeves explains, Winnicott conceptualised this in terms of an 'economics of therapy', not in the sense of economising or rationalising, but at the deepest level of promoting what fits the child and the child within the family.

### Recalibrating research

A post-modern perspective presents us with the recognition that we cannot isolate a particular treatment such as time-limited psychodynamic psychotherapy for children, adolescents and their parents from a broader critical reflection of professional practices concerned with contemporary child and family mental health. Within this context a values- and ethically-based position is one in which psychotherapy and advocacy are inextricably linked. How does this affect research? We are all agreed that research is a good thing and necessary for the promotion of our profession. We would also agree that psychoanalysis and psychotherapy have come very late to the whole project of research. In this resides a dilemma. In our eagerness to be taken seriously as a profession, we are in danger of carrying out research that all too often tries to hang on to the coat tails of empirical science. It is clear that the pursuit of the randomised controlled trial is a poor fit with the type of inquiry that is required to best approach the psychological and emotional problems of children, adolescents and their parents. Current research inquiries into identifying one variable such as clinical depression in adolescents have also produced less than hoped for outcomes (Goodyer, 2014).

The further challenge of this type of research that is fixed on one variable of behaviour 'within' the child or young person is that it reflects a modernity bias that is already out of date. In response to the *cri du coeur* from psychotherapist colleagues who maintain that the powers that be will only accept research defined within these rigid modernist parameters, I would reiterate that the first principle of our therapeutic work is a duty of care to our patients. As psychotherapists struggling with these issues we tend to display a confusing mixture of timidity and omnipotence: timidity in not creating a united voice to inform and educate the various powers about what type of research has a higher chance of being relevant and that will lead to positive health and wellbeing; omnipotence in the sense that we may go along with these narrow research parameters informed by pathology-based discourse in order to prove our relevance.

In conclusion, if we are to recalibrate research in a meaningful manner then it needs to be constructed in such a way as to involve children, young people and their parents directly as contributors to the research process, rather than solely as the carriers of problematic symptomatology. This has the potential not only to deliver reliable information but also to help shift research into a new paradigm of health and wellbeing and into the important area of prevention. Given their wealth of experience, the fact that child psychotherapists are not at the forefront of prevention is mystifying. If we are to carry out meaningful research then we need to engage directly with children and young people as legitimate informants about their experience. We need to further explore the enormous capacity for growth and self healing in the child or young person even in extremely difficult situations, and how this resource may be harnessed in ways that contribute to positive outcomes in therapy. With respect to the process of time-limited psychodynamic psychotherapy itself, we would want to examine what constitutes the essential interrelationships between children, young people and their parents and how this contributes to therapeutic outcome ■

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Training

# On 'not knowing'

*By Carolyn Butler*

*Thoughts on a trainee placement at the Maudsley Hospital*

ONCE I HAD BEEN shown round the ward, a softly spoken nurse asked me what I would like to do next. We were standing in a large communal area where several patients were watching a wall-mounted TV. 'I'm not sure,' I replied tentatively. And then, turning to the room in general… 'Does anyone feel like a chat?' As I took in the different faces – bemused, hostile, worried, giggling – my question was met with total silence. It seemed no one wanted a chat, and I felt completely out of my depth. I then noticed a young man sitting on the floor in a corner. I walked over, crouched down and asked if he felt like talking. Smiling shyly he said 'Okay,' and as we found a couple of chairs to sit on I inwardly thanked him for rescuing me. Meanwhile the nurse retreated to his nursing station leaving me alone with 19 adult male patients – most of whom have a diagnosis of schizophrenia. It was the first of many experiences on this acute psychosis ward of 'not knowing' – what to do, what to say, or how to say it.

My next encounter was with a very tall man in his thirties. This time we met in the 'interview room' – a small room with a locked door, to which I had the key. I explained that I was a volunteer and asked whether he would like to talk. He looked wary and said, 'What do you mean?' 'Well,' I ventured, 'perhaps we could talk about how you've been feeling today…' He looked at me intensely and the small, airless room suddenly felt oppressive. The silence continued and as he stared at me I sensed his increasing agitation. As another few seconds passed – and his expression turned thunderous – I realised I should never have let the silence continue. 'It's okay,' I said, 'we can leave it for another time.' 'No!' he shouted and stood up very suddenly, towering over me. 'No! I don't know who you are, I don't know what you want!' As the patient walked out it was another lesson in 'not knowing' – that in this kind of 'soft' therapy silences are to be avoided because they can be experienced as persecutory and threatening. As I tried to understand his complex state of mind, I felt the fragility of my own.

In the meantime I also attended the weekly ward round – a gruelling five-hour, multiprofessional meeting – punctuated by home-made cakes and caffeine. Several patients would be seen during the course of the morning, many accompanied by family. Their entry into this room full of professionals seemed exposing and they all coped with it differently. Some were clearly looking forward to the meeting and would shake hands with each one of us, while others barely acknowledged our presence. Some would dress for the occasion and make an effort with their appearance, while others in the early stages of illness would shuffle in wearing hospital pyjamas and slippers. Each man was unique, and yet most had psychosis in common.

**'As I tried to understand his complex state of mind, I felt the fragility of my own.'**

And psychosis was a new and complex phenomenon that I was struggling to understand. With my own background in psychodynamic psychotherapy I felt unprepared for the variety – and also the danger – of psychosis.[1] I knew we were all on a 'spectrum' – that we all had our own 'psychotic patch' – but this seemed different – more disturbing and much more fragmented. Bits of Kleinian theory came to mind, especially the paranoid schizoid position – but these 'bits' were only partially helpful in the here and now of the moment, when faced with the incoherent thoughts and powerful emotions of a distressed patient.

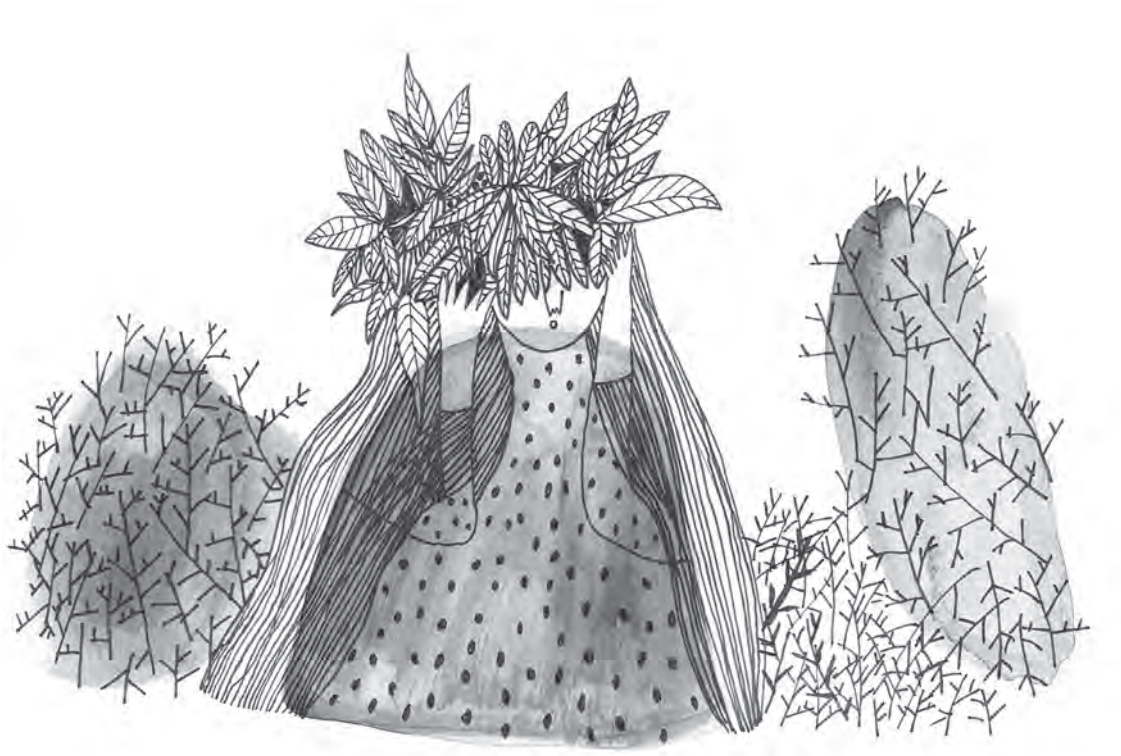
I was also learning more about what it meant to be detained on a section of the Mental Health Act.[2] Mental health workers have the power to section people considered to be suffering from mental illness who pose a risk to themselves or others, but who lack the insight required to receive treatment voluntarily. They can also section people for not adhering to medication, and this can set up a catch-22 situation whereby patients stop medication because they feel well, only to find themselves sectioned again for not taking it. At the Maudsley patients frequently had no idea why they were in hospital, and would often accuse family members of colluding with professionals to have them 'locked up'. They felt bewildered and there were times when I found myself identifying with them. The consultant psychiatrist, Dr Dele Olajide, would use Socratic questioning to help these patients acknowledge their need for medication and also the fact that their behaviour may have led to their admission. Some would respond quite well to this questioning but soon become paranoid, hostile or grandiose in their behaviour. Others were sad and confused as they tried to describe the voices in their heads, or the bizarre thoughts in their minds. Others simply clammed up and left the room. Occasionally a patient would become aggressive and the alarms would start to go.

One patient in particular stood out for me. In the ward round he was polite and calm; however he declined to answer any questions at all, afraid his responses might incriminate him. After much probing and interrogation he still refused to explain why he had stopped his medication, except to say that he felt well. At the end of the interview the verdict was pronounced: 'Restrain him' – and even then this man retained his composure, knowing that he was about to be subjected to enforced medication. Over the coming months I met with him regularly and witnessed this man's internal battle to understand why he had been sectioned. His only rationale was that it must be some kind of government plot to send him back to his country of origin. He also battled with the weight gain caused by medication, forcing himself to do press-ups in his room. The more the weight gain, the harder the exercise regime, but it proved too difficult and in the end he gave up. According to his notes, he was not a risk, to himself or others; however, many years ago he had attempted suicide while psychotic, and so had become part of a system that was not prepared to take that risk again. While staff at the Maudsley were willing to give him a chance, the community mental health team was not. As the relationship between this patient and his care coordinator broke down, I wondered about his future, trapped in an endless cycle of sectioning and re-sectioning, even though his actual behaviour – with or without drugs – was harmless.

In the meantime there were ongoing debates in the ward rounds ranging from philosophy, through colonialism and its effects on black Londoners today, to cannabis, and whether or not skunk induces psychosis. The cannabis debate in particular was interesting because a British pharmaceutical company is developing new, cannabis-based drugs for several conditions – including schizophrenia.[3] Very little is known about the different compounds in cannabis (and there are hundreds of them), but some are believed to protect against psychosis. The reality however is that many patients simply smoke whatever is available in order to self-medicate – with consequences that are still unclear.

