OUTWRITE

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Acknowledgments

1) The photograph on the front cover is by **Jessica Evans**. Its subject matter is an ironic comment on the following passage from John Berger's novel *A Fortunate Man*:

> John Sassall is a country doctor. He is also a man with a passion for knowledge. In the remote rural community where he works Sassall daily confronts birth, anguish and death. This intimate contact with his patients results in him being attributed with the power of the clerk of the records. He is therefore a man who can speak what his deprived community can only feel and know in an inarticulate fashion.

2) The engravings in this issue derive from Thomas Gibson's *The Anatomy of Humane Bodies Epitomised*, London 1694.

3) The rest of the illustrations are made by Michael Evans who also took the photograph of Chardin's *La Raie*, the original of which is to be found in The Louvre, Paris.

Editorial

Poets have often made great claims for literature. Shelley in a famous moment of hyperbole claimed that 'poets are the legislators of mankind.' More seriously he argued that poetry was a means of defending what is properly human against the assualts of a narrow, technico-scientific, calculating logic.

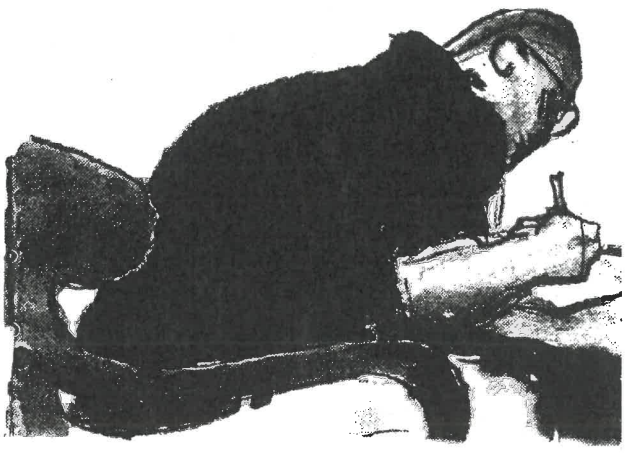
Both in literature itself and in the thinking of writers about their art we may find illumination and resonance with psychotherapy. Imaginative writing is not easily yoked to the strictures of a utiliarian framework. It is opposed to a single, unified view of the world but delights in unexpected connections. It enjoys ambiguity and strangeness and embraces and reveals the unconscious. It ranges across the whole of human experience giving it form and expression in new and subtle ways.

Most psychotherapists appreciate the contribution literature and art bring to their work. Nonetheless, the dominant framework for thinking about psychotherapy remains scientific- or as some would have it, pseudo-scientific. Whether psychotherapy should owe its allegiance to science or to art is a continuing debate which the writers of this issue approach in a variety of ways.

Peter Lomas and Michael Evans engage with the subject head-on while in their personal and imaginative discussions of spirituality and of Chardin's paintings, Glenys Plummer and Pamela Arriens draw clearly on the strengths of artistic and literary sensibility. Pat Tate's description of the work of a Balint group amongst G.P.s emphasises the importance of bringing something subtle and human - an art perhaps - into the scientific and medical world of the doctor.

These questions - of art, science, sensibility and technique - are crucial to our work and we would welcome your thoughts on them. Is science the essential, intellectual heart of the matter, as Freud wished it to be? Or is the relation of science to psychotherapy more like that of linguistics to literature? Interesting, but not necessary in writing a poem or reading a novel. Let us know what you think - in letters, articles, poems, stories or illustrations.

Rosemary Randall and Michael Evans



Glenys Plummer

Meaning: reflections on an ancient culture, modern living and psychotherapy

Recently, I caught a train which traversed the Continent of Australia, from Sydney on the east coast to Perth on the west coast. This was a journey of some 4,400 kilometres which took 72 hours - a lot of time for a free associative state of mind. I had requested a single compartment and without the distractions of responsibility I was free to explore and move around in my own thoughts.

As the train travelled steadily across the green-grey ochre anchored stillness of the Nullabor Plain, my imagination played with the emptiness outside the train, setting Aborigines in the landscape with the emus and kangaroos, imagining how they might have moved in this seemingly barren and stony land. The book I was reading at the time described the nature of their culture; socially ordered and rich in strange mythology. This order and mythology created connective bonds to their tribes and clans,[1] to their totemic ancestor, to the land and to the cosmos.

It was a materially simple and spiritually complex culture that remained relatively unchanging from the Stone Age until white settlers arrived from Great Britain in 1788. It was an ordered culture, with the Aborigines identifying themselves 'according to kinship, marriage, territory, totemism, language and ceremony'. (Gowan 1992: 63) These were clear social structures. In particular the symbolic identification with the relevant Dreaming ancestor, their totem, which could be plant, animal or element, created harmony with the natural world. This totemic identification reflected back to them their ideal form and connected them to the land in powerful spiritual bonds. They seem to have had mystical access to the bonds that connect all elements to each other. An Aborigine without these connections, particularly the totemic identification, is an Aborigine devoid of his spirituality. He has no inner life or connection to creation. These connections are expressed symbolically through ritualistic dance and most poignantly around the time of death. A dying man is said to make movements imitating his totem. In this way 'he is becoming like his totem'. (Gowan, 1992: 113) The dying man can now merge with his Dreaming or his source, and rejoin the supernatural realm.

> All rite and ritual is directed towards binding the spirit to the body, making them one, a whole, and then allowing them to separate without rupture. Life in its contingency supports the existence of a celestial landscape, a landscape made up of an all-pervading spiritual reality which underpins the cosmos. At the time of death this relationship is brought into sharp relief and acknowledged, making it possible for Aborigines to join with the Sky Heroes, those invisible spirit entities who orchestrate these spiritual forces in serving note that the universe is indeed one rich and undivided whole. (Gowan 1992: 125)

My train stopped at Kalgoorlie, a mining town, and a group of Aborigines, grubby and unkempt, arrived at the station to board the train. Seeing them I felt beset in my mental wanderings with an intense disturbance. The contrast between the literary account and the modern day reality seemed so great. I perceived there a loss of an intricate and meaningful culture involving a dissociation from the old ways and their law.

So how did this culture begin to break down? An English missionary wrote in 1840:

> On this river the effect upon the Aborigines of the occupation by Europeans of the country was forcibly presented. Before the occupation of this district by colonists, the Aborigines could never have been at a loss for the necessities of life...

> But when the country was taken up, and herds of cattle introduced, not only did the cattle drive away the kangaroos, but those who had charge of the cattle found it necessary to keep the Aborigines away from the river...After some fatal conflicts in which some colonists and many Aborigines were slain, the blacks have been awed into submission...And what is the consequence? Black fellows coming in from the west report that last summer very large numbers, afraid to visit the river, were crowded round a few scanty waterholes, within a day's walk of which it was impossible to get sufficient food...that owing to these combined hardships many died. (Reynolds 1981:67)

The white Europeans had a belief that their culture was superior. There developed a deliberate political and social policy of breeding out the inferior and savage 'native' race. Children, in large numbers, were forcibly removed from their families, placed in orphanages or used for domestic labour, with a view to diluting the race with European marriages. The Aborigines accepted their subordinate position and the culture weakened as they readily absorbed European culture into their own, bringing about further dilution. Loss of dignity resulted.

Recent Australian governments have returned certain sacred sites to the Aborigines and in certain places there has been some attempt at social integration. There remains however deep fracture in the culture, especially in urban areas, with an imposition of white ways and a denial of the need of the Aborigines to belong in their tribes and clans. Where there exists a well-intentioned policy of social integration, crime rates are high and some materially disadvantaged white Australians are resenting the recent gains of the blacks.

Dissociation from old ways and the meaning in them is by no means confined to the Australian Aborigines. Many ancient cultures have been all but destroyed by modern progress and this is probably inevitable to some extent if civilisation is to advance. Is it inevitable however that modern white culture is assumed superior? Is it inevitable that, in the civilising process, instinctive elements that involve meaning and relatedness are lost?

Meaning

> Meaning is invisible, but the invisible is not contradictory of the visible: the visible itself has an invisible inner framework, and the in-visible is the secret counterpart of the visible. (Merleau Ponty)

Meaning, as a concept feels to me too complex, too difficult to define or simplify, especially in a brief article such as this. What do I mean by 'meaning'? There seem to be many levels of interpretation. Here I am exploring the level of existential meaning. How do we experience meaning and how do we attune to the psychological significance (if there is any) of events we live through? Do we create meaning and apply it to events or is there meaning inherent in events? Is there perhaps a mixture of creative application of meaning together with some sort of keying into or attunement with an already existing energy?

An American writer, Ken Wilber, has written comprehensively on meaning in a number of books over a number of years. (See for example, Wilber 1997). He writes about the developmental matters of living, the expansion of consciousness, the transcending of psychological limitations, emphasising the integration of spiritual processes with psychotherapy. He suggests that those who choose to so engage may participate in the evolutionary process, expanding our psychology by tolerating our primitive aspects and envisioning the transcendent. By accepting and tolerating our internal struggles, we learn and grow. And if we maintain relatedness to the many levels of our contexts, we can experience purpose and meaning. As an easily accessible example, my train journey from Sydney to Perth had layers of meaning. It was achieving a number of purposes. I needed to travel to Perth - this purpose was fairly functional. I have travelled in an aeroplane many times before but not travelled for three days in a train. Here was a new experience - for me, more meaning. The journey was an experience, free of responsibility. This led into the meaning gained by having the time and space to contemplate and integrate the very complex experiences I'd had in the previous fortnight during my return to my homeland. There was space within the small compartment to think about the material I was reading in my book and to extend that experience imaginatively outwards to the context of the surrounding terrain. And all the while I was participating in the life and routine of the train culture as part of life in Australia, together with remaining emotionally and spiritually bonded to my husband and daughters and life in England, 13,000 miles away. Through an imaginative empathy there was an even greater context, that of a sense of spiritual connection to the mysticism of the traditional Aboriginal culture.

Wilber suggests that, although each of us has a narrow perspective on life, we can still create meaning in the engagement with that perspective. And we can experience *deeper* meaning if we open our minds to the complexities and breadth of what there is, and to perceive in an integrated way rather than in a dissociated way. His challenge is to see and engage with the parts, and to be open to the whole.

It is my idea here that we can experience meaning in the *process* itself of integration and connection. If one's mind and soul are integrated in one's body, if one feels the emotions, tolerates and engages with the conflicts, and if one contemplates the purpose of things and connects with the layers of context, one both creates individual and personal meaning and resonates intuitively with higher order meaning, which may be beyond ordinary understanding.

