The Therapeutic Conversation

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Editorial

Welcome/Kia Ora to the 4th issue of The Therapeutic Conversation.

It is encouraging to see the continuing high calibre and diversity of contributions to The Therapeutic Conversation (TTC). It is with mixed feelings that I wish to let you know I have decided to step down from the role of TTC Editor. I have seen the journal grow from the seed of an idea in the minds of a group of therapists from the UK, NZ and Australia. This group explored ways of forming an international, collaborative group committed to The Conversational Model. I first became involved when I began as Editor for the ANZAP Bulletin in 2018. At that time, the Bulletin comprised information about ANZAP committees. Trainee dissertations were published and members of ANZAP were profiled. The first shoots of TTC appeared in January 2021, and it now provides an opportunity for trainees and members of ANZAP and the UK's Psychodynamic Interpersonal Therapy Special Interest Group (PITSIG) to publish work relevant to the process of psychotherapy. I have thoroughly enjoyed my work with the PITSIG/ANZAP strategic planning group and with authors of papers, reviews and reports both for the ANZAP Bulletin and for TTC. I thank you all for your generosity of spirit, your hard work and your sense of humour as we have all worked together to nurture a high quality, thought-provoking journal. I would also like to acknowledge Leo LaDell for his fabulous work in formatting the journal. Thanks Leo.

Within these pages, we again have a range of powerful papers and reviews. The first paper presents the rationale and case studies for the use of psychodynamic interpersonal therapy (PIT) for psychosis. The 2nd paper outlines the extensive, moving involvement that is part of psychoanalytic infant observation. The 3rd paper contains an important review of indirect learning methodologies in developing beginning and experienced psychotherapists. A review of the film and book The Lost Daughter incorporates themes from Freud's The Interpretation of Dreams and Robert Graves' Greek Myths as it skillfully articulates the portrayal of multiple layers of our psyche in motherhood. We also have our much loved section which reports on the activities of our organisations, PITSIG and ANZAP.

I hope you enjoy the contents of this issue of TTC and I look forward to accompanying you as a fellow reader of the journal into the future. I am delighted to introduce Chris Garvie who will be the new Editor for TTC. Originally from Scotland, Chris Garvie is a psychiatrist who works in private practice in Wellington. Chris trained in the Conversational Model with ANZAP. I wish you well in your adventures with TTC Chris.

Warm regards, Margie Darcy

Part I: Papers

PIT for psychosis: rationale and case examples

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Psychosis

Psychosis refers to a 'loss of contact with reality' and is defined by experiences such as hearing voices and other unusual sensory experiences ('hallucinations') and holding beliefs that are considered unusual ('delusions'). Diagnostic categories of psychosis include schizophrenia and other psychotic disorders. Psychosis can be associated with severe suffering, disability, and 15 to 20 years reduced life expectancy (Schizophrenia Commission, 2012). One percent of the population is diagnosed with psychosis, but it accounts for 30% of adult mental health and social care expenditure in England, with total societal costs estimated at £11.8 billion a year (Schizophrenia Commission, 2012).

Current treatments and evidence gap

Antipsychotic medication is the mainstay of treatment, but 40% do not respond and 50% do not take medication as prescribed (Samara et al., 2019). People with psychosis want access to psychological therapy as adjuncts or alternatives to medication (Byrne & Morrison, 2014). In the UK, psychodynamic therapy is not widely accepted as an intervention option in psychosis services or clinical guidance (National Institute for Health and Care Excellence (NICE), 2014). There is a similar absence of psychodynamic therapy from treatment guidance in the US (Keepers et al., 2020). A major barrier is the lack of relevant randomised controlled trial (RCT) data, upon which treatment guidance is based. A handful of early RCTs of psychodynamic therapies for psychosis conducted in the 1970s and 1980s resulted in mixed findings (Malmberg et al., 2001). However, these early studies occurred in inpatient settings, lacked manualised treatment protocols, and were influenced by traditional psychoanalytic perspectives rather than a contemporary psychodynamic approach with supportive elements. There is a stronger tradition of psychodynamic therapy for psychosis in Scandinavian countries. A more recent Danish trial of supportive psychodynamic therapy for psychosis found a significant improvement in social functioning among those receiving therapy versus treatment as usual (Rosenbaum et al., 2012). However, treatment allocation was not randomised, leaving the study open to criticism (e.g. potential bias).

The largest evidence base is for cognitive behavioural therapy for psychosis (CBTp). Research groups, largely in the UK, have been conducting CBTp RCTs since the 1990s. As a result, national clinical guidance in the UK recommends that CBTp is offered to everyone with psychosis (NICE, 2014). This has resulted in significant national investment in accredited CBTp courses to train more therapists. However, problems accessing CBTp remain, especially for those outside of early intervention for psychosis services (The Royal College of Psychiatrists, 2018). A further proportion struggle to engage or ultimately benefit from CBTp, with efficacy being modest overall (Jauhar et al., 2019). There is a need to "energetically pursue" (Waters et al., 2022, p.25) new treatment options for voice hearers, who frequently voice a need for treatment choice (Byrne & Morrison, 2014).

Psychodynamic and interpersonal processes in psychosis

Over recent years there has been a shift in our understanding of psychosis. Contemporary researchers are returning to the ideas of Janet, Blueler and Freud in recognising the role of trauma, emotional processes, attachment and dissociation, and their role in the development of psychosis (Moskowitz et al., 2019). Bleueler (1906) argued that affect is the driving force of schizophrenia, an idea extend-

ed by Birchwood (2003) who describes emotional problems as intrinsic to psychosis and its development. Bleueler originated the term 'schizophrenia'; meaning 'split mind' (Bleuler, 1908). The concept of 'splitting' is broadly similar to current definitions of 'dissociation' as 'the disruption of the usually integrated functions of consciousness, memory, identity, or perception of the environment' (American Psychiatric Association, 1994, p. 477), and is a psychological response to trauma. Several contemporary researchers assert that psychosis is a dissociative affect regulation response to overwhelming emotions, associated with childhood trauma and disorganized attachment (e.g. Berry & Bucci, 2016; Liotti & Gumley, 2019; Longden et al., 2020).

There is robust evidence from meta-analyses that childhood adversity (physical, emotional and sexual abuse, bullying and neglect) is a risk factor for psychosis (Varese et al., 2012), as well other forms of relational trauma such as caregiver unresponsiveness, misattunement, and contradictory communication, termed parental communication deviance (de Sousa et al., 2014). There is some evidence of specificity between trauma and symptom type; with childhood sexual abuse associated with voices, emotional abuse and neglect with paranoia, and communication deviance with thought disorder (Bentall et al., 2014). There is good evidence that dissociation is associated with psychosis overall (Longden et al., 2020). Brown (2006) makes a distinction between dissociative detachment and dissociative compartmentalisation. Moskowitz et al. (1999) argue the latter mechanism is more relevant to psychosis, akin to structural dissociation of personality (Nijenhuis et al., 2010). However, further research is required. Voices have been conceptualised as dissociated aspects of the self (Longden et al., 2012) or dissociated, trauma-based intrusions (Hardy, 2017). Many delusional beliefs arise as a way of making sense of powerful emotions and unusual sensory experiences (Maher, 1974; Freeman et al., 2002), which may be trauma-memory related (Moskowitz & Montirosso, 2019). It has been argued that psychosis has a shared pathway with dissociative disorders and borderline states in terms of trauma and attachment disorganization leading to affect dysregulation and dissociation; with a more specific psychosis pathway being the subsequent development of an avoidant attachment style in a defensive attempt to deactivate attachment needs (Liotti & Gumley, 2019). Where psychosis is hypothesised to have other causes (e.g. drug induced psychosis or other neurobiological causes), relational and affective processes are still key to the maintenance of distress and symptoms. For example, early relational experiences shape the way people make sense of, feel emotionally, and cope with their psychosis symptoms, irrespective of symptom cause (Morrison, 2001) and further influence how people relate to others and engage with services (Liotti & Gumley, 2019). People with psychosis frequently present with social withdrawal, high levels of social isolation and poor support networks (Palumbo et al., 2015), which can be a greater source of distress than psychosis symptoms themselves.

Service user perspectives

The international Hearing Voices Movement (HVM) is a prominent mental health service-user/survivor movement that promotes the needs and perspectives of experts by experience of hearing voices, seeing visions and related phenomena. The main tenet of the HVM is the notion that these phenomena are meaningful human experiences, which, in most cases, be understood and interpreted in the context of emotional life events and interpersonal narratives (Corstens et al., 2022). We can greatly enhance our understanding of psychosis by listening to the perspectives of experts by experience.

Eleanor Longden, now respected researcher in the field of trauma and psychosis, provides the following account in her powerful TED talk "The voices in my head" (Longden, 2013): "My voices were a meaningful response to traumatic life events, particularly childhood events, and as such were not my enemies, but a source of insight into solvable emotional problems." She goes on to state: "Throughout all of this, what I would ultimately realise was that each voice was closely related to aspects of myself, and that each of them carried overwhelming emotions that I'd never had an opportunity to process or resolve. Memories of sexual trauma and abuse, of anger, shame, guilt, low self-worth. The voices took the place of this pain and gave words to it. And possibly one of the greatest revelations was when I realised that the most hostile and aggressive voices actually repre-

sented the parts of me that had been hurt the most profoundly, and as such, it was these voices that needed to be shown the greatest compassion and care. It was armed with this knowledge that ultimately I would gather together my shattered self, each fragment represented by a different voice, gradually withdraw from all my medication, and return to psychiatry, only this time from the other side…". Longden speaks eloquently about her voices as a source of insight, her realisation that they were different parts of herself which functioned to contain unbearable emotions related to past trauma, and how this insight led towards her recovery.

The themes of the meaningfulness of psychosis experiences, and the importance of understanding and acceptance, are mirrored by others with lived experience of psychosis. Rachel Waddingham, independent mental health trainer and consultant, states: "I choose to live alongside my experiences, rather than suppress them with large doses of medication. To me, they are not symptoms - they are meaningful responses to a life that has thrown many challenges my way." (Waddingham, 2022). Rufus May, clinical psychologist with personal experience of psychosis writes: "For us there seems to be two attitudes that can help us get closer to psychotic experience. Firstly, there is acceptance; it seems essential to become more accepting of diverse ways of perceiving the world. Secondly it seems useful to try to understand and find meaning in psychotic experiences. They are imbued with social and psychological meanings and if we can find ways to explore these meanings together, the experiences may lose their power over us." (May & Svanholmer, 2016). May is also vocal in his criticism of current service provision for psychosis, particularly medical models of treatment, but his criticism also extends to CBTp. In a 'rap' he performed at a debate on CBTp (May, 2008), he asserted:

"You must go very carefully

With techniques that push rationality.

Because it is only one world view

And the person on the receiving end may not thank you…"

"So my last word is creativity holds the key

Listen to your heart as well as your head

And together we can demand more than just CBT!"

Finally, Alison Branitsky, service user researcher, offers the following view on services:

"Mental health services are terrified of strong emotions. They don't look deeply enough at emotion." She adds, "If you can express your feelings like your hurt, anger and despair, then there is less need for a voice to do that for you." (A. Branitsky, personal communication).

In summary, their perspectives concur with a relational and emotional understanding of psychosis. The implication is that services need to offer choice and alternatives to medication and CBTp, including exploration of personal meaning and of the 'heart as well as the head' (May, 2008). Psychodynamic Interpersonal Therapy (PIT) offers a 'heart to heart' conversation and is distinct from anything currently offered in psychosis services. It has the largest evidence base of the relational therapies in terms of RCTs, with at least 17 such trials conducted to date and another 3 in progress (Murphy et al. 2022). PIT has been shown to help people who are deeply traumatised with a diagnosis of borderline personality disorder (Stevenson & Meares, 1992; Walton et al., 2020) and people with severe mental health problems that have not responded to previous treatment (Guthrie et al., 1999). Due to limited evidence in the psychosis field, PIT cannot be formally recommended for psychosis at this stage. However, growing evidence from research into relational processes in psychosis, service user perspectives and our clinical experience working with psychosis, suggest that PIT warrants further exploration and evaluation.

Clinical experiences delivering psychosis therapy

Across the field of psychotherapy research, it is known that effectiveness is broadly equivalent for different types of bona fide psychological therapy in comparative research trials across large groups

(Walmpold et al., 1997), including psychosis interventions (Jones et al., 2018). However, at an individual level, a particular therapy may be advantageous given personal needs and preferences. For example, crossover trials in PIT for depression showed that some people had better outcomes in PIT compared to CBT, as well as vice versa (Shapiro & Firth, 1987). We provide the following reflections from clinical experiences of providing adherent, protocol-driven therapies for psychosis within context of research trials. We consider limitations of prescriptive approaches and whether PIT may have been a better fit in these instances.