The group dynamics of the ward emerged during these debates and were also interesting. The consultant psychiatrist used a lot of humour and was clearly in charge of his ward; however, members of staff were constantly encouraged to speak up and question the decision-making process. Initially I found this intimidating – more 'not knowing' – but the variety of perspectives felt important. The patients were also encouraged to express their thoughts and feelings, and often struggled to hold themselves together in the face of this challenge. Only when the meeting was over, and the doors locked behind them, did they let rip with their frustration. Doors were kicked down and nurses attacked as their precarious states of mind began to fragment. Again I felt the fragility of my own mind as the ward round continued to the roars of their fury in the background.

I found these episodes upsetting – surely there was another way to help them – and yet as the weeks went by I often saw how their outlook improved as the medication somehow returned them to themselves.



# Time to get out of our heads

*continued from page 7*

partly because we insist on living in our heads. This makes us feel extremely vulnerable. Is it why the decapitations carried out by ISIS add to this by filling us with such a peculiar sense of horror – as though other kinds of death and destruction in the Middle East were less shocking? As psychoanalytically-informed psychotherapists I believe we have a unique contribution to offer to understanding how we understand ourselves. Therefore let us hold our nerve and not get sidetracked by the study of neurons ■

*Johnathan Sunley is a psychodynamic psychotherapist in private practice in London.*

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# On 'not knowing'

*continued from previous page*

I also witnessed the staff doing their best to help the patients and especially to prevent relapse. A lot of work goes into treating early psychosis in order to try to prevent a recurrence. This consists of medication, therapy (CBT and ACT), and also community-based initiatives such as the Maudsley's 'Recovery College' with workshops such as 'Hearing Voices' and 'Spirituality and Wellbeing'.[4] I also saw many moments of ad hoc kindness towards patients – a chat, a joke, a hug – simple, basic human warmth.

**'A lot of work goes into treating early psychosis to try to prevent a recurrence.'**

I was left wondering if psychosis could be reversed. Historically Kraepelin, who first described dementia praecox, believed that remission was a sign of wrong diagnosis, whereas Bleuler, who invented the term schizophrenia, held that some cases do experience spontaneous remission – a view that made me think again about those individuals who are not causing any harm, but still end up on a section for not adhering to medication. According to Dr Olajide, between 14% and 30% of patients with first episode psychotic disorder will have spontaneous remissions. He cites research which suggests that in developing countries the prognosis is even better because individuals are often supported within more cohesive communities.[5] In Nigeria, for example, the lack of welfare means that people in remission are supported by families but also expected to obtain employment. By contrast, he says, the welfare system in the West provides a safety net, but can also paradoxically trap patients in poverty and alienation from mainstream productive roles. This view – like so many at the Maudsley – is the subject of ongoing debate.

Overall I am left with an even deeper sense of 'not knowing' – the human mind and how it works – my own and others, but especially others. While neuroscience and therapeutic models of the mind can help, they rarely seem to capture the mystery and elusiveness of human complexity. This lack of certainty brings with it a loss of control which feels uncomfortable. I found my placement at the Maudsley humbling, and this has led to a certain reticence which grounds my clinical practice today. Just when I think I might be getting to grips with something, I remember that angry patient who walked out – a useful reminder that in this difficult and thought-provoking work we never fully understand the complexities of the person before us. We just keep trying ■

*Carolyn Butler works as an honorary psychotherapist in the NHS, has a private practice in South West London and is currently undertaking a Masters degree at the University of Exeter.*

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1. According to a BBC report, mental health trusts in 2015 recorded a 20% rise in unexpected deaths over a two-year period. www.bbc.co.uk/news/health-35403827

2. The Mental Health Act 1983 was amended in 2007 to include Community Treatment Orders. These give mental health workers the right to re-hospitalise patients for not taking their medication. www.legislation.gov.uk/ukpga/2007/12/section/32

3. The British company GW Pharmaceuticals has recently published the results of its phase 2 clinical trial on CBD as an adjuvant in the treatment of schizophrenia. GW Pharmaceuticals plc, Press Release, September 2015.

4. www.slamrecoverycollege.co.uk

5. WHO. *Report of the International Pilot Study of Schizophrenia*, Volume I. Geneva, Switzerland: World Health Organization; 1973.

## News

### Young people are under too much pressure

Helen Morgan and Heather Stewart, the Chairs of, respectively, the BPC and the Association of Child Psychotherapists (ACP) have had a letter published in the *Independent* (4 March). The letter states:

'Geraldine Bedell's article on the teenage mental health crisis was sobering and disturbing.

'The dominant narrative of the time we live in is of austerity and competition. In both public and private sector consulting rooms across the country our psychotherapists and child psychotherapists increasingly see anxious and traumatised individuals, troubled by matters such as work pressure, money worries, addiction to social media, and loss of control over one's life. As a society, we will likely face worsening adult mental health if we do not begin to challenge the expectations and unrealistic pressures foisted on young people today. With the enormous pressure placed on young people, where the prevailing narrative is that everything is down to individual endeavour and anything less than the highest grades in exams is failure, is it any wonder that so many teenagers are suffering?

'The British Psychoanalytic Council is greatly concerned about the teenage mental health crisis and about what the legacy will be for these teenagers as they grow older.'

### Longer-term therapeutic approaches on the NHS

The BPC has had a letter published in the *Guardian* (26 February), written in response to an article by Richard Bentall. Professor Bentall's article, written in response to the BBC's 'In the Mind' series of programmes on mental health, contended that mental illness is primarily caused by misery and by traumatic life experiences. The BPC's letter picks up in particular on the following lines from Professor Bentall's article:

'For one thing, many psychiatric patients in Britain feel that services too often ignore their life stories. In the words of Eleanor Longden, a mental health activist, "They always ask what is wrong with you and hardly ever ask what happened to you." Patients are routinely offered powerful drugs (which clearly have a place but only help some patients), but very rarely the kinds of psychological therapies that may help them come to terms with these kinds of experiences, or even practical advice (debt counselling probably has a place in the treatment of depression, for example).'

The BPC responded: 'It has been frustrating to see services which offer such therapeutic approaches suffer so many cuts on the NHS in recent years. Clearly, there is a role for medicine and shorter-term therapeutic interventions in the treatment of some people, but a way forward must be to acknowledge the need for many to voice their experience and story in a longer-term therapeutic relationship. With one in four people in the UK experiencing a mental health problem each year, how much longer can this country afford to treat mental ill health without looking at the wider socioeconomic causes that so often impact on life experiences?'

For further information on the efficacy of psychoanalytic psychotherapy, please visit the BPC's research and evidence web page: www.bpc.org.uk/about-psychotherapy/evidence

### Psychological therapy professional bodies respond to 'The Five Year Forward View for Mental Health'

The Mental Health Taskforce, created to come up with a vision and plan for mental health on the NHS in the next five years, published its report yesterday. The BPC, BACP and UKCP responded with the following statement to the press (this is an edited version). In the coming weeks and months, we will be carrying out extensive work in response to the report.

'The British Association for Counselling and Psychotherapy (BACP), British Psychoanalytic Council (BPC) and UK Council for Psychotherapy (UKCP) welcome the publication of the independent Mental Health Taskforce's report.

'As the report rightly emphasises, the human cost of mental health not being treated with equal importance to physical health is unacceptable, and the report presents an impressive set of recommendations to transform the support and care of those suffering from mental ill health.

'We welcome the focus on psychological therapies and look forward to working with NHS England, local commissioners, government departments and professional colleagues to ensure that those who need therapeutic support can access the right treatment at the right time.'

## Reviews

### Murdered Father: Dead Father: Revisiting the Oedipus Complex

Rosine Perelberg, Routledge 2015

Rosine Perelberg characteristically takes up the cudgels for a rigorously argued psychoanalytic theory, never too far away from the consulting room. In her theoretical exposition she takes a fundamental tenet of Freudian theory: The killing of the father is in Freud's view a requirement for the creation of the social order that from then on prohibits all killing. (p1)

She elaborates it:

> The father however has only to be killed metaphorically: the actual exclusion of the father lies at the origin of so many psychopathologies, ranging from violence to the psychoses and perversions… (p1)
>
> The shift from the murdered to the dead father represents the attempt to regulate desire and institutes the incest taboo. (p36)

Her Freudian scholarship which, as Michael Parsons comments, means that even the most knowledgeable of Freud's readers will come away from reading her book knowing Freud better, provides the bedrock. This is then honed by her longstanding engagement with French psychoanalysis which has, in collaboration with a number of other redoubtable British colleagues, so enhanced clinical theoretical debate in British psychoanalysis.

Rosine takes her thesis and runs with it through anthropology, mythology, theology, to the opera house and the art gallery. It is a breathtaking endeavour. One of my particular favourites is her revisiting the story of Abraham and Isaac through the prism of her murdered father, dead father lens. She invites us to view Caravaggio's and Rembrandt's depiction of Isaac's near sacrifice and argues that the two painters differ: Caravaggio renders the scene by inclusion of the violence of Abraham's act and Isaac's pain, Rembrandt softens the image. Rosine describes the extraordinary moment where Abraham, wielding the knife, stops in mid-air. She argues that this

> marks the passage from the rule of the murderous, tyrannical, narcissistic father – God, who has the power of life and death over his son – to the dead symbolic father, the father of the law who forbids all killings. (p65)

There are countless other examples and my intent of course is not to give a resume of the book, but to whet your appetite or perhaps to excite your interest. Her thesis inaugurates an adventure abundant in scandal. She reminds us of the forever scandalous nature of the Freudian discovery of the desire to kill the father and its concomitant expression in infantile sexuality. These scandalous notions of incestuous wishes, murderous fantasies even against those we love, maternal seduction and patricide underpin Rosine's theorising. She critiques some contemporary theory which views psychoanalysis, particularly in the central notion of thirdness, as a theory of co-creation and symmetry. Her thesis, by contrast, emphasizes a non-linear temporality, disruption and challenge:

> A profound dissymmetry, trauma and violence inherent in the analytic situation (p70)

And yet alongside the scandal of the violence, disruption and discontinuity and the centrality she gives to the traumatic nature of sexuality inherent in psychic development, Rosine traces how

> …the desire to kill the father initiates the process of mourning. (pp41, 53)

echoing I guess her own paternal line to André Green (dare I say the dead father not the murdered father), who accompanies both author and reader as a sort of internal interlocutor throughout the book. He famously writes how that which differentiates present day analyses and those in the past

> …surely would be found among the problems of mourning. (Green 1986 p142)

In my view it is this link to mourning which returns us to what I said at the beginning. Rosine is never far from the consulting room, and the book attests to her commitment to a clinical technique which may be rooted in a metapsychology, which includes disruption and violence, but is certainly not characterised by doing violence to the patient's experience on the couch.

