NewAssociations

NEWS, ANALYSIS, OPINION FOR THE PSYCHOANALYTIC COMMUNITY | **ISSUE** 3 **SUMMER** 2010

BRITISH PSYCHOANALYTIC COUNCIL

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Moving forward in uncertain times

By Malcolm Allen

'Hurray, hurray, hurray!
Misery's here to stay'

NOEL COWARD, FROM *THERE ARE BAD TIMES JUST AROUND THE CORNER*

IT WOULD BE HARD to find a more apt commentary on our current position than Coward's roguish lyrics. Are we to heed his sardonic advice and keep our peckers well and truly down?

David Cameron has been clear that the scale of public expenditure reductions will affect 'our whole way of life'. But there is little certainty about how the next few years will pan out in real terms for most people. The economist David Blanchflower thinks the impact will be differential: 'Some places are going to do fine. Some places are going to be bloody terrible'.

More specific uncertainty surrounds the public health sector and as part of that mental health provision. The coalition's programme for government states that health spending will increase in real terms each year. But the King's Fund suggests this may be offset by the costs of additional demand from demographic change. All the key decisions on health and social care spending now await the Spending Review, to be published on 20 October 2010.

The coalition's programme proposals on the NHS make no specific reference to mental health, other than prioritising dementia research. Health Secretary Andrew Lansley is due to unveil a White Paper on mental health policy in early July. But many broader policies will impact on mental health, for example strengthening GP-based commissioning and the right of patients to choose healthcare providers. In a section on public health, the programme also states: 'We will ensure a greater access to talking therapies to reduce long-term costs for the NHS.'

Psychotherapists and counsellors in the public sector will face a constantly fluctuating environment. Some of the themes from the previous government's New Horizons policy – prevention and early intervention – will probably remain fairly central for this government. But how services will be provided, and in what form, will be a major question.

In this difficult environment, the continued strengthening of psychodynamic psychotherapy's evidence base is important news. *Scientific American* reported in February:

> 'A leading, peer-reviewed journal has published the strongest evidence yet that psychodynamic psychotherapy... works. In fact, it not only works, it keeps working long after the sessions stop... We can state as fact: the movement to establish an evidence base for psychodynamic therapy has taken a giant new step forward.'

The BPC and its partners will be negotiating with regional and local NHS bodies, as we are now with the national IAPT team, about how to embed brief dynamic therapy within IAPT services. We have also been able, working with other professional bodies, to advise a number of existing psychodynamic therapy and counselling services about how best to negotiate with commissioners about their future position in the new world. The next Psychoanalytic Psychotherapy NOW Conference in October will also highlight the role that psychoanalytically-informed approaches can play with more complex disorders.

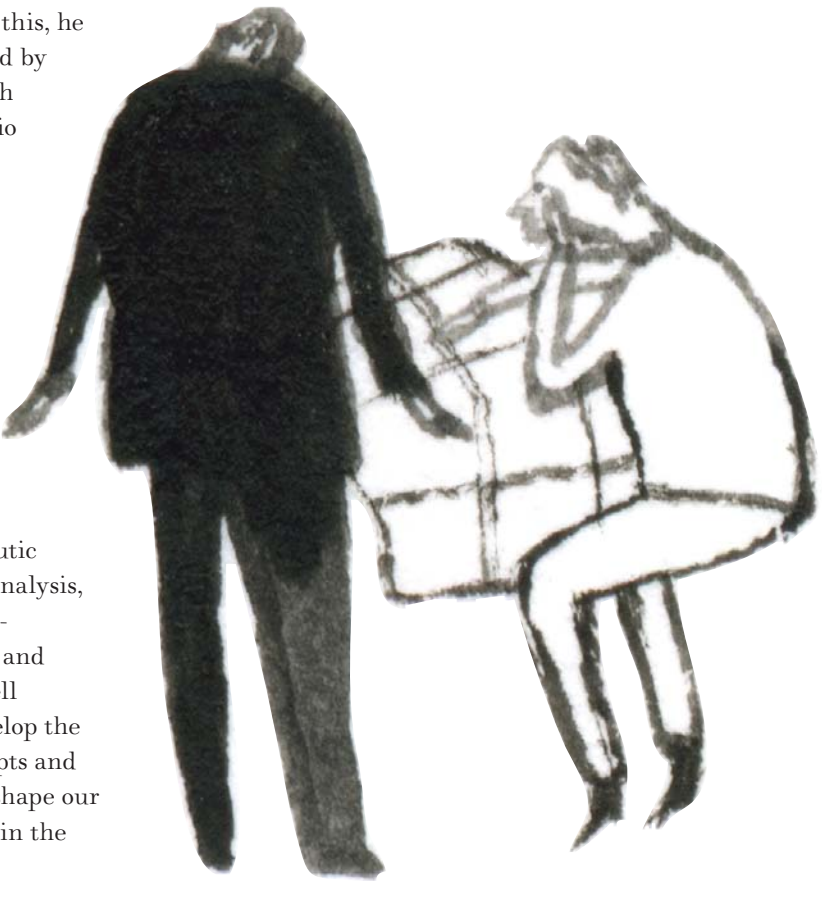
The NOW conference will also engage with the theme of complexity as it applies to wider concerns around, for example, psychosexuality and development, the nature of the family and the impact of urbanisation. Some of these debates are previewed inside. Susanna Abse talks about couple and family policy, while Heather Wood gives her take on the compulsive use of virtual sex. David Morgan reviews the first season of HBO's drama *In Treatment* – the subject of a major symposium with the show's psychiatric advisor along with two of the writers.

Apart from economic uncertainty, many commentators have marked an absence of compelling narratives shaping our vision of society and community. Edward Rowley, a Demos researcher on its Progressive Conservatism project, illustrates the point:

> '...the Coalition needs to provide a narrative that offers a broader, more fully encompassing agenda for Britain's future that isn't solely characterised by the bleak economic outlook.'

The psychoanalyst Drew Westen has previously analysed the role of 'master narratives' within contemporary politics. Bill Clinton has called Westen's *The Political Brain* 'the most interesting, informative book on politics I've read in many years'; it describes how these broad narratives are constructed and resonate with the public. Westen was an advisor to Obama's election campaign – psychoanalysis, it seems, still has plenty to offer.

The RSA's Matthew Taylor is currently promoting a cogent narrative around the notion of a 21st century Enlightenment. Taking autonomy as one of three core concepts identified by Tzvetan Todorov's book on the original Enlightenment, Taylor argues for a 'self-aware form of autonomy, informed by a deeper appreciation of the foundations, possibilities and frailties of human nature'. In this, he has been influenced by neuroscientists such as Antonio Damasio who have engaged in a long-standing productive dialogue with psychoanalytic ideas.



As well as advancing the psychotherapeutic mission of psychoanalysis, psychoanalytically-informed thinkers and doers should be well placed to help develop the overarching concepts and agendas that will shape our society and values in the decades to come.

Our ambition for *New Associations* is to allow for the exploration of such new, creative and innovative ideas. How else can we pass on to this next century the powerful, transforming and emancipatory project that psychoanalysis has at its heart? ■

Malcolm Allen is CEO of the BPC

Opinion: Personality Disorder

Living with personality disorder

On 27 May 2010, The Guardian *published the article, '£1m each spent on most dangerous killers',reporting on a paper by Professor Peter Tyrer in the journal* Medicine, Science and Law, *criticising the DSPD programme (dangerous and severe personality disorder) for being 'about locking people up' rather than treating the mentally ill.*

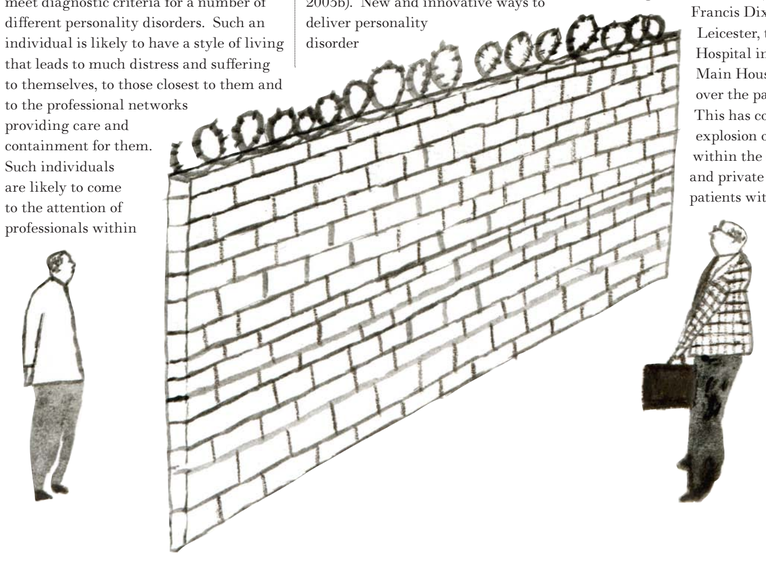
Kevin Healy (Clinical Lead, Cassel Hospital) and Anthony Maden (Professor of Forensic Psychiatry, The Paddock, West London Mental Health NHS Trust) deliver their opinions on personality disorder, the provisions of services and assessment of value for money.

By Kevin Healy

A diagnosis of Personality Disorder (PD) is a man-made abstraction justified only by its convenience. It usually encompasses persistent patterns of thinking, feeling, behaving and relating in an individual that are rigid and inflexible and that lead to symptoms and signs of distress and disability for the individual concerned and often for those in contact with them. We professionals aggregate our diagnostic abstractions into formal 'International Classifications of Disease' or 'Diagnostic and Statistical Manuals'. Sometimes, as in the case of dangerous and severe personality disorder (DSPD), we work with diagnostic groupings that been have determined by the whims of politicians.

An individual with complex and severe personality disorder (CSPD) will usually meet diagnostic criteria for a number of different personality disorders. Such an individual is likely to have a style of living that leads to much distress and suffering to themselves, to those closest to them and to the professional networks providing care and containment for them. Such individuals are likely to come to the attention of professionals within mental health services (BPD) and within the criminal justice system (APD). Those with less socially obvious personality disorders suffer their difficulties alone or within long suffering families.

Clinician and commissioner champions of PD have been very pragmatic over the past ten years in developing services for individuals with personality disorder within generic and forensic mental health services. This has been done under the guidance of the National PD Programme at the Department of Health with relatively small pots of money set within the overall larger spend on DSPD. Personality Disorder: No longer a diagnosis of exclusion (NIMHE, 2003a) set the framework for these developments. The training needs of those delivering services were outlined within the Capabilities Framework (NIMHE, 2003b). New and innovative ways to deliver personality disorder services were piloted in community and in forensic settings. A training programme for those working with individuals with personality disorders, the Knowledge and Understanding Framework for PD (KUF, 2009), is now being delivered nationally.



Patients are increasingly recognised as experts by experience within services for PD and have become central in planning, delivering, evaluating and adjusting such clinical and training services to best meet patient need. It is a real pleasure to work alongside knowledgeable, curious, questioning 'experts by experience'. Working together in this partnership of experts by experience and experts by training usually leads to further learning for all involved.

'Residential PD services have been decimated over the past five years.'

However, the provision of services for those with a diagnosis of personality disorder remains patchy throughout the UK. There is increasing recognition that most people with PD will be managed within the primary care system. Most of those with complex and severe PD (CSPD) will be managed within mainstream mental health services. Professionals within both of these settings benefit hugely from having awareness of PD, awareness of its presentations and knowledge and understanding of its best management. They also need support and containment for themselves and for their services from more specialised targeted PD services operating within each mental health trust.
Historically such local trust services were backed up by the availability of residential PD services in the NHS. Such services have been decimated with the closure of Therapeutic Community Services North, Francis Dixon Lodge in Leicester, the Henderson Hospital in London, and Main House in Birmingham over the past five years. This has coincided with an explosion of NHS spending within the independent and private sector on patients with personality disorder. Clearly the independent sector is offering something important to patients with PD, to their clinicians and to their commissioners. But the quality of relational containment achieved is often low, the integration of independent clinical services with care pathways in a patient's local NHS service can leave a lot to be desired, and evidence of value for money spent is sparse.