Early formulation as too anxiety provoking

Therapy protocols typically involve developing a psychological formulation during the initial sessions from the perspective of a particular treatment model, from which to base intervention plans. For many people, the potential link between past experience and psychosis is outside their awareness. A well-timed link between past and present can bring a huge shift in understanding and relief, but this 'developmental' formulation can be painful if premature. Often, CBTp protocols prioritise work at the 'maintenance' formulation level for such reasons, though can arguably risk leaving core issues unaddressed. PIT can also involve developing a working formulation in the early sessions, but the formulation is continually developed in the conversation throughout the course of therapy, arising from shared feeling rather than an intellectual process (Barkham et al., 2016). There is less separation between formulation and intervention phases. Hobson wrote 'the form of a developing conversation often is the diagnosis and also the treatment' (Hobson, 1985, p 177).

When working with a man who experienced significant childhood losses and trauma, a developmental formulation was created prior to the intervention phase as outlined in the therapy protocol. His voices were experienced as demons who ranted incessantly about his losses as an orphan and child refugee; yet he denied any sadness. The formulation link between his trauma and voices appeared to make immediate sense to him. For one week he allowed himself to grieve, and interestingly, the voices stopped. However, the following week he felt overwhelmed and developed panic attacks. Although he continued to meet with the therapist, he rejected the psychological formulation and subsequent intervention tasks. Perhaps if he had been offered a PI therapy, the formulation links could have been made gradually through conversation and developing a 'shared feeling language'. The sharing of grief could have been facilitated throughout the course of therapy, attuned to his window of his tolerance, and he may have experienced more lasting relief from his voices.

'Jam jar' versus feeling language – therapy as too rational/intellectual

CBTp can bring genuine relief from distressing beliefs; however, cognitive work does not always result in a head-heart connection. One example involves working with a man with a diagnosis of treatment resistant schizophrenia, who believed that he was horribly disfigured and avoided leaving the house. He engaged with a full course of CBTp involving interventions such as video feedback, and 'behavioural experiments' where he visited shops with the therapist to test his fears that people would stare and recoil. There was a temporary shift in his view of himself, but the change was not maintained. He remained socially isolated despite persistent attempts to facilitate social engagement. At the end of therapy, he communicated having valued the therapeutic relationship, but he ultimately remained in his state of loneliness. On reflection, the therapy had not enabled a deeper exploration of the feelings linked with the roots of his problem; his deeply low self-esteem and a lifelong theme of interpersonal rejection, which his disfigurement beliefs may have been a symbolic expression of.

Anxious avoidance of therapy sessions

Protocols for trauma focused CBT involve memory interventions such as 'reliving' the memory (Foa & Rothbaum, 1998). When working with a woman who heard voices and experienced severe flashbacks of childhood trauma, despite her initial difficulties with trust, she started to engage in an emotional conversation. She disclosed more openly about her painful feelings and her fractured sense of self, but also her search for meaning through spirituality and her sense of compassion. However, when approaching memory work, she repeatedly cancelled sessions. She eventually confessed that

she was fearful of facing her past. Her distressing flashbacks and intrusions remained unaddressed. Although she did not engage with the structured intervention sessions, she engaged for a final goodbye session. She communicated that it was a unique experience feel listened to and understood. An exploratory PI therapy may have offered her an opportunity to explore at a pace that was more responsive to her window of tolerance. Perhaps she could have felt able to process her painful past experiences within the conversation and an attuned relationship, as opposed to being confronted by the daunting task of a memory work session.

Presenting with interpersonal problems

People with psychosis often prioritise problems that do not involve direct work on psychosis symptoms, many of which may be considered suitable for PIT. These include problems of low self-esteem, grief and loss, self-harm and trauma; and relationship problems such as fears of intimacy, difficulties with assertiveness, or feelings of jealousy or mistrust. Psychosis symptoms themselves can be conceptualised as relational problems. For example, paranoia concerns a sense of interpersonal threat; and distressing voice hearing involves a problematic relationship with the voice itself. Other people appear to prefer a different kind of conversation, a sense of wanting to explore more meaningfully and deeply. When asked for feedback at the end of sessions about what was most helpful, they say it was the experience of sharing and being listened to, rather than the technical interventions used in the session.

Treatment resistant psychosis

People with diagnoses of 'treatment resistant psychosis' are usually on very high doses of antipsychotic medications, and often experience long stays on psychiatric wards with limited access to psychological therapy. Our experience is that some people with this diagnosis have responded well to CBTp, seemingly because no one else had engaged them in a conversation to gain a different perspective on their distressing experiences. However, for others it can be difficult to identify goals to work on in a structured therapy, and conversations to identify the main difficulties can feel vague and confused. It has been suggested that PIT may be suited to engaging people with a lower level of assimilated understanding of their problems (Stiles et al., 1990). Others have presented as very withdrawn and as struggling to answer questions and may have benefitted from a 'statements' rather than questions approach and time to develop a shared feeling language. Some people may present with significant thought disorder and can appear tangential and distracted, but often feeling drives the thought disorder, and there is a sense of meaning and symbolic communication in the tangential speech. Perhaps therapists can arrive somewhere meaningful by following the signs and symbols in the conversation, rather than having to keep re-directing to a structured agenda. These themes are explored further in accounts of case studies of psychosis, as follows.

Case studies of PIT for psychosis

There is one peer-reviewed publication of PIT for psychosis. Sarah Davenport published two PIT case studies with a diagnosis of treatment resistant schizophrenia in inpatient settings, in collaboration with Frank Margison and Robert Hobson (Davenport et al., 2000). Both individuals had complex needs, poor engagement, and had made little improvement despite intensive psychiatric inpatient nursing for over a decade and repeated attempts to engage them in CBT. A description of one of the case studies is provided below.

Case study A

The 43-year-old male was described as "violent and inaccessible' and 'unmanageable, exquisitely sensitive to interpersonal stress and impossible to engage'. He had a history of repeated childhood sexual abuse by staff in residential unit for epilepsy, and in adulthood during a prolonged hospital admission. His symptoms included auditory, visual hallucinations and thought disorder. He presented with recurrent violence to others and with severe self-injury of swallowing sharp objects or penetrating his abdomen with pens.

Although the early sessions were described as being 'flooded with material', he commented that he was eventually able to feel calmer and reflect on the content of his thought disorder, both verbally and via pictures that he drew to use in the sessions. Davenport writes: "Gradually links about

fears of penetration were possible, linked with past events and also his abrupt shifts from hypervigilance to sudden violence if he felt any interpersonal intrusion. When over-aroused he would hallucinate a gun and react violently as though to flee the threat. These experiences were reflected to him in nontechnical terms with tentative explanations linking past with present and suggestions about why he might overgeneralize from earlier trauma (particularly given the history of abuse by staff in the past). The essential links concerned the fear of penetration by his abusers and his way of controlling these fears by making penetrating injuries on himself. At about the time he was able to put these connections into words, his self-harm reduced markedly. Further work has continued on his experience of the power relationship with the therapist, and how he was able to hold onto a degree of power by bullying or intimidating others." (Davenport et al., 2000, p.293).

After 17 months PI therapy he made notable changes. He achieved a 42% decrease in a measure of psychosis symptoms (Krawiecka et al., 1977) and 75% change in severe problem behaviour scores (Wykes & Sturt, 1986). Although the case study design does now allow inferences of causality with respect to treatment effect, the outcome is remarkable given the history of a chronic lack of engagement and progress. Davenport et al., (2000, p. 292) summarise their learning for how the PIT model needs to be used with people with psychosis and schizophrenia:

- Working with the extreme levels of anxiety present in a psychosis, it is important to establish empathic contact early whilst being aware of the patient's fear of being understood too deeply, too soon.

- The sensitivity to the patient's level of anxiety needs to be finely tuned as the gap between being overwhelmed and `shutting off' is very narrow.

- Boundary issues and containment often need to be specifically mentioned to allay anxiety, for example, by being clear about the purpose of the meeting and how long it might go on for.

- The therapist uses a clear and unambiguous style, but offered with tact and a willingness to negotiate the meaning of what is being discussed.

- The therapist needs to be especially aware of the possible sudden drops in self-esteem if a comment attacks the current defensive style, or discounts the delusional beliefs that sustain feelings of self-efficacy.

- Therapists using this model often draw on metaphor as a `meaning bridge' between different, split off aspects of discourse. In psychosis it may be hard to maintain this metaphorical quality as the patient may have experienced serious difficulty with basic reality testing.

In summary, they report examples of the feasibility of building a treatment alliance using PIT even for people with severe presentations of psychosis who have not responded to lengthy hospitalisation or other therapies. Poignantly, this may also have been the last published work that Robert F. Hobson contributed to before he died in November of 1999. Hobson was reportedly very interested in working with psychosis (R. Hobson, personal communication) as can be seen in the next example.

The case of 'Stephen'

Hobson describes some of his work with psychosis in Forms of Feeling (Hobson, 1985, p. 9 to 5). He was asked to see a boy of 15 years, 'Stephen' who had a recent diagnosis of schizophrenia. Stephen presented as motionless and never looking at him. Hobson describes trying to understand what Stephen was experiencing in response to his barely detectable body language: 'I reckon that you are all screwed up inside'; 'I feel that you are really scared. It is terrible to be locked up with a volcano inside but terrified to emerge'; 'Just now I sensed that you felt really mad, but scared… I wonder if you are scared of hurting… or being hurt'. He describes 'hoping for a conversation; a dialogue in which I am involved. I seek a "togetherness" whilst respecting Stephen's "aloneness"; not wishing to either to intrude on his personal space or promote alienation. Although all the suggestions that I made at the time were subsequently shown to be reasonably "accurate", at that time they were wrong because I could not find an appropriate feeling language with which he and I could share, here and now.' (Hobson, 1985, p. 9).

One afternoon, on impulse, he takes an old envelope out of his pocket and puts it on the table. 'Do you know that party game, Stephen? Someone draws a line and then someone else goes on with the picture. There's a line. Let's play together and see what comes out of it.' He states: 'The phrase "see what comes out" of it suggests a "symbolical attitude" as described by Jung. It is an invitation to explore the unknown, an adventure which calls for courage. It can only be undertaken by Stephen in the security of a relationship which involves trust.' (Hobson, 1985, p. 10).

Hobson draws a sweeping line. Stephen hesitantly takes the pencil and draws a ship. Hobson's line emerges to be a terrifying tidal wave. Hobson then takes the pencil and draws a landing stage, but Stephen indicates non-verbally that this is not what he is seeking. He takes the pencil and draws a man or boy waving goodbye. Hobson quickly draws a woman waving goodbye, hypothesising that Stephen's problem is associated with an emotional separation from his mother. Stephen draws again and speaks for the first time 'a flying fish'. Hobson says he does not seek to 'explain' his peripheral awareness of phallic fishes and clinging devouring mothers, but continues with the game and draws an octopus. Stephen slowly marks lines across the picture. ''It is raining" he says with a sigh of sad resignation. Bob draws a sun with its ray's conflicting with the rain. Stephen pauses, then looks at Bob. With a sweeping hand her draws embracing lines; "A rainbow." Stephen smiles. Bob smiles. A moment in and out of time. (Hobson, 1985, p. 13).

Hobson concludes: 'Stephen remained in therapy for just over a year. That Thursday was a turning-point but it was only the beginning of a tedious-exciting process of exploration. The spectacular vision of a rainbow was certainly not a miracle cure. It washowever, an important step – an evocative "phrase" in developing a conversation.' (Hobson, 1985, p. 15).

Summary and conclusions

Given that PIT fundamentally targets emotional and interpersonal processes, it appears to be a fitting treatment model given our increased understanding of these processes in psychosis both from research evidence and the personal accounts of experts by experience. Case studies of PIT further reveal its potential, and PIT is known to be of benefit to other groups of deeply traumatised individuals in clinical trials. However, further evaluation is needed. We currently in the process of applying for research funding to evaluate PIT for psychosis further, involving a collaboration between the worlds of PIT, psychosis research and university colleagues in Manchester, UK (Liz Murphy, Sandra Bucci, Frank Margison, Richard Brown, Rebecca Hughes, Joanna Brooks and Tony Morrison). It is timely that we finally work towards a randomised controlled trial of PIT for psychosis so that we can provide meaningful choice to meet the needs of our service users.

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What's Love got to do with it?

An infant Observation

It's not for the faint hearted

Dianne Hendey

Abstract

Psychoanalytic infant observation is an experiential approach to training that was developed at the Tavistock Clinic in London by Child Psychoanalyst Esther Bick. In 1948 she collaborated with Dr John Bowlby to develop the approach to training psychotherapy students in conducting an infant observation. It has since become an essential feature of pre-clinical training in child and adult psychotherapy, psychoanalysis, and related fields throughout the world.