She argues for a technique which privileges the classical setting,

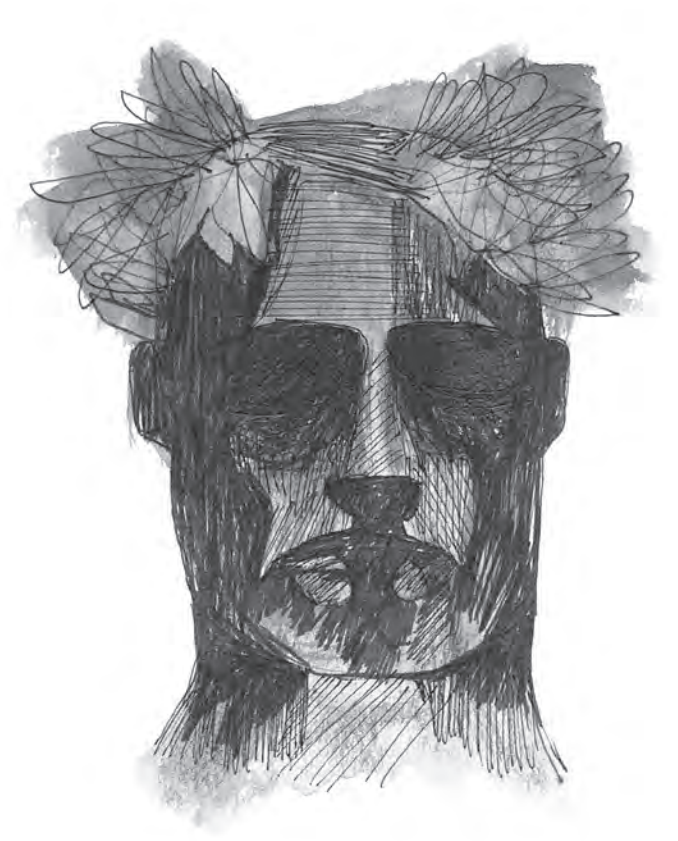
> …the rules of which both analyst and patient submit. (p71)

She describes how the psychoanalytic setting reflects the dead father complex:

> It is present in the construction of the setting that requires the invisibility and silence of the analyst, the abstinence (sacrifice) of both analyst and patient. (p79)

Furthermore her clinical practice, demonstrated throughout the book by vivid clinical accounts, insists that there is no place for the omnipotent analyst, but rather the analyst who as she describes 'inaugurates a process' (p76), characterised by such things as the 'open interpretation', and the special form of listening.

Any of those who have participated in Rosine's much lauded teaching on psychoanalytic technique at the Institute of Psychoanalysis, or those of us who have recently been enjoying her inspired chairing of a series of Contemporary Freudian clinical presentations, will know the scrupulousness and compassion of her attention to the patient's lived experience.



**'Rosine takes her thesis and runs with it through anthropology, mythology, theology…'**

Whilst we are reading Rosine's new book, she of course will be venturing on another psychoanalytic journey, so these last thoughts consider the next part of her journey. One of the many fascinating threads in the book which I find very compelling is the allusion in a quotation of Freud's to the vital difference between the maternal and paternal in its link with the differing challenges the child faces. She or he feels more certain of the maternal line, knowing who his mother is (Oedipus excluded!), but always and forever unsure of the paternity. Rosine quotes Freud in his last writing in 1939. He writes:

> …this turning from the mother to the father points… to a victory of intellectuality over sensuality… since maternity is proved by evidence of the senses while paternity is a hypothesis, based on an inference and a premise. (Freud 1939 p113)

In her book, Rosine demonstrates her pleasure in the interrogation of myths. So what about the link here with Telemachus as he contemplates leaving his mother, Penelope, to the rabid ruthlessness of her warring suitors and the interminability of her weaving, when he goes in search of his father Odysseus? Telemachus declares,

> My mother [he challenges not the truth of her claim to be his mother] says that I am Odysseus' son, though of course I cannot know that; no man can ever be sure who his own father is… (Homer's *The Odyssey* translated by Stephen Mitchell 2013 p6)

Nor woman either I might add! What we can be sure of is that to alert Rosine, perhaps even to challenge her with such a conundrum redolent with consequences for our clinical theory, she'll run with it… a sequel then to this wonderful new book might be entitled: Whose Father is He anyway? ■

**Rosemary Davies**

*This is a slightly edited version of a brief piece given at the book launch of Rosine Perelberg's book* Murdered Father Dead Father, Revisiting the Oedipus Complex.

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## When The Sun Bursts

Christopher Bollas, Yale University Press, 2015

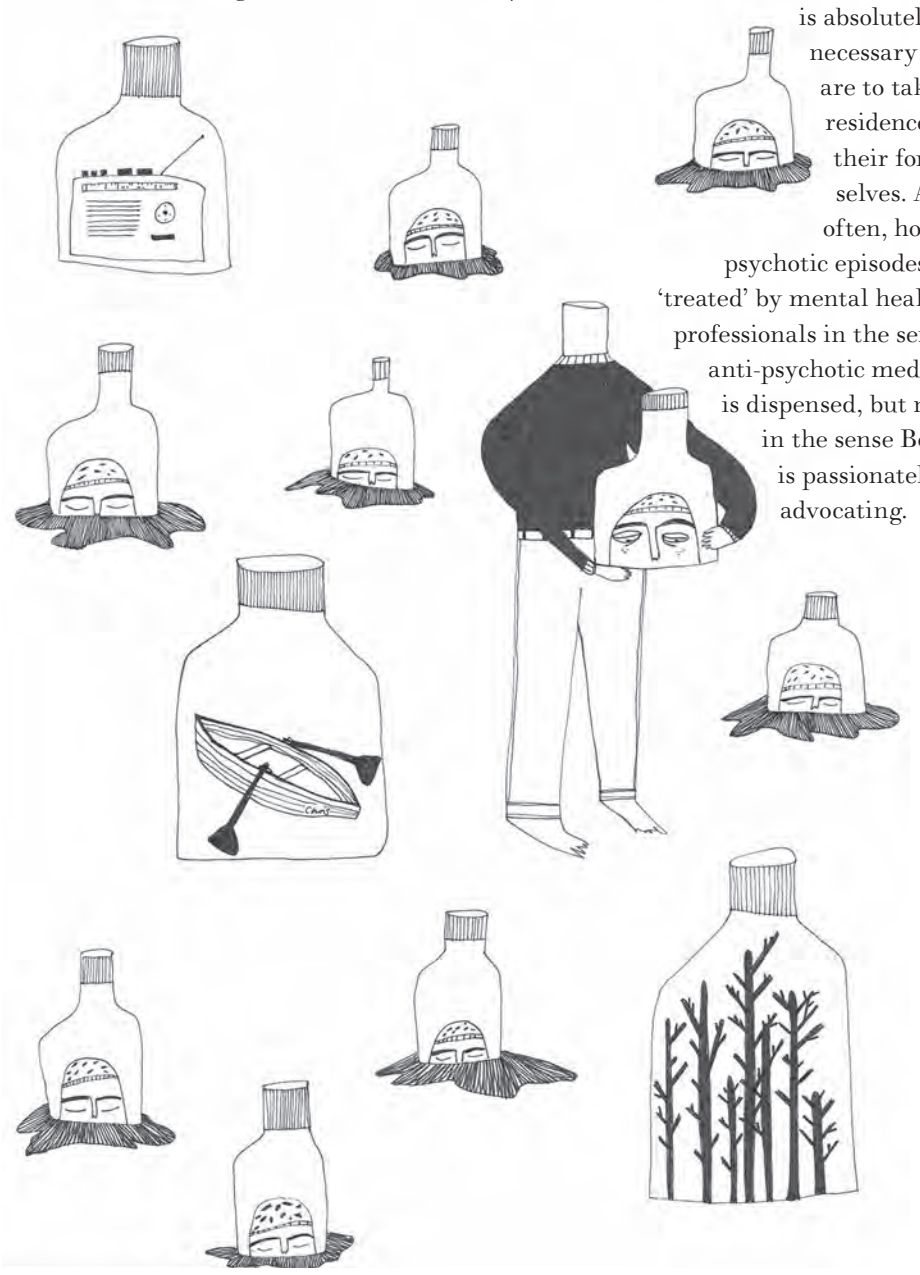
Christopher Bollas' new book, *When the Sun Bursts*, is a refractory look at his long career through the lens of schizophrenia. It begins well before he trained as a psychoanalyst when, as a young man, he worked in a school for psychotic children, EBAC, in Oakland, California. In a characteristically practical fashion, he recalls the day when instead of having to wrestle his charge, Nick, to the ground upon arrival to prevent him attacking anyone (which could involve restraining him on the cold, wet ground for an hour or more), he discovered he could tell him a story about all the children and the teachers embarking on a big orange boat. Nick, thenceforward, greeted 'Chris' with an exclamatory demand for 'Orange boat'. It might have got a bit repetitive, but at least it kept his bum dry!

Bollas's central preoccupation in this book, it seems to me, is to grapple with what communication is for and with what the psychotic mind is all about. Having trained at the BPAS in London in the mid-70s under the post-Kleinian generation of psychoanalysts who felt the analysis of psychotics was an essential aspect of the psychoanalytic endeavour – Hanna Segal, Herbert Rosenfeld, Henri Rey etc. among them – Bollas also took these very ill patients into treatment, in five times weekly private practice. A decade later, in the mid-80s, he returned to America to treat schizophrenic patients in the residential setting of the Austen Riggs Center in Stockbridge, Massachusetts. His 40+ years of experience are deeply grounded in the premise that there is method to all madness, and this latest book is his sensitive and imaginative account of the psychotic mind's methods.

As human beings (unless we are midwives or palliative care nurses) our encounters at the astral portal of birth and death are usually limited but very profound. To witness the birth of a human being or to accompany them in their passing is to be exposed to life at its very edges. An essential aspect of 'holding' these liminal experiences – sewing them into our ongoing sense of ourselves – is the task of narrating the story to another.

When Nick demanded 'Orange boat' all those years ago, he was asking 'Chris' to hold his mind together as a substitute for holding his body together. Bollas argues that the story can contain feelings which threaten to fragment the self. It is no coincidence that we all start as babies in swaddling blankets then progress to the verbal containment of being told a story before we go to sleep. The same holding function is at work, when like the Ancient Mariner before us, we are compelled to tell our own stories of encounters at the astral portal. I have noticed a palpable sense with patients that if they don't tell me *that* story, they cannot re-inhabit the self they were before it.