Modern living and psychotherapy

Carl Jung, towards the end of his life wrote:

> Primitive man was much more governed by his instincts than are his 'rational' descendants, who have learnt to control themselves. In this civilising process we have increasingly divided our consciousness from the deeper instinctive strata of the human psyche, and even ultimately from the somatic basis of the psychic phenomenon. (Jung 1964:36)

The Aborigines, before white settlement, resisted external change and complexity, leaving abundant space for experience of meaning in the instinctive inner life. Like Freud, Jung saw instincts as biological - urges that exist inherently and are perceived by the senses. Attachment is an instinct, as are self-protection, aggression and the urge to procreate. These are aspects of our libidinal energy. Jung diverges from Freud in the realm of the unconscious and spirituality. Freud saw spirituality as defensively transformative of oedipal desires whereas Jung saw it as an instinct unto itself. He noted that all civilisations have had a religion of some kind, 'an inherent striving towards a relationship with something or someone...a higher power.' (Hopcke 1989:66) This experience of relatedness to a higher power can also involve a sense of deeper level relatedness to each other, as on the level of the archetypes - those instinctual patterns of behaviour we all share, and therefore through which we are connected.

The spiritual context for the Aborigines was mystical, involving the belief and experience of the connectedness of all things. Some people today do experience this sort of connectedness but it often requires retreat from modern material living. So what is it about modern living which can disallow the coexistence of spiritual living and materialism? Loss of meaning for the Aborigines through loss of connectedness is not too distinct from the loss of meaning in modern living.

In relation to the impressive and fast moving advances of the technological revolution, we are both master and slave. Computer technology can be a great communication asset (I can e mail my friends in Australia at night and receive a reply by the next morning). It can also be a liability when the printer is broken and the busy computer company send the wrong replacement part. The internet, too, is a great paradox; a metaphor for the potential of connectedness, yet it can be an unreal form of relating. There has been a development of a parallel universe of virtual reality. Some people I meet who work in business seem to have a way of thinking which almost mimics a computer - rapid and impersonal, almost un-relating. This way of thinking is quite different from the deeper contemplative thinking on our human experience and matters of the soul, which to my mind is central in processes of integration and the meaning experienced in those processes.

What I see to be overpopulation of this region of the UK can lead to competitive living, with many people working long hours in order at least to cover expenses and sometimes to make lots of money for more material comfort. The political trend, initiated in the 1980's of an individualistic, competitive ethos - 'there is no such thing as society' (Thatcher, 1987) - has developed, in my view, into an almost narcissistic society, where many people live and earn for their external image, to the detriment of the deep internal energies of what I see as instinctive relational needs, involving care, tenderness and love. The instinctual search for meaning through connectedness with soul, for many, is divided and dissociated from ordinary living. There is a void of meaning. Living on the surface dulls the deep flame of spirit, the essence of understanding and experiencing who we are. Whatever the forces which are determining the modern pace, fast and pressured living leaves little time for this inner contemplative life.

An integrated inner life - mind, soul and body - partly involves feeling comfortable and at one in one's body. A mind, of course, is more than a brain, it is the personalisation of neural processes. But is the mind experienced just in the head, or in one's whole being? I see our being as involving soul, both individual and collective. It is the divine matrix within us wherein we can seek some integration with the purpose and meaning of our existence. Mind and soul are experienced in a body and if this body is tense and blocked with defenses, mind and soul become dissociated. Living in the head is living partially; but, equally, living in a body without thought and mind is also living partially.

It is my understanding that psychotherapy is about integration. We aim to accompany people on a journey of re-integrating into a fluid psyche the previously unbearable elements of experience. If our patients (and ourselves) can tolerate the resulting pains and anxieties, they can feel more whole. When we feel whole, Jung suggests that the

principle of self-regulation will operate, (for instance, on a physiological level, the sympathetic branch of the autonomic nervous system - which is action oriented - is balanced by the restorative function of the parasympathetic nervous system). If we can live in this balanced and fluid way we are more able to reflect upon experience and the meaning of it, and be open to forces greater than ourselves.

When we therapists are open to experience, are we then able to recognise not just the neurotic and psychotic symptoms we are trained to recognise, but also the unconscious instinct of a need of meaning in living, a need of integration with our soul, a need of a sense of connection, purpose and belonging?

Recently in my practice I was being referred a number of people diagnosed with depression. One of them, Martin, described the chronic endogenous depression suffered by himself, his siblings, father and grandfather. It was at its worst after a bereavement and an illness. (Later we worked with the difference between depression and mourning.) He also told me he felt something was missing. His own association was, 'I am so logical, I believe we're born, we die. I envy religious people'

Although Martin was in a relationship, he felt unhappy and unfulfilled and sought e mail relationships with women. He thought that people do not have a central cohesive self and that we are what we are according to the demands of the environment. He lived from the outside of himself, the surface, with a focus on external matters only, which involved him acting in response to others' requirements. He said he had no feelings, except when he was swimming; this he enjoyed. The transference situation initially was greatly uncomfortable for me, as his rational, logical orientation to living was accompanied by an omnipotent expectation that I would fit into his linear perception of how things were, that I should be perfect and that my understanding of his depression would be immediate. Any failure on my part brought about his 'sinking feeling' and a return to his depression. I decided that the blank screen stance mirrored his inner landscape too painfully and that I might try being more appropriately 'real' in the sessions. I offered my perception that I sensed great sadness in him and that I thought his depression was not genetic and that I thought we could work with this depression. In the next session he reported a dream in which he was leaning on me and crying, following which the therapy became more solid and accessible. We had something from inside him to grapple with. However, the incident that most brought the therapy alive and seemed to spark his inner life into acceptability involved him telling me about a fantasy he was having about me. He felt that he was a little boy and wanted to look up my skirt. In my counter-transference he did feel like a little boy, and in response to his laughter I allowed myself to laugh, evaluating that his laughter was not defensive. This experience of spontaneous laughter was pivotal for him in feeling that his internal world was acceptable and of value, and from there he felt more able to relax into a process of accepting his conflicts. We spent weeks and months engaged in a transference relationship where I seemed to represent a merged mother/ grandmother over whom he kept control with his intense eye contact. He realised he had set up within himself an 'inner prohibition - a stopping or falling over a cliff of my impulses'. Concurrently there were issues of oedipal confusion, conflicts between false self and real interaction with people, together with a gradual acknowledgement of his own inner needs of people. He became able to tolerate his need of intimacy and tenderness and was more accepting of his own sexuality. One day he described his relationships, 'it feels like drinking water instead of air', and that he was beginning to experience emotions bodily as well as mentally.

One week a friend of his died. He began to examine his views about death and therefore life, realising how he'd organised his intellectual defence around these existential matters; 'Logically I know that I will end but I now feel that I'm not just a biology, my sense of myself is that I could go on, that I can't be confined. I feel that I'm in the Universe, not in an egotistical way, just that I'm part of it.' He went on to say that the most important part of New Year's Eve was that he was participating in the event, along with many others, and that he felt belonging in it. In re-connecting with the complexities and conflicts of his emotional life, he integrated physically, mentally and emotionally, as well as beginning to reflect upon possible broader contexts and therefore gained meaning in living. He had relaxed internally, allowing a natural process of gradual re-integration with his instinct for connectedness and participation.

As a whole, the profession of psychotherapy itself, in all its complexities, is a divided profession. Our organisations themselves can manifest the very splits, divisions and dissociations that we aim in individual therapy to repair. It seems all too easy to lose sight of the greater contexts in which we operate. Many people seem to feel that psychotherapy is an ethos unto itself, somehow separate from the ordinary workings of the world. Because our work takes place behind closed doors, involving private, confidential and complex relationship, there seems to me to be a tendency for it to be perceived as being unnaturally separate. And why do some psychotherapists seem so awkward with each other? The analytic style, which involves engaging but standing outside situations seems to me occasionally to go too far in

terms of how we can be with each other. Is it not possible to remain observant and reflective and maintain ordinary human warmth?

There are many people suffering this meaning void in today's world, as well as those of yesterday. I do not intend to take a stand on the rights or wrongs of replacing ancient cultures with modern ones; nor do I wish to idealise either of them. I simply wish to ask the question: is it necessary for our advance in living to leave behind all 'primitive' elements of living? Is it possible for technology to serve and for us to maintain connection to the wisdoms of the older ways? Modern life can gain meaning through the contemplation of experience, through thoughtful and moderated connection with our instincts, and through keeping an open mind about our contexts. This is an integration of truth. It is my belief that we need to work at maintaining relationship between science and soul, thought and being.

Notes

1.Tribes are a group of people who live together; clans consist of different tribes who share the same 'Dreaming' ancestors.

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Pamela Arriens

Object relations: a view of Chardin

In March this year I found myself keenly reading reviews of the Royal Academy's exhibition 'Chardin 1699-1779', which led to a trip up to London to see it for myself.

In Proust's appreciative essay on Chardin and his work, he used the example of a bored young man looking beyond the simple things in front of him: 'a ray of sunlight, glinting on a tumbler of water', (Proust 1902) or his mother at the further end of the room tranquilly 'winding-off a skein of red wool', (ibid.) as he dreamt restlessly of grander scenes (mountains, the sea, cathedrals). Proust imagines leading the young man to the rooms of the French School at The Louvre where he would 'halt him before the Chardins', (ibid.) to be amazed by these sumptuous renditions of what he had previously thought dull and commonplace.