This Infant Observation training was under the auspices of the Wellington Centre for Psychotherapy - Lucy Zwimpfer, Alisa Hirshfield, Matthew Harward who all trained at Tavistock. They explained the practicalities of setting up an observation and the process of finding a baby. That the observer is not to interact or talk with the baby, or take notes. That observations take place weekly for one-hour over the first 18 months of the infant's life, in her home. The group in training met for monthly supervision to discuss our observations. The material was anonymous.

Every observation was written up, from memory, in detail, as soon after it as possible. This took about an hour.

The process of infant observation began the minute I started looking for a baby. It was difficult to find a baby and family to observe. It took a very very long time to find them. I was very nervous on my first visit before baby is born. It was evening and dark and the entrance to their flat was out of the way down a steep set of unlit wobbly steps. They both invite me in. They are at the table and eating their meal. Even though I am there at the time arranged I feel very uncomfortable that I have interrupted their meal. I apologise. They say no we've finished. They stay at the table, and I sit on the couch, and I am lower than them. I continue to feel extremely uncomfortable.

The mother was open to the idea of someone observing and the father was guarded. I directly asked their ages the mother is 36 and the father is 49. The father was not happy that I asked. On my second visit they ask some more about what I will be doing, and I repeat I will be looking at their baby and how it interacts with people. Father asks will I give him a report after each visit – about how they are doing. I say no, the purpose of doing the observation is for me to improve my skills with my clients. I say I will take a photo every month and at the end of 18 mths I will give them that record. I say that during the visits I will not interact with them as I am now, it will be as if I am a fly on the wall. I say that I've heard that at the end of the time families say they notice the person is not there and they miss them.

It was often hard to see this baby's face because except when breast feeding mother mostly wore him in a sling with his face against her body.

At around 2 months of starting the observation he and his parents moved to another city. There was sadness, anxiety, annoyance, the feeling that it was too hard to begin again and an urge to give up. The first family referred me to the second family, and I began my observation with another baby born around the same time. It was somewhat discombobulating to begin a second observation with a baby that was not a new born. I felt unsettled. This paper is about the second baby. It was enlivening to observe a baby who was responsive to me.

Before starting out, none of us can imagine what gets evoked in an Infant Observation.

The family

Mama is Samoan. Papa's family is from Europe. Mama is a medical professional. Papa is a public servant.

Baako was born at home May 2015. Papa and both grandmothers were present.

'We want Baako to be connected to where she comes from and with her languages. We enjoy watching her practicing new skills – we want to give her time to practice and master and for her to work through emotions like frustration – so she becomes resilient. We want her to learn at her own speed and our aspirations for her are she will be happy, curious, kind, independent and to find her own time and space in the world.'

There are musical instruments all around the living room, a full drum kit, guitars, and an electric keyboard. They intend to start Baako on drums and then guitar and ukulele.

The living room, including the kitchen, runs the width of the house. It is a very big space with enormous windows that look out over raised gardens with a mixture of green vegetables and pumpkins, beyond, kowhai trees and further away to the green of the distant valley. It is a beautiful view. It is open and expansive.

Almost all the things Baako plays with are ordinary everyday objects such as infant hand size pebbles, plastic bottles, metal spoons, ceramic egg holders, sea shells, sand, metal goblets, small oval glass flower holders, things with lids (and surprises inside), wooden pegs, strings of beads, glass bottles and jars. Objects Baako can put into other objects, objects that make noises, objects with lids, objects she can scoop with a spoon. Objects that can be picked up with tiny fingers. Mama puts out a selection of objects, within other objects and sits with Baako. Sometimes she puts a spoon in Baako's hand and watches what happens. Mostly she sits with Baako and talks a bit about what Baako is doing. When Baako tires of one selection, Mama puts out another and clears away the first.

Mama is relaxed about me observing. Papa is much more hesitant. Both Mama and Papa interact with Baako – feeding, changing, playing. From 2017 to mid 2018 Papa is her primary caregiver.

Imaginings
What is an infant?
What does an infant observation have to do with working with difficult emotions in psychotherapy?
Maybe the observer's trauma is re-wakened?
And then what happens?
What about hate?
And, love?

Theoretical Underpinnings

Conversational Model
I examine my experience of this infant observation from within the frame of a psychotherapist trained in the Conversational Model by ANZAP.[1] The model is designed for working with people who experienced severe trauma, often during infancy. I want to better understand what they missed out on by examining the early experience of an ordinary infant.

Russell Meares theorises that the early affective experience of babies is likely to be a 'diffuse conglomerate of sensation from skin, bowel, muscle, and other body parts'. The later distinction between physical and 'psychic components depends upon appropriateness of expressiveness of the caregivers to facial, bodily and visual manifestations of particular affective states.'… 'At first the responsiveness will be non-verbal – demeanour and facial expressiveness representing a particular affective state….

Meares describes two aspects to the self – the first 'the ordinary experience of personal existing – of the on-going flux of feelings, sensations, images, memories, and imaginings that we sense as uniquely our own and which William James called Self, (James, 1890)' and the second, ourselves in relation to our social context and specifically in relation to others. There is an ease, an enhanced sense of ones own experience and it's boundedness and at the same time a feeling of at-oneness with another that Hobson (1971) called 'aloneness-togetherness' and Meares calls 'intimacy', and used it in a technical sense to describe the exchange between two people of their inner experience.

Meares' conceptualisation is expanded in the work of McGilchrist and Schore.

McGilchrist
Modern attachment theory conceptualizes attachment transactions of early right brain-to-right brain as socio-emotional communications…….The intersubjective brain-to-brain, mind-to-mind, body-to-body construct is part of the ongoing relational framework.

Schore
Secure attachment depends upon a mother's attunement not with her infant's cognition or behaviour but instead with her infant's dynamic alterations of autonomic arousal, the energetic dimension of the child's affective state.

Lyons-Ruth et al
In my practice, the Lyons-Ruth et al paper on the

1 http://www.anzap.com.au

long-term impact of day-to-day care giving slights, is critical. Because it happened so early there are no words, the impact is not immediately apparent, it is very easy to overlook. I use it to guide my formulations and the process of my clinical work. When it's difficult to develop a therapeutic relationship, when I feel disconnected, when I realise there's been a disruption, I track back to see how I have overlooked my client, where I have not been attuned.

Lyons-Ruth and colleagues (2005) noted that quieter care giving responses such as withdrawal from emotional contact, being unresponsive or showing contradictory, role-reversed, or disoriented responses when a child is needy are the maternal responses most associated with the pathways to dissociation. Parental inability to respond is not in itself hostile or intrusive, but it has the effect of 'shutting out' the child and leaving her without an internal form of relational dialogue, and without 'an internal working model that can provide a sense of safety and reliable comfort in times of distress'[2]

Bendit

Many people we see in therapy do not experience a good enough attachment, so it is useful to consider the traumatic attack that occurs when attachment fails.

Nicholas Bendit's (2011) [3] paper about the origin of chronic suicidal thoughts illustrates the link between early relational experiences and memory in the following way. Implicit memory is the first part of memory to develop. It develops slowly after many repetitions and is quite resistant to change. Because it specifically encodes the actions and emotional experience of being with another, the interactional aspect of implicit memory is critical. Since the interactions are encoded and stored and learned non-verbally, they cannot be recalled to conscious memory. What remains is the experience of how someone did or didn't care. When a mother does not respond consistently to her baby's distress, two sets of 'facts' are stored, 'nobody cares' and 'I'm not important'. Since the interactions cannot be recalled to conscious memory they cannot be addressed by rational thought or cognitive reframing.[4] The 'facts' are difficult to describe and are 'experienced and acted out in relationships throughout life, with little understanding where it comes from or why one feels this way'.[5],[6]

> There is a phase in life when we have little control over our actions, mind or feelings, and time is endless. In the first 8 months of life, babies have little control over anything unless a caregiver helps. Furthermore….babies do not have the mental capacity to bring up the past or speculate about the future. The capacity to contextualize time as past or future occurs usually around age 8 months... Babies are 'in the moment', and therefore suffering is endless (as is pleasure!). In the situation of chronic parental non-responsiveness, the baby is stuck in an endless suffering that is recorded in implicit memory, as the events of non-responsiveness are repeated many times. [7]

Bendit's paper indicates the structural and psychological damage that can arise if early caregiving responses are not available.

Ordinary Development

This paper is about ordinary development of a child with loving and attentive parents.

The interaction between the baby and her mother begins soon after birth and is the basis of protoconversation, from which the self-organising system and the self emerge (Graham 2002).

When a mother responds to her baby's distress and to her expressions of joy and pleasure the child feels secure, safe, and protected.

A mother's responses to the child's fundamental needs for comfort and soothing are the basis of the child's biologic stress regulation (Lyons-Ruth et al 2005).

The amplification aspect of protoconversation adds a feeling of being held in regard – an affirmation, a sense of value. This transforms the baby's felt experience in the moment from something nebulous and formless to something solid and substantial (Graham 2002).

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2 Hendey. D. (2013). Dissociation: From Both Chairs. PG.Dip Dissertation. 10.

3 Bendit, N (2011). Chronic suicidal thoughts and implicit memory: hypothesis and practical implications. Australasian Psychiatry. 19:1. 25-26.

4 Meares, R., and Graham, P. (2008). Recognition and the Duality of Self. International Journal of Psychoanalytic Self Psychology. 3: 439-440

5 Hendey. D. (2013). op cit. P11

6 Bendit, N (2011).op.cit. P 27

7 Bendit, N (2011). op.cit. P 27

Relational information from the mother's very early words, facial expression and tone are stored in implicit memory. What is imbedded in memory is 'I am cared for', 'I matter'. (Bendit 2011). Memory is important to the development of self because it means an adult can locate themself in time and space. 'I' continue. I have a past, I exist now and I have a future' (Graham 2002)

Winnicott

'There is no such thing as a baby… If you set out to describe a baby, you will find you are describing a baby and someone. A baby cannot exist alone, but is essentially part of a relationship' (Winnicott, 1947).

Observation: 3 ½ months old 19-8-15

Mama is walking around the room rubbing Baako's back and she burps. Mama wipes her mouth. Mama keeps walking and rubbing and murmuring sometimes singing. Baako is fighting going to sleep. Round and round. After 10 minutes Mama places Baako into her cot and drapes the paisley gauze across the top. She tucks Baako in. Baako is not happy she wriggles and screws up her face and lets out a loud cry. Mama stands beside the cot and rocks it still murmuring. Baako does not settle. Then Mama moves around, sits on the sofa behind the cot, leans over and rocks it still murmuring and singing. Baako wriggles, gnaws at her hands, quietens looks at her mother looks at me then unsettles again. Mama keeps rocking while she rubs Baako's tummy. Baako wriggles and lets out another loud cry. Mama keeps rubbing and rocking. Baako settles for a bit and then wriggles and cries. Mama picks her up and says I'll put you on my shoulder and begins again to walk around the perimeter of the room holding Baako and rubbing her back. I can see Baako's body and some of her face. Baako settles for a little with her eyes closed and then her body tenses and she cries, then settles and cries. She is fighting her sleepiness. Mama keeps walking around the room. On one circuit Mama rolls a Swiss ball out from under the dining table with her foot and in one-movement sits on the ball bouncing still rubbing Baako's back. Baako is quiet but she is not asleep. Her eyes keep drooping and then opening. Then she stretches her whole body her legs, her feet, her arms, her hands, and her head. Then her eyes droop again. She stretches her body her legs, her feet, her arms, her hands, and her head again and begins to cry. Mama moves from the Swiss ball to the rocking chair that is in front of the window and begins rocking. She lifts her top, places Baako on her back and offers her left breast. Baako settles, a bit. She sucks some more and her eyes close. Then she stretches her legs and feet, her arms and hands and makes little noises, I think these are noises of discomfort. Mama says she's been unsettled I think we are both a bit unwell. I think she's teething. She removes her breast and adjusts her clothing, moves Baako so Baako is lying against her front and keeps rocking. Mama's eyes close a bit. Baako is quiet but not asleep.

Impact on me.

I remember what it's like with a baby who cannot settle. I feel a surge of admiration and a rush of jealousy of Mama who is more able than I was to tolerate being unable to soothe my baby.

Theory

Mama continues soothing, even though nothing seems successful. She seems able to bear Baako's distress and just keeps on. It's as if she is aware that her being with Baako and her distress is what is important. Graham, P. & van Beine, L. (2007)

At the end of the observation, Mama and Baako look like Madonna and Child and this image illustrates the perfection of the child/mother bond. But Mama and Baako are exhausted and it's a reminder that while mother/child images look restful, it's easy to overlook what a mother has been doing for them to reach that place. As Winnicott says a mother has to be able to tolerate being frustrated, even hating her baby without doing anything about it. Baako is telling Mama that she hurts. We could describe this as if the feeling of being 'one' is disrupted. Mama holds Baako loosely to her body, gently rubs her back, sings, moves around with her, and offers the comfort of her breast. At this age there is no distinction between physical and psychic pain. Because she has no concept of time, without Mama Baako might have experienced her pain as being forever. However, by being with Baako and soothing her, Mama is ensuring she does not feel alone, repairing the togetherness. In this way Mama is establishing the basis for Baako to be able to regulate her affect by herself later on.