In like fashion, Bollas makes a plea for us all to recognise how essential is the need in the person who has had a psychotic episode to tell the story of how their doors of perception opened. The nitty-gritty of what happened when, where and how, is absolutely necessary if they are to take up residence inside their former selves. All too often, however, psychotic episodes are 'treated' by mental health professionals in the sense that anti-psychotic medication is dispensed, but not in the sense Bollas is passionately advocating.



If first-time sufferers do not get this vital opportunity; 'if the self is not restored to its history', as Bollas poetically puts it, then the psychotic process can start to take root. In Chapter 13, 'Hiding the Mind', Bollas elaborates this by showing the allegorical nature of psychotic thinking. The 'as if' dimension of thinking recedes; symbol and object flatten one on t'other. For example, a particular teacher to a psychotic child 'is' security, so safety must be concretely acquired by touching this person several times a day. Or anger is the vacuum cleaner while the radio is communication. When fragments of the self start to be assigned to physical rather than interpersonal objects (always using an underlying logic but the longer this goes on, the more hidden the threads of meaning become), the person moves further along the trajectory of the psychotic process towards a schizophrenic existence in which the fabric of the scattered self has been so well distributed around the physical environment that it can, tragically enough, never be recovered.

**'Bollas's central preoccupation is to grapple with what communication is for and what the psychotic mind is all about.'**

Bollas argues that, 'In the schizophrenic order, a self fulfilled is a self endangered. But a self intelligently emptied is a self protected.' He expands this by saying,

> By connecting the self to things, by thinking the self into an it rather than an I, by abandoning the symbolic order, the schizophrenic tries to evade the perils of thought and language. (p.143)

Mindlessness is the objective, as having a mind is felt to be far too dangerous. Why? In Chapter 10, Bollas introduces the helpful concept of 'metasexuality' to describe the ways in which 'the schizophrenic aims to eliminate the disturbing psychic effects of the primal scene by incorporating it, thereby nullifying the reality of sexuality altogether.' And there is seduction there too. He goes on,

> At the very moment when he is cut off from the I that might position representations of unconscious thoughts into consciousness, he feels that thought, being, and action are bundling up into an extraordinary intimacy. Rarely have mind, body, existence, and reality felt so intimately connected. (p.145)

We are all asked to give up the 'extraordinary intimacy' of the Maternal Order when we enter the Symbolic Order and most of us manage, by and large successfully, to do this on entering the world of language. Words stay embedded in their chain of signifiers rather than the things-in-themselves they once were to our pre-verbal brains. Of course, this does not mean we give up on experiences of the 'intimate connection' between mind, body, existence and reality – what else are our essential excursions into poetry, music and art?

The interesting point I think Bollas is making is that, to quote Richard Lucas, the 'psychotic wavelength' is a place on the spectrum of experience that as babies we all intimately knew – the place of somatoform experience and representation. The schizophrenic seems to find a way back there and, once there, seeks to stay lost (and keep you lost with him) in his way of experiencing the world where he does not think things but he does things. His difficulty is that he is continuously flooded by unconscious thinking which penetrates consciousness – especially the rage and terror-filled aspects of the primal scene – which arrive as vivid visual images, powerful bodily dispositions, the sound of accusing voices, or as a smelling of the world, shifting from moment to moment. The schizophrenic can find rest either by controlling mental process and restoring themselves to the everyday (at which moments you cannot call them schizophrenic) or by outsourcing the mind through projective processes in the hope of becoming mindless. The choice they make at such moments is critical to their eventual destination as people.

Bollas argues, convincingly I think, that by being with a listening Other trained in the psychoanalytic tradition, the psychotic can be gently encouraged to discover 'the generative potential of intrapsychic change.' The task, however, is far from easy, 'since the schizophrenic is not trying to tell you something; instead he seeks to wrap you up, syntactically, in his way of experiencing the world', and in doing so '…deconstruct[s] the defences crucial to our own peace of mind.' The task before the courageous clinician is therefore a mighty and fascinating one; the work demands a great deal of patience, imagination and sensitivity. Or, in a word, love ■

**Annie Pesskin**

*Annie Pesskin is a psychodynamic psychotherapist working in private practice in London and Oxford and also as a reflective practitioner for Oxford Health NHS Trust's Forensic Services.*

*Readers can purchase this book at a special price of £14.00 (rrp £18.99) when ordering direct from the Yale Books website: www.yalebooks.co.uk Please enter promo code Y1567 when prompted at the checkout stage of your order. Free p&p UK only. Promo code expires 31 July 2016.*

Culture

# Birdman, or the reality of unreality

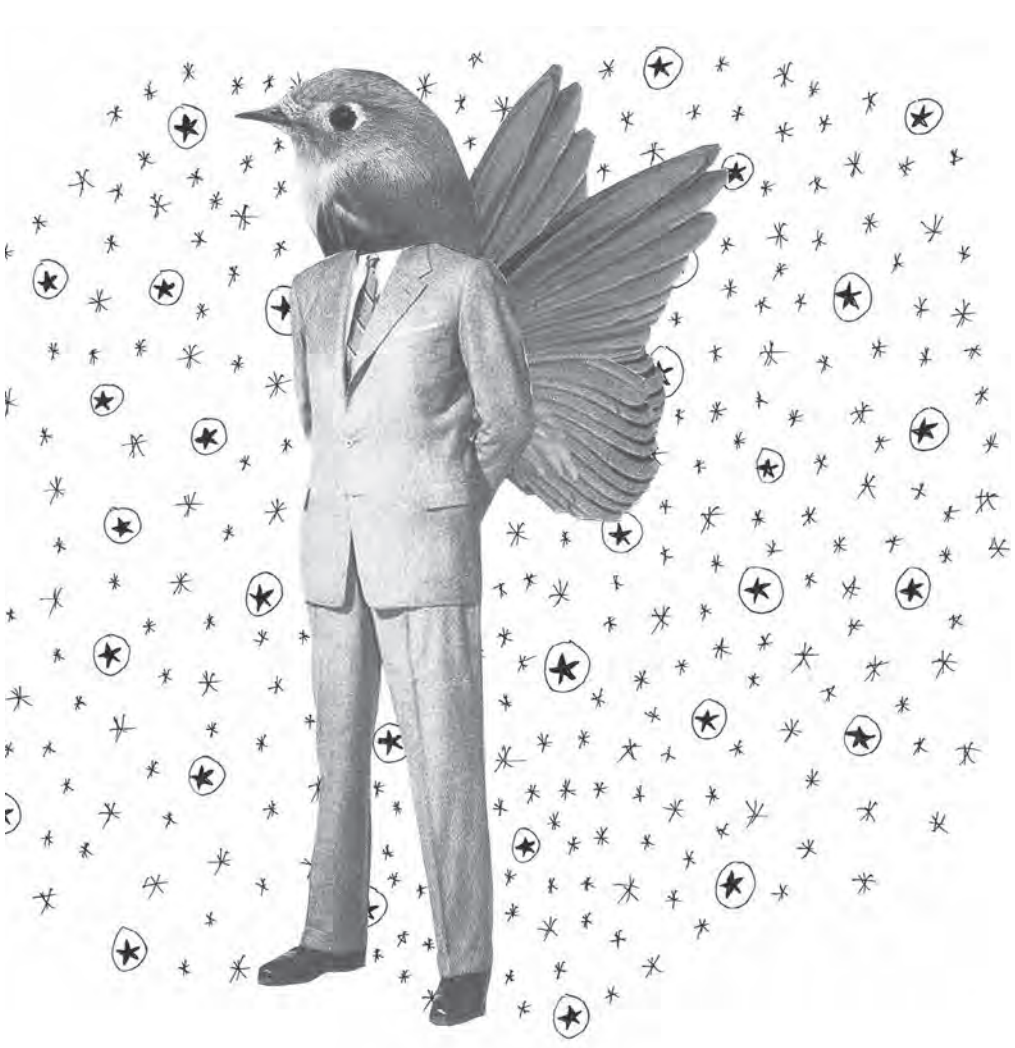
*By Clea McEnery-West*

'HOW DID WE end up here?' asks the voice of Birdman, the eponymous feathered superhero from a series of popular films made over twenty years ago. This comment, in a sense, sums up the mood of a film which illustrates something about the lengths people will go to – the defences they put in place – to deny the painful feelings of regret and loss that come with ageing and the recognition that one's ambitions have not been realised. The film blurs the lines between external reality and the protagonist's internal world, shifting between apparently psychotic states of mind and a more reality-based perspective.

The protagonist, Riggan Thomson, is an ageing actor trying to reinvent himself on Broadway with his own stage adaptation of a Raymond Carver short story, 'What We Talk About When We Talk About Love', in which he has invested his life savings. With a nod to the confusion between reality and fantasy, life and art, that pervades the film, Riggan is played by Michael Keaton who struggled to restart his own career after starring in a series of Batman films in the late 80s and early 90s.

The film is shot to look as if it is one long take seen mainly from Riggan's perspective. At times the other characters have a separate external existence, but at others they appear to be parts of his internal object world. This is particularly the case as the camera repeatedly follows Riggan walking anxiously through the narrow, windowless corridors of the theatre to or from the stage, the tense irregular drum beats on the soundtrack mimicking the sound of his heart. In the corridors and the dressing rooms leading off them relationships are enacted with primal intensity: here is love; erotic attraction; jealousy; rejection and Oedipal rivalry that spills over into violence.

The very first scene shows Riggan in his dressing room levitating about a foot off the floor while we hear the critical voice of Birdman telling him, 'This place is a dump! We don't belong here.' As Riggan is called to the stage he steps down onto the floor and pulls on his clothes. The viewer enters directly into his world. We are not asked to question whether what we see is 'real' in the constructed reality of the film (superheroes have super-powers after all), but to be with and alongside Riggan and his experiences.



From a psychoanalytic point of view, we might see this as a manifestation of the character's incipient psychosis or psychic retreat (Steiner 1993) as a response to repeated experiences of frustration, humiliation and powerlessness. It reminds me of the way we are asked to step into the worlds of our patients, no matter how mad or confusing these may be, in order to understand them, but how we also need to be able to step out again and regain our own perspective in order to be of help.

There is a similar audience relationship set up here as in 'A Beautiful Mind', where the viewer is placed inside the protagonist's world at the start of the film and believes, as John Nash does, that he has been given a special assignment by the Department of Defence to thwart a Russian plot. The film was based on a true story and the protagonist, Nash, who has paranoid schizophrenia, eventually learns to live with and recognise his delusions for what they are.