As Proust emphasises, Chardin's was a simple view, finding inspiration in the mute interior world of familiar objects, which become unfamiliar when seen freshly in their juxtaposition to each other. Analogies to the process of therapy went through my mind as I read a critic's description of his paintings:

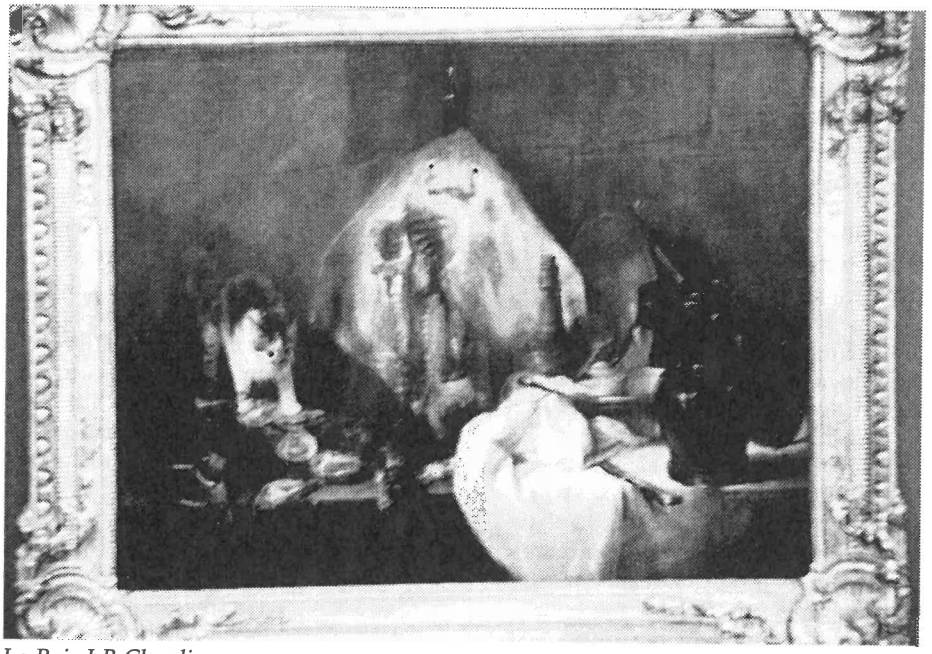
> ...around 1726-28 the urge to fill the canvas with incidental baggage had disappeared. Shadows spread over half the picture surface. Through the gloom an apple is discernible and, more prominently, a bunch of red and white grapes next to it. But they are little more than a foil for the real drama: an encounter between a peach and a silver goblet. (Cork, 2000: P.43)

This could be a description of the explorative process of therapy: the recognition of incidental baggage, but resisting the urge to fill the session, as the canvas, with it; the discerning of an apple through the gloom, but noticing also a bunch of red and white grapes next to it. To look at the apple, or the grapes, might cross the therapist's mind: or is it in the relative tension between the two that the interest lies? But Chardin's picture has a real drama: the encounter between the peach and the goblet. It is possible to see in the inter-play between these painted extraneous objects the fluctuating light and shade, the changing shapes, the weight or lightness of the inter-changes in therapy: the objects are internal, but the sense of what is to the fore, what is in the shadow in the moment in which it is caught, is similarly vital.

The critic describes the 'soft, glowing texture of the fruit, Chardin further enhancing its appeal by allowing the peach a generous reflection in the polished surface of the goblet', (ibid.) thus tying the disparate objects in his painting together in their blending inter-faces, and emphasising the importance in art, as in life, of generous reflection, a process which seems to double the value of a moment of interaction: as when the child (or adult) sees himself reflected positively in the eyes of the other and his own value is enhanced in the process.

Chardin also explores the tension between (imagined) hunter and hunted, aggressor and victim, exploiter and exploited, an inevitable theme of life, and one often explored in therapy. The critic describes the limp forms of dead rabbits and the painter's broken, blurred handling of the fur implying that the very texture of their bodies is on the point of dissolution. This is a visual recording of the process of decay, with the physical and the mental collapse of the organism closely bound to each other. The patient in therapy will silently illustrate through physical appearance - eyes, skin, expression (or illness) his despair, and the perceptive painter/mother/therapist will read something of the inner world from the outward picture.

Experimenting with greater movement in his pictures, cats are introduced into some of Chardin's larger pictures, cats 'disrupting the larder-like calm, reaching forward to poke a slice of salmon or claw some oysters from their shells', (ibid.) revealing



La Raie J-B Chardin

Chardin's interest in violence and its aftermath. In his masterpiece, 'La Raie' (The Skate), the cat has an expression of almost demonic ferocity as it considers the array of dead fish and shellfish in front of it. The dead skate hanging above has a ghostly, lurid ambience of horror around its eviscerated body and oddly tragic face. The intense force of life, and death, in the cat, and the skate, are intensified by the contrasting timeless, inanimate stillness of the copper bowl and jug to their right. The refreshing fierceness in these pictures echoes the eruption, in their time and place, of primitive feelings, expressed in the therapy: ferocity, anger, stark hunger, erupting out of the 'larder-like calm' which might prevail in the room. An extension of this is the tender and compassionate manner in which Chardin shows, in another picture, a dead pheasant hanging crucifix-like above a calm still-life set on a table below: set perhaps with the bread and the wine of the hunter, linking the sacrificed and the sacrificer, emphasising the close and complex link between victim and perpetrator, the powerful and the powerless, a theme arising in therapy.

The painter was interested in ordinary subjects, 'scullery maids, children playing games, or women drinking their breakfast chocolate'. (Gayford, 2000: P.66) Although by all accounts a humble man, deliberately choosing humble subjects, his technique was masterly. The descriptions of his sensitivity to textures, 'the hazy blue bloom of plums as contrasted with the light furriness of peaches', (ibid.) and his appreciation of the sensuous and the subtle, links to the value of a perception of the instinctual in the therapist, an ability to take account of the world of the senses, an area in which the pre-verbal child lived and still lives.
But most usefully this dissolving, sensual quality rests on a hidden geometric rigour in Chardin, comparable with the bones of the work of therapy, with its set time, place, reliability; and the necessary stiffening of theoretical knowledge, and experience. Without these elements, the work is in danger of collapsing or softening, as might have happened with Chardin's paintings, had he been a sentimental painter of pretty pictures rather than a man with a clear knowledge of structure, a sense of the transitional, and of the importance of the spaces, the shadows and the gaps.

> A sizeable gap separates a trio of cherries on the left from two nestling by the goblet. Chardin does nothing to disguise the emptiness in between, or the even greater distance separating the peaches from the apricot and a large green apple. These voids become almost as potent as the full substantial immediacy of the objects themselves. (Cork,2000: P.43)

This echoes the many references in analytic literature to the spaces, the silences; and what remains unsaid. He notices, too, the subtly apparent: 'the thin rim of a goblet slices into the dark and swollen bulk of the carafe behind it'. (ibid.) One thought or idea can resonate unexpectedly against another, creating a revelatory shock at a connection, an inter-section, or a contrast, made within a usually familiar context, something momentous realised by 'placing a glass of water near a coffee pot; and punctuating the gap between with three bulbs of garlic'. (ibid.) The process of free association might assemble such an

array of thoughts, randomness breaking an accustomed pattern to reveal a fresh perspective. Or the seemingly bizarre, oddly assembled, sequences of a dream can reveal a truth in its intriguing incongruities, drawing us in to look deeper.

Chardin shows visually that the ordinary becomes extraordinary through its connections, disconnections, spaces, textures and shadows. In the ordinary discourse of therapy clear insights emerge within the often humdrum everyday nature of the exchanges. The high-flown, either personal or theoretical, does not necessarily reveal greater truths: Chardin's contemporaries in 18th century France vied with each other to concoct elegant and fanciful Rococo showpieces (analogous to the competitive element in some esoteric analytic writing) while Chardin stubbornly concentrated on simple groups of dead animals or equally motionless objects posed on a bare stone ledge. However sombre and austere these might seem, the groups hold within them light, shade, colour, depth, menace and beauty; and each phase of his painting was part of a progression through Chardin's own life and the processes of his mind. The fragility of life (and mental life) is explored by Chardin in a painting of a young man who blows a soap bubble, which sags down into the blackness below the ledge on which it momentarily rests. In another, a sumptuous bowl of strawberries is 'soon to be overtaken by the shadows spreading across the wall beyond.' (ibid.) These images point to the invisible partition between conscious and unconscious, within the greater realities of life and eventual death.

Although Chardin was not the first, nor by any means the only, artist to explore the theme of 'nature morte' or 'memento mori', drawing attention to the transitoriness of life, his was a fresh and unique view. Towards the end of his life he painted, for the first and only time, a 'delectable bouquet of carnations, sweet peas and other flowers erupting from a porcelain vase'. (ibid.) Perhaps he had reached at that moment a sense of urgency in seizing, on the canvas, a glimpse of beauty while it lasted.

Chardin later recalled telling himself: 'I must forget everything I have seen, even including the manner in which such objects have been painted by others'. (Catalogue of the Royal Academy Exhibition, 2000) This is echoed by Bion's often-quoted aim of approaching each therapy session without memory and without desire. Similar words to this, and to Chardin's, have been attributed to Poussin and, later, to Constable. 'But the sober observer will realise there is all the difference in the world between trying to forget and never having known it'. (Gombrich, 1960) How well the artist, or the therapist, succeeds in his attempts to neutralise his pre-conceptions might depend on qualities of courage, originality and innate talent, which will lift him beyond a conventional theoretical stance to the uniquely personal view which distinguishes an independent thinker.

It is not easy to understand why it takes great paintings, or a painter like Chardin, to crystallise what we all see but might not recognise; or why the process of therapy might be needed to crystallise what we know but do not understand. Proust attempts to describe this process when he writes of what Chardin revealed to us:

> Your consciousness was too sluggish to reach down to it. It had to wait for Chardin to come and lay hold on it and hoist it to the level of your conscious mind. Then you knew it, and for the first time in your life knew it as enjoyment. (Proust 1902)

Connecting two such disparate areas as painting and therapy night seem as incongruous as the relationship between the peach and the silver goblet; or perhaps they are as congruous, seen from Chardin's perspective.

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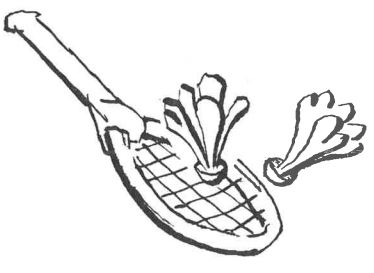

Pat Tate

Balint in two worlds

Michael Balint, distinguished analyst and writer, head of the Tavistock Clinic, is also remembered in quite another sphere – that of general medical practice. Long before I learned about psychotherapy, I knew of Balint and his important book, *The Doctor, His Patient and The Illness* (1957), which is still a standard read for trainee GPs. General practitioners know that Balint belongs to them. It is sometimes disconcerting for those of us who inhabit both worlds.

Exactly fifty years ago, in the autumn of 1950, Michael Balint started his first GP seminar at the Tavistock. The object of the work was to spotlight psychological issues in the doctor/patient relationship, and to enable GPs to become more skilled in dealing with them. The means was a case-discussion seminar of about 8 GPs with two analysts as leaders.

In the immediate post-war period, general practitioners had found that the training they had received at medical school for the care of organically ill patients, though essential, had left them ill-prepared for much of the work they were called upon to do. Emotional difficulties were present and relevant in a large proportion of cases, but doctors had no training in how to approach them.

Those early 'Balint Groups' provided the material for Balint's book mentioned above. Reading it now, it is striking how well Balint's idea have stood the test of time. For Balint, the doctor's ability to listen was of central importance, and gaining this ability involved a process of personal development. 'Listening', wrote Balint, 'is a new skill, necessitating a considerable, though limited, change in the doctor's personality.' He remarked that doctors were often quite unaware of how much their own perspective determined their behaviour, even when this seemed obvious to the other members of the group. The 'personal change' he spoke of was the dawning of self-knowledge in the physician.