Not only this, when Mama responds to her, Baako experiences agency. Baako's crying initiates Mama's response. This is in line with Beebe's (1982) Micro-Timing research of infant-mother interactions that concluded it is the infant who leads in getting the mother to react, and also with Trevarthen and Delafield-Butt (2017) who go much further. They consider the foundations of conscious human agency are built when the in-

tentions and feelings and their evolution in life of an individual infant are created intuitively and communicated directly to sympathetic others, without words. 'We do not believe any formulated meaning of the word (conscious) can make sense without accepting the primary impulse to act with anticipation of the consequences.

Mothers' right frontal areas are activated during episodes of infant distress. When they see their own infants in distress, mothers express negative affect matching—sadness, concern, irritability, and the absence of joy. Attachment is thus fundamentally the communication and interactive regulation of emotion. (Schore 2017)

Secure attachment depends upon a mother's response to and attunement …. with her infant's dynamic alterations of autonomic arousal, the energetic dimension of the child's affective state. (McGilchrist 2009)

A mother gives meaning to the baby's otherwise diffuse and amorphous experience. …. The baby looks into her mother's face, and finds there a 'meaning' for her feeling at that moment (Meares 2016).

The basis for the feeling of 'ongoing' is being developed. Mama's ongoing presence holds Baako's experience.

Observation: 5 ¾ Months 28-10-15.

Baako sees Papa come into the room and waves her arms and legs. She makes pre-verbal noises and Papa response mimics her exactly in sound and pitch. Papa is in the rocking chair at Baako's head – she can't see him (but she could if she rolled over). Baako turns her body to left, but her arm gets stuck, rolls back a bit, and then forward still stuck on her arm then over she goes and her hands open and close and open and close sort of like she is imagining a rattle in her hand and then she finds the rattle and Mama says ka pai (well done, or oh wow!). Baako seems to clap her feet.

When Baako's whole body tells her Papa that she is pleased to see him and he tells her he is delighted in her they demonstrate that language originates as an embodied expression of emotion.[8] It is as if their delight radiates out over me as well.

Language is bodily skill that is acquired through imitation, by the emotional identification and intuitive harmonisation of the bodily states of the one who learns with the one from whom it is learnt. … it originates in the brain as an analogue of bodily movement, and involves the same processes.[9]

This is an example of both Mama and Papa engaging in protoconversaton with Baako. It consists of coupling, amplification, and representation. Here, coupling describes the Papa's response to Baako's positive emotional state – he joins in and this leads to an escalation of emotion and its expression. This amplification includes the experience of value for Baako when her father's face shows his delight and adoration. Baako experiences this as a delight in her. The first representation is the reflection of the Baako's emotional state in the father's face and voice. His expression is equivalent to a word and it gives a reality to what his baby is feeling.[10]

The amplification aspect of protoconversation is more than mirroring back or doubling of what is seen and felt, it adds a feeling of being held in regard – an affirmation, a sense of value. The recognition aspect of amplification is an affirmation of worth. Value and worth transform the Baako's felt experience in the moment from something nebulous and formless to something solid and substantial. 'Gradually, a shared meaningful reality is shaped, and it is the game-like quality, that elicits pleasure in both, which seems to be the foundation stone for development'.[11] When Mama says ka pai, she puts words to the feeling of achievement and adds to Baako's experience.

I am struck by the way both parents let Baako struggle to work out for herself. They are both there with her and they encourage, notice and admire when she manages to free her arm and roll over and pick up the rattle and can also see Papa.

Observation: 9 months. 17-2-16. Two

8 McGilchrist, I. (2009) The Master and his Emissary: The Divided Brain and the Making of the Western World. Hobbs the Printers Ltd. UK. 122.

9 McGilchrist, I. (2009) op.cit. 122.

10 Meares, R. (2005). The Metaphor of Play: Origin and Breakdown of Personal Being. 3rd edition. Hove, UK: Rutledge Taylor and Francis Group. 172-173.

11 Graham, P. (2002). The Duality of Consciousness. The Self in Conversation. V i. ANZAP 39.

Babies

Ona and her mother are present. Mama is going to be caring for Ona too. Ona is two weeks older. The two babies have spent a lot of time together. Ona is coming Wednesdays and Thursdays. When I hear this, my inner self becomes dysregulated.
Much later I realise that this dysregulation is alerting me to an early mostly unconscious trauma.

Ona says bababa. Mama says bababa. Baako says bababa. Mama does not respond to Baako. Baako turns away from Mama, throws the cushion away and turns back to Mama. Mama is talking with Ona. Ona is pushing the keys on the keyboard and Mama says you want to make a noise I'll turn it on. When she does Ona puts her palm down on a lot of keys and makes a noise. Baako has been watching then she turns her back on her mother, picks up another cushion and throws it down. Then she stops and focuses on something dangling. Mama says you're looking at the feather Baako. Baako doesn't move. It's like she is frozen. While this is happening, Mama continues to talk with Ona. She and Ona's Mama talk about Ona's Mama leaving the room and where else she might go in the house. Mama picks up Ona and puts her on her knee. Ona's Mama leaves the room. Mama talks with Ona and both Baako and I hear Mama is using the same words and tone she usually uses with Baako. Baako turns stretches out her arms and her legs and screeches. Mama continues to talk with Ona who remains on her lap. Baako gets on her hands and knees and rocks and then goes back on her tummy. Mama and Ona continue focusing on each other. Baako looks at Mama. Baako stretches her arms out to Mama (like Mama does to her every time she picks her up). Mama ignores her. Baako starts somehow moving in the general direction of Mama – not quite crawling – but moving in some way. Mama notices and says come over and join us Baako. Baako does not move. Mama says it again. Baako does not move. Mama gets up from the floor with Ona and they come over to Baako. Mama leaves Baako where she is and passes her a box with something in it, Baako discards it and, still holding Ona on her lap, Mama passes Ona a string of buttons from one of Baako 's toy boxes. Baako puts her hand out to grab. Mama passes Baako another object, Baako throws it away and continues to grab the string of buttons that Ona has. Mama passes Baako a string of beads and Baako throws it away and continues to grab Ona's string of buttons. Mama says oh don't want that one and passes Baako a different string of beads. Baako flings them around. Ona has crawled off Mama's lap and has got her leg tangled in the string of buttons – Mama says oh Ona you've got tangled. Baako moves round to grab the string of buttons. Mama passes Baako two round lidded boxes with objects inside and Baako tears the lids off and throws them.

Baako must come to terms with the paradox - How can my Mama be my Mama and behave like she does with me, to another?

Baako is no longer the centre of her universe. Ona is on Mama's lap, in Baako's place. Mama is talking to her in the way she talks with Baako. Baako cannot speak her upset and anger. Yet her posture, gesture, actions and sounds clearly demonstrate her objection. She shows her feeling of being put aside by turning her back on her mother. When that doesn't work she throws things, screeches, grabs things. In particular, she takes the things Mama gives Ona and throws them away. It is as if she is showing physically that she wants Mama back for herself and to throw Ona away. Later it was pointed out to me that the fact that Baako is free to express her feelings in this way indicates a resilience: a strong attachment (or as Meares describes it 'form of relatedness'): a differently attached child may have ignored what was happening, might have frozen, might have shut down.

It was painful to watch Baako's distress. I am the oldest in my family and my next sibling was conceived when I was 6 months old. My mother had extreme morning sickness. After the birth it was hard for her to successfully attend to my needs and meet those of her sickly newborn. In the moment I am both Baako and my young self. I am angry with Mama. Right in that moment, the anxious part of my adult self is drawn strongly to step in and make it better: I try to show Baako nonverbally that I feel how she is feeling. Or perhaps it is so I do not have to tolerate the anxiety Baako is experiencing. My adult self judges Mama as cruel and uncaring. I expect her to become angry, and she doesn't. I want Mama to fix it for Baako and for me, to make it better. She doesn't. I want to tell her what to do. I find it difficult to sit with my feelings and judgements and urge to make it better.

Afterwards I weep in my car. It is hard to keep going back, for seven more months. Difficult emotions. Thank goodness for therapy.

Baako and Mama and Papa negotiate this para-

dox. It is as if Mama being there with Baako as Baako experiences her rage and loss somehow helps Baako tolerate the pain of Mama being with Ona. Just as she helped her tolerate the pain when Baako was teething.

Observation: 13 Months 8-6-16. Mama is with Ona. Baako is with Papa.

At times when Mama is with Ona, Papa and Baako play.

Baako looks in the direction of the swing that is hidden inside the cedar tree. Papa asks want to go on the swing Baako – she keeps looking – you want a swing – she points in the direction of the swing.

Papa carries her over to the swing and puts her in. He pushes her, she swings out, he pushes a bit harder, and she swings a bit more, you help Baako he says and she makes the soles of her feet meet the palm of his hand and he pushes harder, she is mostly looking at Papa. He leans forward so their faces meet when the swing comes back – they are both laughing – and he leans forward again when the swing comes back and they giggle at and with pleasure in each other. Then he says want to go round Baako and he turns the swing round and round so the ropes that hold it to the tree are twisted together and then lets go and the swing goes round and round and round and she laughs a bit and he says some more and turns the swing round and round again and lets it go – she's not so fussed with this and he says perhaps back and forward and does this – she's not so fussed – he says time to get out? And she stretches out her hand to him. He leans over and lifts her out into his arms.

Baako cannot see it when she tells Papa she wants a swing. She looks in that direction, he asks her and she points. When she gets onto the swing, she and Papa do it together. He swings her and she helps by making her feet push from his hand. They swing vigorously.

Studies indicate that paternal care significantly affects the development of play behaviour, especially active, full-body play.'[12]

They play the up-close-far-away game together and giggle in joy. Baako has different relationships with Mama and Papa. Although Baako doesn't have Mama to herself, she has Papa and she is the centre of his attention. And it's as if the pain of not having Mama is eased a little.

McGilchrist indicates attachment relationships regulate both distressing negative and playful positive states.[13]

Observation: 15 Months 10-8-16. Ona is present.
Negotiation of Paradox[14]

When Mama goes to change Ona, Baako comes with her. She leans beside Mama at the changing table. Mama says can you bring me a clean napkin for Ona, Baako? Baako looks at her. Mama says the napkins are in Ona's bag. Baako crawls over to her own napkins. Mama says Ona's bag is over there Baako, by the door. Baako finds the bag and rummages in it – she pulls out some tights and then a jersey and looks at Mama. Mama comes over and looks in the bag, finds the nappy and says to Baako it was right at the bottom of the bag, no wonder it was hard to find. Baako comes with Mama back to the changing table. Baako stands with one hand on the table and watches the changing of the nappy process intently, Mama says Ona has a poohy nappy it must be very uncomfortable for her. Baako bends down and passes Mama some ointment for nappy rash and Mama takes it. Then she passes Mama a cloth for bottom wiping – Mama does not take this – she says I have the wipes for Ona and Baako hangs onto the cloth. Mama finishes and says to Baako I'm just going to deal with the nappy and wash my hands. While she is out of sight Baako uses the cloth to wipe her own groin area on top of her trousers. Then she stretches out her hand and makes her asking noise – Mama comes back and says do you need a change too Baako. Baako nods. So Mama picks her up, brings her to the changing table. Quite wet Baako she says as she changes her.

Baako and Mama and Ona seem to have come to some accommodation. Baako helps Mama, it is as if they are together. Baako follows instructions and she also anticipates some. Then Baako uses the cloth she gave Mama that Mama didn't want, on herself. When Mama comes back, she tells Mama she needs changing too, as if 'I need you too, Mama'. Baako has worked out a way of getting Mama to herself.

What does an infant observation have to do with working with difficult emotions in psychothera-

12 Schore (2017). op.cit. 124

13 McGilchrist, I. (2009). op. cit. 111.

14 Pizer, S., (1998). Building Bridges: The Negotiation of Paradox in Psychoanalysis. The Analytic Press, New Jersey

py?

As Winnicott says a mother hates her baby before a baby hates its mother. And in a way sometimes I hate my client before s/he hates me. I can become entangled in the transference and countertransference and wonder what is going on, why things are stuck. I stumble on and then we work it out together. It's often messy.

How difficult it is not to participate at times. I experience a client's pain and it's overwhelming or it triggers something in me and I either want to fix it or I want to avoid it. But like Mama and Baako, I can only be with my client as s/he experiences the pain. It's hard to refrain from acting because I want to make it better – for me and for them.