Alone in his dressing room we see Riggan move objects across the room as if using telekinetic powers, often smashing them to the floor or against the wall in a destructive infantile rage. These episodes always seem to occur after experiences of frustration where he feels powerlessness and impotent. Riggan even claims responsibility when a falling chandelier hospitalizes the other male lead. The short-notice replacement, Mike (Edward Norton), displays the type of false-self persona identified by Winnicott (1960 p.150), who describes actors 'who can only act, and who are completely at a loss when not in a role, and when not being appreciated or applauded (acknowledged as existing).'

Mike is incapable of becoming sexually aroused when alone with his actress/girlfriend (Naomi Watts), but gets an erection when he is playing her lover on stage. This draws laughter – and a degree of admiration – from the audience in a way that Riggan, playing the jilted partner, experiences as acutely humiliating, disrespectful to the play and a threat to his own potency. Mike becomes a catalyst for Riggan's Oedipal rage, also seducing and seduced by Riggan's ex-addict daughter (Emma Stone).

The film is a fascinating study of the tension between reality and fantasy and the type of psychotic splitting that can take place under extreme levels of stress and anxiety. This culminates in a scene where – believing his play is going to be rubbished by New York City's most important and influential theatre critic (super-ego), Riggan flies over the city in a literal flight from his fears of humiliation and the ruins of his ambitions. Back in his dressing room later, Riggan hears the voice of Birdman suggesting he should abandon the play and make Birdman 4 instead. Birdman in all his feathered glory stares down at him from a giant poster on the wall – an alternative manifestation of the super-ego. Perhaps the fantasy of flying is another form of psychic retreat, a borderline state of mind where uncomfortable reality can be avoided, and Birdman is part of the perverse organisation which controls Riggan, restricts his professional development and attacks the part of him which wants to connect with others in a more truthful way (Steiner 1993). Riggan both wants to rid himself of his character and simultaneously longs to merge with him. To be Birdman is to possess super-powers (be omnipotent), to be a hero and to have certainty, but – in a contrast expressed through the tension between popular culture and what is considered highbrow – it is also to be a figure of ridicule. There is something about a search for authenticity here.

This difficulty tolerating reality reminds me of a patient of mine who has an addiction cycle where he will get clean, start a new job and a new relationship, engage in therapy, but when the ordinary frustrations of his daily life become too much he retreats into a paranoid state of rage and turns to substance abuse where the object is constant and can be controlled. His destructive and neglectful internal objects overwhelm him and no good-enough ordinary object relationship is ever satisfying.

In the film, there are moments of insight when Riggan's anxiety levels are lowered and some degree of authentic connection is possible, such as when he is visited in his dressing room by his ex-wife (Amy Ryan). He tells her, 'I have this voice in my head. It tells me the truth about things. Sometimes it's scary. It's me you know.' She replies, 'I'm going to pretend that I didn't hear that.' Here Riggan acknowledges the internal splitting but it is not possible to maintain this state of integration. The message is that 'voices' – less acceptable parts of the self – must be ignored, perhaps because facing the pain and humiliation would be unbearable. This is like being with a patient who is able to tolerate the different parts of themselves as a whole, though only fleetingly. For example, the client above who can briefly get in touch with the idea that, as well as using alcohol to escape from everyday frustrations and disappointments, he also uses it to get alongside, and perhaps even become, his hated emotionally abusive and heavy-drinking father.

Riggan craves recognition as a serious actor – he is recognised everywhere by the public as Birdman, but this does not satisfy him. The characters in his life are objects in the original Freudian sense – to be used in order to release tension and satisfy his libidinal desires (Freud 1905 pp123-243). He ignores or attacks those who care about him and ruthlessly gets rid of those who stand in his way. Although he has already invested all of his life-savings in the play, he remortgages his house – his daughter's inheritance – in

Interview

# Tea with Brett

*NA interviewed Brett Kahr in the hope of discovering the motivations behind the creation of his new book series, 'Interviews with Icons', and of the first title in this series,* Tea with Winnicott, *just published by Karnac Books. What we found is a passionate scholar, creative writer, and advocate for the preservation of our profession's history and its key theories.*

*The informality of the prose and the access to the playful nature of the man who placed play at the very heart of his thinking makes the book a joyous romp of a read.*

*By integrating the history of the field and the man behind some of the profession's cornerstone ideas, Kahr has provided not only an accessible insight into Winnicott for a new generation, but has also given an opportunity for contemporary practitioners to establish a more rigorous understanding of some of our founding fathers and mothers by exposing both the brilliance and the blunders of these great thinkers. Personally, I cannot wait for the other titles in this 'Interviews with Icons' series!*

**60 pages in and I almost forgot that this was a fictitious work!**

Well, I am not certain that I would describe this as a work of fiction, perhaps more an exercise in 'imaginative non-fiction'. I did try as hard as I could to bring Winnicott back from the dead for one last 'posthumous interview' about his life and work, in the hope that students and colleagues might be able to meet the great man in a more chatty way. Winnicott, you must understand, was a marvellous, engaging raconteur. He spoke in such a beautiful and quirky fashion. And having now studied his unpublished correspondence for many years, I felt emboldened to try to capture his idiosyncratic speaking style. I also wanted to find a more playful way of writing a guidebook about Donald Winnicott.

**The book is filled with archival nuggets; weaving this into a realistic conversation must have been difficult. Where did the idea come from?**

The concept emerged, quite literally, over a cup of tea with Oliver Rathbone, the publisher of Karnac Books. We conceived the idea of inviting Winnicott back to earth for just one day, for multiple cups of tea, and for a conversation in which he might provide the reader with a survey of his biography, the historical context in which he worked, as well as a synopsis of his theories of human development and of psychotherapeutic technique.

You may know that I have been working on a much more extensive biography of Winnicott. Over the years, I have interviewed over nine hundred people who knew him personally, and in doing so I have had a wonderfully privileged education. From talking to all of these people, I really learned a great deal about what he looked like, how he spoke, how he held his body – all the sorts of detail that one simply cannot find in published sources. And I hoped to put as much of this information as possible into *Tea with Winnicott.*

Years ago, Charles Rycroft told me, 'I will never forget how Winnicott held his cigarette. He would put his arm around the back of his head, and he would bring the cigarette round to his mouth from the other side'. Other people have confirmed to me that Winnicott did, indeed, hold his body like a pretzel, with his limbs in funny arrangements. He never sat in a tight, stuffy way. He comported himself with a great deal of bodily fluidity, almost like a dancer. I hope that these sorts of details will help to bring the man alive for us.

**How did the idea of the series come about?**

Oliver Rathbone asked me, 'Who else would you like to have tea with?' I became very excited at the prospect of meeting not only Winnicott but also some of our other great foremothers and forefathers. I blurted out that, after *Tea with Winnicott*, I would love to have *Coffee with Freud*. So that will be the next title in the series. In that book, I have invited Freud back to the Café Landtmann in Vienna – his regular Kaffeehaus – and we discuss his life and work. John Bowlby will follow thereafter, and I have already started working with members of his family on that one.

**There is an array of positive attributes in the book for students. What kind of benefits could such an in-depth portrayal offer a practitioner?**

It would be a lovely bonus if seasoned practitioners could find something of value in this book. I suspect that *Tea with Winnicott* does contain a fair bit of material that will not be known to most of our colleagues. Some of it derives from interviews that I undertook with his secretary, Joyce Coles. So there will be plenty of previously unknown biographical nuggets. But I also hope that the book might serve as a useful refresher guide for those who already know his theories reasonably well.

Throughout the series, I have endeavoured to pay great tribute to these truly wonderful thinkers – these icons – but, also, I have offered a glimpse into their shadow sides as well. I hope that my portrayal will be neither idealising nor denigrating. To me, these 'icons' represent the apotheosis of rich, complex human beings from whom we can learn, both as role models and, also, in certain respects, as counter-role models.

**How worried are you about being challenged on the authenticity of these characters?**

Fellow Winnicott scholars might well quibble with some of my observations; they might even conclude that I have got it all wrong. But I did research Winnicott's life and work as thoroughly as I could. Certainly, I gave the manuscript to several very senior colleagues who knew Winnicott personally, and they very kindly read the text prior to publication and, happily, gave me the 'thumbs up'. Also, Winnicott's famous child patient, 'The Piggle', now a woman in her fifties, whom I have come to know, also read the book in typescript form, and she, too, very graciously gave me her approval. But of course, I hope to be challenged and questioned and corrected. I trust that people will feel that they can let me know ■

*Interview by Leanne Stelmaszczyk, BPC Development Officer*

# Birdman

*continued from previous page*

order to keep the play going when the money starts to run out. He cheated on his ex-wife, missed the opportunity to develop a relationship with his daughter, and his girlfriend complains he has never shown her any real affection.

In fact the film plays like an exploration of a disturbance in early object-relating, highlighting the difference between true intimacy, which is connected with a sense of being loved for who you are, and a false connection based on what you do or can give to others (Winnicott 1960). There is a difficulty engaging with the other and defining the self in relation to the other. Riggan has an insatiable demand for narcissistic supplies and when these are not forthcoming he retreats from frustrating external reality into a fantasy world where he can control objects and even fly. This is a world where he is omnipotently in control; where he rises above and sees everything. He is alone but magnificent – though actually cutting a rather forlorn figure with his old cream overcoat flapping in the wind.

I am reminded of an older client who was having difficulties at work because of a difference of opinion between himself and his managers about how the rather challenging and risky work within the criminal justice system should be carried out. His determination to hang onto his job well after retirement age, despite the risks involved, and his rigid insistence that he was completely without fault eventually gave way to anxieties about having made a terrible mistake and to thoughts about ageing, physical deterioration and fragility, and the loss of financial resources and status that letting go of his professional identity and retiring would entail.

The words that flash up on the screen at the start of the film, *'And did you get what you wanted from this life, even so?' 'I did.' 'And what did you want?' 'To call myself beloved, to feel myself beloved on the earth'*, are part of a poem from a late collection by Carver written shortly before his early death addressing difficult questions about life and relationships. However, the film is full of characters who are unable to connect, who 'talk about love' without really being able to love, or who want to be loved without loving in return. The desire for emotional intimacy has been replaced by a sort of grandiose fantasy which involves being seen in a particular way, but not really known. Later, as Riggan gets more in touch with his feelings he says, 'I wasn't present in my own life and now I don't have it.' True intimacy would involve facing up to and working through the embarrassment, humiliation and shame that Steiner (2011) has identified as arising when one eventually emerges from a retreat and is properly seen (or heard).