In doctors, the daily encounter with suffering can evoke strong emotions: helplessness in the face of incurable illness, fear of discussing questions that frighten them, guilt at their failures, anger at the patient's demands, and sadness at the suffering of someone who has become a friend. If the doctor fails to acknowledge and deal with these disturbing emotions, they may be acted out – in avoidance of the patient, emotional distancing, exclusive concentration on the technical aspects of care, and even cruelty. Lack of emotional insight can disturb or destroy the relationship between doctor and patient, adding to the patient's suffering and often leaving the doctor with a sense of failure.

Traditionally, medical teaching has not included emotions. The teaching with regard to the doctor/patient relationship was 'Don't get involved.' In one respect, fear of the emotions was well founded: to be involved at the level of one's unexamined emotions is potentially harmful. But what traditional medical teaching did not say was that involvement is necessary if one is going to be in any way a healer as well as a competent technician. Traditional teaching was also profoundly mistaken in suggesting that one can encounter suffering and not in some way be affected. The doctor's emotional response may be repressed, but this exacts a heavy price, since repressed emotion may be acted out in a destructive way. There is no such thing as 'non-involvement' for a doctor.

Balint's ideas, developed through the case discussion groups, have influenced current general medical practice enormously, well beyond the small number of doctors who have actually worked in a Balint group. Attention is now paid to the skills needed in the consultation, to doctor/patient communication, and to being 'patient-centred'. Balint's aphorisms have entered the language of medicine: 'If you ask questions, all you get is answers.' And, 'Don't just do something, sit there.' He pointed out that the most potent drug at our disposal is the doctor himself, and wrote about the

doctor's 'apostolic function' as follows:

> By this we mean that every doctor has a set of fairly firm beliefs as to which illnesses are acceptable and which not; how much pain, suffering, fear and deprivation a patient should tolerate, and when he has the right to ask for help or relief, how much nuisance the patient is allowed to make of himself and to whom, etc. These beliefs are hardly ever stated explicitly but are nevertheless very strong. They compel the doctor to do his best to convert, if possible, all his patients to accept his standards and to be and to get well in accordance with them. (Balint 1957)

I was fortunate in being able to attend a weekly Balint case discussion group for ten years. It was educational in the truest sense. Not many ongoing Balint groups exist at present, but doctors interested in this approach get together for case discussion, and publish a Journal. I wrote the essay which follows for the annual essay competition of the Balint Society. The title, *Time and Patients*, was assigned and entry was under a 'nom de plume'. I entered under the name 'Bagatelle', meaning 'a short, unpretentious composition'. I hope this preface puts the essay into context. Please read it in that light.

Time and Patients

Sometimes an important thing happens suddenly during the consultation - when doctor or patient or, wonderfully, both, have a new insight. It occurs during a mere moment of time, and can be exciting and change-making. The incidence is not high.

More commonly, a change in the doctor/patient relationship comes about through the passage of time: through the prevalence of the relationship. Perhaps this is what Ovid refers to when he says, 'The art of medicine is generally a question of time', and why Kenneth Lane (Lane 1992) described general practice as 'the longest art'. Significant change of this sort can only come about because of the accumulation of many, probably individually unremarkable, consultations over a period of months and years, in the course of which patient and physician each formulate an increasingly detailed picture of the other's personality, humour, fears, weaknesses, strengths and prejudices. Consider the young man of 18 who has been a child patient for 10 or 12 years, and who makes his first appointment to see the doctor on his own. "I'm not growing properly" says the good-looking 6-foot-plus youngster. He wants the doctor to inspect his (entirely normal) penis. Where did the courage and trust to initiate that consultation come from, if not from the accumulated time spent in that consulting room with that doctor, dealing with earaches, coughs, sprained ankles and spots?

Similarly, a girl of 15 and her school friend come together for an appointment. She has known the doctor since she was tiny, has been brought in many times with minor illnesses by her mother and latterly, since mother's death, by father. The doctor has spent time in her home, with the young mother dying of cancer. "Doctor, should we have sex with our boyfriends? Does it hurt?" Because of the time shared over the years by girl and doctor, it is possible to ask these excruciating questions with neither giggles nor solemnity.
It is not necessary for the doctor in these cases to have been perfect during all those consultations, all that time elapsed together. Almost certainly, that will not be the case. It is not that the doctor has impressed the patient as uniformly knowing and wonderful, but that the doctor and the patient have become real people for each other: the drip, drip, drip, of shared time has built up a stalagmite in human form.

Sometimes, people being complicated and unpredictable, the effect of the long-term relationship is to erect a temporary barrier to openness which, once breached, then reveals the strength of the bond built up over time. A middle-aged woman had been taking a non-therapeutic dose of antidepressant for years, and was unaccountably unwilling to dispense with it. When referred to the nurse-therapist specialising in coming off substances, the patient revealed her one-year history of bulimia, which the doctor had never suspected. "I couldn't tell the doctor that, because I've known them so long, and what would they think of me?" But she was then able to follow the nurse's advice, tell the doctor, and use the length of the relationship constructively, rather than as an obstacle.

A man in his 30's, lonely and a refugee, developed strange physical symptoms after the death of his only friend. Once physical causes seemed to have been ruled out, he and the doctor agreed to meet for a series of long appointments at the end of surgery, even though the doctor did not find the patient an attractive person in any way. A substantial total of time together accrued, with much in the way of mutual discovery, and the doctor was surprised to discover a genuine liking for the patient. One evening the doctor felt moved to say, "We've talked about so many aspects of your life, but one thing that hasn't been talked about is sexuality." "No, and it isn't going to be", replied the man firmly, and indeed, that remained, strictly speaking, true. But gradually it emerged that, due to intense fear and shyness, he had never had a relationship with anyone - until now. He continued not to talk about sexuality, even when, after a visit abroad, he made an appointment to introduce triumphantly his pretty fiancée. The time together had paid its dividend, although he retained his area of privacy.

This issue of time and patients could, in a practical or mechanistic sense, be regarded purely as 'continuity of care', enshrined as a principle of general practice since the establishment of the NHS. But it goes further than that. It is important to remember that every relationship works both ways, and to consider the effect of the patient on the doctor. One obvious effect, noticeable in all the cases mentioned here, is that when a person comes and asks for one's help, it is an enormous compliment and morale-booster. The doctor is grateful to the patient. Aside from those patients we fear or really dislike, the more time spent with a patient, on the whole, the more we like them, and the more grateful we are when they ask our help. They give the doctor a sense of value and of purpose. This can overcome simple uninformed dislike, as in the case described of the young refugee.

When Michael Balint evaluated the results of his initial groups for GPs (Balint et al, 1966) time was one criterion. More than half of the early doctors had dropped out before one year of attendance at a case discussion seminar. There had not been time for the 'limited though considerable change of his personality' (Balint, 1957) which was considered the aim of group participation. In fact, it became apparent that successful 'change' took place generally in the third year of group participation.

Just as the relationship between patient and doctor benefits from accumulated time together, so does the development of the doctor in a Balint group.

> The doctor derives from his work enough 'deep' satisfaction to compensate him for the strains caused by the training. In this way he will be able to give up without too much pain some of his accustomed ways of behaving towards his patients. (Balint et al, 1966).

But it takes time, patients and patience.

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Peter Lomas

Can there be a unified psychotherapy?

Human beings have developed an impressive capacity to discriminate: to arrange their perception of the world into precise entities to which they then give names so that they can communicate about them. In achieving this feat they have, however, become very dependent on this ability. Indeed, we may wonder whether it has become counterproductive. In contemporary society everything that is studied, and the methods by which it is studied, are divided into categories. It has now come to a point where, to be considered a person of worth, one must be a specialist.

The phenomenon of fragmentation is not of the same degree in all areas of study. Despite the fact that, since the Renaissance, art has been considered a pursuit to be distinguished from the making of beautiful things in the course of ordinary living, people can still attend the Royal College of Art to learn something called art. They do not have to commit themselves to, say, an Impressionist or Dadaist course of learning. And one can go to a university to learn something called philosophy without having first to choose between the Pragmatists and the Logical-Positivists. There are, as we know, wide variations of approach. Sometimes a new theoretical position can threaten the foundations of a discipline, as has happened in recent years in the field of literature - yet, despite the powerful efforts of the post-structuralists, we can still go to a university to learn English literature. Psychotherapy is a different matter. There is, so far as I know, nowhere that one can go to learn psychotherapy; there are only training organisations which offer instruction in a particular kind of psychotherapy with a particular name to it. Consequently, this is what is on offer to anyone who wishes to be on the Register of the United Kingdom Council of Psychotherapy, a register which is considered by many to be a mark of professional competence and respectability. The fragmentation of the profession is one of the reasons why psychotherapeutic theory and practice is in such disarray.

This confusion of tongues is often lamented and it is widely recognised that there is much overlap between the thinking of various schools of thought. Indeed, attempts have been made to combine forces - for example, the emergence of 'cognitive-analytical' therapy, an undertaking with much to recommend it - but the result of such mergers seems only to add yet another voice to the tumult. One wonders how this state of affairs has come about and whether anything can be done to alleviate it. Is it intrinsic to the nature of psychotherapy? Where is there solid ground on which we can begin to address the dilemma?

Although the practice of psychotherapy can be traced back for millennia there is no doubt that there has been a renaissance in the past century. The most obvious reason for this was the genius of Freud. In the early part of the century there were few rivals and even they found it necessary to define their beliefs in relation to Freud, continuing, for the most part, to consider their work to be analytical. What has emerged was less a regeneration of psychotherapy than the advent of a new discipline, psychoanalysis, which until recent years, was sufficiently powerful to replace whatever concept we had of the practice of trying to help emotionally disturbed people by means of talking to them. It would seem that, however much we may nowadays wince at the political rallying call of 'back to basics', we do need to attempt an endeavour of that kind in the field of psychotherapy or counselling.

The problems are many. A formulation in any area of thought is of necessity a distancing from other views and it would be difficult to suggest an approach to psychotherapy that was not seen as merely another subdivision of the discipline. And an attempt to produce a blue-print which transcended and included all other methods may appear the height of arrogance. Moreover a 'non-specific' psychotherapy can readily be thought woolly and vague - the product of an amateur mind. It is no wonder we sheer away from the idea.

Any wording that might be generally acceptable as a description of psychotherapy would need to be exceptionally broad. In a recent paper Thomas Szasz refers to psychotherapy as the attempt to help another person to 'live his life better". This is not a bad place to begin despite the fact that the statement already raises many questions, for example: Who can claim to know what a good life should be like? Does the statement eliminate the possibility of thinking of certain states of mind as illnesses requiring care?