The lead specialist mental health commissioners in the four regions in the South East of England, acting with the delegated and agreed authority of 62 PCTs, are currently finalising the specifications for Specialised Tier 4 PD Services for their geographical area (population of 22 million people). A contract will likely go out to tender to deliver Tier 4 Residential PD Services linked to one Managed Clinical Network/ Outreach PD Service in each of the four regions in the South East of England within the next nine months.

Is getting a diagnosis of PD helpful to the patient involved? Fifty percent of patients find that it is helpful as it gives them a sense of not being the only one attempting to live with these difficult feelings and problems. It is especially helpful if it links them with services and workers that can begin to meet their needs. Fifty percent find it unhelpful to have had such a diagnosis as it has lead to their being excluded from mental health services. For these individuals PD unfortunately still remains a diagnosis of exclusion and such individuals remain 'patients that psychiatrists dislike'. The stigma against patients with PD remains a challenge for patients and for those committed to working with them. How can we best take up this challenge and the other challenges highlighted in this brief overview of wider PD service developments? ■

Dr Kevin Healy, Lead Clinician at the Cassel Hospital, has been actively involved with PD developments locally in West London MHT, regionally in London and the South East, and Nationally in England, Scotland, Wales, and Northern Ireland. He is a strong advocate for service user involvement in service planning, delivery, and evaluation.

References:

NIMHE (2003a) *Personality Disorder: No longer a diagnosis of Exclusion.* Department of Health, London.

NIMHE (2003b) *The personality disorder capabilities framework.* Department of Health, HMSO, London.

Department of Health, Ministry of Justice, Borderline UK, Tavistock and Portman NHS Trust, PDI (2009) *Working effectively with personality disorder: the new KUF framework.* HMSO, London

Dangerous and Severe?

By Anthony Maden

When my patients formed a band they called it 'The Incurables'. They understood that DSPD was about treating the untreatable. Before the new service came along most of them were not just locked up, they had been locked up for eye-wateringly long periods. They had been rejected by mental health services and had failed in any prison rehabilitation programme that would have them. DSPD never sounded great (Dangerous and Severe? Who thought that up?) – but for them it looked better than nothing.

And nothing was what they would have got had it been left up to the professions. Most psychiatrists spent their energy on proving patients were beyond all help rather than on helping them. That was where the money was. Nobody would pay to treat PD; nobody would pay you to research PD; but Legal Aid paid for endless arguments about whether it could be treated. Never mind the obvious futility of the debate when there is no service and no empirical basis on which to evaluate the non-existent intervention.

Ten years on the world looks different. Personality disorder is no longer a research desert. The NHS has developed PD services at all levels of security. Staff are trained to assess and diagnose PD instead of slapping the label on any patient on the wrong end of a negative counter-transference. We even have the ultimate seal of approval of a NICE Guideline on ASPD. Politicians would never have signed up to any of this without DSPD as a spearhead.

Like the space programme and non-stick frying pans, DSPD can be justified by its spin-off benefits alone. But does it work? First you need to define success. As the target population was a heterogeneous group united by high pathology, high risk and previous treatment failure, magic bullets were going to be in short supply. The realistic aim would be first to deliver treatment safely without mass disorder or revolt; and second to expect that a minority of patients would make substantial progress, a greater number would make modest gains, many would stay the same, and a few would get worse. If the ambition seems limited, remember all the experts telling Tribunals treatment is useless or damaging.

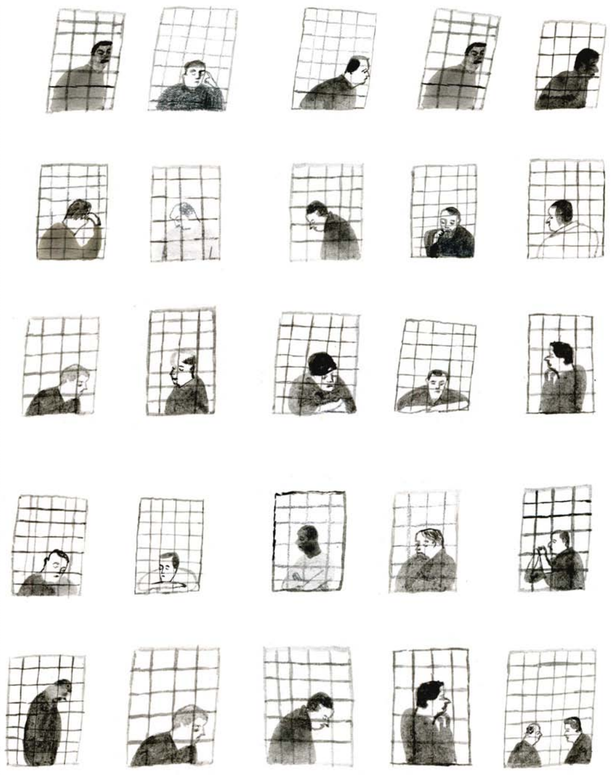
Judged by these realistic expectations, DSPD has probably done all right. Certainly there has not been the mass disorder or hopelessness predicted by many. All the high secure services maintain standards of care that compare favourably with the rest of their host institutions.

Of course it does cost a lot of money, as does any form of highly secure care. These were high cost individuals in any case, whether through indefinite imprisonment, 24-hour surveillance in the community, or the less easily quantified cost of serious re-offending. Value is not easily assessed in this field. Yes, the same money would have bought more public protection if spent on probation and community services; but it is only on the planet Zogg that politicians quietly spend money on the mundane. Here on Earth they like flagships and palaces.

'The DSPD programme had its heart in the right place.'

In a democracy it is difficult to argue with the fact that elected politicians rather than professionals decide on spending priorities. And maybe we get over-excited by the cost. We have such low expectations for mental health. Averaged out over the last 25 years, resources for PD break no health spending records. For acute medical services, the sum would probably not be worth getting out of bed for.

The most unfair charge against DSPD is that of cynicism. The people who devised the programme may have been naive at times but they believed in it, sometimes more than the clinicians who delivered it. The programme had its heart in the right place. Far from locking up people unnecessarily, it brought treatment to a neglected group and helped them to progress through the institutions in which they were already detained. Evaluation was built in and there was generous funding of external research scrutiny. Sceptics should remember that some of the most vocal critics received generous funding from the programme. That is at it should be. I know of no better test of integrity. ■



Family policy: a psychoanalytic perspective

By Susanna Abse

Each of us is defined, and enriched, by our relationships to others. It's the strength of our relationships, the warmth of our friendships, the time we have with our partners, parents and children, the respect we're given in the workplace and by our peers, the achievements we forge collaboratively and collectively, which generate real happiness and fulfilment.

Michael Gove MP, Secretary of State for Education (UK)

Becoming a psychoanalytic psychotherapist was such an absorbing and challenging experience, I found my previous enthusiasm and interest in politics and policy rather faded into the background. Seeing the world through a lens which focussed almost exclusively on the micro systems between couples, and between an individual and the complexity of their internal objects, rather distracted me from the macro outer world concerns of politics and policy making. However, taking up the role of Chief Executive of The Tavistock Centre for Couple Relationships in 2006, I once again found myself needing to be concerned with the political agenda and have surprised myself at how interested and re-engaged I have become with these issues. The middle years of life seem particularly enjoyable when passions of youth and bits of the self discarded along the way can re-emerge in new and creative ways.

For any government, family policy is a bit like walking a political tightrope in which they can find themselves teetering on the tricky path between state and personal responsibility. If they stray too far into what are felt to be private family matters, they are accused of nanny statism, but on the other hand if they leave family issues to the private sphere, they face recrimination for creating a 'Broken Britain'.

Broken Britain may well be a political catchphrase but it is unfortunately true that when families break down, there are far-reaching emotional, social and financial effects. A recent report from the think tank, the Relationships Foundation, estimated the cost to the public purse of relationship breakdown as £41 billion; so one would think that spending some money trying to ameliorate or prevent family breakdown would make excellent financial sense. And of course, for the couple themselves, the breakdown of their relationship is likely to cause significant emotional distress, often for a long period of time. Further, and unsurprisingly, relationship breakdown can have detrimental effects on adults' life expectancy, health and financial stability.

Together with these significant difficulties, there is also now convincing evidence that children are affected too. Not necessarily by the dissolution of their parents' relationship, but by the many consequences that frequently flow from this life event. Parents have a habit of finding their post-separation relationship very tricky, which may be manageable for them but seems to be extremely problematic for their children. Inter-parental conflict we now know adversely influences children's psychological development, social competence and academic achievement. Moreover, children who experience sustained inter-parental conflict are at greater risk of anxiety and depression, increased aggression, hostility and anti-social behaviour. Inter-parental conflict also adversely impacts parenting, with parents who are embroiled in hostile couple relationships being typically more hostile and aggressive towards their children.

But on a more hopeful note, families are actually very positive drivers within the economy and within our lives. There are 3 million family businesses in the UK which account for 65% of all private enterprise and these family businesses contribute £73 billion in tax revenue each year.

Given all this evidence, one might expect that family and the relationships of adults to be central both to government policy and to the practice of those working with children and adults; yet this isn't so. Indeed, work with adult couples has been a very specialist kind of intervention, and one often avoided by practitioners. Why working with adult relationships seems such a tricky area has, no doubt, both conscious and unconscious aspects to it. Oedipal anxieties about intrusion into the parental bedroom are undoubtedly at play, together with unconscious fears linked to frightening phantasies of hostile couplings. On the other side of this split, is the wish to idealise marriage, placing the fantasy of a harmonious mother and father at the centre of the charmed circle of family life – a fantasy created in part to defend against more disturbing images of adults in intercourse. Within the political landscape the difficulty with developing realistic policy at central and local level has been linked to the extremes of feeling that the whole issue seems to engender. On the one hand we have this rather idealising support for 'marriage' which led to the moralizing 'back to basics' messages of the early 90s, and on the other hand we have had a kind of aversion to supporting 'marriage' which has stemmed from the supposedly socialist feminist agenda that simplistically equates marriage with male oppression.

Despite all these complexities, 13 years of Labour did bring many advances in family policy but, sadly, it was only in the dying months of the last government, after years of turning a blind eye, that policy around adult relationships began to emerge from behind the shut door of the parental bedroom.

'Broken Britain may be a political catchphrase but when families break down, there are far-reaching effects.'

Labour policy on the family throughout its term was directed into policies and practice aimed at supporting children and improving their life chances. The Children Act (2004) enshrined in law the need for agencies to work together to protect children and ensure their well being, and in 2003 the government published their framework 'Every Child Matters' listing five key outcomes for children that all government agencies and those working with children should strive to ensure. Much of the guidance and policy that flowed from this document made no reference to the emotional context of children's lives, ignoring the family context and in particular the couple relationship.

Recognising this limitation, government began to take an interest in 'parenting' and with new evidence and interventions emerging from the USA, local and central government enthusiastically took up the parenting agenda, encouraging a new breed of parenting practitioner delivering a set of psycho-educational programmes designed to support parents with the job of caring for their children. And parenting was discussed and focussed on as if it could conveniently be separated from the adult relationships in which most parents were engaged.

By 2006, the cabinet office, concerned with the number of families with complex and intractable problems, had published the 'Think Family' policy framework. This document recognised the inter-connection between children's well being and the well being of their parents. The initiative focussed on the most deprived of families and a range of intensive supports were developed. Sadly, even within the Think Family policy framework, the 'thinking' didn't extend to the needs or impacts of the adult couple, and the only reference to adult relationships in these policy documents was in relation to domestic violence.

At this time, there was an interesting development in Conservative thinking through Ian Duncan Smith and the work of the Centre for Social Justice. This new think tank, set up by the former Conservative leader, had ambitions to change the agenda and re-introduce the links between poverty and social exclusion and family breakdown. At the end of 2006 the report 'Breakdown Britain' was published, which put the need to support and encourage family stability at the heart of family policy. At that time, this seemed like a fresh approach to the issues which, despite its emphasis on marriage as the solution to many social evils, won some cross party support for its focus on early intervention.