I look for the possibility of very early trauma. I ask about clients' early experiences. I'm curious about the extent parents may have been emotionally available. I ask about place in the family and spacing between children. I notice whether/how these early experiences of relating emerge in the room between us. I have some possibilities for us to make sense of things for which there are no words.

It is hard to be there, experience and hold difficult emotions. I think this is love.

Formulation
Baako's early experience has been in a stable environment with emotionally available mother and father. Mama is so finely attuned it is as if she responds almost before Baako cries - she does not feel alone. In this way Mama establishes the basis for Baako to be able to regulate her affect by herself later on. When Baako's cries initiate Mama's and Papa's sympathetic responses, Baako experiences agency. Papa enters the room Baako's whole body tells her Papa that she is pleased to see him and his response tells her he is delighted in her. She has a robust sense of self.

She interacts with me too. Each week she proudly shows me the new skills she has achieved. Later she invites me to the table to share food. She is relational.

Because of the quality of her early experience with Mama and Papa, Baako is likely to develop into a secure well-adjusted woman and to not only meet but to exceed her potential.

Conclusion
Baako's parents lovingly created an environment where Baako can experience frustration, develop resilience, learn at her own speed and be happy, curious, kind, and independent. I consider her experience of this relatedness is the reason for her earlier than expected mastery of developmental milestones. The quality of her relatedness has enhanced her verbal and non-verbal communication. Her relational experiences facilitate acquisition of her three languages and expanded the possibilities and use of varieties of channels of communication. She demonstrates she understands cause and effect, she recognises herself and me in the mirror, solves problems well ahead of the predicted average attainment, because her loving holding by Mama and Papa has freed her mind to expand and explore.

The experience of psychoanalytic observation allowed me to observe a mother and baby, living through and resolving routine and difficult situations in their own ways. With the help of the supervision, I learnt to process my inclination for judgmental and blaming thoughts that arose when my anxiety was stirred. I learnt to recognise my urges to intervene. I identified what triggers me to intervene. I developed sensitivity and precision in observation. I learnt how to think freshly and inductively from observation, including trying to understand how the developing infant is making sense of his world.

Just as a mother stays with her child when her child is in pain, I am learning to stay beside my clients when they are in pain. It's important for us both that I can tolerate being with them when they are in pain. Just as a mother must be able to tolerate hating her baby without doing anything about it, so do I have to bear my frustration and even hate towards my clients. As Winnicott puts it, I have to display all the patience and tolerance and reliability of a mother devoted to her infant, have to recognise the client's wishes as needs, have to put aside other interests in order to be available and to be punctual and objective and have to seem to want to give what is really only given because of the clients' needs.

And love. What's love got to do with it?

'Let's define the terms first. Love can be a noun denoting deep affection or a verb, to love, that describes the feeling of tenderness and passion that one lover communicates to another. The contrast in these two usages mirrors the ongoing shift from a one-person, intrapsychic to a two-person, interpersonal perspective in psychology, including the most prominent theory in developmental psychology, attachment theory. I used data from neuroscience to shed light on the ability of humans to love one another. The paradigmatic expression of this strongest of all emotions is forged in an attachment bond of mutual love between a mother and her infant and this right brain-to-right brain, growth-promoting, emotional experience acts as a relational matrix for the emergence of the capacity to share a loving relationship with a valued other at later stages of life.' Schore 2017

'As such, love proves essential for the preservation of the human species.' Schore 2017

Everything that takes place in the therapy room matters, including our non-verbal responses, how we gaze at each other and follow where our clients lead.

We hold the emotional anguish of our clients, in a boundaried space where they and we become able to disentangle the unspeakable and reach some sort of ease. A little like a good enough parent.

In short, love is everything.

Especially in therapy

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Psychotherapy for the YouTube generation: Can educational technology make us better psychotherapists?

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ABSTRACT

There has been a longstanding debate about how we can best develop the ability to be a psychotherapist. Traditionalists have relied primarily on the memory of the therapist to recollect the nuances of sessions in supervision. This review looks at progress in alternative methods using indirect learning methods such as self-ratings, role plays, video feedback, training films, remote supervison and similar technologies. These have grown in importance in the last decades and within the CM/PIT networks there has been a widespread acceptance that these approaches help in the development of psychotherapists. However, there is still considerable debate about how big a contribution can be made from these methods of indirect learning.

The paper reviews some key questions from the research on CM/PIT over the last forty years and reviews evidence showing that these technologies are effective and cost-effective. The approach has been developed across a wide range of professions, each with differing levels of prior experience from complete novices through to established psychotherapists refreshing their skills through Continuing Professional Development.

A self-directed, and peer-led, approach to learning utilising modern remote learning methods can make a significant contribution to making psychotherapeutic skills more widely available in a cost-effective way where trainer resources are limited. Up-to-date educational methods makes possible the training of larger numbers of professionals from many disciplines working outside traditional psychotherapy settings.

Introduction:

Matarazzo &Patterson (1986, p822) in their review of methods of teaching therapeutic skills commented:

"It is hard to imagine now the psychotherapeutic hour was considered so mysterious and sacrosanct that a supervisor could not observe it nor could it be recorded for later discussion" .

They point out that this severely curtailed the effectiveness of teaching as Covner (1944) had shown nearly eighty years ago that a student's recall of an interview contained significant omissions and distortions, and that finding has been replicated many times.

By the 1950's Carl Rogers (1957) and colleagues were using audio-recordings and a one-way mirror to define the "facilitative conditions" for counselling and developed ways of teaching the core conditions of empathic understanding, unconditional positive regard, and congruence or genuineness. Truax and Carkhuff (1967) responded to some of the methodological problems in teaching broad concepts like empathy and helped to break down the skills and evaluate them. They developed the idea that therapists do better when they learn a few behaviours at a time, with immediate feedback and gradually refined discrimination until the skill is mastered.

This approach was developed further by Ivey and colleagues (Ivey, et al, 1968; Ivey, 1983) in research on Microtraining. This took one skill at a time , such as attending or reflection of feeling, and broke it down into tiny components such as eye contact and body language. Learning each skill was broken down into five steps: didactic teaching, modelling positive and negative examples of the skill, videotaped practice, followed by feedback from an empathic, experienced supervisor.

However, exposing students to such direct feedback about something they value in their self-image had its own hazards: Friedman and colleagues (1978) introduced videotaping as a routine for half their trainees. The researchers were reassured that it did no obvious harm to clients or trainee thera-

pists, but nevertheless anxiety went up in trainees and they rated their experiences less positively than they had expected before the training session.

Kagan (1980) took a quite different approach, paying attention not just to therapist anxiety but to the potential for narcissistic injury to trainees exposed to their harshest critic- that is, through self-scrutiny. He described how both client and therapist can play a complex game of "Diplomats", each avoiding open communication because of fear of being exposed. He described "feigned clinical naivete" where exploration is kept at a falsely superficial level to avoid basic anxieties. A prime example of this confining the discussion to questions and answers. Kagan described the four basic anxieties as fear of being hurt by others; being taken over by others; hurting others; and incorporating / seducing others. Individuals then behave "diplomatically" to avoid real engagement so as to minimise these risks when a therapist is in discussion with a client or with a supervisor.

This is another way of expressing the basic approach-avoidance dilemma described by Hobson (1985: p27) and Kagan developed a fresh approach that prepared trainee therapists in a safer environment. He developed techniques for "coping with interpersonal nightmares" by the novel technique of exposing the trainee to a "stimulus vignette" on videotape where a simulated client behaves in either seductive or confrontational ways. This is done in a supportive environment where trainees can share their fears and their real experiences – often with strong feelings of shame about the feelings evoked in them that, as "diplomats", they would normally bury.

Kagan's work was highly influential as it tied in very closely with the ideas developed independently by Hobson and colleagues and guided the development of the teaching methods that have become characteristic of CM/PIT.

Developments in the UK

A criticism of these educational methods was that they artificially simplify and isolate skills from the "lived experience" of being with a client.

"Hobson has a helpful analogy with playing "scales" and improvisation (Hobson, 1985, p.207). A skilled musician can improvise based on a particular scale that has been practised previously. Each performance is different but the underlying structure is shaped by the detailed knowledge of that particular scale. By analogy, a psychotherapist can become skilled in using a scale but does not need to be consciously aware every second as the material is so familiar and well-practised." (Barkham et al, 2017, p 137-138

'The procedures are akin to the scales of notes for a musician or to the words and phrases of a literary artist. Broad theoretical ideas and psychodynamic formulations are of importance only in so far as they are incarnated in the minute particulars of what we do. We need to practise our scales. Technical accomplishment is essential in achieving a unique "true" voice of feeling'. (Hobson, 1985: 207).

The analogy with learning scales and gradually being able to improvise was an accurate and helpful metaphor. For example, Del Nero (2006) commented on his contribution to the Berklee method of learning improvisation in jazz-

"The goal is to develop an expectation of sound- an intuitive sense for what harmonies will follow, for which notes will sound good, and for where your chosen notes will lead you in your improvisations" (op cit, p.1)

As this quote demonstrates, the aim is not to slavishly copy a more experienced therapist seen on a recording, but to develop an inner sense of direction. The developments in CM/PIT training have shown that combining several learning approaches is the most effective way of helping a new therapist develop a therapeutic conversation.

Learning the Conversational Model

Before the model was even described, Robert Hobson and Russell Meares had already pioneered the use of audiotape and videotape feedback for teaching and supervision. Hobson established the routine use of recordings in supervision (in those days in the form of audiotapes and less commonly videotapes) and he was one of the pioneers in the use of recording as a teaching me-

dium to model how therapists work. He led from the front by making his own sessions available to explore (Hobson, 1985, pp 247-254).

From the outset, learning from feedback was intrinsic to this way of working. Hobson developed a repertoire of ways of introducing new therapists to effective practice, and his systematic use of feedback from sessions is still as relevant today. His concept of the "minute particulars" (Hobson 1985, p 161, citing William Blake Jerusalem III: vs. 60-68) was brought to life by spending most of a group supervision immersed in just a couple of minutes of recording, listening for minute nuances of tone of voice and imagining ourselves into the place of therapist or client.

Hobson was a principal investigator in a research programme initially funded by the Medical Research Council to describe the key elements of the Conversational Model (as it was practised in the late 1970's). The process of developing the Conversational Model in a research context is summarised in Psychodynamic Interpersonal Therapy: A Conversational Model (Barkham et al, 2017, chapter 10)

The original reports (Maguire et al., 1984, Goldberg et al., 1984), showed how the research had been influenced by the work of Ivey et al (1968) in the use of microskills teaching of counselling and therapy, but in this context it was applied for the first time to a relational form of therapy. The original teaching package had three teaching films introducing basic skills, putting the skills into practice, and rehearsing the key skills, with the third film facilitated by an educator. The films were followed by facilitated groups of three trainees to practise the skills and reflect on how the approach might apply to their existing clients in their current work setting. Gradually, as the programme was further researched the use of role play was developed in ways that could be used by less experienced trainers (for example see, Palmieri et al, 2007).

In summary the early phase of development of the model in terms of teaching showed that the Conversational model could be described clearly and rated reliably and the micro-skills teaching package was able to use inexperienced teachers to achieve a dramatic effect in changing the interviewing style of psychiatry trainees from a style reliant on questions ("interrogatory") to a more collaborative, conversational style which used statements rather than questions, used personal pronouns - "I" and "We", was more tentative, and used "understanding hypotheses" to develop the conversation (Maguire et al 1984, M argison, 1991, Margison &Moss, 1994,). The microskills aspect was so effective that the supervision group had little added behavioural effect but it increased the trainees' level of confidence in using the skills in practice and their change of style persisted after two years (Moss et al., 1991).

The original, prototype films had drawn examples from real therapies carried out when the model was being described and for obvious reasons of confidentiality could not be used beyond the specific research setting. These prototype films were re-made with simulated interviews of high plausibility (Margison & Moss, 1994). The films used role plays rather than scripts and the interviews typically ran for at least twenty minutes with believable, and often moving, examples being selected. The films are still available and the content is still relevant. However the films now look dated in style and, consequently, the films have been remade in the last three years. The recently remade films are described below.

This early research focused on the development of skills in trainees who had not offered any psychological therapy before so the next stage worked with counsellors to see if they could learn CM/PIT for use in their existing primary care work settings.

"Guthrie and colleagues (2004) showed that counsellors already working in primary care could be trained efficiently to deliver PI therapy using this approach. Twenty counsellors received a 12-week training course in PI therapy including supervised practice of their cases from primary care settings. The client outcomes were good with 50% showing clinically significant and reliable change.

