

Tavistock and Portman Staff Publications Online

BOOK CHAPTER

Original citation: Wren, Bernadette and Kavner, Ellie (2012) *A plurality of just answers*. In: Contemporary developments in adult and young adult therapy: The work of the Tavistock and Portman Clinics, Volume 1. Tavistock Clinic Series . Karnac, London, pp. 42-62. ISBN 9781780490069

© Bernadette Wren, and Ellie Kavner, 2012

This version available at: <http://repository.tavistockandportman.ac.uk/>

Available in Tavistock and Portman Staff Publications Online

The Trust has developed the Repository so that users may access the clinical, academic and research work of the Trust.

Copyright © and Moral Rights for the papers on this site are retained by the individual authors and/or other copyright owners. Users may download and/or print one copy of any article(s) in Tavistock and Portman Staff Publications Online to facilitate their private study or for non-commercial research. You may not engage in further distribution of the material or use it for any profit-making activities or any commercial gain. You may freely distribute the URL (<http://repository.tavistockandportman.ac.uk/>) of Tavistock and Portman Staff Publications Online.

This document is the published version of '*A plurality of just answers*'. It is reproduced here with the kind permission of Karnac Books. You are encouraged to consult the remainder of this publication if you wish to cite from it.

CHAPTER TWO

A plurality of just answers

Bernadette Wren & Ellie Kavner

Multiple identities and tribal loyalties

With the introduction of a more competitive, outcomes-oriented, and micro-managed NHS political economy, many mental health institutions have become ideological battlefields where struggles for disciplinary primacy are being waged daily. In our workplace, rival modalities—articulating competing theories about and remedies for troubled behaviour relationships and inner worlds—are often seriously out of sympathy with each other. Many staff express anxiety about the way one model may gain favour over another within the NHS, and a fierce determination to defend time-honoured principles and practices in their clinical and teaching work.

With backgrounds in clinical psychology (BW) and social work (EK), we are two systemic psychotherapists working in an NHS institution, the Tavistock and Portman Trust, facing a future full of uncertainty. How and where we will be working in another five or ten years' time is unpredictable. But, whatever is to come, we think there are a number of related risks attached to our adherence to the often sharp boundary marking that informs the working practices in our own and other mental health services.

In our work we are both engaged in multiple roles in training, clinical practice, management, and research. Like many colleagues, we think we avoid being rigid in the reach of our ideas. We engage regularly with discourses from systems theory, sociology, developmental psychology, psychoanalysis, philosophy, politics, and social learning theory. Our work as managers and clinicians is often cross-disciplinary, and we enjoy our cross-modal interchanges. We are aware that many of the names most proudly associated with our institution drew on ideas and insights from a range of disciplines to develop powerful and influential new models of explanation and intervention.

Indeed, on the face of it, numerous disciplinary identities are available for people working in clinical, research, and teaching posts in mental health. One's professional self may be linked to one's original profession, one's psychotherapy training of choice, the client group with whom one has developed some expertise, and the setting of the work. In our Trust the development of services in community settings, once thought highly unlikely places for psychotherapies to thrive, with people who might once have seemed unlikely candidates for therapy, has necessitated a high degree of flexibility and adaptability in the choice of modes of intervention. The context of such work—schools, special-needs teams, GP practices, baby clinics, community drop-in centres—can press for the convergence of ideas about what approaches are required and possible.

But such seemingly multiple opportunities to build a layered professional identity often belie the extent to which many people experience the world of mental health as rigidly organized, permitting little interplay between different ideas and approaches. Practitioners, allied with others in their professional discipline and/or their therapeutic modality, often set great store on emphasizing differences in their precepts and praxis. The virtues of cross-modal working may be trumpeted at an institutional level, but attempts at collaboration frequently falter: innovative cross-disciplinarity seems elusive. In scholarly work, cross-citation between modalities is rare. Like many, we experience the strong tug of tribal loyalty when our guiding principles are misunderstood or undervalued and a sense of pleasure in cleaving to our preferred disciplinary or modality-based certainties. But our failures in this regard remain local and personal and do not often become occasions for institutional self-examination.

In this chapter we reflect on what we have learned about why it can be so difficult to work together among differences and how we might respond from an organizational point of view to the challenge to support cross-disciplinary and multi-modal work. We consider what would help people to function with more generosity and curiosity towards their colleagues from different modalities. In doing so, we explore the dangers of ossification, the fear of losing creative energy, and the obstacles to renewal.