A significant aspect of Szasz's formulation is that it enables us to explore the nature of psychotherapy from the point of view of ordinary living: we can all talk to those in distress in an effort to help them live better. This, to my mind, is a pivotal issue. Do we consider psychotherapy as an extension of our ordinary capacities or do we think of it as a specialised method quite distinct from the conversations that therapeutically untrained people manage to have when faced with distress in their friends and relatives? Those who favour the former view will be likely to emphasise special techniques, while the latter approach will lead to a greater consideration of the quality of the personal relationship. To my mind it is the difference between these two approaches rather than the sheer number and variety of organisations that constitute the most formidable obstacle to a unified psychotherapy. How should we conceptualise this difference?

If one looks at the approaches of the various schools of thought now with us it is not easy to tease out where exactly each stand in relation to the division between the technical and personal. It may be thought that, for example, cognitive therapy is a very technical undertaking yet when Robert Hobson presented his 'conversational' model to colleagues, whether they were cognitive therapists, Rogerians or psychoanalytic psychotherapists, they said that it was no different from the model they practised. I can readily empathise with that situation. Since my own stance emphasises the continuity between what is happening in the consulting room and conversations which occur in our everyday life I have met with similar criticism. One of the factors leading to this confusion is that those therapists who emphasise technical manoeuvres rather than personal interaction lay themselves open to being thought lacking in warmth and feeling; in short, to being somewhat inhuman. And this hurts. It would be invidious to think that those who use technical methods care less for their patients than others. On the other hand, those of the 'humanist' or 'personal' turn of mind have to face the charge of lacking rigour. This also hurts; and is equally unjustified.

Let me give an example of a theoretical difference between two schools of thought which, though significant, would seem to be of insufficient importance to merit a division between organisations or courses of training. Psychoanalysis lays great emphasis on the effect of the past on the presenting problem whereas humanistic psychotherapy focuses on the present and the future. I imagine, however, that in practice only someone who has lost touch with reality could talk to people and completely ignore the fact that human beings live in a world that is constituted by past, present and future. The difference, surely, is only one of emphasis. There are, however, some conceptions about experience that genuinely embrace our deepest sense of how we want to be and live with others and which we cannot discard without an unacceptable betrayal of what we believe ourselves to be. Such conceptions stand in contrast to those of a more arbitrary and superficial nature. I would like now to return to the kind of distinction that, I believe, is more fundamental and more difficult to resolve than most of those usually emphasised by the various schools of therapeutic practice, i.e. that between a technical and non-technical approach.

Although, as I have suggested, these two areas are not entirely dissimilar (for example, they both, in their unique ways are searches for truth) they require of their practitioners ways of approach, of method, of learning and of imagination that are utterly contrasting. The student who trains at The Royal College of Art will receive a very different experience from those who attend the science department of a university.

I have written at some length elsewhere on the nature of this difference, emphasising, especially, the moral dimension of the personal approach and its continuity with the experience of daily life; here I shall try to meet some of the criticisms I have received for sustaining this view. The point has been elegantly made to me by a colleague, Rosemary Randall, who is, in the main, sympathetic to the view I take of psychotherapy.

> I still find the dichotomy of technique versus the extension of ordinary capacities a difficult one. I came up with an analogy - that of singing. There is no doubt that what Kathleen Ferrier does and what we do round the campfire are both singing. There is also no doubt that the difference between them could not be summed up as technique. Technique would not describe the ineffable beauty of a voice such as Ferrier's or the inspiration of her interpretation of a piece of music. Neither would technique adequately describe the years of practice that had gone to make up that voice, that interpretation and that performance, although technique might be a word that is sometimes used. Our campfire jollity and Kathleen Ferrier's performance are

certainly connected but are also different. You concentrate, I think quite rightly on the connections between psychotherapy and ordinary conversation, but how are we to talk about the differences? How can we value both and not demean one or the other? The campfire would be no fun if we all tried to sing like Ferrier and I'm quite glad she never tried to record 'Ging Gang Gooly'. Of course, most of us psychotherapists are not up there with Ferrier but we do do a little more than sing in the bath.

I cannot pretend that I can fully answer this criticism but I think some things can be said in answer to it, although here I can only do so briefly. Even without training I think it likely that Kathleen Ferrier would sing in the bath better than I do, provided she had not been inhibited from singing. Natural ability, encouragement, passionate interest, ambition can take us a long way in becoming good at something. Given these qualities it is likely that the person would search out settings in which they may gain inspiration and learn much from others known as good singers. If singing is regarded as one aspect of ordinary living she would learn to do it better; to improve on her natural capacity. It may be that she would learn certain things - to do, say, with voice control and breathing - which will help her and which we may call techniques. But this would not necessarily be the main feature of her development as a singer. If she wished to specialise, to become, say, an opera or a blues singer, more precise techniques may be necessary.

The urge, and ability, to help someone in distress is at least as much a part of everyday life as singing. And, as in singing, it would seem important, for anyone who wishes to improve their ability, to cultivate those characteristics that are widely recognised as helpful, for example, to be able to listen. Also, as in singing, it would make sense to be amongst people who value, enjoy, are experienced in this field and would be likely to give encouragement, criticism and act as possible models. If they have learned special techniques they would no doubt introduce them to those wishing to learn, judging when and whether certain techniques may be useful to a particular individual. What I am describing here is, I believe, fundamentally different from a project which is based on the idea that a special technique is the main means by which someone becomes accomplished and that this technique should take priority over the natural way a particular person functions in relation to others.

As Randall points out in the quotation I give, technique cannot account for the 'ineffable beauty' and 'inspiration' of the interpretations of Ferrier's singing. How we can teach this, in singing or psychotherapy, is a major challenge which is not easy to get a purchase on. Knowing little about singing, but something about therapy, I feel safer in pursuing consideration of the latter. I will take the capacity to listen as an example. To listen attentively is, I think, the *sine qua non* of any attempt to understand another. We have all had years of practice at it and are no doubt good and bad in various ways and various situations. Elements of a scientific method or an artistic method are likely, willy-nilly, to enter into our ability without our being aware of this. What we do is not a science nor an art; it cannot be classified in that way. In this sense it is ordinary, unspecialised. At its very best it may approach inspiration or even have a quality that is akin to beauty. To try to turn it into an art or a science would be to distort it, although we may learn things from art or science which stimulate us to listen better. In short we should surely be careful not to impose a programme of teaching which may take away our natural gift unless we are convinced that we have a technique which is so good that it eliminates the need to listen in an ordinary way. And I do not believe we have such a technique.

I have, I think, made it clear where my own prejudice lies. I believe that a unified theory of psychotherapy would need to start from, and be an elaboration of, the ordinary capacity to help people. Special methods or techniques would be likely to play a part in, but not replace this way of conceiving the work. Whether my view is reasonable or not it is clear that this is not how psychotherapy is at present conceived. The technical and non-technical approaches vie for attention, are emphasised in a different degree, and are often confusingly presented in the various schools of psychotherapy.

One could envisage - and I hope this will not occur - a split between two approaches to therapy which would not be unlike that between science and art. Although, as I have suggested, these two areas are not entirely dissimilar they require of their practitioners ways of approach, of method, of learning and of imagination that are utterly contrasting. The contrast that is most relevant to this discussion of ways of relieving mental distress is that between organic psychiatry and psychotherapy. Any division within psychotherapy itself is likely to be less striking. Nevertheless, the difference between humanistic and technological understanding is not a minor matter: the priority of quantitative measurement of experience is an anathema to many of those who work in a personal way and recognise that the problems they face are essentially moral ones.

In considering the difficulties standing in the way of unifying psychotherapy we have to take note of the contemporary intellectual climate of opinion in

society. There is little doubt that the star in the ascendant is science - in particular, a form of science characterised by bureaucracy and technology. Quantification increasingly appears in most areas of human endeavour, and not least in psychotherapy, which tends to be derided if it cannot be measured. Training organisations found acceptable for national registration are increasingly required to teach their students to learn, as in science, a body of knowledge, rather than to help them cultivate their own innate capacity to do the work.

To protest that science is not necessarily the royal road to becoming a good psychotherapist is, in the present climate of opinion, to swim against the tide. But, if we are to foster a psychotherapy worthy of its subject, the personal, human, artistic, intuitive, moral approach must not be neglected or relegated to a subdivision of an undertaking that is primarily considered to be technical.

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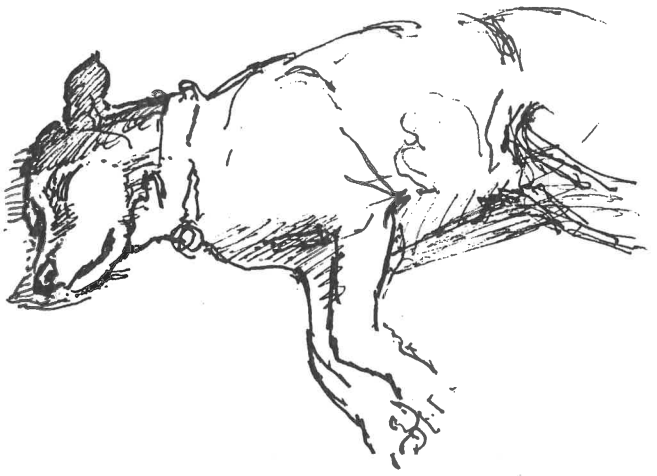


Letters

Dear Editors,

I would just like to mention SAD in relation to my own experience.

In Finland, where I come from, SAD is reported as a major problem. In the north of Finland where the sun sets in October and the next sign of light is noted in February, the Lapps have the highest suicide rate in the world. The part of Finland where I come from gets daylight about 2-3 hours a day from November to mid-February. I have a bleak memory of that part of the year and I expect you need to feel unusually stimulated not to go down with SAD.

Finland has taken SAD seriously and those people who suffer from the symptoms -such as sleep problems where you oversleep but are not refreshed, overeating where craving for carbohydrates leads to overweight, lethargy,and some symptoms of depression - are advised to sit in front of bright light lamps for half an hour a day. The lightboxes are provided by some employers, such as health and local authorities, in coffee rooms where employees take turns to use them.

Personally I am aware of SAD and I note this on my arrival at the airport in Finland in winter where the bleak faces greet those arriving without even a simple physical gesture such as lifting an arm. It is simply too heavy. Sometimes I expect a newsreader to fall asleep in mid-sentence. The nation appears unmotivated, slowed down in every way and sleepy. The silence all around is striking. The only noise seems to come from the traffic and the occasional skating rink where young people play icehockey. SAD does not naturally explain all of this because it is also freezing cold which restricts your life to a large extent. We also bring in our personal dispositions and states of mind which can be difficult to separate from SAD.