At the end of the film Riggan is transformed by a desperate act of self-annihilation and, rather than managing to finally engage with the painful realities of his life – ageing, divorce, limitations of his career, the loss of a relationship with his daughter – he embraces the unreal, the omnipotent and narcissistically isolated position in a final psychotic flight in which his internal world becomes reality. For our patients we hope to offer something different – to help them work through and accept painful reality and loss and to engage more deeply in relationships with others: to have a better relationship with their internal reality as well as with the external world, and to be able to tell the difference between the two ■

*Clea Mcenery-West is a Senior Tutor on the MSc in Psychodynamic Counselling and Psychotherapy at Birkbeck College, University of London, and works as a psychodynamic psychotherapist in private practice.*

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Opinion

# Turning a blind eye

*By Richard Sherry*

PSYCHOANALYTIC thinking is potentially undergoing a transformation of relevance. Deeper appreciation of the fragility of the sustainability of societal as well biosphere ecosystems is necessitating that we open up a very new approach in our thinking. This need is especially being seen with the rock and a hard place that vulnerable populations are increasingly facing. The plight of the poor, the traumatised, and the disenfranchised is daunting to consider, especially how to begin to own a meaningful sense of responsibility in how to expertly address these interconnecting problems. One of the clearest and most relevant examples to illustrate the issues of social collapse would be the current issue of Syria.

Syria brings to the world stage the devastation that is happening within the country as well as the mass exodus of refugees fleeing the region, and how this affects the wider world. The increasing reports of Syrian state torture, sandwiched between a hotbed of even worse militia and sponsored terror groups perpetrating rape, torture, and murder on the remaining Syrians, exporting their violence around the world. The vulnerable populations who are being subjected to these atrocities encapsulate an international humanitarian issue on an unprecedented scale. Of the nearly three million Syrian refugees who have been able to leave the country, 51% of them are under 18 years old, and there are increasing questions of what will happen for an entire population of basically children.

The very real horrors facing millions of people may seem literally a world away from the germane application of psychoanalytic thinking. The traditional analytic, aloof reflective screen held in the popular imagination, as well as a professional self-identity, requires updating. There is tremendous value in bringing the penetrating insights from psychoanalytic thinking into examining perhaps a new level of interlocking complexity not previously appreciated within human history. To update the adage, 'When you see the writing on the wall, read it.' However, I want to postulate a further layer of process: namely not just reading it, but understanding and leading the actions of change drawn from these insights. Namely, 'Don't just read the writing on the wall, follow through to actually make the required changes.' Within the psychoanalytic profession, even including the various professions we usually have before entering the therapeutic discipline, we are taught to work on these more direct and individual levels and leave the social well enough alone. We are taught to predominately leave the daunting complexities required in confronting interconnected social structures to the politicians or civic planners.

My hope is this article will create a paradigm shift in the relationship as well as the imperative to properly address this issue of a type of societal indifference, to transform the very privileged training we have received to better apply these to the real-world problems that need – actually, require – real remedy and, ideally, healing. Moreover, in actually testing psychoanalytic thinking with these greater challenges, it could open up and possibly resolve many inconsistencies or even unresolved theoretical and practical issues within the psychoanalytic field itself.

I want to explore three key concepts that will need to change for us as a discipline to truly evolve. The challenges offered by deeply getting to grips with the issues focused around societal collapse provide an essential framework for us to adequately visualize these problems.

1. By looking at the worst aspects of human capability, without miring ourselves or getting lost within these exemplars, we need (much in the way an aircraft pilot trains for the worst situations) as psychoanalysts to 'grasp the nettle' and adroitly understand the nature of these transformative triggers for collapse – whether this be on an individual basis or on a larger social level.

2. As a discipline we need an integrated spectrum of illness and health, and this also needs to be environmentally contextualised. Without this real-world grounding, I argue, psychoanalytic thinking, never mind ethical frameworks, break down.

3. We need to heal the tools to heal – specifically if we are using traumatised, dysfunctional, or problematic concepts (especially working with similarly stressed individuals), modes of therapeutic approaches, or similarly impacted modes or models – all of these aspects will negatively impact on the efficacy and the fullness of what we are capable of thinking about as well as in healing.

**'We need to heal the tools to heal.'**

### Defining societal collapse

For the first point, looking at the worst aspects of human functioning requires defining highly unpleasant issues like social collapse. Some of the ways to describe these aspects of collapse reference Tainter (2003) and Diamond's (2005) seminal research. At its most basic level, this could include a reversal or simplification of the social and technological structures. An incorporation or absorption into another more dominant culture. Significant death or complete obliteration would also be another possible outcome. Diamond outlined in his book *Collapse* the five-point framework determining causal contributing factors to societal collapse:

1. Human impact on the environment
2. Climate change
3. Relations with neighbors
4. Relations with hostile societies
5. Political, social, and economic factors for problem solving or the quality of thinking

are all key determinant factors.

Simply put, the degree of scarcity and the quality of thinking significantly determines where on the sliding scale of functioning a social group sits, as well as in which direction it will go: towards a resolution of its difficulties, or towards outstripping its sustaining environment, turning on others or itself, leading ultimately to implosion. All of these aspects have haunting reverberations from psychoanalytic thinking.

Returning to the focus on societal collapse, Tainter's earlier work focuses on balance and sustainability where outstripping the tipping point will overwhelm resiliency and the planet's self-recuperative capacity. One concept critical to this paper is that there are many ways to describe tipping points, and these are likely to link to aspects of further variants of deeper ruptures and more catastrophic outcome types of societal collapse. It would be missing an important link if I were to ignore the similarity between the social and individual psychic functioning, where analogous ruptures or collapses can occur with corresponding similar levels of disruption in both.

World climatology and geological events have always had some degree of impact on human populations throughout history. However, factors that have contributed to climate change dysregulation have altered natural cycles and drastically increased the incidence and scale of disasters. This was Diamond's point, that, in careful review of many of the natural disasters, the leadership and the prioritization for the political elites determined much of the directionality for the mitigating or intensifying of these issues and their resultant consequences.

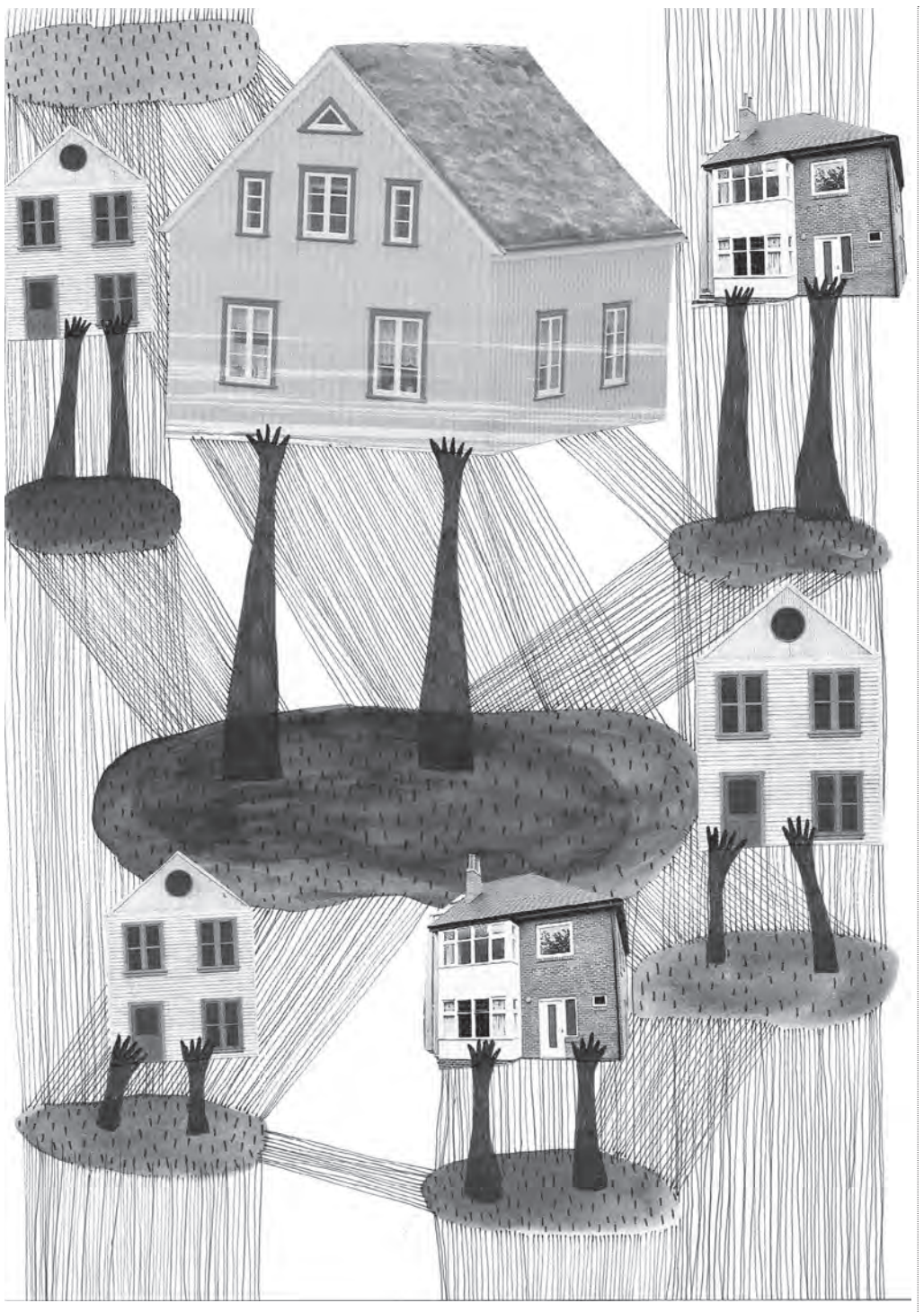
From a cross-discipline examination of these issues, besides a potentially cataclysmic natural disaster, what is most likely to contribute to societal collapse is ecological mismanagement. Many of the climatology issues have begun to be understood in a greatly interconnected way with seeing the severity of the ecological impact upon our planet, and how the leadership and conservation change the directionality of the health of the environment and its supporting population.

For example, during the last decade, melting of the polar ice caps has increased over a thousand-fold, changing the salinity and wind patterns, and ocean ecosystems appear to be changing course. The increase of desertification has rapidly been reducing carbon re-banking and has increased temperatures. Our dysfunctional neglect of our planet can be dramatically seen on land with massive deforestation (in areas like the Amazon and Indonesia); within our oceans, with floating islands of rubbish (the Western and Eastern Garbage Patches – each is over 600 miles across); and even outer space in Low-Earth Orbit is now littered with flying debris.