Disciplinary responses to changing contexts

The new political economy of the NHS has come to embrace the apparatus of evaluation and controlled outcome research, the presentation and debate of results, and a range of techniques for the micro-assessment of practitioners. While it is widely argued that the primacy of evidence in medicine—designed to ensure that money is allocated efficiently and that patients are protected through knowledge of the most effective treatments—has translated awkwardly into the world of mental health, services have been obliged to make a commitment to routine assessment and outcome monitoring and to learning ways to promote, evaluate, and sell their services. The idea that science will determine how people can be helped has gained strength. Psychotherapeutic models that show their quality through good randomized controlled trials (RCTs) deserve to do well, it is argued, and should push others out of the marketplace. The NHS, we are told, should not support unproven psychotherapies, no matter how well-meaning and well-liked. Unsurprisingly, treatments that ostensibly make a better fit with the technologies of standardized assessment are those like cognitive behavioural therapy and structured parenting group work whose methods are largely rational and based on the client establishing treatment goals, learning new skills, and testing out beliefs.

Alongside these changes have also been moves, welcomed by many, for the greater involvement of patients/clients in their services. The expressed wishes of clients are increasingly accorded respect, options for treatment are outlined to them, and their views on their experience of therapy are sought. These various transformations have created a new context for considering how well the established psychotherapy schools are serving the public and whether further

innovation, determined collaboration, or a return to tradition is most needed.

For the Tavistock and Portman, these changes within the NHS have been dramatic. Until the introduction of the internal market in the 1990s, the institution thrived for several decades within a mostly benign and stable NHS context, staff working almost exclusively in psychodynamically informed ways, with family systems psychotherapy developing in the Child and Family Department in the 1970s a small but active clinical team.¹ The last ten years have seen the introduction of a range of brief therapies—such as structured interpersonal therapies, parent training, and cognitive behavioural therapy. While some staff see these as psychologically naive interventions whose effectiveness has been greatly exaggerated, others see this widening of brief and pragmatic treatment options as a progressive change forced on an essentially conservative and elitist institution.

Reading of the Tavistock and Portman's history suggests that innovation in the face of changing times is nothing new, that adapting models to novel settings and client groups is an activity that has long been a recognizable part of the Tavistock and Portman's intellectual and operational repertoire. In Dicks' history of the institution published in 1970, he clearly demonstrates that in its early days the Tavistock pioneered an approach that was avowedly eclectic and multidisciplinary:

While psychodynamic, the Clinic's doctrine beyond this general orientation was to "have no doctrine", but only aims: to help, to understand more and to teach its work. As such it was the meeting-ground of psychotherapists of several schools or of none, making for a certain vagueness and lack of theoretical homogeneity, but also for flexibility and a wide variety of techniques and viewpoints. [Dicks, 1970, p. 2]

While Dicks allows for doctrine-free thinking only within the confines of a broadly psychodynamic thought-space, his perspective on theoretical heterogeneity is, nevertheless, striking. The current crisis tends in contrast to evoke feelings of intense anxiety about the capacity of institutions to meet the challenge of change without catastrophic loss of core ways of working and teaching. Patrick writes about reactions to the way psychoanalysis in the public sector has evolved:

We can come to feel that even evolution involves an abandonment of our internal objects. So electrically charged is the history of

psychoanalysis that such crimes can feel quite unforgivable. . . . Our household gods, and indeed our cultural superegos are powerful entities. [Patrick, 2010, p. 9]

This kind of anger and fear in response to change may be presented simply as a passionate concern to defend a venerable and valued model of clinical and teaching practice. But we will argue that such a response has a more complex character, representing a problematic amalgam of reactions to a set of taxing demands at a personal, disciplinary, and institutional level.

If one accepts that psychological and psychotherapeutic understandings are immersed in a historical process, then it has to be that new kinds of knowledge continually emerge as a result of theoretical, social, or even technological change. As new contexts arise, mental health institutions have a responsibility to foster exploration into diverse new areas. Disciplinary or psychotherapeutic modality groups, which may be said to "own" knowledge, must accommodate and explore these new contexts and the questions they throw up, authorize new knowledge extensions, or become moribund. Yet this need for a discipline to reach beyond itself can be fundamentally at odds with the institutionalized nature of disciplines and the organizations that represent the different therapeutic modalities. As such professional groups and networks form and elaborate; they of necessity build around themselves administrative and institutional superstructures that can become rigid and increasingly unable to adapt to new contexts. From the perspective of an anthropologist struggling to work in conjunction with economists, Harriss notes that