Leila Gordon

Dear Editors,

The arrival of a name – in this case SAD – can certainly help some people in identifying what is troubling them. But it can also of course close off certain ways of seeing the problem. The identification of SAD has pulled thinking about it into the scientific, medical arena. Research concentrates on understanding physiological mechanisms and developing technical solutions. Over the last few years a number of people have asked me what I think about light boxes. These devices simulate daylight, producing up to 10,000 lux, ('lux' is the unit that measures light intensity) and the sufferer sits underneath it for between 15 and 45 minutes each day.

The manufacturers of these devices say that to be effective at least 2500 lux is needed and that brighter lights of up to 10,000 lux will work more quickly. They contrast the amount of light available indoors (500 lux in a well-lit office) with what their devices can provide. What they omit to point out is that on most winter days, even in the depths of December, with an overcast sky, 2,500 lux is available simply by stepping outside. The higher intensity of 10,000 lux is achieved in October and March for 70% of the working day, and even in December for a small part of it.

The inescapable conclusion is that for most people in this country, suffering from mild symptoms of SAD, a half hour walk at lunchtime would be just as effective as a light box. There might be the added bonus of the endorphins mild exercise is supposed to produce and the reflective space away from work.

Rosemary Randall.

Reviews

Psychotherapy and science

Doing good? Psychotherapy out of its Depth. Peter Lomas. Oxford UP 1999. and *Peter Lomas and the Question of Science.* Peter Rudnytsky. In Committed Uncertainty in Psychotherapy: Essays in Honour of Peter Lomas Edited by Lucy King Whurr Publications 1999.

Reviewed by Michael Evans

For more than a hundred years the debate about whether psychoanalysis is a science or not has rumbled on, and sometimes raged. It has been accompanied by another connected debate, about the credibility of Freud as an honest man and as a bona fide researcher. Of course Freud himself was a qualified doctor of science and throughout his life he maintained that psychoanalysis is a science. The ordinary psychotherapist, practising privately in a hospital or an institution, might sometimes wonder as to the relevance of this debate to his or her work. Does the outcome really matter? What difference would it make to one's practice and to one's patients if it was conclusively shown that psychotherapies based on psychoanalysis have no credibility as a science? There is the fear that such an outcome might lead to the therapist losing status in the eyes of hospital authorities and psychiatrists. Psychotherapy, it is feared, might be seen as a sort of arcane black magic which is both expensive and ineffectual. This fear influences the profession to have a vested influence in sustaining credibility of its practice as science or at least allied to science. This pressure has a profound influence on the way we therapists are trained, through the range of theories that are prescribed, the values passed on through the work done with training patients, and through supervisions.

In his otherwise appreciative tribute to the work of Peter Lomas, Peter Rudnytsky takes him to task for inconsistencies in his writings, and for ways in which he is critical of psychoanalysis as a science. Rudnytsky disagrees with Lomas' assumption that there is an incompatibility between an adherence to scientific principles and the qualities of empathy and compassion that are vital to being a good therapist. He criticises Lomas for conjoining the scientific in a triad with the impersonal and the hierarchical, as though these terms were interchangeable and equally opprobrious. Rudnytsky draws on analysts like Winnicott and Bowlby to support his view that the scientist must be humble in his approach and adopt an attitude of humility to the work, and that therefore there is no incompatibility between making a scientific diagnosis of a patient and being compassionate and sensitive to human suffering.

This view of scientific work seems to me to ignore the relation between science (as an institution) and power. Diagnosis itself is a powerful technique in relation to patients, however humble the 'scientist' is as an individual. Rudnytsky advocates the proposition that the therapist has much to gain if he works from a theory that is grounded in science. This may be so, but the question is also, what does the patient gain? And what effects does scientific theory have? He cites Bowlby as a champion of psychoanalysis as a science. But Bowlby does not ask the above questions, but speaks of scientific method and metapsychology as a means to access the patient's problems as if they were transparent, while remaining innocent about the effect that such diagnoses have. I will return to this point later.

Rudnytsky maintains that Lomas' position is untenable because it abandons scientific criteria for distinguishing between valid and invalid claims, and ways of judging between true and false statements. He also detects a contradiction in Lomas' position, and quotes from his writing to show where he has relied upon psychoanalytic and Gestalt theory to make assertions, while at the same time 'turning his back on scientific standards'. I think that Rudnytsky is wrong if he supposes that scientific criteria are the only means of distinguishing between true and false statements. For there are other means of making such

distinctions, the disciplines of law and philosophy to name only two. But I think he may be right to find a contradiction in Peter Lomas' position for, as he points out, Lomas is highly critical of the project of scientific psychoanalysis as a way of doing therapy, but he still relies upon its underlying theories in many ways.

These are serious criticisms and I want to try to address them here by considering the debate on science and morality launched by Peter Lomas and by reviewing his latest book *Doing Good?*

Lomas seems to think that psychoanalysis is a scientific project but that it is unfortunate that it should be so. But why does Lomas conflate science and technique? And why does he so vigorously reject both? By so doing he lays himself open to the criticism that he advocates a sort of therapy that is overly subjective and relative, and he is called by Rudnytsky 'the last romantic'.

In his latest book Peter Lomas returns again to the theme of ordinariness, and argues that expertise in all fields and professions tends towards a retreat from the ordinary and a fragmentation of culture. As therapists we should drop the pretence of expertise which is often a defence. A different approach is needed. But he accepts that we grow up within a Freudian tradition and cannot simply throw it off and start again. The Freudian project needs modification for present day needs. He notes that we therapists have a tendency to an air of certainty and moral righteousness, even at times a heaviness and religiosity in our expert stance.

It is not difficult to find contradictions in Freud towards the scientific stance and his recognition that it is not best suited to therapy:

> Cases which are devoted from the first to scientific purposes and are treated accordingly suffer in their outcome; while the most successful cases are those in which one proceeds, as it were, without any purpose in view, allows oneself to be taken by surprise by any new turn in them, and always meets them with an open mind, free from any presuppositions. (Freud 1912: 114)

On the next page Freud notoriously likens the analyst to the surgeon 'who puts aside all his feelings, even his human sympathy, and concentrates all his mental forces on the single aim of performing the operation as skilfully as possible.' (Freud 1912: 115) In his book Lomas is opposed to the Freud who advocated a technical and scientific approach to psychotherapy.

The aspiration to a scientific approach to the work necessitates an attitude of neutrality. In particular the analyst must abandon any moral position that would conflict with the efficacy of the work as science, for to have a moral position would lead to a distortion of emphasis. Moral feelings will influence his understanding of the 'evidence' and they will lead to the repression of material. It is generally recognised that if the patient is to obey the first injunction, to free associate, that is to tell all, including the trivial and the shameful, then he is hardly likely to do so freely if he feels that a weight of moral condemnation or some disapproval is coming from the therapist. The source will dry up. The project as a science depends on the white coat of objectivity.

It is as if the release of the repressed material by the patient is balanced by the analyst having to repress his own moral feelings. Lomas' view is interesting because it represents the return of the repressed realm of moral values to the discourses of psychotherapy. Hence his sub-title 'Psychotherapy out of its Depth'. Lomas insists that it is not just undesirable but it is impossible to leave behind one's moral opinions when entering the consulting room. Moral values are not just opinions on behaviour that we have worked out at a rational level. Freud placed the super-ego as straddling both conscious and unconscious levels in his 1923 model. Our values are not something we can put on or discard like a suit of clothes. Some morals may be passionately held, others are inscribed in our identity.

This means that there is a real difficulty for the scientific/technical project when the scientist and the material for study are both human beings with perhaps different moral values to each other. The therapist tries to adopt a morally neutral stance but cannot fail to communicate moral values to the patient because they are inseparable from who he is. Lomas does not believe that Freud was neutral, and produces accounts that his patients did not find him so in the way he worked, or how he lived. He was a deeply moral man with severe ideas as to how life should be lived. He lived his own life with rigour and focus, at the expense of short term impulsive pleasures. He did not believe it was justified to be resentful about the harshness of life. These moral values that he held could not fail to be communicated to his patients even though he sought to liberate them from their persecutory sense of guilt. Lomas takes the view that therapists should acknowledge this side of themselves and be prepared to be honest with their patients, otherwise there is a danger that they might unconsciously coerce the patient into accepting their own unstated, unacknowledged, moral position.

Furthermore patients frequently behave or hold opinions which are incompatible with the therapist's own deeply held values. Our patient

might believe that it is perfectly acceptable to seduce his best friend's partner, or to pass on a sexual disease, or bring down a colleague by means of conspiracy. He can speak disparagingly of others who have done him no harm. He can show sexual, racial or class prejudice to which the therapist might object. Patients can sometimes threaten the welfare or even the life of others or behave in ways that they themselves regard as shameful. Can the therapist acknowledge what he hears so that the patient feels he is heard and yet remain morally neutral? But if he comes off the fence, is the therapist entitled to be an authority on moral issues? Lomas does not believe that our trainings can prepare us for making judgements on moral matters, yet we are confronted with such issues on a daily basis about which we are bound to have a view. The therapist may or may not call upon science to make a distinction between that which is true or false, but science is not much help where morals are at stake.

Lomas also holds that psychoanalysis as a science does not make for effective therapy. The metaphor of surgical detachment is quite inappropriate and unhelpful when one is confronted with someone who is faced with naked grief or suffering, or loss which is beyond words. There is no technique or rule book that we can fall back on in these situations. He advocates that it is sometimes more helpful to the patient to 'speak what we feel, not what we ought to say'. We have to use our intuition and judgement born of experience, rather than any scientific criteria, to decide as to when those times are.

But even in ordinary sessions Lomas argues that a human approach is more effective than the denial of feeling that technique and codes of conduct involve. If the patient feels inhibited by the therapist's capacity for making moral judgements, so also will he be inhibited by the neutral stance. Lomas will advocate that on balance a therapy session should if anything be more like old friends meeting, than it should be like a formal dinner party. Although to be spontaneous may lead to revealing to the patient some personal vulnerability or idiosyncrasy, from the patient's point of view the therapist appears more human and approachable when that happens. It may help him to be less defensive.

Lomas devotes a chapter to spontaneity and argues against the Freud who wrote that

> the justification for emotional coldness in the analyst is that it creates the most advantageous conditions for both parties: for the doctor a desirable protection for his emotional life and for the patient the largest amount of help that we can give him today. (Freud 1912: 115)

Lomas asks why it is that we have to be so defended? This remoteness can only create an imbalance of power which is unproductive and in this chapter Lomas is arguing for a reduction in the force of the transference in which the therapist so often appears to be on another planet to the patient. He is careful to show that he is not advocating wild or inconsiderate behaviour, but rather to come off our high horses and learn to be responsive and real. He believes that ordinary human qualities of compassion, warmth, spontaneous interaction, conversation and humour are essential to being an effective therapist or counsellor.