Together with the challenge from the Conservatives' new social justice policies, campaigning from TCCR, Relate, One plus One, and the 'Kids in the Middle' coalition brought the issue to the fore. The matter began to make an impression on the Labour leadership with the result that Ed Balls took up the issues with some energy and called a Relationship Summit to begin a process where policy on relationships within families could at last be addressed.

Sadly, the economic climate saw off ambitious plans for radical change and the families and relationships green paper published this year, 'Support for All', whilst excellent on rhetoric, was modest in its ambitions, and the hoped-for breakthrough where relationship support would be given more of a mainstream role did not materialise.

Now, weeks into a new government, there is still uncertainty about how family policy will play out. The Conservatives' manifesto commitment to 'put relationship support on a long term and stable footing' was reiterated in the coalition manifesto, and in a speech by Nick Clegg in mid June where he also announced that the government has set up a task force on families chaired by the Prime Minister. Certainly, there remains an appetite, despite the cuts, for some new policy development. Four areas have now been announced as key to government family policy and these include family breakdown, support for disabled children, parental leave and providing secure environments in which children can flourish. Further details will be announced after the spending review.

And the wider family policy issues? Sure Start, Labour's flagship initiative, will probably survive, but the universalism of the delivery will go, with resources re-targeted on the neediest families. At the Conservative party conference last October, it was interesting too in two fringe meetings to hear shadow ministers and prospective parliamentary candidates talking about attachment theory and the importance of early infancy for each child's future life chances, but these are not the only voices in the Conservative Party. Strongly held faith-based convictions about the importance of marriage as an institution are also central to Conservative thinking, and the belief in marriage as a 'cure all' for society is strong. Evidence showing that married couples are more likely to stay together and have children that thrive lends weight to these beliefs, despite the fact that analysis shows that the selection effect is at work here. Those who choose to marry are of course in a better place on many indices of well being, making the correlation between strong relationships, children's well being and marriage not about marriage itself but rather about the nature of the people who choose to marry. But should we mind the 'nudge' politics of the tax break for marriage? Is sending a signal that stability and commitment are important really such a problematic thing? On the other hand in this economic climate can we afford this 'nudge', or should government be using any money it has to tackle family breakdown in other ways?

'Weeks into a new government there is still uncertainty about how family policy will play out.'

So policy around the couple remains problematic. Perhaps, because of the growing evidence base linking relationship quality and children's wellbeing, we are closer than ever before to some consensus on the importance of adult relationships; but the waters ahead are tricky.

And how does this matter for psychoanalysis? Most of us have been long attached to the intensity of the relationship between analyst and analysand. Is there always room in this twosome for the couple relationship? Is there always room in this twosome for the couple relationship and the needs of their children? Whilst the intimacy of the consulting room is sacrosanct, we need to find ways to include in our thinking, the real families that our patients live their lives in. Increasingly, however, psychoanalytic psychotherapists working with individuals are referring their patients for couple therapy and, on the whole, this extension of responsibility for the emotional life of the family is working well. Sharing and not splitting is, hopefully, becoming the order of the day. Perhaps now in our consulting rooms we are becoming able to do something that has been challenging to politicians for decades – I certainly hope so. ■

Susanna Abse is Chief Executive of the Tavistock Centre for Couple Relationships, www.tccr.org.uk
Susanna will co-present, alongside Jean Knox and chair Beverley Tydeman, 'Complex Interdependencies', discussing the relationships between the individual, the family and society and how they impact on mental health and models of therapeutic intervention, at Psychoanalytic Psychotherapy NOW 2010.

Interview

Boundary violations – our friends and colleagues

An interview with Glen Gabbard
By Jonathan Coe

Jonathan Coe interviews Brown Foundation Professor of Psychoanalysis and Professional Director at Baylor Psychiatry Clinic Glen Gabbard on the transgression of professional boundaries

Glen O. Gabbard

Jonathan Coe

On a recent study tour to the USA, funded by the Winston Churchill Memorial Trust, I visited seven places providing specialist evaluation, rehabilitation or educational services for professionals who have transgressed professional boundaries. These services typically deal with a range of different professions, including health workers, clergy and psychological practitioners. Whilst some services use a model of treatment stemming from work with sex offenders, many are informed by an understanding of psychodynamic processes. Foremost in this field is Professor Glen Gabbard who is the Brown Foundation Professor of Psychoanalysis & Professor Director at the Baylor Psychiatry Clinic in Houston Texas. Gabbard came to public view in the US through his popular book, *Psychiatry and the Cinema*, and through his regular blog posts on the psychology of the TV series The Sopranos and a subsequent book on the same topic. This article is compiled from a conversation with Gabbard in Houston and a subsequent email exchange.

Evaluation and Rehabilitation

The Baylor clinic provides three day multi-disciplinary evaluations of professionals accused of boundary violations, most often involving sexualisation of the relationship, but also including financial and other transgressions. The clinic sees about equal numbers of priests, physicians and talking therapists. Gabbard notes that the majority of those assessed have either a psychiatric condition on Axis 1 of the DSM or a Personality Disorder. Sometimes they have personality traits that do not reach the threshold for a disorder but account for some of their behaviours. The clinic also sees people who are psychologically healthy but under tremendous stress.

Do you have a structured approach in terms of assessing the potential for risk and rehabilitation?
Psychological testing is very structured, there's a whole series of standard instruments, but in my interviews I rely more on open ended questions and my sense of where the midline is in terms of responses, [and] what are the outliers.

The question would be – is this guy amenable to rehabilitation? Some are and some aren't. One of things I look for in my evaluations – the simplest way to put it is 'do they get it: do they get the problem?' A lot of them say things like 'The other guys [working] in the hospital are so much worse than I am.'

The other thing is [to see] if there is any real genuine remorse. In my writing one of the points I make is that there's a difference between narcissistic mortification on the one hand, and genuine remorse on the other. I'll ask an open ended question – do you feel bad about what's happened?' 'Do I feel bad? Are you kidding, my life is destroyed, my family is disgraced, my career is destroyed. If I could rewind the tape I would never do this again.' And in all of this they haven't mentioned the victim one time.

'Sexual exploitation is a rip-off. One comes for therapy and instead receives sex.'

Are you mandated to report where the person admits additional offences?
It goes in the report and generally the referrer will report it. There's a certain percentage of people who will break down – I look them in the eye and say 'are you really telling me the whole truth?' Are you really being completely honest with me?' And there's a percentage who get tearful and say 'Well there's another [victim].' Now the hard-core narcissist may say 'Yes of course' but some will break down.

I'm wondering what the places that run treatment programmes are treating, as a Boundary Violation is not a medical condition?
I think a lot of times it's denial. But I'm talking about three to five years [of rehabilitation] – a programme that goes on and is monitored for years. Usually there's no need for in-patient or residential. The programmes we set up are independent, to some degree, of disciplinary systems. Boards may get in touch and say 'We've suspended this person for 18 months, but we'd like you to see him and determine [if] it would be worthwhile to set up a treatment and rehabilitation programme.' So here's a typical [programme] – individual psychotherapy every week, with someone who knows boundaries; an educational seminar and restriction on practice, so if they're in solo practice they need to work in an institution or a group under supervision, and they have supervision on all their cases. We might say 'no patients with childhood trauma histories', restricting who they can see. Sometimes marital therapy, sometimes medication if they're very depressed. Those would be the major components. Then it needs to be monitored for three to five years. Before they can be outside the monitoring programme they need to be re-evaluated to see if they get it, if they have really benefitted from it. Many of them do.

You have been very clear that often the issue is not black and white and that an understanding of the complexities of each case is vital. I am interested in whether ethically there are there some practitioners that simply shouldn't be rehabilitated?
Absolutely. There are severe narcissistic personalities and sociopathic therapists who are essentially predators who have no remorse for their transgressions. This is why a careful evaluation with substantial collateral information is needed to assess who can be rehabilitated and who cannot be rehabilitated.

Victims

Sometimes the issue of Sexual Boundary Violation is taken as a kind of technical breach, an offence to good manners – could you give a perspective on the ethical basis for its proscription and something of what is established about harm to clients?
The essence of a fiduciary relationship where one pays another for a service is beneficence and non-maleficence. The relationship exists to help the patient and to avoid any harm. So sexual exploitation is a rip-off. One comes for therapy and instead receives sex. The problems that brought the person to therapy go unaddressed. Moreover, there is a power differential built in to the therapeutic relationship by virtue of one person paying another with a specific expertise. Hence it is a breach of power and a situation where one cannot give informed consent. There is ample evidence from clinical studies that patients feel harmed, betrayed, and may be refractory to subsequent treatment since they cannot trust future therapists. Some may not complain initially if they are in love with the therapist or marry the therapist, but that love is temporally unstable in most instances, and there is rage when the relationship goes sour. This is what [Tom] Gutheil and I call cessation trauma.

Could you expand on the ways in which non-sexual boundaries are breached, and the consequences of this for the patient?
There are many, many ways that nonsexual boundaries are breached. I will cite just a few: gossiping about a patient, making a business deal with a patient, soliciting a donation from a patient, asking a patient to babysit one's kids or work in the office, telling the patient you are in love with him/her. The patient is harmed because for therapy to work, it has to be clear that the patient is there only for treatment and for no other purpose. It is placing the therapist's needs before the patient's. Moreover, patients who are told 'I love you' or are treated as friends have false hopes raised that they will be something other than a patient for the therapist.

Do you see people who've been abused by practitioners?
Yes, as [therapy] patients. Sometimes a victim will come to me and want to make a complaint. Historically the victims have been neglected, not taken too seriously. One of the things I have done before is mediation, sitting down with the therapist. Getting the therapist to apologise can be tremendously important for the victim. And I've negotiated [within] mediation the therapist giving the client their fees back. Some of the practitioners feel they haven't done anything wrong so they don't want to apologise or explain. They can see the victim as responsible. I've had a [mediation] situation where the practitioner expressed his anger at the patient for ruining his career. It took several sessions for him to see that it wasn't just him who had been harmed. It turned out pretty good. He had to listen to the damage he'd done. [Mediation is not right for everyone] but it's good to have options available.

Risk Factors and Types of Transgressor

What is known about practitioners who violate boundaries?
A whole spectrum of different people do this for different reasons. I'm convinced that people hate complexity – they like to say 'all of these guys are bad, they're evil, they're predators, let's throw them out, throw the bad apple out of the barrel, then everything will be fine.' But it doesn't work that way. My students say: 'Why are you teaching us this Professor Gabbard, this is like, nothing I'm ever going to do, why will I ever need to know about this?' So yes, everybody's vulnerable and people who think they'll never get in trouble are the people who may get in trouble because they're not thinking about it. Everyone of us is a master of self-deception. If you're working alone in a private office somewhere, without consultation, you can convince yourself 'I'm an exception. This isn't in any way exploitative, it's true love, there's nothing wrong with this.' So I teach that if you're going to be a therapist for the rest of your life you need a supervisor or consultant. You internalise them, you carry that person into the room with you and you're having a dialogue in your mind. That's the best prevention. Isolation, the solo practitioner working alone is a high risk, as there is a boundary problem built into that. You tend to drift away from what is accepted practice if you're totally by yourself.

'People hate complexity – they like to say "all of these guys are bad, they're evil."'

Practitioners more advanced in their careers and often well respected are high risk. I have so many examples of that – the narcissistic guy who's well known in the field who says: 'Well you know the rules don't really apply to me anymore, because I know what I'm doing. If one of my supervisees did this I'd be worried about it, but I know what I'm doing, so I can get away with it.' Or 'I'm unorthodox, people wouldn't understand. I couldn't talk to a supervisor because they wouldn't understand my approach – I've done it with lots of people and it's different but it works.' Narcissism, it's a huge problem.

Have you determined any differences between therapeutic modalities in terms of clinical profile or in how transgressions play out?
No, therapists of all persuasions are vulnerable. It has much more to do with the particular characteristics of the patient and therapist than any particular theory, technique or modality.