"Discipline" . . . produces the conditions for cumulation of knowledge and deepening of understanding of the physical and social worlds. But it is also clear that "discipline" is constraining and that it may be pushed to the point where it limits thought (and so becomes constraining and even repressive rather than productive). [Harriss, 2002, p. 1]

For Harriss, working *against* the disciplinary grain is essential for intellectual health:

Disciplines, like other kinds of sects, may be characterised by "religiosity", when particular practices or ways of acting come to be venerated in themselves, and others treated as quite unacceptable for no other reason than that they do not conform to the currently accepted canon. . . . The development of knowledge

and understanding requires both "discipline" in the key sense of "instruction and exercise" that inculcates the system of rules, and a healthy disrespect for particular systems of rules when they stand in the way of the pursuit of knowledge. [Harriss, 2002, p. 1]

It is sometimes said, carelessly, that different psychotherapeutic modalities operate within different "paradigms". Perhaps we are used to thinking of the early-twentieth-century stand-offs between biological psychiatry, psychoanalysis, and behaviourism, believing that very different epistemologies are at work when mental disorder is under consideration: incommensurable norms of reasoning, causality, and truth. But do different therapeutic approaches differ so fundamentally? Is translation from the language of one into the language of the other so problematic? Does divergence in notions about how one comes to formulate a client's difficulties, how theory is developed, or how the idea of "evidence" is understood mean that we are condemned to misunderstand the reasoning within other modalities?

This seems unlikely; indeed, the fact that we can detect differences already presupposes a large degree of consensus, a common coordinate system on which to plot the different discursive positions. But it is only by making the effort to translate that we will come to a better realization of where and for whom sticking points are perceived to be. Consider Bolton and Hill's (2003) bravura account of parallels between a Freudian conception of intrapsychic defences and a post-empiricist conception of scientific theories.² There is real excitement in thinking about how a consideration of the points of difference between these conceptualizations may tell us something important about each and about their application in our work.

From many standpoints, lay and expert, mental health disciplines are seen to substantially claim the *same* subject matter and suffer only from being unwilling to share their knowledge easily and generously and to collaborate. Certainly, the two key models in the Tavistock and Portman share an orientation to the significance of relationships for how mental distress and disturbance emerge and develop, and to a recognition of

how disturbed individuals, communities or institutions may impact upon the minds and functioning of those engaged with them, or . . . the manner in which teams and organisations can come to act in manners determined by their work and the relationships that constitute such work. [Lemma & Patrick, 2010, p. 6]

But despite such important shared positions, what tends to be emphasized in this Trust are the differences: differences not only in the guiding theoretical concepts and key forms of practice, but also in the relationship to theory, to tradition, and to the idea of change.

Family systems thinking sustains an insistent emphasis that a person's life is not merely coloured, but radically shaped, by the values and beliefs associated with his or her wider community and the prevailing power structures of gender, class, and race. Systemic therapists constantly work to theorize the social in explanatory accounts of clients' intimate lives, to elaborate the way in which subjectivities are formed within familial processes and relationships and the way in which the social and cultural are played out in these processes and relationships. This broadly post-positivist and social constructionist epistemology is also influential, however, for clinicians working within other models. Some psychodynamic practitioners acknowledge that

subjectivities are racialised, they are genderised, they are laced with the context of culture and epoch, and these phenomena constitute forms of identity and forms of difference that are powerfully multi-dimensional. [Harris, 2005, p. 1090]

Like systemic therapists, some psychodynamic practitioners may also be committed to the view that social and psychological theories, far from mirroring a reality independent of them, partly define and form that reality and, importantly, can transform it by getting people to articulate their actions and feelings in new ways (Fairfield, Layton, & Stack, 2002). From this standpoint all theories are seen as contingent, with people invested in them for complex reasons; as therapists, we would accept the "complex unsettledness" (Harris, 2005) of our central theoretical constructs, to a point where, as Mitchell wryly notes, "it sometimes appears that the capacity to contain the dread of not knowing is a measure of clinical virtue; the fewer the convictions, the braver and the better" (Mitchell, 1993, p. 43).

Of course this emphasis on different models as provisional, socially situated templates for understanding some portion of human experience, the stress on the *ethics* of the therapeutic encounter in balance with the *technical*, is for many cognitive, psychoanalytic, and indeed family therapy clinicians profoundly wrong. For these more traditionally minded professionals, therapeutic equipoise is a hollow creed; the need for certified, rigorous expert knowledge remains important,

with the different disciplines or modalities seen as offering completely contrasting skills, often in competition, for formulating clients' problems and providing solutions to them. Thus it is that splits can occur among modalities, as much as they can between them.