Performance was assessed using videotaped sessions with simulated patients at 3 points in time: before training, after an intensive first week of

training, and at the end of 12 weeks of supervision. Counsellors' adherence to the model was assessed in relation to three patient scenarios: chronic depression, somatisation, and suicidality. Validity of the simulated sessions was verified by reference to counsellor behavior with actual patients using audiotaped sessions. After training, counsellors' adherence to PIT increased without affecting their basic counselling skills". (Barkham et al, 2017, pp 139-140)

The research had deliberately chosen challenging clinical situations even for experienced counsellors and the clients with chronic depression and those with somatisation demonstrated clear improvement after use of the model. However, it was hard for counsellors to apply the Conversational Model with suicidal patients, where concerns about managing risk dominated.

This finding led to a modification in more recent studies to "bracket off" for the practitioner the space they need to ask questions needed for clinical governance but still encourages the exploration of these answers within a therapeutic conversation.

The counsellors also reported a positive experience working in this way, and felt their anxiety was contained effectively.

Over the years these training methods have been evaluated across several professional groups including psychiatrists, nurses, counsellors, psychiatric social workers and clinical psychologists (see review in Barkham et 2017, p139, Paxton et al, 1988)

A recent development of these structured ways of using CM/PIT skills has been with Psychological Wellbeing Practitioners [PWPs] who support people with common mental health problems (Guthrie et al, 2018a). The PWPs were helped to develop a therapeutic conversation within brief encounters with clients using a CBT model.

Training focused on five basic components of PIT: negotiation; picking up cues; using statements rather than questions; focusing on feelings; and understanding hypotheses- all focused on staying in the "here and now". When used skilfully together they helped the practitioners to empathise and deepen the collaborative work with the client, even though the overall method used was still CBT-oriented.

The most recent iteration (Margison, 2022) of structured teaching materials has been a series of films based on the original videos (Margison & Hobson, 1985). They involve three films together called "The Minute Particulars" which introduce the three levels of skill in PIT, Introductory, Intermediate and Advanced, focused at the level of learning specific skills. The films are mainly based around extended role plays using PIT therapists as both therapists and clients following an outline for the improvised role plays. There are also four films based on sessions called Loss, Anxiety, Shame and the Body. All of the parts played in the main films were developed with therapists experienced in using role play in an authentic way (supplemented by additional examples using additional actors) (Margison, 2022)

Role play

Role play has been used extensively in developing psychotherapy skills

Kagan (1980), as part of the programme described earlier, developed ways of trainees working together using role plays of increasing difficulty in a small group where one acts as facilitator, one as timekeeper and two as the client-therapist dyad. A key ingredient was having rules that emphasised exploring each participant's feelings in the situation. This allows a very effective use of trainer time as one person can support several groups running autonomously with trainees rotating through the different key roles.

In our adaptation of Kagan's methods, a standard format is used for all the role-plays (Margison, 1991, pp. 178-180). Roles are rotated around the group, so each participant has a chance to be in client, therapist, feedback lead, timekeeper, and with more experienced groups they take turns at being facilitator. The structure of the room is kept consistent with a chair each devoted to therapist and client roles with explicit debriefing from the

roles when the session ends. The role play may start with a simulated client saying a few words setting the context, initially based on a first session but role players quickly become adept at starting as though they are several sessions into an ongoing therapy.

In the introductory sessions, cue cards are used which have a brief instruction explaining what should be done. In the early sessions these may be brief statements about what is the "agenda", for example, early sessions might "interfere" with the process by saying to avoid eye contact, but they quickly progress to more realistic scenarios such as a therapist saying he or she will be away for a few weeks. Trainees report feeling more comfortable with these initial "props" as it is easy to attribute difficulties to the cue cards so they feel less anxiety about "getting it wrong".

The facilitator stops the role-play after two or three minutes in the early examples, or somewhat longer in the later, more complex examples. The group follows a set routine of getting feedback from the two individuals playing client and therapist first- focusing on their feelings about the experience.

The facilitator's main task is to maintain a climate that is conducive to learning, and the sense being encouraged is a mixture of focus in depth while also being playful. Other group members are encouraged to describe what they saw, heard or felt. Also they are asked to comment about how they might have felt as the client or responded as the therapist. Criticism of the "therapist" is forbidden and the facilitator models giving feedback about the scenario with a mixture of pointing out subtle cues ("minute particulars") and also responses based on feelings evoked by the role play.

Some trainees have had earlier bad exposure to role-plays and may have felt exposed or even humiliated. So, the role players rely on the facilitator initially and then the norms of the group to maintain a safe atmosphere. Participants quickly become open about their anxieties about becoming therapists. The reliable structure provides a safe environment and also prevents "inappropriate drift towards the training group becoming a quasi-therapeutic group" (Barkham, et al, 2017, p141).

Some of the structured role-plays focus on how easily the therapeutic alliance can be damaged and persecutory dynamics established. For example, one early role-play simply asks both participants not to take anything the other says at face value. This simple instruction amplifies the feeling of being invalidated and mistrusted.The teaching links to the key paper by Meares and Hobson (1977) on the development of the "persecutory spiral". Being in both client and therapist roles brings home how even these most uncomfortable feelings are often being mirrored by both parties, and how easily they are generated.

Realising just how sensitive the atmosphere is to minor discrepancies, ambiguities or inconsistencies in the therapist, these examples also give practice in how to recognise and repair therapeutic alliance ruptures. A great advantage of role playing these difficult scenarios is in having a safe environment to make mistakes and learn in a way that is not at the expense of therapeutic failures with actual clients.

After the formalised sequence of pre-set role-plays, it is possible to extend this model of training into actual clinical work. For example, in a supervision group a trainee can role play his or her client, or can ask another group member to role-play the client whilst the trainee stays in the therapist role.

The effectiveness of this role play training in acquiring therapy skills was assessed by Palmieri and colleagues (2007):

"[T]he research suggested that role play training was effective in learning new skills. A 15-item role-play competence measure was developed. Ratings by three judges of 34 role plays from psychodynamic interpersonal therapy training showed good inter-rater reliability (.73–.79) and internal reliability (.84–.96). Validity was supported as scores were statistically significantly associated with the length of psychotherapy training experience. Most

participants achieved satisfactory ratings on the key skills of this model of therapy after the training". (Barkham, et al,2017, p143)

We have used these role-played sessions regularly with therapists at different levels of experience and it is possible to develop new role-plays relevant to any specific topic such as working with somatic distress or managing self-destructive behaviour depending on the experience and clinical setting of the participants. Participants include those learning PIT and also established PI therapists who take part in role play sessions regularly to maintain their skills as part of continuing professional development.

With established therapists who want to progress to the role of supervisor we have used the same structure to role play the difficulties that arise in a supervisory setting where members role play supervisor and therapist and reflect on experiences with different styles of supervision.

Summary

When we consider the role of the supervisor or facilitator it should reflect Vygotsky's (see Hess, et al, 2008) model of striving to provide the conditions for optimal learning. This can be by providing enough conceptual scaffolding for the developing therapist always to be in their zone of proximal development- able to reach beyond what they already know by the judicious input from a supervisor, mentor, or facilitator, and not paralysed by anxiety.

This paper suggests that the holistic education in psychotherapy can use "scaffolding" of this type beyond the supervision setting and include different approaches to learning that fit different learning styles.

If we talk about training people to do psychotherapy there is an implicit model of learning skills to fit someone for a predetermined task. If we frame the question in terms of facilitating someone's growth into becoming a psychotherapist we see the world from a totally different perspective where the therapist has the flexibility to listen attentively and use their imaginative capacity to develop a shared understanding. The research reviewed in this paper shows we can describe psychotherapy accurately and in a non-trivial way, and then use that understanding to develop resources to assist learning.

CM/PIT has done more to develop a framework for learning psychotherapy using the modern approaches discussed in this paper than most models, but we are still at an early stage in understanding the most effective combination of approaches. New ways of working remotely are being developed- partly as a result of the Covid-19 epidemic but also to provide educational experiences to a broader group of professionals in diverse work settings.

For example, Guthrie et al, (2001) have already shown that nurses in a liaison role in Accident and Emergency departments can be trained to be effective therapists working with patients who had self-poisoned. Research currently in progress (Guthrie et al 2018: FReSH START, Guthrie et al, 2021 SAFE) is further developing brief training and remote learning methods to prepare large numbers of nursing staff to deliver brief PIT in a liaison setting.

We know from a pilot study that this approach seems to be a safe and effective introduction as trainee therapists can safely use these brief training methods to facilitate change when they take on their first cases as psychiatry trainees (Shaw et al, 2001).

Films of psychotherapy can be made that do not breach confidentiality by using therapists as actors drawing on wide experience in using role play already. The films can be used to generate discussion about what has been noticed, different approaches to developing a therapeutic conversation, and to prepare therapists for the range of metaphorical and poetic expression that is part of the experience of psychotherapy.

Additionally, role plays bring in a safe structure where the developing therapist can experience the nuances and variability of a real therapy.

Conclusion

This paper outlines the developments we have already seen in using modern educational approaches to help colleagues to learn this approach to psychotherapy

Developing as a psychotherapist can be described as the gradual growth of "therapeutic tact":

"Tact encompasses many things, including emotional intelligence , respect, discretion, self-awareness , thoughtfulness, compassion, subtlety, honesty, diplomacy, and courtesy.

Tact involves the ability to tell the truth in a way that considers other people's feelings and reactions. It allows you to give difficult feedback, communicate sensitive information, and say the right thing to preserve a relationship". (Mind Tools, 2022)

A challenge for psychotherapy researchers lies in describing such human capacities in the language of observable and replicable science whilst maintaining the spirit of a therapeutic conversation. CM/PIT has developed a range of strategies for developing therapists to learn how to be part of authentic conversations.

If we speculate where this path is taking us we might wonder when Artificial Intelligence and the use of virtual simulations of therapy will be at a stage to play a role in developing competence as a psychotherapist.

A framework is already in place to "guide the clinical use of virtual humans" in a clinical psychology setting (see Gaggioli, et al, 2003) and several studies suggest that avatars can be used as part of treatment (Garety, et al 2021). Chapman and colleagues (Thompson, et al, 2020) have already demonstrated that avatars can be used to improve clinical practice with real-time interactions in simulated work settings- initially in pharmacists.

However, the quality of simulation, especially fine facial movements and subtle changes in tone of voice have not yet evolved to the point where it is used for relational therapy education, but changes in technology could make this potentially achievable in the next few years.

Following the Covid pandemic there has been a huge increase in therapies conducted remotely, and a recent review gives some reassurance that interactional aspects of therapy may not be hindered (Irvine, et al, 2020)

"The review identified 15 studies [which when reviewed] revealed evidence of little difference between modes in terms of therapeutic alliance, disclosure, empathy, attentiveness or participation".

In a study of therapists responses during the pandemic "[t]he great majority of therapists [in a survey of 335 therapists] thought that remote working skills should be part of formal therapy trainings" (McBeath et al, 2020).

In practice, this has always played a significant role in training therapists where distances encourage remote learning. The training offered by ANZAP in the Conversational Model already has extensive experience of offering all seminars live and interactively on line, with seminars held via Zoom, and supervision remotely or in person as circumstances allow. CM/PIT is in a strong position to build on this heritage in developing psychotherapy training using modern technology.

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Film Review

The Lost Daughter (Netflix)

Brendan McPhillips

It is strange, and yet not, that most of Freud's early patients were women, but ground zero of The Interpretation of Dreams – the Oedipus Complex – is based on the psychology of men. And yet not, because, although women in general were, at least in the view of the Viennese patriarch, simply castrated men, one woman in particular packed more of a punch than the rest, and indeed formed the core of men's Oedipal turmoil, the Mother.

Much has been made of Maggie Gyllenhaal's debut as a director in this film, an adaptation of Elena Ferrante's eponymous novel. Not that it explicitly references therapy, and not that any of the characters come within coo-ee of an analytic couch, which, believe me, all of them need in spades. But Freud's attempt to contain the matriarchal aside, it is a film about profound psychic disturbance of the most ordinary and prosaic kind lifted to a level of intensity that makes watching it without an analyst holding one's hand, or, even better, a kilogram of pethidine nearby, almost impossible. As a review in The Seattle Times put it: *The Lost Daughter is about as sentimental in its view of parenting as a Mother's Day card inscribed in battery acid.*

The brilliance of Ferrante's novel, its extraordinary translation to film by Gyllenhaal, and (I muse) the subject matter itself – the experience of being a mother – have fused to create quite a flurry. Nominations and awards galore, and serious critics penning serious critical reviews in no less a magisterial publication than the New York Times, have made it a sensation. And yet, throwing caution to the winds, and climbing on the dizzying heights of the shoulders of hubris, I contend that most have missed the point of the film, and certainly the book, by a country mile. Or, if not missed the point, concentrated on what is obvious – the ferocious cost of bearing children – in both expositions, and turned a blind eye to what lies beneath. Manifest and latent: Freud would have loved it.