Are the majority of people that you see one time offenders?
Yes but we see multiple offenders too. I'd say maybe 60% were one time.

How about those who are not the long-term predators of dozens of victims but may have 2,4,6 victims?
The narcissistically organised person. There are many narcissists who are generally womanisers, but haven't been doing it with patients. The guy who fancies himself a Don Juan, lots of girlfriends, several wives. But one patient, and that's why he gets sent to me. Then others who are quite superego ridden, very obsessive compulsive, do everything right, and they have a kind of mid-life crisis 'My God I've done everything by the book my whole life – I deserve one little transgression with one patient. For once I'm going to throw off the shackles of oppressive orthodoxy, I've earned it.'

Epidemiology, Regulation and Denial

The research into epidemiology [of sexual boundary violations] has some variation – what is your working view about how widespread an issue this is in the psychological therapies?
The simple answer is that we don't know the prevalence. There are questionnaire surveys but they all have notorious methodological problems. The return rate is low. Those who fill out the questionnaire may be different than those who don't complete the survey. Many do not trust the confidentiality of their responses since there is often a numerical coding involved. Some people don't tell the truth on questionnaire surveys. We certainly cannot rely on figures from ethics committees and licensing boards because they see only the tip of the iceberg. What I can say from over 30 years of evaluating and treating practitioners with boundary violations is that it is not rare.

You have led the way in enabling a conversation about boundary-less professionals to take place internationally; yet there remains significant and sometimes virulent denial of the extent of the problem in some quarters – do you have a view about why you think this is?
Sexual boundary violations are quite close to the incest situation symbolically. Someone in authority who should care about you and protect you instead exploits you for his/her own sexual pleasure. It taps something in all of us that is abhorrent, but unconsciously desired. There is a line in Sophocles' Oedipus Rex, where the chorus, commenting on Oedipus says something to the effect of: 'He did what most men only dream of.' There is a huge tendency to project this vulnerability into a handful of psychopaths rather than to acknowledge the universal vulnerability, i.e. it is an occupational hazard for all of us.

One of the things I've noticed is that often when these boundary violations come out there's been knowledge in the [practitioner] community, but nobody really wanted to say. It's like they see it but they don't see it. One of the thing that goes on is, unconsciously, often the community of practitioners have a secret admiration for this guy who gets away with things. That makes it difficult sometimes to get information from the community because no-one wants to say anything. A lot of these practitioners, who are experienced, president of some organisation, respected, they often are good referral sources, they send patients to other people. They want to be loyal, they don't want to lose their referral source so they say nothing.

In the UK there is currently much debate about the statutory regulation of counsellors and psychotherapists. As someone who has been subject to statutory regulation for your whole professional career, have you ever felt that this impinged on your clinical practice, or your ability to innovate in the field?
No, I have never felt that. Any innovation that challenges statutory regulation must be scrutinized carefully because it is likely to contain problematic aspects that may get the practitioner into difficult situations with the patient.

Cultural Imperatives

I've been interested in cinematic and TV depictions of psychotherapy. The audiences tend to love the kind of guy who'll do something radical to save the patient. Then the Ethics Committee is a group of stuffy old men who say: 'You shouldn't be doing that.' You know there's a whole cultural influence to be that kind of maverick, who does his own thing. And that's seductive.' ■

Glen Gabbard Biography

Gabbard earned his Bachelor's Degree in Theatre from Eastern Illinois University and a M.D. from Rush Medical College in Chicago in 1975. He completed his psychiatry residency at the Karl Menninger School of Psychiatry in Topeka, Kansas. He then served on the staff of the Menninger Clinic for 26 years and served as Director of the Menninger Hospital from 1989 to 1994 and Director of the Topeka Institute for Psychoanalysis from 1996 to 2001. He moved to Baylor College of Medicine in 2001.

Gabbard has authored or edited 24 books and over 300 papers, including a book on media depictions of psychiatry and mental illness in films with his brother Krin. He was Joint Editor-in-Chief of the International Journal of Psychoanalysis and was Associate Editor of the American Journal of Psychiatry. Awards include the Strecker Award for outstanding psychiatrist under age 50 in 1994, the Sigourney Award for Outstanding Contributions to Psychoanalysis in 2000, the American Psychiatric Association Distinguished Service Award in 2002, the American Psychiatric Association Adolf Meyer Award in 2004, and the Rush Medical College Distinguished Alumnus in 2005.

News In Brief

BPC Trainee Association Conference: 'Making Contact'

On Saturday 8 May 2010, trainees from several BPC member institutions (MIs) came together at the Institute of Psychoanalysis for their second annual conference. The event was organised by a small planning group of trainees to take forward a proposal made last year for ongoing contact among trainees of BPC MIs, as well as for some mechanism by which their views could be represented to the BPC. This year's conference title: 'Making Contact', with speakers, Professor Mary Target and Serena Heller, was intended to bring together the theme of the conference, writing up clinical work, with the development of the Trainee Association.

A range of BPC MIs were represented including the BAP, Institute, LCP, Lincoln, Tavistock, and WPF Therapy, as well as out of London trainings, including the BAP Wessex and NEAPP based in Newcastle. A total of 40 trainees attended.

Julian Lousada, Chair of the BPC, opened the event, welcoming the proposal for the new trainee association and encouraging trainees to become active both within their own institutions as well as the BPC. Malcolm Allen, Chief Executive of the BPC, went on to give his full support to the creation of the Association, and encouraged trainees to rise to the challenge facing psychoanalysis in the 21st century. Malcolm confirmed that the Trainee Association would in future have two places with voting rights on the Council of the BPC.

Those attending the event agreed to the formation of the BPC Trainee Association and agreed as its purpose: 'to provide an opportunity to trainees of BPC MIs to input directly into the life of and development of the BPC', as well as 'to promote information sharing and networking amongst trainees of the BPC MIs'. This and last year's conference confirmed a strong interest and need amongst BPC trainees to forge links.

Following the conference nominated trainees from each of the MIs met to start laying the foundations for the new Trainee Association. Over the next year we hope to further the work already begun of promoting links and networking among BPC trainees. Officers for the new association were agreed as follows:

Lee Smith, Chair (Institute of Psychoanalysis) lee.smith@ukonline.co.uk
Carolyn Walker, Vice Chair, (Tavistock M1) cwalker@tavi-port.nhs.uk
Elizabeth Ford, Secretary, (LCP) lizzieford@talk21.com
Julie Gaudion, Assistant Secretary, (Tavistock D59) juliewulie5@hotmail.com

UK's first Deaf psychoanalytic psychotherapist

A recently qualified BPC registrant working at South West London and St George's has become the first profoundly Deaf person in the UK to qualify as a psychoanalytic psychotherapist.

Jane Douglas, who graduated from the Lincoln Clinic and Centre for Psychotherapy, overcame many barriers to train in psychoanalytic psychotherapy. 'People didn't seem to think a Deaf person could manage this type of work,' she said. 'Also I didn't have a first degree because when I was at school it was very difficult for Deaf people to access higher education.

'I'm particularly grateful to Janet Fernando, Consultant Adult Psychotherapist, and to Dr Nick Kitson, the previous Consultant Psychiatrist to the Deaf Service and Clinical Director of the Trust, for the belief he showed in me and the support he provided in the early part of my career.'

Jane has worked at the Trust since 1989. She will be providing a range of different kinds of psychotherapy for Deaf people at the Trust's National Deaf Services, communicating with her patients in British Sign Language. Jane's qualification means the Trust is able to continue providing a high quality service that Deaf people can access in their own language.

Vetting and Barring Scheme on hold

The new government has put on hold the unpopular Vetting and Barring Scheme (VBS) and has said it intends a review to 'scale it back to common sense levels' (The Coalition: our programme for government, 20 May 2010). The move, announced by Home Secretary Theresa May on 15 June, follows through on the Conservatives' pre-election promise to revisit the VBS, as well as a statement by Clegg (19 May) that the coalition intends to 'strip away government's unelected, inefficient quangos'.

The Independent Safeguarding Authority (ISA) had set a deadline of 2015 for all working in regulated activities with children and vulnerable adults to register. The definition of a 'vulnerable adult' includes any adult receiving healthcare including, we understand, psychotherapy treatment. Registration under the scheme would not have replaced enhanced CRB checks. The Health Professions Council had been advising that they expected the majority of HPC registrants would need to be registered in due course, although registration with the VBS would not have been a requirement of registration with the HPC.

Ministers including the Home Secretary were careful to stress that the government still intends to implement a scheme to protect vulnerable groups. The scope of the remodelling process – to be co-ordinated by the Home Office in partnership with the Department of Health and the renamed Department for Education – is currently being finalised and will be announced shortly.

New Associations is published by the British Psychoanalytic Council, Suite 7, 19-25 Wedmore Street, London N19 4RU
Tel. 020 7561 9240
Fax 020 7561 9005
www.psychoanalytic-council.org
mail@psychoanalytic-council.org

Three issues of *New Associations* are published each year in February, June, and October.

Subscriptions
UK annually (5 issues): £10
Overseas annually: £16

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

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

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

Views expressed in *New Associations* under an author's byline are the views of the writer, not necessarily those of the BPC. Publication of views and endorsements does not constitute endorsement by the BPC.

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

Deadlines: The next issue of *New Associations* will be published in October 2010. The deadline for article proposals is 23 August 2010. Contributions and letters to the Editor should reach us no later than 15 September 2010.

ISSN 2042-9096

In Treatment: psychoanalysis on the screen

By David Morgan

Popular culture has attempted many times to accurately portray the psychoanalyst – why is the common depiction one of failure of containment and abuse? David Morgan investigates.

There have been many attempts to portray psychiatrists, psychoanalysts and psychotherapists in literature and film. Invariably the plot involves the sexual opportunism of the therapist who invariably becomes enamoured of his patient, as in *Prince of Tides*, or is driven by more orally-based appetites as in *Silence of the Lambs*, in which the psychiatrist played by Anthony Hopkins uses his extensive understanding of the human mind to turn his victims into tasty snacks. In *Dressed to Kill* the psychoanalyst played by Michael Caine is a transvestite killer who stalks and murders his patients. Clearly it is more interesting and exciting for the plot to be able to portray the clinician in these circumstances as grossly abusive or downright psychopathic. It is the pathology of the therapists who are as ill as their patients who, instead of having the mental space to think and process what is projected into them, identify and act out in exaggerated forms. They are portrayed as using their patients as receptacles for their own violence and sexuality. Thus the most popular form of representation for the metal health profession is often one representing failure of containment and abuse.

Whilst boundary violation clearly occurs in our profession, particularly in the form of sexual seduction and boundary violation, a layman, looking at our image as represented in popular culture, would be forgiven for thinking that the analytic relationship is an extremely hazardous one. In other films our profession has been treated humorously: one only has to think of *Zelig*. Indeed, Woody Allen seems to have made a good living from the humorous side of psychoanalysis in all his films, as in *Manhattan*; 'I only knew my strict Freudian analyst was dead when he stopped giving me the bills.' The amusement is perhaps less compelling however when one thinks of his marriage to his adoptive daughter, and this a man who was in psychoanalysis for many years.

In *Good Will Hunting* Robin Williams plays another popular psychiatric stereotype common to Hollywood films, the bumbling, cardigan-wearing, eccentric avuncular male figure. Whilst Robert de Niro in *Analyze This* is a gun totting mafia boss who congratulates his analyst for a good interpretation, at the same time using a Magnum 45 to negotiate the negative transference! Another strand of humour has often been based on anti-psychiatry, as in *One Flew over the Cuckoo's Nest*, where the patient is a revolutionary who challenges social norms and stereotypes, owing much to Laing et al.

Two portrayals of psychiatry and psychotherapy in literature come to mind. One is in *Mrs Dalloway* by Virginia Woolf, where Sir William Bradshaw tries to engage with his patients by bullying them to agree to his precepts. 'Converting the mentally ill to his sense of proportion.' Perhaps an indicator of why Virginia Woolf never turned to psychoanalysis for her suicidal depression, despite living in Bloomsbury with the proximity of psychoanalysis and being a relative of James Strachey, the translator of the *Complete Psychological Works of Sigmund Freud*.