As in his previous writings he attacks the foundations of psychoanalytic method which psychotherapy and counselling have unthinkingly inherited. He equates science with technique and wants us to abandon our reliance on that tradition and to use our intuition and ordinary judgement when we are working. Here are some typical Lomasian statements:

> Science and morality are uneasy bedfellows. Morality is a very personal matter and the current scientific vision does not take kindly to the personal. (Lomas 1999. P.5)

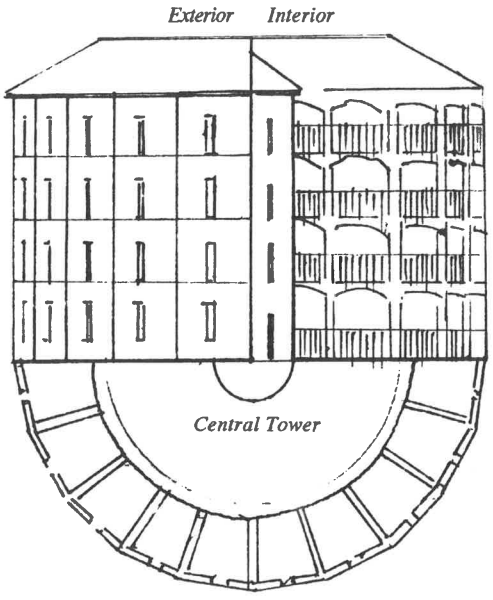
> The science against which the contemporary therapist has to struggle in finding an acceptable voice is limited to a Procrustian bed of technical procedures and quantitive methods.(ibid. P.5)

> Technique, moreover, has expanded from a method of controlling things to the control of ways of living. (ibid. P.4)

Lomas' equation of science with technique is also made by Michel Foucault who, far from idealising science, regarded it as an instrument of power. Foucault uses Jeremy Bentham's concept of the panoptican prison as a paradigm of the inseparability of science, technology and power . (Foucault 1977:194) Bentham had a project for the scientific management of all kinds of people. Briefly, in his model penitentary the prisoners occupy separate cells which are situated on layered storeys around the interior wall of a huge architectural drum. In the centre of this drum Bentham proposed that there should be a tower with curtained windows at every storey for the peripatetic warder to look out from, and observe the behaviour of each prisoner behind bars in his cell. The curtains and the interior darkness of this tower provide such concealment that the prisoner cannot know if or when at any given time he is being observed. Since he may be constantly observed by someone he cannot see, he begins to observe himself, and to feel a sense of guilt, shame and remorse etc. We can say that the prisoner is an object of study by an imaginary jailer and so by himself. Thus he

Jeremy Bentham's

PANOPTICON



Ground Plan

Interior of a cell in a panopticon prison. A penitent kneels before the central inspection tower.

becomes a new subject of a very particular kind, for his subjectivity is formed by the process of observation. I think Foucault intended to use Bentham's project as a parable of the way power operates in psychiatry and psychoanalysis. For he concludes that power is not necessarily oppressive, but is always productive. How can this be ?

Along with Foucault one can make an argument that psychoanalysis is an instrument for making individuals recognise themselves in certain ways. It involves certain kinds of codified techniques (the couch, the analytic hour), procedures for deciphering material (counter-transference for example) as well as schemas for explaining it (the unconscious, repression, the oedipal complex etc). Thus the argument might go that psychoanalysis presumes a certain kind of subject (suitable for therapy) and indeed produces one in situ, one who relates to himself as the subject of a sexuality, one who has a capacity for 'self knowledge', one who is coerced into finding the truth of himself and his own past, one for whom the conditions for happiness /unhappiness lie within himself, one who is obedient. The patient is under observation, and like the prisoner in the panoptican, he develops accordingly. Not just psychoanalysis but behaviourism too offers the construction of a subject, although it proposes a different kind , one who is a tabula rasa, malleable to any impression.

It is in order to establish their credentials as scientists that analysts have attempted to behave as doctors. Indeed many, like Freud, had their initial training as doctors. When we speak of psychoanalysis as a science we refer to medicine, for it grew up on the back of medical science, that of Drs Charcot, Breuer and Freud. Many therapists today would deny that they behave in an impersonal manner or feel dispassionate, but the rituals and the largely unwritten code of conduct is not the invention or property of the individual. As therapists we all conform to a structured behaviour which is based on the rituals of medicine. Appointments are made, a timetable adhered to for the sessions, and a code of behaviour on both sides is strictly respected. Deviations from those codes is defined as 'acting in' and is interpreted accordingly. In supervision certain techniques are passed on to the trainee in which the minutiae of behaviour are scrutinised in terms of boundaries: money, holidays, clocks, furniture, decor, looking, being looked at, style of speaking, speech gambits and strategies of defence. Lomas points out that one therapist he knows believes it is wrong even to smile at a patient. Others will not shake hands. Many are cautious about making jokes or admitting humour. Most behave more humanely of course. But many therapists refuse to initiate the beginning of the session on the grounds that they should wait to see what 'objective' evidence emerges in the form of unprompted speech. What therapists actually do is generally spoken of by them as 'clinical work', because the model is the same as that of the GP, the dentist, the psychiatrist and even the laboratory technician. Like them the therapist makes assessments, diagnoses, and speaks of symptoms, and 'presenting' and 'underlying' problems. A topology of illnesses is constructed with medical terminology - hysteria, borderline, personality disorder, neurotic, psychotic, manic, depressive, paranoiac, endogenous/ reactive depression, obsessive-compulsive disorder. People become 'cases' and we speak of writing 'case studies'. The transference has always been a difficult problem for analysis as a science because the patient is seeking the approval of the therapist and therefore the inner thought process of the patient is distorted or not made available. But these defences too, can be analysed , 'objectively' it is claimed, and even the analyst's own feelings about this particular transference can be interpreted (by him) as 'objective' evidence about the patient's fantasies that conforms with scientific hypotheses. Thus the patient's subjectivity in the clinic is a formation of scientific technique, methodology and discourse. Psychoanalysis as science constructs its object of study.

In *Doing good? Psychotherapy out of its Depth* Peter Lomas addresses the complex of morality which is largely repressed in psychoanalytic writings. This is the positive side of Lomas's book and it takes up the larger part of it. Just as there is more than one kind of science so there are differing concepts of morality.

Although there is a very wide range of problems that patients bring to their therapy, it is not infrequent to meet patients who describe how they feel that life has lost its meaning, that they feel dead inside, or feel screened off from experience or frozen in their relationships. They seek from therapy some way in which they might change their lives for the better. They are asking what might be a good way to live. This is one of the central problems that Lomas confronts, and he recognises it is a deeply moral question. He tackles the problem of morality in psychotherapy head on, but he recognises that he is entering a minefield. His arguments and examples are often subtle and he is willing to chase them out by means of a dialectic with himself, and sometimes with Freud and with others. In taking on ethical issues he draws on an older tradition of healing which is outside of psychoanalysis. That tradition is based on classical philosophy.

He asks why is it that we become therapists? What motivates us? What is goodness ? Can we legitimately do good or foster goodness? Can we believe in love as good, or is it self serving? Is duty the only basis for goodness? These are incredibly difficult questions and many would find them

awkward to discuss, particularly in the context of the professional, quasi scientific project that psychotherapy, based on psychoanalysis, has become. They are discussed with great sensitivity by Lomas, because he is aware of the dangers of self righteousness, hubris and smugness that notions of 'doing good' evoke. He is willing to say that when we practise counselling or psychotherapy most of us intend to do good, and he firmly believes that in so far as client and therapist achieve anything it is a joint project and its effectiveness is more to do with the climate of love and its vicissitudes, between the participants, than it is to do with the language used, interpretations made or knowledge gained.

In our culture the questions around morality are still mainly based on Christian values. The connotation around the word 'morality' suggests that certain forms of behaviour, even thoughts, are irrevocably bad and are to be condemned. The kind of ethics that Lomas addresses in connection with psychotherapy rests on a different, pre-Christian, notion of morality but which is also part of our culture, and it is this older concept which is the reference point when moral questions are discussed in Lomas' book.

Lomas point out that the notions of ethics in Greece in the classical period are broadly based and emphasise a positive rather than restrictive approach to life. Instead of asking 'What is my duty?' or attempting to define what is evil or good, Aristotle, for example, asked the question 'How best should we live? or 'What is it to lead a good human life?' The question does not imply that there shall be a single answer. A good life might be any number of things, but not just anything. It might involve questions of intellectual commitment, loyalty to friends and lovers, the construction of an edifice, a dedication to helping others, or learning to go with the flow. More modestly, perhaps 'How can I best get through the day ?' Aristotle's conclusion was that a good life was a balanced one. Life of course does not often permit that, but his view offers something to work towards. It is refreshingly positive.

Patients do, in a different way, often ask the kind of questions posed by Aristotle. How can I live better than I do now? What do I want? Can I have what I want? What if I get what I want? What is blocking me, internally or externally from achieving a good way to live? All these kinds of questions are ethical questions. Lomas shows us that in the Greek tradition the pursuit of philosophy was regarded as both moral and therapeutic. He quotes Epicurus: 'For just as there is no use in medical art that does not cast out the sickness of bodies, so too there is no use in philosophy, if it does not throw out the suffering of souls.' (Lomas 1999: 69)

To-day philosophy has lost much of its status, and we tend to think of the philosopher as a rather lonely figure, a Casaubon or a Nietzsche quietly going mad in an ivory tower. But the Greeks practised philosophy in the open air, first of all in the garden given to Plato by one Academus. It was essential to philosophy that it was spoken discourse rather then written. In fact for the Greeks philosophy was a matter of conversation and it took place as a dialogue between two people, or as a symposium when conducted as a group discussion, perhaps over a meal. Even Wittgenstein discoursed with his students from a deck chair, and what was said was later written down by his students.

I have a feeling from Lomas' book that he would have been much happier if psychotherapy had derived from a philosophical tradition that addresses the ethical problems that preoccupy people in their ordinary everyday lives, and works through dialogue, rather than from a medical model of science that treats the individual as isolated, and which carries with it the trappings of the clinic which constructs the patient as ill. The term patient meant simply 'sufferer' but has developed the connotation of a person who has ill health, relative to the 'well' doctor giving treatment.