A woman (Olivia Coleman) in a white dress walks unsteadily in the littoral zone of a beach. It is night. She collapses. And so we begin. The same woman is driving, seemingly at ease, in bright sunshine. Her destination a village. It is Greece in summer, and she is helped to her apartment by an elderly man (Ed Harris) – Lyle, an American – who has lived here for a long time and manages the accommodation. He points to a bowl of fruit – a welcome gift. We know nothing about her. A lighthouse beams intermittently into the bedroom. She closes the shutters and sleeps.

The next morning it is again a bright day. Going to take a piece of the fruit, she finds that, underneath, they are all rotten. She tosses it into the rubbish and goes to the beach. Swims. Comes back to her umbrella and beach lounge. A young man approaches offering to move the lounge into the shade. She is momentarily disoriented until he tells her that he is Will (Paul Mescal); he works at the beach shop. She has brought books with her. She opens one: it is Dante's Paradisio.

So much of the film and the book is about the contrast between the pure and the putrid. More emphasized in Ferrante's work, our heroine – we don't yet know her name – is repulsed by the animal realities of the world. Hardly mentioned in the film except for her shouting at the husband she was leaving that she didn't want him taking her two daughters (she was also leaving) back to her mother and the 'shithole' she grew up in, is the wretched childhood in Naples. A violent mother always threatening abandonment; violent men; poverty. Lying down to sleep on that first night:

I turned drowsily and touched something on the pillow that felt cold, something made of tissue paper. I turned on the light. On the bright-white material of the pillowcase was an insect, three or four centimeters long, like a giant fly. It was dark brown, and motionless, with membranous wings. I said to myself: it's a cicada, maybe its abdomen burst on my pillow. I touched it with the hem of my bathrobe, it moved and became immediately quiet. Mute, female. The stomach of the females doesn't have elastic membranes, it doesn't sing, it's mute. I felt disgust. The cicada punctures olive trees and makes the sap drip from the bark of the mountain ash. I cautiously picked up the pillow, went to one of the windows, and tossed the insect out. That was how my vacation began.

But so much of this disgust is within her; literally inside her belly. Her first experience of being gravid was pure:

I … wanted my pregnancy to be under control … I imagined myself a shining tile in the mosaic of the future … What later became Bianca was for me Bianca right away, a being at its best, purified of humors and blood, humanized, intellectualized, with nothing that could evoke the blind cruelty of live matter as it expands … but then came Marta, she attacked my body, forcing it to turn itself, out of control. She immediately manifested herself not as Marta but as a piece of living iron in my stomach. My body became a bloody liquid; suspended in it was a mushy sediment inside which grew a violent polyp, so far from anything human that it reduced me, even though it fed and grew, to rotting matter without life.

The vacation unfolds. A rowdy American family invades the beach. There are lots of them, and they want to be together. They ask others on the beach to move so they can appropriate the beach lounges. She is asked by an older, pregnant woman if she would mind. She does mind, politely. It's uncomfortable. Later – it's the woman's birthday – she comes up with a peace-offering of cake. Callie (Dagmara Domińcsyk) is forty-two and having her first baby. She points out her sister-in-law, Nina (Dakota Johnson), who is twenty-two, and has a three-year old, Elena (Athena Martin). She has already noticed Nina, a sublimely beautiful young woman. Noticed the effortless play between her and her daughter, and the attachment Elena has to a doll. Callie asks What is your name *– Leda – Neda? – no Leda … Caruso*. Callie is more impressed by the surname. Callie *Do you have children?* Leda *Yes, two daughters*. Callie *What was it like bringing them up?* Leda *Children are a crushing responsibility.* Walking back to her car through the pine forest behind the beach, Leda hears a noise, and becomes fearful. Suddenly she is hit on the back. It is a large pinecone. She isn't sure if it has fallen or being thrown. At home, she sees in the mirror that it has gouged a hole.

The next day at the beach Leda is in the water. There is a commotion. A speed boat arrives. It is Nina's husband, Toni (Oliver Jackson-Cohen) and his cousins. They disgorge and spread. The invasion worsens. Back on her lounge, Leda watches Nina leave Elena playing in the sand with her doll, and shirt-fronts her husband (to use a current Australian expression, usually applied, unlike here, as an empty verbal threat from a long way away) for bringing his rowdy family. Leda goes back to Paradise, but is soon unsettled by another commotion. The family is running up and down the beach. Elena has gone missing. Leda gets up and walks to the back of the beach. She finds the child wearing her mother's large hat, playing in the sand. She picks her up and takes her to a relieved and grateful Nina. Leda tells Nina that she knows this feeling: when she was young one of her daughters got lost on a beach. C*ut to a scene of the young Leda, holding baby Marta, running on a beach in a crescendo of desperation, screaming out Bianca's name.* Callie notices the wound on Leda's back, and brings some lotion which she applies. But Elena is crying. Her doll is missing. The searching begins again. Leda leaves. Back in her car she puts her bag on the seat. The doll is inside.

Nowhere in the novel is the myth of Leda nor the poem by Yeats directly mentioned. In the film there is one reference: a scene where the young Leda's about-to-be lover, Professor Hardy (Peter Sarsgaard), quotes the opening lines in Italian:

A sudden blow: the great wings beating still

Above the staggering girl, her thighs caressed

By the dark webs, her nape caught in his bill,

He holds her helpless breast upon his breast.

According to Robert Graves, in his Greek Myths, there are conflicting accounts in the Greek and Roman authors of the rape. Some have it that it was the Moon-goddess Nemesis who Zeus pursued in various increasingly fierce animal forms until she succumbed. And before that, when matriarchy held sway southern Greece, when it was the time for the sacred king to die, it was Nemesis herself doing the pursuing. But, as Graves says, the version that has crested the waves of time, while the others subsided, recounts the rape of Leda, queen to Tyndareus of Sparta, by Zeus in the form of a swan by the river Eurotas. The spawn of this unnatural union were two daughters, Helen and Clytaemestra. And the rest, as they say, is (sort of) history. Atreus, the king of Mycenae, was murdered by his nephew Aegisthus, and his sons, the Atreidae, Agamemnon and Menelaus, sought refuge in Sparta with Tyndareus. Not quite an American rom-com, the two sisters married the two brothers, Helen to Menelaus and Clytaemestra to Agamemnon. To say the least, post-marriage, things did not go well. Helen, beautiful beyond imagination, was abducted by the love-smitten prince of Troy, Paris. Present-day Mariupol gives a hint of how Troy fared when the Greeks went to get her back. Ten years on and the war won, Agamemnon, the Greek commander,

headed home to a slightly less than loving welcome by his wife, who, in cahoots with her lover, Aegisthus (not apparently a great name to have if you're in the running for Most-Trusted Man-of-the-Year in Ancient Greece), murdered him.

Both the film and the book move between forty-eight year old Leda having a holiday, and twenty-something Leda (Jessie Buckley), married to Joe (Jack Farthing), with two small daughters, Bianca (Robyn Elwell) and Martha (Ellie Blake). Joe is nice. But Joe is flying high in his career and isn't much at home. Leda is drowning. She escaped from not-nice British shithole to nice Cambridge, Boston (Ferrante has her flee to Florence). And now, being a mother, she is flailing between nice Mummy and not-nice Mummy. It is violent, even the love. As a child Leda had a doll, Mina. In a moment of remorse – she had refused to kiss Bianca's finger pierced accidentally with a knife – she gives her daughter her doll. But Bianca doesn't 'respect' it, and, rage pouring back in, Leda throws the doll out the window watching it smash to pieces on the road below. More remorse, and Bianca caught in a bear-hug Mummy, you're hurting me. The ambivalence repeats. Leda doesn't know why she stole the doll. She alternates between caring for it, throwing it in the bin, hiding it in the cupboard. Whenever she's forgotten where she's put it, she panics. She wants to give it back. And she doesn't want to give it back.

Now in the town, Leda has gone into a toy shop to buy clothes for the doll. Nina, her daughter, and Callie come in. Elena (not a million miles from Helen), bereft of her doll, is utterly distraught. Nina is drowning, and clings onto Leda: Nina says *You are so calm and wise; I wish I was like you*. Leda replies *Don't worry, Nina, the doll will turn up*. Callie asks Leda what her daughters were like as children. Leda says she can't remember because she abandoned them for three years. Calm and wise Leda stumbles into a shelf and flees the store, herself distraught.

The men in the film also separate into nice and not-nice. Nice first. Lyle pays her a lot of attention and she, reasonably, thinks he is trying to crack-on. But when he turns up with a fresh octopus and cooks it for her, it seems he just wants companionship, and someone to reminisce with about his life, his kids, his disappointments. She has dinner with Will, who seems in awe (and perhaps a bit in love) with her, her life as a professor, her daughters, her wisdom. Later she finds he and Nina kissing. She is afraid for Nina. And with good reason. Toni, her husband is not-nice. Quiet, controlled, violent. In the book, there is the intimation that they are Mafia. Nina tells Leda that if he caught her with Will, he would cut her throat open. All the men in Nina's circle spread a shadow of threat: sexual, destructive, criminal, uncaring:

How can those terrified vague fingers push

The feathered glory from her loosening thighs?

And how can body, laid in that white rush,

But feel the strange heart beating where it lies?

Nice Joe can't, won't help Leda. She is trying to keep her academic career afloat. Her mentor, Professor Cole (Alexandros Mylonas), rings her. There is a conference he wants her to attend, probably as a cheer-squad for his paper, but, hey! What the hell! It's not the bottom of the Mariana Trench where she currently resides. Cut to a recent holiday at their house in the country. A pair of hikers ask to stay the night. A young woman (Alba Rohrwacher) and an older man (Nikos Poursanidis). They have tossed aside spouses, children and careers and now are living the life of love and unresponsibility. The woman is particularly interested in Leda's work, and asks her for a copy of a paper she wrote. Leda is utterly 'interested' in the woman. In quotes, because 'interested' is like saying Russia is conducting a 'special operation' in Ukraine. It's as if she wants to devour her, be her.

Not-nice Professor Cole couldn't give a toss about Leda. He wants her to review his paper – he is sure it is not up to scratch and he will make a mess of the presentation. She dutifully praises it and is one of the two attendees. Another speaker, the famous Professor Hardy, is up next. Standing-room only. An immediate sexual fantasy. He is pushing himself up inside her dress. He begins to speak. She is pulled out the fantasy when she hears him say her name. He is quoting the paper she gave to the woman-hiker. The paper is ground-breaking. It is extraordinary. Leda now exists. She is feted. She sits next to Hardy at dinner. She caresses his chest in his room. It is covered in hair. She leaves Joe and her daughters. But before her escape, she buys them white dresses. And accedes to their request to 'make the snake'. The reference is to a poem Leda likes, *Haciendo serpentinas*, by the Mexican poet, María Guerra. She peels an orange with a knife, not breaking the coil. For three years she

has no contact with Bianca or Martha. An affair with nice-Hardy sets her career up, and then she leaves him and roams the academic world, bedding men and becoming a professor.

Nina is in the Mariana Trench. She meets Leda at the market. She tells Leda that she met her husband when she was sixteen; had Elena at nineteen; and now is exhausted and confused.

Nina says *I know you saw me with Will, but it doesn't mean anything. I just want to be a girl again, a little, but pretending.*

Her hat, given to her by her husband, keeps blowing off. Leda buys her a large hat pin, and sticks it carefully through Nina's hair. It is sharp. Elena is in a stroller, looking disconsolate.

Nina says *She wants her doll.*

Elena says *She has to take her medicine because she has a baby in her stomach.*

Nina says It's a game. My sister-in-law takes pills and she pretends to give them to the doll, too.

Nina says to Leda *You're beautiful, you're refined, it's clear that you know a great many things. You have such self-confidence, you're not afraid of anything. I saw it the moment you arrived on the beach for the first time. I looked at you and hoped that you would look in my direction, but you never did.*

Nina asks Leda *Why did you leave your daughters?*

Leda replies *I loved them too much and it seemed to me that love for them would keep me from becoming myself.*

Nina asks *You didn't see them for three years. How did you feel without them?*

Leda replies *Good. It was if my whole self had crumbled, and the pieces were falling freely in all directions with a sense of contentment.*

Nina asks *You didn't feel sad?*

Leda replies *No, I was too taken up by my own life. But I had a weight right here, as if I had a stomachache. And my heart skipped a beat whenever I heard a child call Mama. I was like someone who is taking possession of her own life, and feels a host of things at the same time, among them an unbearable absence.*

Nina asks *If you felt good why did you go back?*

Leda replies *Because I realized that I wasn't capable of creating anything of my own that could truly equal them.*

Nina asks *So you returned for love of your daughters.*

Leda replies *No, I returned for the same reason I left: for love of myself. I felt more useless and desperate without them than with them.*

Nina asks *You found what you were looking for and you didn't like it*?