I can think of one notable exception to this negative imagery in cultural representation of the clinician, and that is Dr William Rivers in the *Ghost Road Trilogy* by Pat Barker. Rivers is portrayed as a deeply caring therapist who struggles with the horrors that his patients have been exposed to in the First World War, culminating in a powerful dream in which he bleeds, he gradually appears to discover through his countertransference a sensitivity to the human being he is treating and the hell of the trenches that he is seeking to return them to. This conflict in Rivers is a powerful evocation of the move from man as machine and cannon-fodder, from the inhumane aspects of the industrial revolution, man as machine mentality, to the beginnings of a sense of human vulnerability.

Two television programmes recently attempted to move away, albeit only partially, from the trend of superficially portraying therapists and analysts as sick and boundaryless. Both by HBO, one was the wonderful *Sopranos*, again utilising the idea of a mafia boss seeing an analyst, but sensitively portraying the struggles of the analyst to resist the pathological world and organisations of her patient's mind. Of course again she inevitably fails and is seduced by his power, later realising the vulnerability of her position in the setting she operates within, terminating his treatment abruptly. This was beautifully portrayed, although again relying on the mistakes of the naive clinician; it demonstrated an awareness of the sensitivity of the transference and the dangers of forensic work and the seduction of working with dangerous patients for the 'heroic' clinician.

In Treatment's Paul Weston, the psychotherapist played by Gabriel Byrne, is its central character, boundary-challenged and deeply conflicted. In the first series we see him struggle with his patients whom he sees in the front room of his house. As a trained analyst one is continually confronted with one's own prejudices and training: watching Paul respond to his patient's communications, one wants to supervise Paul, who seems to make one mistake after the other. After a while you realise that there is very little evidence of transference-based work in Paul's approach to his patients, and this is rather frustrating as allegedly the show had plenty of qualified advisors, as did the show's Israeli progenitor *Be'Tipul*.

In the first series we see him struggle to keep his private life separate from his work with patients. However, gradually the boundaries inevitably begin to erode. First, the problems of a blocked toilet and an eroticising female patient who demands to use the private facilities. Then the young patient who gets wet on the way to the session due to the weather, and is helped in to dry his clothes by the therapist's wife. The development of a strong erotic transference to the female patient is set against the therapist's deteriorating marriage. I think this is sensitively portrayed and begs the question that, if a therapist is dependent on his practice for his income, what does he do if he is unfit to practise? Laura is a young, pretty hospital worker with a fierce erotic attachment to her therapist. Alex is an ace Navy pilot who had a heart attack after a disastrous bombing mission in Iraq. Sophie is a 16-year-old schoolgirl and a gifted gymnast who may have suicidal impulses as well as an unhealthy relationship with her coach. Jake and Amy are a couple straining over whether to have a second child.

By the second series he is divorced, displaced and being sued for malpractice. 'What's left for me now?' he asks his supervisor after the possible suicide of one of his patients and the anticlimax of his sexual attraction to another. It is a good question. The constructs of transference, marital breakdown, vocational crisis, ethical liability, all occurring in a one 30-minute show-a-week is absolutely fascinating. His patients now include Mia, a successful litigator who suspects her treatment with Paul 20 years earlier may have led to the personal dead end of her life (single and childless), and April, a wounded architecture student whose refusal of treatment after a cancer diagnosis belies the destructive extreme of self-sufficiency she lives by. Oliver, a 12-year a boy with food issues whose parents are divorcing; Walter, an embattled, repressed chief executive; and finally Paul the therapist, who each week goes to visit his children and attend his increasingly revelatory sessions with his supervisor. Gradually Paul's life unravels and we see that despite his sensitivity toward his patients Paul's own training and personality are not up to the job.

In the end *In Treatment* is a very good rendition of a therapist who is breaking down and who is unable to cope with the needs of his patients because he fails to separate his own problems from theirs. His supervision is also flawed, as there seems to be unresolved issues between himself and his supervisor which relate to his problems with his patients. He is unable to be truthful with his supervisor and alters reality to make it more amenable to her critique. In his avoidant behaviour I think I see why Paul's patients react to him the way they do, as he is as ill and unhappy and as unable to bear reality as they are.

Despite using the usual format of the failing ill-equipped psychotherapist as its central motif, *In Treatment* is a good evocation of a therapist on the edge. ■

David Morgan is a consultant psychotherapist at the Tavistock and Portman NHS Foundation Trust (the Portman Clinic) and a BPAS psychoanalyst.

Letters to the Editor

From PNC to IE

Sir – the Samuels/Lousada/Gabriel debate (*NA* 2) was illuminating. Lousada skilfully exposed the inherent contradiction in so-called Principled Non Compliance (PNC): '…you think it is probable that HPC will prevail. Yet you [Samuels] are arguing from a position of opposition rather than trying to make something work.'

For any negotiation to succeed – in a marriage, between nations, between therapist and client, or in the-wider-scheme-of-things minor eddy of the HPC question – a leap of faith is needed. There has to be a genuine wish to make the process succeed, and a sense that any relinquishing of sovereignty will, once each other's position is fully understood, be matched by compromises on both sides. Relationships founded on ambivalence, narcissistic entitlement, or denial of reality, are doomed from the start. Active commitment, not necessarily uncritical, in itself changes the dynamic, so that collaborative striving replaces passivity and suspicion.

Of course there are difficulties with regulating psychotherapy. Of course the essence of what we do cannot be fully captured by protocols, narrow health parameters, and clumsy malpractice models borrowed from other professions, but paranoid negativity is unviable. In place of PNC, I suggest Ironic Engagement (IE) as a healthy starting point from which to discover that one can, within the limits of reality, still be in charge of one's destiny.

Jeremy Holmes
University of Exeter

Transference Focused Psychotherapy

Dear Editor
It was good to read, in Issue 2 of *New Associations*, of a model of brief dynamic therapy for depression which is included in the revised NICE guidelines albeit with the rider about the requirement to inform the patient of 'the uncertainty of the effectiveness of psychodynamic psychotherapy in treating depression'.

In her article Professor Lemma writes about different types of dynamic therapies in terms of how DIT was developed, referring to the evidence base for other established dynamic therapies and suggests what sorts of interventions might be helpful in treating depression. Professor Lemma writes: 'Acquiring special techniques such as systematically confronting defenses (Short Term Psychodynamic Psychotherapy) or focusing exclusively on the transference relationship (Transference Focused Psychotherapy), did not seem necessary procedures for DIT'.

I am fortunate to have had attended a couple of workshops on Transference Focused Psychotherapy (TFP) and to have had a year of supervision in this model. TFP is a manualised treatment for borderline and other severe personality disorders. TFP grew out of the work of Otto F. Kernberg and his colleagues in New York and there is a growing evidence base for the effectiveness of this approach. (The most recent research to be published is 'Transference-Focused Psychotherapy V. Treatment by Community Psychotherapists for Borderline Personality Disorder: Randomised Controlled Trial'. Doering et al., *British Journal of Psychiatry* (2010) 196 389-395.)

TFP is not a therapy that focuses 'exclusively on the transference'. This a long way from an accurate description of a model of therapy that, on closer reading about DIT, seems to have informed, in an unacknowledged way, some theoretical and practical aspects of DIT. TFP emphasizes the presence in the patient's internal world of object-relationship dyads that consist of a self-representation, an object-representation and a linking affect. One dyad can defend against another. These dyads are played out in the transference relationship with the therapist. This is essentially the same as the description of DIT Professor Lemma gives: ' Affects are understood to be responses to the activation in the patient's mind, of a specific self-other representation'.

When I looked further into DIT I found a description of a process with the patient that recommends a move in the session from clarification through confrontation to interpretation. This description is included in the slides describing DIT which are available on the UCL (University College London) website. These slides outline a process that has been detailed in various texts on TFP. (See Clarkin, Yeomans and Kernberg (2006) and also Clarkin J.F., Yeomans F.E., Kernberg O.F. (1999). *Psychotherapy for Borderline Personality*. John Wiley USA.) This illustrates the point that the focus in the sessions is not 'exclusively on the transference relationship'. In fact TFP therapists have always paid attention to the patient's extra-transference relationships and behaviour.

The limits of space mean I cannot go into full details about TFP. I feel it is important for references to psychodynamic models to be as accurate as possible. In the case of DIT I am struck by the number of similarities with TFP and left somewhat disappointed that the only reference in the article to TFP is one which is, unfortunately, not quite accurate.

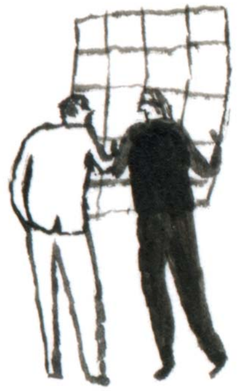
Frank I. Denning
Psychoanalytic Psychotherapist (UKCP)

The challenge of NICE and the need for leadership

Like many others at last year's Psychoanalytic Psychotherapy NOW conference, I was impressed with Malcolm Allen's talk of being at a crossroads, contesting the intellectual arena, building a more cohesive and united professional community and developing a more authoritative voice influencing policy. However, it is unclear whether action is being taken by the BPC. I believe that faced with CBT's onward march, professional registration has taken the attention at the expense of promoting psychotherapy for NHS patients. Given the significance of the NICE guidelines in determining future provision in the NHS, NICE should be the focus of attention. The first job is achieving psychoanalytical representation on each relevant NICE committee. The BPC should fund analytic representatives to attend the committees and support them though the establishment of working groups. Secondly, better research evidence is essential; RCTs are being carried out for some NICE diagnoses only. A single well-designed study can make a crucial difference. Grants are available if the organisational drive is there to bid for them.

Schizophrenia: NICE states that no recent randomised controlled trials (RCTs) have been carried out using psychodynamic methods; "further well conducted research is warranted …into newer contemporary forms of psychoanalytic and psychodynamic therapy" (http://www.nice.org.uk/nicemedia/pdf/CG82FullGuideline.pdf p.245).

Depression (http://guidance.nice.org.uk/CG90): NICE says that the evidence for short-term psychodynamic psychotherapy



is weak and so recommends it only for those who decline anti-depressants, CBT, interpersonal psychotherapy (IPT), behavioural activation, and behavioural couple therapy.

Anxiety (http://guidance.nice.org.uk/CG22): NICE states that the evidence of psychodynamic psychotherapy's effectiveness for panic and generalised anxiety disorder is weak. CBT is the only recommended psychological therapy.

Borderline personality disorder: "(the research shows that)..individual psychological interventions had very little effect on symptoms compared with treatment as usual, other than for general functioning which showed some improvement (http://guidance.nice.org.uk/CG78 p. 131). This is despite the Tavistock and other centres treating patients with borderline personality disorder using individual psychotherapy.

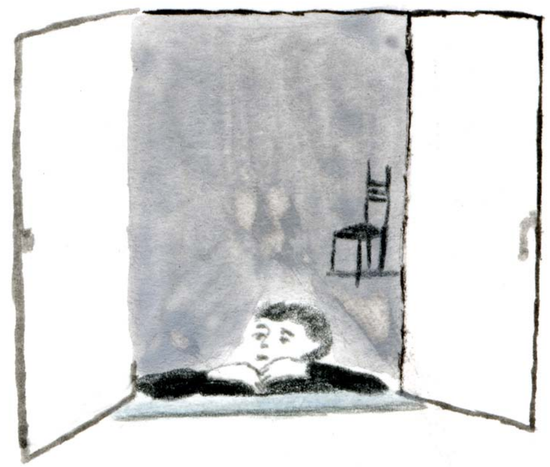
Without one or two key RCTs for each diagnosis, individual psychoanalytic psychotherapy will continue to lose out. There are significant challenges, for example only a subset of patients in any diagnostic category will be suited to psychotherapy, and fidelity of practice and manualisation is controversial. Such challenges need to be overcome. Ernest Jones persuaded the establishment of his day that psychoanalysis might work. We need to do this again now. Rather than leaving it to individuals to 'engage with the issues', the BPC needs to take a more active leadership role.

