

EDITORIAL

What Is To Be Done?

Reflections on the Bowlby Centenary Year

The launch of the journal *ATTACHMENT* last year was a significant marker of Bowlby's centenary. Attachment researcher Howard Steele welcomed the Journal, saying, 'This new journal speaks to the heart of all that John Bowlby devoted himself to . . . in this Centenary year, there may be no greater tribute to him than the launch of *ATTACHMENT: New Directions in Psychotherapy and Relational Psychoanalysis*.'

The first volume of the Journal reprinted Bowlby's groundbreaking work *44 Juvenile Thieves*, alongside contemporary commentaries. Looking back over this history gives us a fresh perspective. The thinking provided by Bowlby and by attachment theory provides us with a revolutionary shift in understanding mental health and wider issues of social relations and social difficulties. In this Centenary year, it is clear that Bowlby's insights are more relevant than ever; but in historical terms they are still recent, still challenging, and still controversial. We still have a struggle ahead until the importance of attachment history and the need for secure relationship becomes integrated into society's understanding and treatment of mental distress.

In 1961 Bowlby wrote, in 'Childhood mourning and its implications for psychiatry',

During the past 20 years much evidence has accumulated, pointing to a causal relationship between loss of maternal care in early years and later mental disturbance. Although there are psychiatrists who still challenge this general conclusion, a more usual attitude is to accept there is probably something in it and ask for more information.

I sighed when I re-read this quote earlier this year. My own experience of the interface with psychiatric services in the UK in 2007 has made me wonder if we have gone backwards, or at least that things have not improved since Bowlby wrote this over thirty years ago.

This was really reinforced for me a few months ago, when I was visiting one of the psychiatric hospitals in an inner London borough. The ward was

overcrowded, with people sleeping on mattresses in the communal areas because of a shortage of beds. Black and Minority Ethnic community patients were noticeably over-represented.

I soon discovered on visiting the person I was there to assess that no one on the ward was being offered talking treatments. The consultants had told me that people in psychiatric hospital were 'too ill' to have therapy. It would distress them and make them worse. I also became quickly aware that the disruption of the high turnover of patients and staff was not mitigated by any awareness of Bowlby or attachment issues generally. Nurses and patients were discouraged from making relationships, or having particular bonds, and this included a policy of not telling patients when a nurse's next shift might be, so they did not come to rely on support or continuity from any particular professional.

The nurses explained that their training focused on enabling clients to cut off from their feelings, distract themselves from their distress as much as possible, and to keep occupied.

The staff's approach reminded me of the attitudes to children in hospital, separated from their parents, when Bowlby first began his work. The 'detached' child who has given up and dissociated from his or her anger and distress at being left was felt to be much more manageable and wrongly felt to be better off than a child who was visited regularly by their parents with the normal result of protest, anger and tears.

I discovered that a high number of other patients on the ward were also being given ECT without their consent. In one instance, a young man's psychiatrist had decided that he was in too much distress because he kept crying. Urgent intervention was needed. Since being in hospital, the only treatment he had been offered was medication. It was now felt that the drugs were not acting quickly enough. The psychiatrist insisted that he needed a course of ECT – sometimes known as electric shock therapy; and that since he would not consent to this, he would need to be sectioned, so that this could be carried out without his consent. At no point had he been offered any talking therapy. ECT, because of the risks and side effects, is usually considered to be a last resort.

The experience reinforced powerfully for me how far we still have to go in this country in even beginning to make a case for attachment-based and relational therapy. The National Institute of Health and Clinical Excellence's guidelines state that psychodynamic/psychoanalytic therapies are not an effective form of treatment for ANY form of mental distress. Yet treatments like bibliotherapy and computerized CBT are recommended for a number of mental health problems. Indeed, a recent Government report (Department of Health, 2007) on psychological therapies recommends both of the above. In this report Patricia Hewitt states that 'evidence is now available which proves particular therapies are effective'. She states that the cheapest, quickest options must be

chosen. The report emphasizes that psychological therapies, NOT psychoanalytic/psychodynamic therapies, are needed alongside medication and ECT in order to enable people to 're-educate themselves, to have a more positive attitude and to think differently about their lives and their past'. This attitude towards mental pain is 100 years out of date. In 1908, Dr George Walton, a neurologist at the Massachusetts General Hospital and author of a best-selling book titled *Why Worry*, said, 'Between getting up and doing something and analyzing a dream it seems to be that an ounce of Muldoon is worth a pound of Freud' (Putnam, 1910). In 1913, William Alanson White and Smith Ely Jelliffe argued the opposite: 'Practically all such works have stopped short at the point they should have begun. They have told us how to patch up the broken machinery but rarely have they suggested or given directions for avoiding the wrecks' (p. v).