Reports of what has been happening to both the Syrians who have stayed within their country and those who have fled show that their environment actually does impact on their sense of safety, coherence, and ultimately on their well-being and identity, individually as well as collectively. Moreover, the leadership and care of how the environment is looked after very much change every aspect of the well-being of the population. Institutions like my own (Psychological Systems), the Institute for Applied Social Innovation, the Green Belt movement in Africa, and the Dicaprio Foundation, are helping to bring these relationships between our environment and our overall health more to conscious attention. Therefore, if we are ignoring these difficult global realities, it carries with it tremendous implications that are likely affecting us more than we actually realise.

### Bringing in psychoanalytic thinking

In linking and reviewing the environmental context and the internal spectrum of functioning, we can better underline and offer an understanding that such environmental circumstances actually do affect people's mental state, their health, their intergenerational and even genetic well-being (Hosin, 2016). At its most extreme, these weakening or vulnerable states of health can contribute to a profound health breakdown that can be both a contributing factor to and an



outcome of social collapse. For instance, disease epidemics such as with WWI and the 1918 Spanish influenza outbreak co-occurred when there were extreme stresses that significantly reduced resilience factors.

**‘Increasingly psychoanalytic thinking has been required to look at vastly different aspects than it was originally designed for.’**

By changing one aspect, an entire directional shift can evolve in two very different directions, either toward illness or in the direction of health. To develop a more recent example, the Syrian conflict is the first war in history that scientist have *explicitly* linked to *climate change*. Syria has been and is very much the focus for the world fighting for oil reserves, and it provides clear indicators for social and political mismanagement the world over, which has led to global rising temperatures. All of these factors have contributed to a threat multiplier in continually tipping the country further into the outbreak of war and greater degrees of societal collapse. These accumulated factors can spiral into competition instead of cooperation, which changes the direction from care toward coercion, where usually the most vulnerable are worst affected.

Standard psychoanalytic thinking, such as examining the psychic defensive processes of projection, denial, splitting, and jealous or envious attacks, to name just a few, are usually conceptualised as individual intra-psychic or dyadic processes.

At least in psychoanalytic theorising, these processes are limited in their number and scope as identifying pathology instead of being seen in relation to what might be required to heal or transform suffering in a more meaningful way; or perhaps what needs to be done merely just to survive. It is also worth highlighting that social-emotional processes share a ‘group-mind’ that can function in many ways like a stronger personality presence, and can have many of the collective responses that might be present within an individual.

In highlighting the traditional approach, psychological diagnosis has been purpose-built to identify pathology. Developing a less shame-based focus provides a hopeful and more connecting context, one in which primary and tertiary aspects of neurobiology and emotional neuroscience describe core aspects of human functioning, and could proffer a direction for what needs to be done to help the person either on an individual or collective level.

I would highlight these as the potential factors that could offer the biggest difference, enabling us to evolve to a healthier capacity:

| | | |
|---|---|---|
| Shame | → | Confidence |
| Mistrust | → | Trust |
| Illness | → | Health |
| Freezing | → | Action |
| Distress | → | Joy |
| Disconnection | → | Connection |
| Disfranchisement | → | Leadership |

We know that the first column of emotional responses can contribute to creating vulnerability. By improving these factors, one can potentially change health and well-being, which will naturally generate greater levels of emotional response and capacity within the second column.

The increasing centrality of climate change, even within psychoanalytic thinking (see Weintrobe, 2012), describes the interconnected indebtedness and dependency that comes hand-in-hand with being planet- and society-bound. In more clearly understanding that we are actually *a part of* nature, and not merely its assumed master, requires a significant depth of insight and contextualised perspective. These challenges escalate when the dynamics between power, potential, and abuse crescendo. Bowles et al. (2015), in a recent RSM Journal article ‘Climate change, conflict, and health’, connect the the relationship between these factors for resource mis-management and a resultant increase in perceived or actual scarcity. This kind of description begins to resemble a more nuanced psychoanalytic formulation, one between the interpretation of subjective reality, and the negotiation of conflict that actually determines which road of reality is ultimately created. Will it be the direction of care or coercion?

In clearly articulating, for example, within a spectrum of health (from very ill to profoundly healthy) it can be helpful to look at *what are the best interventions to use* to assist improving well-being. Increasingly the scale and complexity of psychoanalytic thinking has been required to look at vastly different aspects of impact than it was originally designed for. As Ross and Ross (2008) define, a commonly held notion of complexity includes issues of:

1. Instability
2. Unintended consequences
3. Vicious circles and error loops
4. Problem of scale
5. Non-robust solutions and redundancy
6. Cross-domain interactions
7. Progressive degradation of human values and quality of life

To deeply understand the roots of how these problems begin and interact, as well as how to profoundly ameliorate this dysfunctionality, has begun to force a sea change in how we are modelling reality-based responsibility towards addressing issues.

The benefit of thoughtfully being able to sit with the extremes of situations, such as the implosion of society, is much like the rigorous, real-time training that pilots are required to undertake to acclimatize within simulation for both human factor issues and mechanical failure.

There are few similar elements available except within a military context, where the breakdown of the ‘social contract’ is synergized within the risk of political uncertainty (for example MARO – Mass Atrocity Response Operations (Sewall et al., 2010)). But within the psychoanalytic sphere there is no clear pooling of collective evidence base or standardization, especially of a full spectrum of not only severe pathological states, but also what the corresponding opposite side of the spectrum, the healthier and higher states of consciousness, would look like individually as well as collectively; or, how these would function.

Returning to my earlier point, it is likely that a fully trained psychoanalytic practitioner may never come in contact, in his or her training, with thinking about the causes, aspects, implications, and possible interventions for multiple modeling in worst case scenarios. Moreover, no such evidence-based link may be made to how the individual dysfunctional behaviour may have links to these social collapses; for example, with a natural catastrophe. Yet it is worth highlighting that the psychological trauma effected by war, societal collapse, epidemics, etc. all dramatically influence long-term and intergenerational physical and mental health stress responses.

Bowers and Yehuda (2015) have found that these physical, behavioural, and epigenetic stress responses are indeed passed on intergenerationally. Equally, the full range of more extraordinary higher capacities of human feats of mind and body would be just as likely to be left without mention or thoughtful exploration in decontextualizing this spectrum of functioning. But without fitting an integrated spectrum together, a real sense of context and meaning will naturally be lost, just like the personal subjective narrative is shared with a larger social-political reality. *This is*, in its essence though, a powerful portion of the psychoanalytic interpretation, which can help in assembling the métier of this context as well as helping to distill the meaning.

*Continues on page 19*

# Diary

## APRIL

**19 April 2016**

PSYCHOANALYTIC REFLECTIONS ON THE WORK OF HANNA ARENDT

David Bell
Institute of Psychoanalysis, 112a Shirland Road, London W9
http://psychoanalysis.org.uk/events

**23 April 2016**

ASSISTED REPRODUCTION: EMOTIONAL AND IDENTITY IMPLICATIONS FOR PARENTS AND CHILDREN

Susan Golombok, Joan Raphael-Leff, Katherine Fine, Lesley Caldwell, Brian Feldman, Alessandra Cavalli, Julia Paton
Wellcome, 183 Euston Road, London NW1
www.thesap.org.uk/sap-events

**23 April 2016**

BEING AND DOING: FROM THEORY TO TECHNIQUE

Mary Morgan, Andrew Balfour, Susanna Abse, Catriona Wrottesley
TCCR, 70 Warren Street, London W1
www.training.tccr.org.uk

**29 April 2016**

WORKING WITH DANGEROUS MINDS AND VULNERABLE BODIES

Stanley Ruszczynski, Marcus Evans, Stephen Blumenthal, Jina Barret, Steve Mackie, Razwana Jabbin, Kate Bond, Geraldine Akerman, Felicitas Rost, Lorraine Maher
Tavistock, 120 Belsize Lane, London NW3
http://tavistockandportman.uk/training/conferences-and-events

**26 April 2016**

THE EUROPEAN UNCONSCIOUS IN TRAUMATIC TIMES: SOME PSYCHODYNAMICS IN HATE AND PREJUDICE

Jonathan Sklar
Institute of Psychoanalysis, 112a Shirland Road, London W9
http://psychoanalysis.org.uk/events

## MAY

**3 May 2016**

CLIMATE CHANGE IN THE CULTURE OF UNCARE

Sally Weintrobe
Institute of Psychoanalysis, 112a Shirland Road, London W9
http://psychoanalysis.org.uk/events

**7 May 2016**

UNDERSTANDING THE EFFECTS OF ATTACHMENT STYLE ON THE TEENAGE YEARS

Niki Reeves
GCS, 52/53 High Street, Stroud GL5
www.gloscounselling.org.uk

**8 May 2016**

'LUST FOR LIFE' (1956, VINCENTE MINNELLI)

Sue Harris
ICA, The Mall, London SW1
www.psychoanalysis.org.uk

**10 May 2016**

THE VALUE OF THINGS: POLITICAL ALIENATION AND PSYCHOANALYTIC ACTION

Robert Hinshelwood
Institute of Psychoanalysis, 112a Shirland Road, London W9
http://psychoanalysis.org.uk/events

**13 May 2016**

WORKING WITH TRAUMATISED CHILDREN IN SPECIAL EDUCATIONAL SETTINGS

Nina Wessels, Alessandra Cavalli
SAP, 1 Daleham Gardens, London NW3
www.thesap.org.uk/sap-events

**14 May 2016**

WORKING ANALYTICALLY WITH EARLY RELATIONAL TRAUMA AND BORDERLINE STATES OF MIND

Marcus West
Friends Meeting House, 173 Euston Road, London NW1
http://agip.org.uk/activities/cpd-events

**17 May 2016**

PSYCHOANALYSIS, COLONIALISM, RACISM

Stephen Frosh
Institute of Psychoanalysis, 112a Shirland Road, London W9
http://psychoanalysis.org.uk/events

**21 May 2016**

ARCHETYPES: HIT OR MYTH? THE NOTION OF ARCHETYPAL TRANSFERENCE IN CLINICAL PRACTICE TODAY

Martin Schmidt
Wellcome, 183 Euston Road, London NW1
www.thesap.org.uk/events/annual-lecture

**24 May 2016**

WORKING IN FEAR: MEMORIES OF PSYCHIATRY AND PSYCHOANALYSIS DURING THE ARGENTINIAN DICTATORSHIP

Catalina Bronstein
Institute of Psychoanalysis, 112a Shirland Road, London W9
http://psychoanalysis.org.uk/events

**28 May 2016**

THE PSYCHOANALYTIC SETTING AND THE FATE OF PAIN

Jeff Eaton
Quaker Meeting House, Edinburgh
http://sapp.org.uk/events/

**28 May 2016**

A PSYCHOANALYTIC ATTITUDE: BECOMING A WELCOMING OBJECT

Jeff Eaton
Quaker Meeting House, Edinburgh
http://sapp.org.uk/events/

**29 May 2016**

A PSYCHOANALYTIC PROCESS: LISTENING TO YOURSELF LISTENING TO ANOTHER

Jeff Eaton
Venue tbc, Edinburgh
http://sapp.org.uk/events/

## JUNE

**1 June 2016**

FILMING THE BODY IN CRISIS: TRAUMA, HEALING AND HOPEFULNESS

Davina Quinlivan, Caroline Bainbridge
Freud Museum, 20 Maresfield Gardens, London NW3
www.freud.org.uk/events/

**4 June 2016**

OVER THE RAINBOW AND BEYOND... AN EXPLORATION OF SEXUALITY AND PSYCHOANALYTIC THINKING IN THE 21ST CENTURY

Alessandra Lemma, Leezah Hertzmann
St Alban's Centre, Baldwins Gardens, London EC1
www.birkbeckcounsellingassociation.org

**4 June 2016**

MONSTERS 'R' US: DO WE CREATE THEM OR DO THEY CREATE US?