Jonathan Radcliffe
South London and Maudsley NHS Foundation Trust.

Inner worlds and virtual worlds

By Heather Wood

A fifth of children and adolescents referred to the Portman have had problems of violence, criminality and compulsive sexual behaviour. Heather Wood reports on new media technologies and the increasing rise in patients presenting problems of compulsive use of internet sex.



It is becoming commonplace for psychotherapists and mental health workers to see patients who have problems with the compulsive use of 'virtual sex', the use of the phone or internet to access sexually stimulating materials. This work raises issues about the theoretical understanding of these problems, therapeutic technique, and the legal framework in which we practice. While a few women present with such problems, on the whole they use the internet in different ways from men – to make contacts with others with the aim of having real-life meetings rather than to access and view pornography. It is predominantly men who present with compulsive use of pornography and chatlines.

Statistics from a range of sources – internet service providers, large scale surveys, mental health services and legal data about convictions for use of illegal pornography – all attest to increasing numbers of people using, and in difficulty with, virtual sex. With any new phenomenon there is likely to be an increase in usage with an eventual levelling off, but in clinical practice we seem to be seeing no sign of a plateau in the patients presenting with problems of compulsive use of virtual sex.

The first world wide web files were made publicly available on the internet in 1991; in 1998 the legal framework for internet child pornography crimes was established in England and Wales, and by the late 1990s clinicians were starting to see patients with problems of compulsive use of internet pornography. The Portman Clinic, part of the Tavistock and Portman NHS Foundation Trust, offers psychoanalytic psychotherapy to adults, children and young people with problems of violence, criminality and compulsive sexual behaviour, and is well-positioned to attract such referrals. The clinic had no referred patients with problems of this kind up to 1998. In 1998 there was just one referral. By 2001 it was a significant feature in 9% of all referred adult patients, although not always the primary reason for referral. By 2007-8 it was a feature in 18% of all referred adult patients, of whom 61% had a history of using illegal pornography. In 2008-9 this was one of the problems identified at referral or during assessment in 22% of all children and adolescents (up to age 21) referred to the clinic.

Within psychoanalysis the original focus on the sexual self and sexual behaviour has been eclipsed in recent decades by a preoccupation with early infantile experience, object relations, and, more recently, attachment. The internet and virtual sex are amongst the social trends that have suddenly cast sexuality back onto centre stage in the consulting room. And virtual sex is a particular kind of sex: The sex is 'virtual' in that new media technologies are the vehicle for the transmission of sexually explicit materials or communications, but it is also 'virtual' because the sexual act consists largely of masturbation. There is rarely a partner present. The 'interaction' which takes place is usually between the individual and an external realisation of his or her sexual fantasy. This is not the repressed sexuality struggling for expression in a culture of denial that Freud and his contemporaries were largely concerned with. This is sexuality which is about the very explicit externalisation of sexual fantasy, sexuality which is traded and paraded. The individual may seek an external realisation of the core sexual fantasy in pornographic imagery or may seek online contacts with whom to exchange sexual fantasies. Whereas in the real world of face-to-face encounters, the progression of a potential sexual relationship is more commonly negotiated step-by-step, relationships forged online with the purpose of sexual gratification do not progress incrementally from 'first base', but often move straight to the exchange of deeply personal sexual fantasies in the first encounter. Exploration of the other as a person and the subtle negotiation of object-relating and the forging of an attachment are by-passed as sexual excitement becomes the dominant currency.

It is not uncommon for patients presenting in difficulty with virtual sex to recount the core sexual fantasy in assessment sessions, particularly when the internet seems to hold up a mirror, enabling people to see – and often leading to them being shocked by – the scenarios they pursue. This combination of new technology and explicit if not perverse sexuality may seem unfamiliar terrain for psychotherapists; it is easy to be left feeling like a Luddite as the technology advances. It may be important to have at least a basic knowledge of the technology, but technological sophistication is only a small part of the required toolkit. When it comes to understanding this particular presentation of adult sexuality, classical Freudian theory offers much that is pertinent regarding the structure of dreams and symptoms, psychosexual development and fetishism. The analytic stance and the analytic setting offer a firm base from which to understand the scenarios the patient creates in his own mind, and the functions which these serve for him.

In the literature there are examples of constructive and benign uses of online sex to educate or to provide avenues for sexual expression for those constrained, for example, by age or disability. From clinical experience, those people presenting for help who are in difficulty with online sex are not using it constructively but defensively, to avoid or substitute for emotional intimacy with another, or to counter inner feelings of deadness, depression or inadequacy.

'This is not the repressed sexuality that Freud and his contemporaries were concerned with.'

Patients with these problems also raise anxieties and technical challenges in the transference and countertransference: when is the patient revealing sensitive material in the service of psychoanalytic exploration, and when is he engaged in an exhibitionistic display, drawing the therapist into the role of voyeur? The relation to the superego is often complex, entailing a thrill in transgression, a triumphing over a weak or collusive superego, and a terror and hatred of a persecutory superego, all of which may be projected onto the therapist. These compulsive sexual behaviours often constitute a manic, sexualised flight from the perils of real engagement with an other, and the therapeutic relationship may present the patient with precisely that situation which they dread: a clearly bounded, intimate relationship marked by contact and separations, vulnerability and dependency. The patient may experience recurrent pressure to take flight by absenting himself, by resorting to sexualised display or by recourse to controlling or seductive behaviours.

When patients report the use of illegal pornographic materials, particularly those depicting minors, the therapist may be faced with further dilemmas about risk and possible obligations to report. Colleagues in a treatment agency in New Zealand have a clear legal framework where, if the image being viewed depicts a child who could be identified and protected, there is an obligation to report this to statutory agencies; if this is not the case then treatment of the person using the pornography may proceed in confidence. A range of indicators suggest that an interest in child abuse images is not the preserve of a few very disturbed people, but is becoming increasingly widespread. This appears to be the result of the accessibility of child pornography on the internet. Quayle (2009) cites reports from one UK Internet Service Provider that in July 2004 they blocked more than 20,000 attempts per day to access child pornography on the internet. Clinical experience shows that, rather than use of child pornography being an unambiguous indicator of entrenched paedophilia and risk of contact sexual abuse of children, for some people there is a gradual slide into looking at illegal pornography driven by a range of psychodynamic processes. There is an urgent need for greater clarity in the legal guidance available to psychotherapists on this subject in the UK, as we have every reason to expect this to become more widespread as a clinical problem and a societal concern. ■

Heather Wood is a Consultant Adult Psychotherapist at the Portman Clinic. Heather will co-present (with Richard Graham and chair Dickon Bevington), 'Virtual worlds & Inner Worlds' at Psychoanalytic Psychotherapy NOW 2010

On The Frontline

Accessible, confidential, adaptable

By Geoffrey Baruch

The Brandon Centre's director recounts 42 years of successfully reaching out to the emotional needs of 12-21 year olds

THE BRANDON CENTRE was founded in 1968 as the London Youth Advisory Centre (LYAC). The Centre, which became known as the Brandon Centre in 1990 in honour of a benefactor, Brandon Cadbury, began as a contraceptive service for 12- to 25- year-old young women. Its founder, Dr Faith Spicer, recognised that young women needed to have access to a service that would allow them to talk through emotional issues that accompanied requests for contraception. At that time, initial appointments were up to 60 minutes in length and follow-up appointments up to 30 minutes – a luxury we can now no longer afford due to the large number of young people requesting appointments. Doctors were encouraged to engage in therapeutic work with young women who needed help with emotional difficulties, and they used a perspective on difficulties in adolescence that was informed by psychoanalysis.

Shortly after the founding of the contraceptive service, due to the scale of the emotional needs of young people in the local community, a psychoanalytic psychotherapy service was started for young women and young men. The contraceptive and sexual health service and the psychotherapy service remain at the core of the Centre's activities: in 2009/10 1,639 young people used the contraceptive and sexual health service, and 301 used the psychotherapy service. A total of 7,179 appointments were offered and 5,679 (79%) were attended. It would be difficult to imagine the psychotherapy service existing without the contraceptive and sexual health service or vice versa. Three overarching goals inform the Centre's approach to psychotherapy. Firstly, a commitment to service delivery in its own right, instead of, for example, service delivery existing to augment training. Secondly, a commitment to measuring outcomes. And thirdly, a commitment to initiating and developing interventions based on what outcome findings tell us about our work – that is, where we are succeeding and where we are failing to help young people. I believe this approach has been attractive to the charitable trusts, public authorities and donors who support the Centre's activities and on whom we depend for voluntary contributions to fund our work.

The Brandon employs six psychoanalytic psychotherapists (including myself) and a child and adolescent psychotherapist. Five of us are registrants of the BPC, including two qualified as adult psychoanalysts and one qualified in both adult and child psychoanalysis. All have previous experience in working with young people in a variety of different roles; for example, as a teacher in secondary schools, as a counsellor in higher education, and as a social worker in hospitals and local authorities. Regardless of their qualification and experience a new psychotherapist can take up to a year to adapt to the patient population seen at the Brandon Centre.

Typically this population experiences many external stressors that are impacting on their internal life and on their capacity to cope with the demands of adolescent development. These stressors include family conflict, abuse, bereavement, poor living arrangements, school and higher education problems, and parental psychiatric disorder and substance misuse. Most of the young people who use our service have no idea of psychotherapy as we understand it, and usually refer to us as 'counsellors', and to our therapeutic intervention as 'counselling'.

Although the age range of the service is now 12 to 21, the service particularly reaches out to 16 to 21 year olds with mental health problems who don't fit into either a child and adolescent mental health service or adult mental health service. The characteristics of the Centre's service have changed little: responsiveness to the mental health needs of young people; accessibility by encouraging self referral in order to make it as easy as possible to get help; confidentiality so that they feel able to reveal their worries and concerns; psychotherapists who are experienced in working with young people and are who are comfortable in adapting psychoanalytic technique for their needs.

Accessibility is key to enabling young people to engage in the service and treatment. We recognise that in seeking help they are typically very anxious about their mental state and how this will be viewed. We make it as easy as possible for them to use the service. I have already mentioned self referral: the young person or a parent on behalf of the young person can phone up, explain the details of the referral, and go on the waiting list, which is four to eight weeks. We refer to young people using their first name and they usually refer to us using our first name. The premises are 'non institutional', comfortable and welcoming. Reception staff, who play an important role in helping young people engage with the service, are friendly without being intrusive.

'We work with some high risk young people who would be less likely to engage with the statutory sector.'

I believe the emphasis on accessibility, confidentiality and therapist adaptability means that we work with some high risk young people who would be less likely to engage with the statutory sector. For example, I recall treating an eighteen-year-old young man who would not give details of his address or GP. He was very depressed and regularly cutting his left arm for emotional relief and as an attack on his parents who he felt didn't care about him. He was encouraged to come to the Centre by his girlfriend. I worked with him for about four months, by which time he had stopped harming himself and wanted to end the therapy. The value of the support of the psychotherapy team in such circumstances cannot be overestimated. Without this support it would be impossible for us to make ourselves emotionally available for the young person's anxieties, pain and, in some but not all cases, self destructive and destructive behaviour. Feedback from young people about their experience of the service confirms how they value the consistent understanding they get from us, which I believe is a unique product of psychoanalytic training. 69% of young people stay for up to 20 sessions, generally ending treatment by then, and 31% stay for longer and engage in long-term therapy.

Since 1993 we have been systematically evaluating mental health outcome from the perspective of the young person, a significant other of their choice, and the therapist. We use internationally recognised measures based on the Achenbach System of Empirically Based Assessment (ASEBA). Young people complete forms at pre-treatment, three months, six months and at 12 months. Nearly 2,000 have completed a form pre-treatment, and nearly 45% have completed a form at three months or at six months or at both time points. Over time we have been fortunate to have the statistical support of three PhD students from UCL Research Department of Clinical, Educational and Health Psychology. We have published our findings in peer reviewed professional journals. The findings are used by the therapists in their clinical work and have strengthened the psychotherapy service. They have also been used to initiate new services for groups of young people who were not benefiting from psychotherapy.