I was also aware, however, from previous visits to other psychiatric wards that year, that having a psychotherapy department – even a psychoanalytic psychotherapy department – is not in itself a solution. In 'On knowing what you're not supposed to know and feeling what you're not supposed to feel', Bowlby (1988) writes that there is a 'Strong tradition in Psychoanalytic thought on focusing attention on fantasy and away from the real life experiences of childhood' (p. 100).

Attachment-based and relational therapists who do manage to get work or placements in the NHS often find themselves accused of not being properly psychoanalytic or of encouraging dependency because of the emphasis on relationship and attachment needs.

It struck me what a similarity in approach I was finding in the few psychoanalytic services in the NHS, the psychiatric services, and cognitive behaviour therapy (CBT). They all share an emphasis on a one-person psychology, and a turning away from what Bowlby terms experience in the real world.

Whether it is genetics, biochemical imbalance, intrapsychic conflicts and fantasies, or faulty thinking and a negative attitude, the aetiology of mental distress continues to be placed firmly within the individual themselves and not as a response to the circumstances in which they find themselves.

The links between early attachment relationships, trauma, loss, and neglect are either ignored or under-estimated. Even where acknowledged, the logical treatment for mental distress that has arisen in the context of a damaging attachment is systematically opposed. The logical treatment would be a long-term relationship to provide a new model of attachment. Current services, if anything, are moving in the opposite direction.

There are two questions here:

1. Why is there such a problem in our society with acknowledging the impact of childhood experiences on our mental health later in life?

2. Why is there so much concern that if these experiences are talked about, we (patients and professionals) will not survive it? We will become more ill. We will get upset and we will be worse.

CBT has a similar concern. Its emphasis is on positive attitude, a need to separate feeling from events, to have a different cognitive approach. The suggestion is that we can out-think the feeling. We might term this intellectualization, or dissociation. The Royal College of Psychiatrists states, in recommending CBT, 'Our thoughts cause our feelings and behaviours, not external things like people, situations and events' (Department of Health, 2007, p. 28) and praises CBT for enabling patients to 'Question a self-critical or upsetting thought and replace it with a positive one that they have constructed in CBT' (*ibid.*). Look on the bright side, keep a stiff upper lip, cheer up – it wasn't so bad really.

In her opening to the Introduction to *The Drama of Being a Child* (1987), Alice Miller writes, 'Experience has taught us that we have only one enduring weapon in our struggle against mental illness: the emotional discovery of the truth about the unique history of our childhood' (1987, p. iv). From our own personal and clinical experience, we know this to be true. The challenge for us as therapists is to struggle against mental illness – and to be heard – in a society which finds the discovery of emotional truth profoundly threatening and disturbing. Our deepest needs for secure attachment and belonging – needs that are at the core of being human – are dismissed at the cost of our health, at the cost of safety from violence and terror, and at the cost of our capacity to create and build harmonious, explorative, and co-operative societies.

The Bowlby Centenary also made me think about the history of attachment-based psychotherapy. For many attachment-based and relational therapists there have been two original major influences: John Bowlby (attachment) and Alice Miller (advocate for the child within). Their insights form the basis of effective and ethical clinical practice.

Bowlby wrote of the importance of real childhood experience and the impact of 'knowing what you're not supposed to know, and feeling what you're not supposed to feel' (Bowlby, 1988). Alice Miller also writes about the knowledge and experience we are supposed to banish from our consciousness. This reminds me of the knowledge and feelings that the NHS currently needs us, as patients and practitioners, *not* to know and *not* to feel.

As clinicians, we know that therapeutic treatment needs to include affect and affect regulation, to include the body, to *integrate* affect and cognition to facilitate a capacity to process and reflect on feelings and experience. We also know that this work needs to be long-term, as it needs to provide a new working model of relationship, a possibility for intersubjectivity in which the whole of who we are is welcomed and accepted, rather than the compliant 'as if' personality described by Alice Miller, or the resigned detached child whose

distress does not upset anyone. As an attachment-based relational therapist and supervisor, I am reminded every working day of the profound, life-changing clinical work that is being done by committed students and colleagues, especially through low-cost work, with patients, many of whom would have been labelled as unsuitable or too ill for therapy.

I want to quote some words from one low-cost Blues Project¹ client, written after three years of therapy. When he came into therapy, this young man was struggling with obsessions and compulsions, psychotic and sadistic episodes, profound dissociation of his childhood and was barely able to function in the world. He wrote to the director of the film *Tarnation*, after he saw it at a screening earlier this year.