Leda replies *Nina, what I was looking for was a confused tangle of desires and great arrogance. If I had been unlucky it would have taken my whole life to realize it. But I was lucky and it took only three years. Three years and thirty-six days.*

Nina asks *How did it happen that you decided to go back?*

Leda replies *One morning I discovered that the only thing I really wanted to do was peel fruit, making a snake, in front of my daughters, and then I began to cry.*

Leda returns to her apartment. The doll has water in its stomach. It keeps leaking out, black and putrid. Leda notices something behind the lips. She gets a pair of tweezers. She pulls out a worm. She throws it away in disgust. The worm is also a *Haciendos serpentinas*.

It is Professor Hardy at the dinner who makes the reference to the Yeats poem. Leda jokes that rape is an interesting place to begin:

A shudder in the loins engenders there

The broken wall, the burning roof and tower

And Agamemnon dead.

Being so caught up,

So mastered by the brute blood of the air,

Did she put on his knowledge with his power

Before the indifferent beak could let her drop?

It's pretty clear that, if not Leda, at least Helen and Clytaetemestra took revenge on men for the rape of their mother. The world-war destruction of Troy, with the deeply ambiguous intimations that Helen was complicit with her abductor. The killing of Agamemnon and the lifetime of misery for his children Elektra and Orestes after they enacted retribution on their mother. Leda is empowered, but taking on the knowledge and power of a god is dangerous stuff, likely to have repercussions.

Will asks Leda if she would lend he and Nina the keys to her apartment so they can have sex. She is angry. Lyle is employed by Toni and could be caught up in the repercussions. Will is contemptuous *Just give him twenty euros*. She asks Nina to come and see her. Nina comes. She is confused,

says she is depressed. Leda gives her the keys; says she has something else to give her. She brings out the doll. Nina is bewildered *How could you do this when you know how upset we have all been?* Leda replies I'm an unnatural mother. Nina stabs her in the navel with the hat pin. Leda flees in her car. She is wearing a white dress. It is night. She stumbles onto the beach and collapses in the littoral zone. The white dress she bought her daughters the day she abandoned them. The littoral zone of the river Eurotas where Leda was raped. Morning comes. She is lying asleep on the sand. She gets up. She sits on a rock and rings her daughters on her mobile phone. Her navel is bleeding onto the dress. A flashback to young Leda with her two daughters peeling an orange and asking them what that part of the body is – *the belly-button Mummy!* Bianca and Martha answer the phone, asking if she is dead. *No, I'm not dead, I'm alive*. In the book the ending is a little different. Bianca and Marta cry *Mama, what are you doing, why haven't you called? Won't you at least let us know if you're alive or dead?* Leda replies *I'm dead, but I'm fine.*

The Lost Daughter is ostensibly about and the relationship between mothers and daughters. And it is. The transgenerational rage and love and guilt and helplessness is evident from Leda's mother to herself and presumably to be repeated with her daughters. Nina is trapped. She loves her daughter, but she wants her life. The two form an oxymoron. She looks to Leda for help but, betrayed by this faux mother, wounds her where Leda's own umbilical cord had attached. Elena, at three, already has put a baby in her doll's stomach. At the end of the film, Leda is again a lost daughter; again raped by the river; yet again impregnated. The lot of women is on an endless loop.

And yet. And yet Leda deeply wanted her pregnancies. And when she deeply wanted something else – her life without them – she took it. The husband she'd stopped loving, she left crying on the floor. Professor Hardy too was abandoned. But there was a price. Nina, being with Will, is taking what she wants. There too there will be a price. Apparently when Aphrodite had sex she would descend to the Mediterranean and renew her vagina as if it had never happened. But Aphrodite is a goddess. Leda and Nina (and we) are not. One way of perhaps reading the renewal of Aphrodite is that the gods don't care. They do what they want and continue as if there are no consequences. Leda and Nina (and we) however are human. If we do something, it has consequences and those consequences matter. We are trapped by what follows from the actions that flow from our choices.

The Yeats' poem, Leda and the Swan was originally titled The Annunciation. It would have been far more chilling in its meaning if he had not changed it. Mary the Mother of God submitting to being raped by God the Father. A god who cares not in the slightest about how she feels; how we feel. Yeats backed off, but Auden didn't. In both the novel and the film, there is a playful saying between Leda and her daughters: *The chill of the crooked wing falls down along my body*. It is from a poem written in 1944, For the Time Being, a recounting of the biblical Christmas story. It is divided into sections. In the one titled "Annunciation", instead of the usual call and response in Luke: Angel Gabriel *Behold the handmaid of the Lord.* Mary *Be it done unto me according to thy Word*, Auden has her say the line that he deliberately lifted from Yeats, transposing the rape from the not-us myth of the Greeks to the deeply-us myth of the mother of Jesus.

I think that Freud did get it right when he pointed to the manifest and latent layers of our psyche. We may think we know what we are doing and what we are choosing, but how are we to know what will happen when, believing we – men and women – are freely choosing, the instinctual forces have their way with us and leave us bleeding by the roadside. Jung was also onto it: *The gods have become our diseases*. Gyllenhaal and Ferrante have constructed works that turn up the rotten underbelly of our desires, that, once seen, terrify and, yes, kill us. Gyllenhaal backs off; perhaps had to as it wouldn't have made sense in the film. Ferrante doesn't. Our desires are sharp and murderous. Make sure that you don't mistake the battery acid for the pethidine.

Call for Papers for Issue 5

Margie Darcy

The Therapeutic Conversation (TTC) provides an ideal opportunity for trainees and members of ANZAP and PITSIG to publish work relevant to the process of psychotherapy. Papers may be relevant to work with individuals or to promoting broad social cohesion and prevention of trauma. Work may have an objective, scientific style although there is also room for personal contributions, reflecting the individual voice, the perspective of lived experience and work that may draw upon literature and the arts or involve poetic expression.

Papers may be up to 5000 words in length and will be peer-reviewed. The peer review is designed to help authors develop their work further – we have a policy of constructive criticism. Papers should include an abstract.

The 5th Issue will be published in November 2022.

The due date for submissions for **TTC 5 is 31 October 2022.**

Please contact the new editor, Chris Garvie on drchrisgarvie@gmail.com if you would like to submit a paper.

Part II: Information

ANZAP Matters

President's Report and Conference Committee Report

Kim Hopkirk

Hello and Kia ora, to all our members spread far and wide.

I won't dwell on covid, but it has been quite a time since I last wrote. New Zealand/Aotearoa are now in the thick of it. We are out of lock-down. but infections are coming through those with children at school, creating many home isolations

Floods in NSW and Queensland have also been a powerful feature, and a constant reminder that climate change is affecting us in the here and now.

It has been a busy time with a large cohort of trainees, creating the conference seminars, and the various educational seminars we have on the go.

Our management committee team all contribute in their various ways to have ANZAP functioning well and strong. Thank you to you all! It is exciting to also have 2 recent graduates to join the MC, giving us fresh ideas and energy.

Anne Malecki is away on leave and I deeply appreciate how much she does. We have a very able temporary administrator in Vanessa Stembridge. I have taken over a lot of the administrative decision making. It has felt somewhat overwhelming, but for Anne, it's just part of her day. I am keen to see her back!

Our ANZAP conference had been postponed twice already, and we, the conference committee (Leo LaDell, and Carol Marando) were having to do it a 3rd time. So, we decided it to split it into 4 linked seminars, all holding the title "Deep Roots of Trauma: Attachment and Adaptation through the Lifespan"

The 1st seminar of the conference series had Jackie Amos, our keynote, Joan Haliburn, and Diane Zwimpfer from New Zealand.

The 3 presenters complimented each other and really held well the theme of the conference. Jackie addressed Bowlby's attachment theory, and showed us so clearly and well how it can offer explanatory frameworks for attachments that are traumatising, and how the infant adapts in order to survive within the traumatising attachment. Diane gave an exquisite presentation on clinical work where all the trauma was held in the implicit memory system, and embodied, and how she worked to process this when it is out of reach in the explicit memory. Joan then gave us clinical examples of children aged around 8-10, and how she played boardgames with them to help them negotiate when they have been immersed in intergenerational trauma.

The 2nd seminar was held on Saturday 9 April, with another gathering of 3 excellent speakers in the area of trauma and attachment.

I also hope you will attend all 4 seminars, to complete the conference via these seminars.

The book launch of "The Silence Between Us" is our own Cecile Barral and her daughter Oceane Campbell's power memoir of a mother and daughter's journey through attempt of suicide, and it's aftermath. This launch was to be at the conference, but we held it via zoom instead. Both Cecile and Oceane gave us a reading, talked freely of the writing, and creating of this moving and wonderful memoir.

Cecile and Oceane will feature in our evening seminar we are holding with PITSIG, our UK colleagues. Seminar. This is on Friday 24th June, from 6 -9 PM (EST). The title is Listening to the Voice of Experience: building bridges between us. We will have 2 other speakers along with Oceane, to speak of their lived experience of mental health.

In October, we will hold our pre-conference workshops (Friday 21st October) and a one-day conference (Saturday 22nd).

- The workshops will be at University of Technology Sydney (UTS), while the conference will be at the Ridges Hotel.
- Our graduating trainees will have a graduating presentation and ceremony on Friday evening of the workshops. Everyone is welcome to listen to their wonderful dissertations.
- Jackie will be coming up to do a pre-conference workshop on Friday 21 October, continuing the theme of the conference seminars. She will present a paper on clinical presentations on the Saturday. Don't miss her – she is fabulous!

- Else Guthrie will present as a key note for this one-day conference. She will zoom in from the UK. Because of the time difference, we are starting this conference at 8:30 AM.
- AGM will be held at this one-day conference.
- Call for papers will be going out shortly.
- We are hoping New Zealanders will travel over here.
- I hope to see everyone joining us for all of these activities!

Faculty Report

Nick Bendit

We have 20 trainees in year one, 17 in year two and five in year three. The intensive training conducted over Zoom went well, but we missed the face-to-face interaction of the trainees. This is the second year in a row we have had to do this because of the pandemic, but hopefully the last! The initial seminars and supervision over the last month seem to be progressing with few hiccups. Our faculty has expanded significantly this year. I would like to welcome the new faculty members and am excited to introduce them to the privilege and satisfaction of training a large cohort of new trainees, some quite experienced but new to the CM model, and others who are inexperienced in psychodynamic psychotherapy.

After a gentle "revolt" by the graduating trainees against the impersonal and possibly underwhelming nature of having a Zoom graduation last weekend, we have postponed the graduation until the weekend conference in October, with the hope that New Zealand and Australian trainees can receive their graduation certificates and give a synopsis of their dissertations in person to the current trainees and faculty and friends. This will allow us to formally congratulate Chris Garvie, Deb Moran and Anna Dickson from New Zealand and Beth O'Brien and Jane Middleby-Clements from Australia on the successful completion of the ANZAP three-year training.

PITSIG Matters

Comments from PIT-UK Chair

Simon Heyland

Since the last issue we have undertaken a soft launch of PIT-UK as a formal organisation to supercede PITSIG. For an interim period the PIT-UK officers will be myself (Chair), Frank Margison (Vice Chair) and Mary Lewis (Treasurer), pending an AGM and formal elections.

I am very pleased to be able to report that face-to-face training in the model is resuming in the UK now that covid restrictions have eased. The Level 1 (Introductory) course will take place face-to-face at the University of Manchester from 9-13th May. The course offers a short introduction to the conversational model, covering theory and practice and of course including skills training in the form of therapy roleplays. Many thanks to our course lead Richard Brown who has worked tirelessly to enable this course to resume.

Richard has also been leading on setting up our long-planned Level 2 (PIT Practitioner) course, which will offer more detailed theoretical teaching and skills training than the Introductory course and also include supervised practice of delivering therapies. We are excited to be moving towards having a start date for the first cohort of students – hopefully later this year. So look out for further details in PIT-UK communications, and if you are interested in applying please email me s.heyland@nhs.net or Richard Richard.J.Brown@manchester.ac.uk

There is also some significant UK research news. Congratulations are due to Else Guthrie who has launched not one but two large-scale randomised controlled trials of PIT for self-harm this year. I'm sure we will be hearing about the formal outcomes in due course in scientific journals (and at PIT-UK events) but in the meantime it's great to think about how many patients will get access to psychotherapy within the two trials. Such treatment is vanishingly rare in the UK for this group of patients.

Returning to online news: the all-new PIT-UK website is approaching completion, and it has

recently been agreed that the site will include (in the 'Resources' section) copies of teaching slides from our bimonthly CPD sessions. Members will also be able to access the full suite of teaching videos and other valuable materials. As the website launch approaches we need to develop a website team – if you have skills/interest in taking part in this work please email Frank Margison frmargison@aol.com or Laurence Regan laurence@lregan.com

And lastly, we are looking forward very much to the second annual meeting between ourselves and our ANZAP cousins, in June 2022. It promises to be an excellent event, and I hope to see you there.