We recently completed the first UK randomised controlled trial (RCT) of Multisystemic therapy (MST), an intensive family-focused intervention aimed at tackling persistent youth offending. We also recently started the first pilot and RCT in the UK of MST for young sexual offenders funded by the Department of Health and Youth Justice Board. We are one of a number of units participating in IMPACT, a national trial testing whether Cognitive Behaviour Therapy (CBT) or Short Term Psychoanalytic Psychotherapy is superior to Specialist Clinical Care in preventing relapse in the long term among depressed adolescents. We also run parent management training for parents of younger teenagers presenting with challenging behaviour.

I believe with our core services of psychoanalytic psychotherapy and contraception and sexual health, the presence of these interventions and our commitment to evaluation make the Brandon Centre an exciting and vibrant service. ■

Geoffrey Baruch is director the Brandon Centre and a Fellow of the Institute of Psychoanalysis

PSYCHOANALYTIC PSYCHOTHERAPY NOW 2010

PSYCHOANALYSIS HAS found its place among the range of therapeutic and cultural approaches to modern life. The pressure to find pragmatic solutions to many of the common problems thrown up by social realities has risked marginalizing this approach; some have feared it might even be forgotten. But as the accelerating rate of social change creates new complexities, psychoanalytic approaches have found a natural, if challenging, habitat.

The conference will review some of the domains where the psychodynamic orientation is proving invaluable because it rejects the obvious and the superficial, and others where it is tenaciously struggling with challenges. These include: traditional concerns such as psychosexuality and development; issues arising from a changing society such as the complex family, and the impact of urbanisation on development; the consequences of the nature and pace of change for psychopathologies such as severe disorders of the self.

Psychoanalytic Psychotherapy NOW 2010 will seek to define new priorities and adventurously explore issues that need to be grappled with for all of us to have a genuine experience of our world.

Welcome and introduction
Malcolm Allen
Bruce Calderwood, Director of Mental Health and Learning Disabilities, Department of Health

The Contribution of Psychoanalytic Thinking to Complexity
Chair M Fakhry Davids
Complexity: a developmental perspective
Peter Hobson
Trauma and complexity in modern ethnic conflicts
Vamik D Volkan

Complex Problems, Complex Situations: Breakout Sessions

1. Complex mental disorders: what works?
Chair: Ronald Doctor; Presentations: Peter Tyrer, Peter Fonagy

2. Complexity and chaos, containment and constraint
Facilitators: Nick Benefield, Rex Haigh

3. Complex connections: virtual worlds & inner worlds
Chair: Dickon Bevington; Presentations: Heather Wood, Richard Graham

4. Complex lives
Chair: Matthew Patrick; Presentations: Camila Batmanghelidjh, Lisa Baraitser

5. Complex interdependencies
Chair: Beverley Tydeman; Presentations: Susanna Abse, Jean Knox

6. Complexity in the curriculum: sexuality in psychoanalytic training
Chair: Mary Target; Presentations: Justin Richardson, David Morgan

Creating a Modern Profession for a Diverse and Complex World
Chair: David Bell; Presentations: Malcolm Allen, Helen Morgan

Breakout Sessions:

1. Why so white?
Chair: Helen Morgan; Presentations: Kamaldeep Bhui, Frank Lowe

2. Homosexuality – moving on
Facilitators: Jeremy Clarke, Mary Target, Trudy Klauber, Leezah Hertzmann, Justin Richardson

3. Working through conflict
Presentations Vamik D Volkan Andrew Cooper

4. Focus on primary care
Chair: Mary Burd; Presentations: Brian Rock, Nick Wood

5. 'Product' and 'brand' in a contemporary mental health market
Chair: Jenny Hyatt; Presentations: Alessandra, Lemma, Chris Mace

6. Training for tomorrow
Chair: Sally Griffin; Presentations: Horst Kächele, James Johnston

Moving Forward
Report-backs and discussion
Chair Julian Lousada

Reception and Awards Ceremony
Hosted by Kathy Lette, international bestselling author

Organised by the British Psychoanalytic Council
in association with:
Albany Trust
Anna Freud Centre
Association for Psychoanalytic Psychotherapy in the NHS
Association of Child Psychotherapists
British Association of Psychotherapists
British Psychological Society, Division of Clinical Psychology
British Society of Couple Psychotherapists and Counsellors / Tavistock Centre for Couple Relationships
Institute of Group Analysis
International Neuropsychoanalysis Centre
The Institute of Psychoanalysis (BPAS)
Lincoln Clinic and Centre for Psychotherapy
London Centre for Psychotherapy
The Maya Centre
North of England Association of Psychoanalytic Psychotherapists
North West Institute of Dynamic Psychotherapy
Northern Ireland Association for the Study of Psychoanalysis
Scottish Institute of Human Relations / Scottish Association of Psychoanalytic Psychotherapists
Severnside Institute for Psychotherapy
The Society of Analytical Psychology
Tavistock and Portman NHS Foundation Trust
Tavistock Society of Psychotherapists
wpf Therapy / Foundation for Psychotherapy and Counselling

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Awards

The Psychoanalytic Psychotherapy NOW conference will once again feature an awards ceremony to celebrate achievement in the psychoanalytic community. Two of the awards presented last year are on a two-yearly basis and so will be presented next year. The three awards for this year will be:

Early Career Achievement Award
This award recognises an outstanding contribution to advancing psychoanalytic knowledge or practice from someone in the early stages of their career as a psychoanalytic or psychodynamic practitioner (normally within 7 years from qualification). The award will be to an individual for a contribution within a period of 3 years before the award.

Award for Innovative Excellence
This award celebrates a striking example of ground-breaking work. The innovative nature of the work could be in terms of clinical practice (e.g., new psychoanalytically-informed treatment approaches), research, or socially inclusive practice (e.g., working with sections of the community who may traditionally find access to therapeutic treatment difficult). The award will be to an individual or project or organisation for innovative work conducted within a period of 3 years before the award.

Psychoanalysis and Culture Award
This is an award to someone outside the profession for a special contribution to the understanding of psychoanalytic or psychodynamic work (broadly understood) through a cultural work (in its widest sense). The work could be a novel, a play, a newspaper or magazine article, a piece of music, a film or TV programme or any other cultural form.The award will be to an individual or group for work produced or presented within a period of 3 years before the award.

Nominations for the awards
Nominations can come from individuals or groups and all nominations will be considered by the Panel on their merit independent of the number of supporting letters. Nominations should be no longer than 250 words presenting succinctly the reasons why an individual, group, project or organisation should receive a particular award. Where relevant the nomination should identify evidence the Panel can consult in relation to specific achievements.

The awards are focused on the UK. Individual award recipients will live or work primarily in the UK; groups, projects or organisations will be based in the UK. The awards are honorific, with a commemorative object to be presented at the ceremony by the chair of the respective selection panel.

Nominations for each award will need to reach the BPC office by **Friday, 30 July:** mail@psychoanalytic-council.org

Diary

JULY

7 July - 22 August 2010
PATIENTS, PORTRAITS AND PSYCHIATRISTS
Freud Museum, London
Collaboration: Artist Gemma Anderson & Forensic Psychiatrist Dr Tim McInerny
Contact: Front of House, 020 7435 2002
alexandfrancisco@freud.org.uk

11 July - 22 August 2010
PATIENTS, PORTRAITS AND PSYCHIATRISTS
Exhibition: Freud Museum, London
Collaboration: Artist Gemma Anderson & Forensic Psychiatrist Dr Tim McInerny
Contact: Front of House, 020 7435 2002
alexandfrancisco@freud.org.uk

11 July - 29 August 2010
LAUDERDALE MANSIONS/HA'ATZMAUT
Exhibition: Freud Museum, London
Artist: Judy Goldhill
Contact: Front of House, 020 7435 2002
alexandfrancisco@freud.org.uk

17 July 2010
OPEN MEETING: Prof. Doctorate in Psychoanalytic Psychotherapy/ Prof. Doctorate in Analytical Psychology
London Centre for Psychotherapy, NW5
2.00-4.00pm
Contact: Dr Matt ffytche, mffytche@essex.ac.uk or Paulene Ford, cpsasst@essex.ac.uk 01206 874554

19 July 2010
UNDER THE SKIN: A PSYCHOANALYTIC STUDY OF BODY MODIFICATION
London Centre for Psychotherapy
Speaker: Alessandra Lemma
Contact: LCP, 020 7482 2002,
info@lcp-psychotherapy.org.uk
www.lcp-psychotherapy.org.uk

24-25 July 2010
11TH INTERNATIONAL NEUROPSYCHOANALYSIS CONGRESS
University of Washington, Seattle
Neuropsychoanalytic Perspectives on Play
Contact: 020 7482 6999,
admin@neuro-psa.org www.neuro-psa.org.uk

SEPTEMBER

3-5 September 2010
UKCP CONFERENCE 2010
York University
Speaker: Emily Cooper
Contact: info@ukcp.org.uk, 020 7014 9955
www.ukcp.org.uk

9 September - 6 November 2010
HOUSE OF GAMES
Almeida Theatre, London
Production team: Lindsay Posner, Richard Bean, David Mamet
www.almeida.co.uk

17 Sept 2010 to 15 July 2011
SCREEN MEMORIES: IGA/GAS monthly film Group
Institute of Group Analysis, London
Contact: 020 7431 2693,
iga@igalondon.org.uk
www.groupanalysis.org

18 September 2010
SEXUAL ABUSE AND TRAUMA: The impact on the emotional life of the child and the subsequent adult
Danson Room, Trinity College,
Broad Street, Oxford
Speaker: Judith Trowell
Contact: 0118 9663993, wessex.
publicevents@bap-psychotherapy.org

19 September 2010
FILM AND DISCUSSION: City Lights, dir. Charlie Chaplin 1931
Institute of Contemporary Arts, London
Speakers: Andrea Sabbadini and Michael Brearley
Contact: Ann Glynn, 020 7563 5017
ann.glynn@iopa.org.uk

24 September 2010
ONE CASE: THREE PERSPECTIVES
Tavistock Centre, London NW3
Speakers: Brett Kahr, Jenny Riddell, David Hewison
Contact: 01728 689090,
info@confer.uk.com www.confer.uk.com

24 September 2010
INAUGURAL DAVID CAMPBELL MEMORIAL CONFERENCE: The experience and development of systemic supervision
Tavistock Centre, London NW3
Contact: 020 8938 2548,
events@tavi-port.org
www.tavistockandportman.ac.uk

25 September 2010
DISTURBING COUNTERTRANSFERENCE WITH FORENSIC PATIENTS
Tavistock Centre, London NW3
Speakers: John Gordon, Anna Motz
Contact: 01728 689090,
info@confer.uk.com www.confer.uk.com

25 September 2010
CRITIQUE OF THE USES OF TRANSFERENCE: Transference complexity in cases of dissociative identity disorder
Tavistock Centre, London NW3
Speakers: Andrew Samuels and Valerie Sinason
Contact: 01728 689090,
info@confer.uk.com www.confer.uk.com

25 September 2010
PSYCHOANALYTIC FORUM: Internal and External Migration in Culture and Society
The Institute of Psychoanalysis, London
Speakers: Michael Rustin and Peter Loizos. Chair, Arturo Varchevker
Contact: Ann Glynn, 020 7563 5017
ann.glynn@iopa.org.uk

25 September 2010
SETTING UP IN PRIVATE PRACTICE
23 Magdalen Street, London SE1
Workshop Leader: Brett Morris
Contact: Mayra Angulo, 020 7378 2054
mayra.angulo@wpf.org.uk

25 September 2010
EQUAL OPPORTUNITIES POLICIES: ARE THEY USEFUL?
Society of Analytical Psychology, 1 Daleham Gardens, London NW3 5BY
Speakers: Dr Farhad Dalal
Contact: Claire Hazelwood,
020 7 435 7696, claire@thesap.org.uk