I saw *Tarnation* a few months ago at a charity screening organised by my therapist in London. I could never have afforded therapy if it hadn't been for the low cost 'blues project'. My parents left me at my grandparents at least a few days a week ever since I was born and I think of my grandparents as my parents. My relationship with my mother is dead . . . it's like talking to someone on the street, except that we know a lot of the same people. A few years ago I tried to confront her over the physical and emotional abuse she inflicted on me as a child . . . but she just attacked my therapy and said it wasn't working. I was told that I was a psycho since I was a boy, and hearing it again made me start to believe it. Now that I've had therapy for a few years, I believe that change has been taking place in my brain (not that I understand neuroscience in the slightest) but I now know it *is* possible . . . and I'm certain that I'm recovering. I can tell from the increased emotional strength and decrease in psychosomatic symptoms. I still wake up scared in the night sometimes . . . but I know that these feelings are from the past, and I won't let them destroy the life I have now.

I feel sorry for my parents because they suffer from their repression too, but the child in me needs to be heard.

Living with denial or dissociation has often been a life history for our clients. Their emotional truth has previously been silenced or has felt too unbearable to acknowledge. We know that denial and dissociation of affect from cognition are very effective short-term coping strategies, but do we want mental health services to promote recovery or to strengthen defensive mechanisms of avoidance and dissociation?

Because we are promoting an approach to mental distress that goes against the tide of the current direction in the NHS, getting funding to subsidise the cost and outreach work will be a struggle. It is no mean task to take on this struggle and influence the culture of funding in this area, to make steps toward building partnerships and being funded by the NHS to undertake attachment-based therapy with very distressed or traumatized clients that they recognize they have not been able to help.

In this context of swimming against the tide, outreach work is more important than ever.

As attachment-based and relational therapists we often find ourselves in the uncomfortable position of being messengers bringing unpleasant knowledge and truths. We are aware of what has happened to prominent therapists who speak out about trauma. A great deal of backtracking has happened in the profession once angry parents accused of child abuse invented the concept of 'false memory syndrome'. And it is fear that leads to this backtracking.

Being a witness to childhood trauma and pain is at the core of attachment-based psychoanalytic therapy. This is part of Bowlby's legacy. He was one of the first psychoanalytic thinkers in the UK to speak out about multiple personality. In wider society, we also find ourselves voicing controversial and painful truths about the care that small children need, and about the consequences of disrupted and broken attachments in relation to violence, social alienation, and mental health.

Alice Miller asks,

Is it possible, then, to free ourselves altogether from illusions? History demonstrates that they sneak in everywhere, that every life is full of them – perhaps because the truth often seems unbearable to us. And yet the truth is so essential that its loss exacts a heavy toll, in the form of grave illness. In order to become whole we must try, in a long process, to discover our own personal truth, a truth that may cause pain before giving us a new sphere of freedom. If we choose instead to content ourselves with intellectual wisdom we will remain in the sphere of illusion and self-deception. (Miller, 1987, p. 29)

Our approach to mental health is a reminder that the past must be remembered and not denied, pain needs to be felt and spoken, that we need to end the secrecy and silence around the damage human beings do to one another. And that we need to understand the joy, health and wholeness that emerge from love and a sense of belonging. This is the only way to bring about lasting change for those in distress or repeating destructive patterns.

The Quakers coined the term 'Speaking truth to power' in 1955, and Anita Hill, who spoke out against sexual harassment by a high court judge, chose this as the title of her autobiography. We need to keep saying what we believe with courage and integrity, including fighting against attempts to silence abuse within our own profession. I hope that we can all continue to do this in our clinical work and in the different settings in which the courage to voice painful truths can be needed. This can be an intimidating and alienating experience, particularly for many therapists who find it easier to listen and to see than to speak and be seen. I find the inspiration to keep fighting in the words of a very courageous woman who is very much the hero of the moment, and a veteran of speaking truth to power – Aung San Suu Kyi, the opposition leader in Burma:

Fearlessness may be a gift but perhaps more precious is the courage acquired through endeavour, courage that comes from cultivating the habit of refusing to let fear dictate one's action, courage that could be described as 'grace under pressure' – grace which is renewed repeatedly in the face of harsh unremitting, struggle. ['Freedom from fear' speech, 1990]

Note

1. Blues Project: A low cost psychotherapy service provided by The Centre for Attachment-based Psychoanalytic Psychotherapy.

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