Yet, as Rudnytsky points out, Lomas still leans on the science of post-Freudian meta-psychology and there is plenty of evidence for that in his writings and even in this book. Sometimes he is explicit in his admiration for Freud of whom he writes 'the main thrust of this approach is so humane and contains so much wisdom and has unveiled so much useful knowledge about the human psyche that it claims our support.' (Lomas 1999: 7) Moreover Lomas resorts to, and finds useful, terms like true and false self, super-ego, transference and counter-transference etc, but he tends to be critical of them or qualify their use. While Lomas might like to throw the whole apparatus of psychoanalysis out of the window and start again from some other tradition, he knows perfectly well that this is not remotely practical, any more than we can re-invent a transport system as if the internal combustion engine didn't already exist.

Peter Lomas was trained as a doctor and worked in general practice, neurosurgery and psychiatry before training at the British Institute to become a psychoanalyst. He was therefore brought up in the scientific tradition of mental health, an institution which is largely and notoriously unself-reflective about its own philosophy and history. He has attempted a critique of that science and questioned if its clinical model offers the best way to talk about how we might live. This critique is offered from within the institution, for Lomas was trained as a psychoanalyst, whereas Foucault's critique of psychoanalysis comes from without. There can be no resolution to the contradictory position that

Lomas is in; he can only hold the balance between science and therapy, and develop the values that he upholds. One appreciates Peter Rudnytsky's shrewdness in pointing out this tension, which is after all a real life contradiction, not something that can be resolved by means of abstractions.

However I think Rudnytsky is quite mistaken to imply that Lomas has no allegiance to the critical spirit of the enlightenment. The principles of the enlightenment were probably best set out by Emanuel Kant in an essay written in 1784. (Kant 1784) He maintained that the modern period of enlightenment (his own and therefore ours) is different from the past. People in the past were in a state of 'immaturity' for they could not overcome their superstitions and customs. We too are in a state of immaturity when, for example, a book takes the place of our understanding, or when a director of spiritual matters instructs our conscience, or when a doctor decides what our diet should be and respond unthinkingly. Kant is referring here to the law, the church and medicine as three major institutions of the modern state all of which stand in authority over us. Kant does not advocate turning against these State institutions; indeed he believed we should obey them, for as individuals we are not separate from the collectivity. But he does define enlightened maturity as an ability to think for ourselves in a rational way. We must take responsibility for our own views. If we take, say, any of the discoveries of science or its methodologies on trust as applicable to every situation, we are reverting to a pre-enlightened state in which we have a superstitious respect for authority - in this case the authority of science.

I take it therefore, that when Lomas questions the precepts of science and its techniques as a foundation for good therapy, he is thinking according to enlightened principles. For his writing is nothing if not a rational and elegant critique of the institution of psychotherapy as it has come to be. But there is a paradox - for Lomas is opposed to science and wishes to restore what has been lost in the age of reason, and in doing so he uses reason to argue against reason. As to the charge that Peter Lomas is the last romantic, I hope I have shown here that he is neither romantic nor idealist, but more of a realist.

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The sense of an ending

How much is enough? Lesley Murdin. Routledge 2000.

Reviewed by Isobel Urquhart

'Most people come to a therapist, do a reasonable amount of work, get a little better and leave.' Lesley Murdin's book is a sensitive and profound reflection upon theorising the act and the process of ending therapy. Her book sets out to develop an understanding of the factors involved in bringing about a mutually satisfactory 'sense of an ending' (Kermode 2000) for both patient and therapist, the better to understand and respond to the times when endings are problematic. In the course of the book, she explores the theoretical and technical implications of the variety of endings, satisfactory or problematic, that we encounter in our therapeutic work, as well as in the processes of supervision and training. Through studying the range of possible meanings of ending therapy, Murdin argues that we may be able to come to a more extensive and theorised explanation of its significance, as well as being able to understand with more insight the meanings of endings in particular cases. We may thereby be able to prevent ending being experienced as an unmindful event that unintentionally takes us or our patient by surprise, leaving the ending unworked through. Theorising about endings may therefore help us by improving our technical competence in recognising and managing endings.

Central to Murdin's argument about satisfactory endings is the idea of the mutuality of the change process: both patient and therapist undergo a process of change together in the work they do. Murdin argues that therapists inevitably have an implicit theory - more or less articulated, more or less idealistic, more or less intuitive - about the process of change, that helps us identify specific indicators within the work that tell us when a patient is ready to end. Our therapeutic aims, and our own ethical values influence what we believe to be the purposes and goals of therapy, and thus what kinds of change are desirable and necessary. Ending, therefore, is understood in two ways: first, as an event in time, the arrival at goals, and second, as a process inherent right from the start in all the work we undertake with each of our patients.

Unfortunately, there are times when patient and therapist are not in agreement about whether achievement of life-goals is a sufficient reason for ending a therapy that is, we must remember, also relationship.

Using vignettes of fictionalised cases as illustration, Murdin indicates what happens when one or other of the participants is not ready to end, or when the therapist is unable to change in ways that are therapeutically helpful to the patient. Murdin also refers to evidence from outcome research that suggests that therapists are not necessarily well attuned with their patients about when therapy should end, with patients sometimes feeling that the therapy had not ended satisfactorily whilst their therapists thought the work had come to an appropriate end. This is also reflected in the nature of many complaints made about therapists - that they abandoned patients too early. Murdin's account explores the complexity of process and event behind these troubling statements.

In the course of her examination of endings in therapy, Murdin offers an extensive overview of the whole process of therapy. She moves from a discussion of its aims and outcomes and the underlying values that inform our sense of when therapy should end, through the vicissitudes of transference, narcissism and un-mutual endings, to the ethics and techniques of how to manage the 'end game' of the last sessions we have with patients with whom we are moving to a mutual and agreed ending. Murdin also considers the particularities of ending in time-limited work and weighs up the advantages and disadvantages for endings in this kind of work. For example, knowing the specific time of ending tends to prevent regression, keeps the patient in adult mode and thus forms part of the optimistic belief in the capability of the patient to stay working at a conscious level that is characteristic of time-limited work. On the other hand, the work involved in entering the fears and anxieties that may have been present since childhood and which involve much deeper levels of change will not be addressed. She explains, in two very useful chapters, why a patient or a therapist may end the therapy unilaterally, providing a whole range of reasons why this might happen, and showing a variety of ways in which premature departure might be predicted or might occur.

The reader is supported throughout this extensive exploration of endings with clear explanations of a range of theoretical positions. Murdin provides succinct and readable accounts of the contributions of the major psychoanalytic thinkers such as Freud, Klein, Jung and Lacan to the

particular topics she raises, as well as referring to other traditions within the psychotherapeutic world. Murdin writes engagingly and with clarity. The discussions are eminently readable, and demonstrate that it is possible to discuss serious and complex ideas without oppressing the reader with jargon. In addition, I found Murdin's compassion and respect for both patient and therapist, conveyed particularly through the insightful interpretations of the illustrative vignettes she describes, were not only moving to read, but also a profoundly persuasive learning experience for this trainee-psychotherapist reader. Through the implied promise of such respectful understanding being extended to the needs of the enquiring reader, Murdin invites us to trust her argument and to take it further ourselves. Other readers may therefore find themselves, like me, led to a willing alliance with the author in which I found myself ready to engage with her ideas.

Some readers might find her interpretation of the meanings of patients and therapists actions a little categorical at times. They may wish to argue with some of the rather authoritative statements she makes about the theory. But the virtues of the book seem to me to be related to its purpose and its intended audience. What Murdin does not do in this book is over-burden her argument with detailed and unnecessarily complicated explanations or counter argument or problematic examples. And so the book may be particularly well suited to trainees who wish to learn about these ideas without getting bogged down in detailed exegesis or argument.

The book ends with considerations of endings experienced in training and supervision. I would recommend this chapter to any trainee thinking of planning their graduation process, if only because Murdin sets trainees in the unusual Outfit set up something of a challenge in terms of the expectations of training. While trainees in the Outfit may believe that individual differences in the kind of work they intend to do after training, the kinds of experience of clients they are able to amass during their training, and the amount of time they spend in training are various and make the graduation process something that is at least partly negotiable, Murdin is quite clear about the need for time and rigour in the training. She expects trainees to have 'studied a theoretical rationale and worked satisfactorily with clients or patients for at least four years part-time with concurrent personal therapy' before they finish. The length of time taken should be however long it takes to assimilate the theory thoroughly through the supervision of practice. This is necessarily linked to the ethical and professional standards which must now be considered by all practitioners and which are intended to prevent harm being done to patients by unsatisfactorily trained psychotherapists. In this chapter, Murdin speaks with all the authority of her position as Chair of the Training Committee of the Westminster Pastoral Foundation and as Chair of the Psychoanalytic and Psychodynamic Section of the UKCP.

It is somewhat uncomfortable reading at times. Murdin writes, 'trainees (in analytic psychotherapy) ...will hope not to have to deal with an ending in their training cases' which came as a surprise to me. I have certainly had to deal with endings, some satisfactory and some not, during my time as a trainee. Murdin provides analytical explanations of endings related to patients' fear of the trainee's lack of experience. For example, patients who say they have to leave because of a new job/course/ relationship, or because they cannot afford the fees might be seen as offering rationalisations that could be interpreted in terms of what the patient is prepared to entrust to a trainee-analyst. Murdin argues that failing to keep a patient in therapy for a long time (specified in more hierarchical, psychoanalytic trainings as one patient three to five times a week for two years and one patient two to five times a week for eighteen months) is a 'disaster' for the trainee. The requirement in the Outfit is less explicit, although our guidelines make it clear that we should be working with patients long term. I respected the honesty with which Murdin discussed how the requirement to keep the patient in therapy could lead trainees to practise defensively and to collude in keeping a patient in therapy. She goes on to point out that, because of this, the trainee 'is least likely to be able to address the possibility of ending in a way that makes it a constructive part of the work. Yet that above all is what the patient needs.'

Some of the assumptions of a conventionally taught training are apparent here. The virtues of our own democratic and open-minded approach, however, have their own vicissitudes. For example, the process of deciding on the readiness of any individual to graduate is a shared, distributed understanding that is sometimes difficult to discern or respond to. The invitation to the trainee to ascertain his or her own readiness and then submit to the scrutiny of his/ her peers certainly leaves space for other ways of assessing whether a trainee is safe to work with patients, but can also lead to misunderstandings and disagreements about whether or how to present oneself for graduation. For this reason, and others - such as our radicalism in not imposing one structure or stricture on the varieties of ways people seem to be able to help other people - we may find the authoritative tone

of this chapter does not fully engage with our different procedure. Nevertheless, the challenge to this reader is to define clearly to herself and others what she does think is convincing evidence of her ability to practise psychotherapy well, and to articulate this clearly when it comes to her own graduation.

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