Martin Weegmann, Gwen Adshead
IGA, 1 Daleham Gardens, London NW3
www.groupanalysis.org

**4 June 2016**

THE EFFECT OF OMNIPOTENCE ON THE ANALYST: RESONANCE, DISSONANCE OR SILENCE?

Francesca Hume, Ignês Sodré, Jane Milton, Richard Rusbridger, John Steiner
Royal College of Physicians, 11 St Andrew's Place, London NW1
www.melanie-klein-trust.org.uk/events

**7 June 2016**

FUNDAMENTALISM

John Alderdice
Institute of Psychoanalysis, 112a Shirland Road, London W9
http://psychoanalysis.org.uk/events

**10 June 2016**

FREUD'S THIRD LECTURE ON PSYCHOANALYSIS

Led by Sara Collins
BPF, 37 Mapesbury Road, London, NW2
www.britishpsychotherapyfoundation.org.uk

**11 June 2016**

TREADING ON EGG SHELLS – WORKING WITH THE EMOTIONALLY COMPLEX CLIENT

Linde Horseman
Enfield Counselling Service, St Paul's Centre, 102A Church Street, Enfield EN2
www.enfieldcounselling.co.uk

**12 June 2016**

'GOYA IN BORDEAUX' (1999, CARLOS SAURA)

Peter Evans
ICA, The Mall, London SW1
www.psychoanalysis.org.uk

**14 June 2016**

PSYCHOANALYSIS AND FEMINISM: A MODERN PERSPECTIVE

Ruth McCall
Institute of Psychoanalysis, 112a Shirland Road, London W9
http://psychoanalysis.org.uk/events

**21 June 2016**

THE ANTISOCIAL ELEMENTS IN SOCIETY: PSYCHOANALYSIS AND GOVERNMENT

Stephen Groarke
Institute of Psychoanalysis, 112a Shirland Road, London W9
http://psychoanalysis.org.uk/events

**25 June 2016**

THE EMERGENCE OF SYMBOLIC IMAGINATION

Warren Colman
SAP, 1 Daleham Gardens, London NW3
www.thesap.org.uk/sap-events

**25 June 2016**

ANTISOCIAL PERSONALITY DISORDER – TREATING THE UNTREATABLE?

Jessica Yakeley
WPF, 23 Magdalen Street, London SE1
http://wpf.org.uk

**28 June 2016**

PSYCHOANALYSIS, POLITICS AND INDIFFERENCE

Joshua Cohen
Institute of Psychoanalysis, 112a Shirland Road, London W9
http://psychoanalysis.org.uk/events

## JULY

**2 July 2016**

A JUNGIAN APPROACH TO EARLY RELATIONAL TRAUMA

Marcus West
Friends Meeting House, 91 Hartington Grove, Cambridge CB1
www.thesap.org.uk/sap-events

**2 July 2016**

BION'S LEGACY: TWENTY-FIRST CENTURY TRANSFORMATIONS

Ronald Britton, David Tuckett, Rudi Vermote, Irma Brenman Pick, Chris Mawson
University College London
www.ucl.ac.uk/psychoanalysis

**5 July 2016**

WHAT'S WRONG AND WHAT'S RIGHT WITH MONEY

Michael Rustin
Institute of Psychoanalysis, 112a Shirland Road, London W9
http://psychoanalysis.org.uk/events

**9 July 2016**

WHITHER OEDIPUS

Elizabeth O'Loughlin
GCS, 52/53 High Street, Stroud GL5
www.gloscounselling.org.uk

**10 July 2016**

'FRIDA' (2002, JULIE TAYMOR)

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**12 July 2016**

CONVICTION AND COOPERATION: FACING THE PROBLEMS WE CAN'T SOLVE BY OURSELVES

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**14 July 2016**

PROBLEMATIC USE OF INTERNET PORNOGRAPHY

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**19 July 2016**

THE CHALLENGE OF CHANGE: PSYCHOANALYSIS AND CONTEMPORARY CULTURE

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# Turning a blind eye

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One of the hallmarks of psychoanalytic thinking is that it is supposed to be able to think through issues and aspects of difficulty. However, has psychoanalysis been guilty of what is a shared blind spot – namely missing the larger interconnected cycles of destructive acts, and their resultant creation of vulnerability?

What are the possible implications for *not looking at* issues that could be fundamental determinants that can synergistically impact on the well-being of the individual, never mind the planet? I believe this linked concept of conflict, environment, and psychic state has not been adequately understood, or actually addressed, within any aspect of psychoanalytic conceptualisations, to the degree that it appears this may drive actual psychical conflict – never mind adequately understanding this phenomenon to develop interpretations or interventions to try to reverse these processes.

This brings in the third theme. What does it mean to heal a concept, a discipline, or everything that needs to come from this transformed reconceptualization?

Creating a new compassion-based leadership model for medicine and psychology – and therefore seeing how these innovations can stimulate valuable developments within psychoanalytic work – can better help us to understand our responsibility to vulnerable populations and how to create a sustainable system for global health. Re-examining the incredibly complicated issues highlighted through the Syrian refugee crisis could perhaps provide a new window to compassionately re-conceptualise vulnerabilities into insight and strength for meaningful change – perhaps ultimately redefining an improved framework for better sustainable health, security, and improved leadership the world over.

The concept I have been working on for about five years (connected with 25 years of research and study to arrive at this place of thinking) is the idea of 'Healing Everything'. Everything can be hurt; every thought, idea, concept, person, organisation, even a society or planet can be damaged; equally, *all can be healed*.

In a way it parallels an ecosystem, in that a bidirectional system can be created. In one direction (toward illness), destructiveness uses force and violence to create inequality and subjugation. In the other direction (of health), care, compassion, and nurturing creates a thriving that positively transforms potentially all aspects of environment and members of that ecosystem.

The Syrian refugee crisis demonstrates that most of the approaches previously used do not actually address the psychological roots, nor for this matter the root problems at all. As Hosin (2016) outlines, issues such as the refugee crisis, the international escalation of terror and violence, and, as I am adding to this work, environmental problems, appear to be compounding and may even contribute to increasing the scale of hyper-dysfunctionality that could lead to further unintended knock-on effects.

**'The Syrian crisis demonstrates that most approaches do not address the psychological roots.'**

To understand this perspective we face as a collective profession, change is required. If we can actually develop an awareness and choice in what direction of health we are heading, this is, to paraphrase the astronaut Neil Armstrong, 'One small step for man, but one giant leap for mankind.'

Being cognizant of what kind of steps we are *actually* making could, in essence, ameliorate needless pain and suffering the world over.

Increasing our individual as well as collective thoughtfulness about these ethical issues is essential to finding ways to compassionately resolve rather than compound them. Perhaps even on an individual level within psychoanalytic therapy, we may need to acknowledge there may be an unconscious incentive to have the analysand continue in therapy longer than might be helpful, thus creating counterproductive cultures of over-dependence.

Regarding psychological health, we need to be able to look at a spectrum of well-being not in a way that shames, but in a way that highlights healthy directions for individuals as well as facilitating a path for larger positive group change. We also need to understand the importance of real relationships and interconnectivity between the individual and effects upon the surrounding environment – healing one will help both psychological and physical components.

One outcome of the work to innovate greater levels of health has included developing a new framework, such as the ICDS Model, which stands for Integration; Compassion; Developmentally-stepped change; and Sustainability.

But what would having an integrated, compassion-based and developmentally-stepped sustainable approach look like?

I propose it would would include:

- Points of focus for meaningful change
- Integration of steps towards creating compassionate change
- Establishing processes of Feedback and Dynamics Changes

We need to acknowledge that change comes from: starting with single points of intervention; building upon on creating stable sustainable blocks of work; these then need to establish cycles of positive meaningful transformation, that then can be supported in dynamic process of sustainable health. As such, psychological and medical health models actually need to link up with compassion-based ecological concepts to provide such a level of integrated health. Weintrobe's (2012) collected work of opening up the dialogue describing the psychoanalytic defenses against climate change is an excellent example of how practical and applied thinking can be developed to achieve such an aim.

Present models for Mental Health and Vulnerability are in my understanding almost too limiting and potentially shaming for all concerned. Established psychotherapy or trauma models for treatment on this scale need significant redevelopment. What I have briefly outlined with the ICDS model could be an enfranchising, sustainable way to address these very real needs to develop a more robust compassion-based framework that will ensure better levels of care throughout the world.

It is my true hope to reverse the destructive cycles in which ecological damage and mismanagement have contributed to increased natural disasters and profound psychological distress; where at the negative edges, even psychoanalytic thinking begins to break down, with no reciprocal thinking to be able to hold it sufficiently to work within. The incredibly privileged pivot point of positive change exists where we can selfishly fight over resources and create needless conflict instead of work to nurture and heal each other as well as the wider world.

Psychoanalytic thinking needs to assimilate these insights into the canon of analytic understanding. The very real dys-functionality that emerges with destroying the outer environment has just as devastating internal impacts as does vice versa. If we are not thinking at this level of interconnectivity, we will miss arguably the most essential areas of understanding, and therefore corrective intervention to change these cycles. Perhaps in being able to actually address these root problems we can create maybe the most fully evolved and healthiest world we have yet imagined ■

*Dr. Richard Sherry, the founder of Psychological Systems Ltd, has worked for more than fifteen years treating aspects of psychological trauma. Within his work he has specialised in assessing and treating vulnerabilities in both individual and organisational systems and their interactions. He's a Psychoanalytic Psychotherapist, Licensed HCPC Clinical Psychologist, and expert in Psychological Traumatology. He has expertise in Neuropsychology, Ethics, and Extreme Environments. He works now in private practice and runs the Institute he has founded, the Institute for Applied Social Innovation (IASI) where he apples psychological and psychoanalytic approaches to improving health and well being around the world.*

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