OCTOBER

1-3 October 2010
WORKING WITH OTHERS: Risk, Conflict & Creativity
British Association of Psychotherapists
Speakers: Francesca Cardona, Miranda Feuchtwang, Sebastian Kohon, Liz Omand, Anne Marie Reilly, Judith Trowell
Contact: admin@bap-psychotherapy.org
020 8452 9823

8 October 2010
'IN TREATMENT' SYMPOSIUM
Cruciform Lecture Theatre, UCL
Justin Richardson, Keith Bunin, Sarah Treem, Chair: Brett Kahr
Contact: BPC, 020 7561 9240
mail@psychoanalytic-council.org
www.psychoanalytic-council.org

9 October 2010
PSYCHOANALYTIC PSYCHOTHERAPY NOW
Mermaid Theatre, Blackfriars, London
'Meeting the challenge of complexity together'
Contact: BPC, 020 7561 9240
mail@psychoanalytic-council.org
www.psychoanalytic-council.org

10 October 2010
FILM AND DISCUSSION: Magnificent Obsession, dir. Douglas Sirk 1954
Institute of Contemporary Arts, London
Speakers: Andrea Sabbadini, Peter Evans
Contact: Ann Glynn, 020 7563 5017
ann.glynn@iopa.org.uk

15 October 2010
BETWEEN BODY AND MIND?
Royal Geographical Society, 1 Kensington Gore, London SW7
Speakers: Ronald Britton, Peter Hobson
Contact: 020 7563 5016
www.psychoanalysis.org.uk

16 October 2010
DREAMS AND DREAMING: A USER'S MANUAL
23 Magdalen Street, London SE1
Workshop Leader: Francesca Raphael
Contact: Mayra Angulo, 020 7378 2054
mayra.angulo@wpf.org.uk

16 October 2010
LCP ANNUAL LECTURE - SEXUALITY
London Centre for Psychotherapy, NW5
Speaker: Rosine Jozef Perelberg
Contact: LCP Office 020 7482 2002/2282

16 October 2010
KLEIN-LACAN DIALOGUES: INTRODUCTION
Sir David Davies Lecture Theatre, Roberts Building, UCL, London
Speakers: Catalina Bronstein and Bernard Burgoyne
Contact: n.harding@ucl.ac.uk

16-17 October 2010
ENGAGING WITH CLIMATE CHANGE: PSYCHOANALYTIC PERSPECTIVES
Institute of Psychoanalysis, London, W9
Speakers include psychoanalysts, scientists, environmentalists, writers, educationalists and policy makers
Contact: 020 7563 5016
www.psychoanalysis.org.uk

23 October 2010
GANGS, DEBT, AND THE ABSENT FATHER: The culture of violence in adolescence
Armarda House, Telephone Ave, Bristol
Speaker: Donald Campbell
Contact: John Lynch, 0117 927 3898
administrator@sipsychotherapy.org
www.sipsychotherapy.org

23 October 2010
MASCULINITY AND THE OEDIPUS COMPLEX
London Centre for Psychotherapy, NW5
Speaker: Brid Greally
Contact: LCP office 020 7482 2002/2282

31 October 2010
FILM AND DISCUSSION: Land of Silence and Darkness, dir. Werner Herzog 1971
Institute of Contemporary Arts, London
Speakers: Andrea Sabbadini and Ken Robinson
Contact: Ann Glynn, 020 7563 5017
ann.glynn@iopa.org.uk

From October 2010
PSYCHOANALYSIS: THE UNCONSCIOUS IN EVERYDAY LIFE
Science Museum, London
www.psychoanalysis.org.uk

NOVEMBER

13 November 2010
'DON'T BRING ME DOWN': WORKING WITH DEPRESSION IN COUPLES
TCCR, 70 Warren Street, London W1
Speakers: Alessandra Lemma, Peta Mees, Christopher Clulow
Contact: Matt Williams, 020 7380 1975, mwilliams@tccr.org.uk

17-19 November 2010
TRANSFERENCE-FOCUSED PSYCHOTHERAPY
Longford Park Athletic Stadium, Manchester
Speaker: Frank E. Yeomans
Contact: Denise Coggins, 0161 205 7555/ 7506, denise.coggins@mhsc.nhs.uk

20 November 2010
GETTING TO GRIPS WITH ONCE-WEEKLY THERAPY: Exploring Aspects of Technique
23 Magdalen Street, London SE1
Workshop Leader: Brett Morris
Contact: Mayra Angulo, 020 7378 2054
mayra.angulo@wpf.org.uk

21 November 2010
FILM AND DISCUSSION: Blind Loves, dir.Juraj Lehotsky 2008
Institute of Contemporary Arts, London
Speaker: Andrea Sabbadini
Contact: Ann Glynn, 020 7563 5017
ann.glynn@iopa.org.uk

FORTHCOMING EVENTS

2-3 December 2010
PSYCHOLOGICAL THERAPIES IN THE NHS
Savoy Place, London WC2R
Contact: www.newsavoypartnership.org
www.psychoanalytic-council.org

Review

KISSING EXPOSED TO THE GAZE

How concepts of transference and the semiotics of photography stop Laura Gonzalez in her tracks: uncovering the phenomenology of the gaze at Tate Modern's Exposed: Voyeurisms, Surveillance and the Camera

The new exhibition at Tate Modern, *Exposed: Voyeurism, Surveillance and the Camera*, is structured around five themes: the unseen photographer (with a display of divinely surreptitious devices), celebrity, voyeurism, violence and surveillance. All the images in the show have something in common: they point to the fact that our involvement in the act of looking begs reflection. Yet, it would be impossible to analyse in depth the rich connections between the photographs exhibited and psychoanalysis – and for that reason I urge a visit to the show before it closes on 3 October 2010 – so, in the name of free association, I will explore the first thought I had when I engaged with these images.

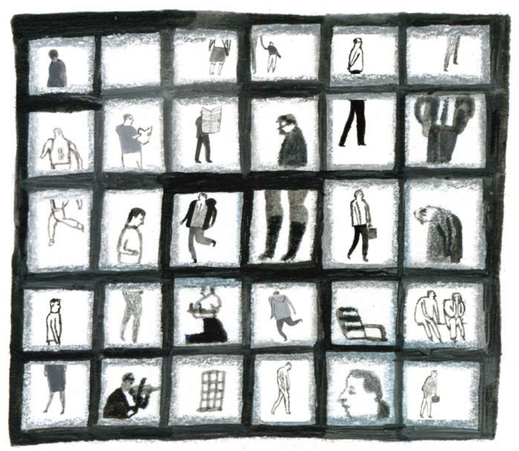
A fair amount of the work captures couples in the act of kissing, an act that has both public and private dimensions. There is one by Marcello Geppetti showing Richard Burton and Elizabeth Taylor on the beach, reminding us of the time when seeing the private moments of public people became a socially acceptable activity and being a paparazzo became a profession. Nan Goldin's epic *The Ballad of Sexual Dependency*, a slide show with images taken over 30 years, displays a few shots of her friends and acquaintances touching lips. We see a mirror reflection of a couple kissing in bed in Brassaï's *Chez Suzy*, a series depicting brothel life.

Most notably, there is a series of exquisite images by a photographer named Arthur Fellig, better known as Weegee. They depict couples kissing in theatres, or at the movies. Out of these *Audience in the Palace Theatre* (1943) stands out. It shows the half-filled seats of the venue, in the same diagonal angle one takes when approaching the lips of one's lover. Amongst the empty seats and the concentrating audience, a young man and woman have eyes only for each other. They are oblivious to the performance – which everyone else is watching attentively, engaged, even smiling – the people in the theatre, and the photographer, his gaze remaining unseen by his subjects. There could not be more contrast between this scene and that depicted by Garry Winogrand (entitled *New York*, 1969), also in black and white. Here, the kissing couple is in the street, half concealed in what seems the recess in a shop. One of them is engrossed in the physicality of the act while the other, the girl, cigarette in hand, looks directly at the camera. Close to them, a third person, a girl in a dark T-shirt and white shorts, also acknowledges the photographer with her look.

Photographs depict scenes, but they are made of stuff, they are material. Yet, the shades of grey created by the silver gelatin of the photographic print, when arranged in the manner of Winogrand's image, look at us. Moreover, I would say that the framed paper displayed at the Tate Modern addresses me directly, makes me stop in my tracks. What is it about these two images that has such an impact in me?

Gaze may help us find an answer. Jacques Lacan considered it to be one of the four fundamental concepts of psychoanalysis. It is certainly present in the consulting room. When the analysand takes her place on the couch, the analyst sits behind her, out of sight. He is absent and present at the same time; the analysand cannot see him, but feels looked at. In this way, gaze plays an important part in transference, the complex relationship between analyst and analysand. But it also operates in the field of vision.

As the partial object of the scopic drive, gaze cannot be assimilated and has no representation; it is an essence-less object, an area of analytical impossibility and theoretical resistance. Lacan separated it from the concept of the look, the latter being concerned with the organ of sight and related to the subject. By extension, he placed gaze on the side of the object, in particular of *Objet Petit a*, which is not the object to which desire is directed, but what causes desire. And desire is what is at play in the rooms at Tate Modern.



Garry Winogrand, *New York*, 1969
Gelatin silver print 11 x 14 in. San Francisco Museum of Modern Art, and promised gift of Dorta Emi and Rich Silverstein
© Estate of Garry Winogrand, courtesy Fraenkel Gallery, San Francisco

'Gaze is an area of analytical impossibility and theoretical resistance.'

In the dialectic of the eye and the gaze, Lacan warns us that 'there is no coincidence, but, on the contrary, a lure.' Moreover, he establishes the pre-existence of the gaze and its lure with the phenomenological argument: 'I see only from one point, but in my existence I am looked at from all sides.' It has, thus, the function of interpellation, as it is related to the experiences of addressing and being addressed. The latter is imposed from the outside and cannot be readily defended against. For that reason, gaze can become invasive and threatening, as the section on surveillance in this exhibition shows. When the gaze of the photographer – through the camera – is made visible to the subject, the phenomenon of the pose, and its performativity, occurs. This is what the girl in the dark T-shirt in Winogrand's photograph is engaged in.

In her 1977 book *On Photography*, Susan Sontag wrote that photographs are pieces of the world, more than statements about it. They relate to desire and the erotic feelings aroused by unattainability and distance. When one encounters a photograph, one encounters an object of fascination. To photograph is to participate through active observing, she argues, 'like sexual voyeurism, it is a way of at least tacitly, often explicitly, encouraging whatever is going on to keep on happening.' Photographs certify experience, but also resist engaging with it directly; they limit experience by converting it into an image. Photography has resistance embedded in its process. Moreover, it demands exclusivity, full attention, if the powers of observation of the photographer are to be improved. Photographs make us see, but, in that process, they demand that we surrender to its product. It is the ambiguity of the engagement with the experience, its tyrannical demand for attention and the resistance embedded within it, that make it an ideal form for capturing the seduction involved in kissing.

Yet, all of this refers to the *studium* of the images – to bring about French semiotician Roland Barthes' analysis of photography in *Camera Lucida* – their obvious symbolic meaning and, as such, do not explain what makes these images so compelling for me above all the others in the show. To find that out, I must seek the *punctum*, that which pierces me as a viewer, provoking an unexpected emotional response. I look at Weegee's image, intensely, without blinking, and an amorphous form to left of the kissing girl – her light coat ¬– takes on the significance of abandonment that gives me so much pleasure in this image. If I look at some of the other photographs in his series, the *punctum* emerges in a blurred head in the foreground or some comical 3D-type glasses worn by the audience, but not the kissers. The cigarette in Winogrand's girl hand – I must be identifying with girls – makes me taste how the kiss must seem to the boy. These are elements of the image that are off centre, but it is in them one finds the gaze, just as in the analytic room, meaning is found in the peripheral, in the form of, for example, unintended acts or mispronounced words. ■

Until 3 October 2010
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