Whether one sees the different modalities as operating according to incommensurable and competing logics or as sharing a common thought-space, the fact is that the phenomena with which we grapple—mental distress and disturbance—exhibit a degree of complexity that our current models can hardly encompass. Multilayered and multidimensional explanations are required, and it seems foolish to take intellectual sides too vehemently. We need to develop our preferred models for their capacity to illuminate certain dimensions of experience, unpack certain processes, and analyse certain occurrences and observations. Yet we also need to somehow hold in mind alternative or additional theories in the human and natural sciences as relevant to our quest to understand and intervene in the forms of distress and disorder that present to us.

*Multidisciplinarity, cross-disciplinarity, interdisciplinarity:
what inhibits collaboration?*

What forms of collaboration might we imagine? We are all familiar with *multidisciplinary* teams in mental health. These usually involve a non-integrative mixing in which each discipline or modality retains its methodologies and assumptions without mutual change or development. Typically, the key question in multidisciplinary teams is how well a clinical problem facing the group can be unpacked into separable subparts and then addressed via the distributed knowledge in the team. This is certainly the extent of collaborative work at many mental health institutions. Knowledge from more than one discipline is drawn on, but the disciplinary identity of each is preserved. While principles and practices are not held to be directly in contradiction, boundaries nevertheless remain firm. One discipline typically emerges as dominant in any interpretative enterprise. This kind of multidisciplinary can be a benign and comfortable stance, or it can amount to no more than working in parallel and in bad grace. There is always the danger of rigidity and stereotyping, with defensiveness precluding a really thoughtful response to the other's ideas.

A more thoroughgoing *cross-disciplinary* form of collaboration aims to illuminate the subject of one discipline from the perspective of another. It rejects the old multidisciplinary paradigm of highly bounded traditions and half-hearted collaboration and makes a bolder attempt to negotiate meaning, with encouragement for the expression of differences and the articulation and open questioning of assumptions. There is genuine curiosity about how one set of ideas could be theorized and perhaps made operative within another tradition. From this position we can imagine the emergence of fruitful innovations—new questions and new interventions—in full awareness of differences. One example in child-focused work is the new respect among child psychotherapists for empirical research in developmental psychology and cognitive neuroscience (Music, 2010). Here the test of genuine cross-disciplinary respect will be whether empirical research is valued not just because it bolsters certain cherished psychoanalytic conceptualizations of infant and childhood experience, but also because it interrogates them—and, of course, whether the empirical science allows itself to be influenced and challenged by clinical forms of knowing.

This kind of cross-disciplinarity may be especially relevant where the subject matter is felt to have been neglected, or where it cannot be adequately understood from a single disciplinary perspective—such as the impact of trauma, severe developmental disorders, or serious forms of eating or behavioural pathology. Such cross-disciplinary alliances can bring different kinds of science and clinical practice into conjunction, as well as direct attention to neglected issues of power and culture.

Beyond cross-disciplinarity of this kind, deep *interdisciplinary* relationships (Hulme & Toye, 2005) that blend the practices and assumptions of two or more disciplines seem more elusive still. Here clinicians try to connect and more fully integrate several modalities in the pursuit of a common task. Interdisciplinary collaborators adopt a perspective unique to the collaborative effort and distinct from those of the cooperating disciplines, creating a new hybrid field. In such work—if the interdisciplinary effort can be sustained—the boundaries are re-drawn, and an overarching and coherent conceptual framework may be forged. This is a radical stance, threatening existing allegiances and identities but perhaps offering opportunities for a re-alignment of interest groups. In turn, deep interdisciplinary initia-

tives support the development of each contributing group by helping to make the implicit foundations of its discourse explicit. There are some in our field who believe that only such newly forged, integrated academic and professional disciplines will provide adequate answers in the future to the taxing intellectual questions that perplex and confound us.

The anxiety of influence and other fears

Let us return to the question of what makes a collaborative mindset so elusive. Fear of cross-disciplinarity may, we believe, reflect the “anxiety of influence”.³ By this we mean the unwillingness to acknowledge the way other traditions have played a part in the development of our preferred models. Attempts to remind ourselves of the “mongrel” nature of much of psychotherapy’s theoretical heritage and the theoretically nomadic career of some of its leading figures can arouse worry that the intellectual integrity of our theoretical position is under attack. There is a fear of mopping up too many diverse influences and creating an unpalatable theoretical “soup”. In preference, ideas and theories are often reconstructed retrospectively as having a clear and unambiguous story of development. The current threat of new and unfamiliar, but influential, modalities gaining favour with our public-health paymasters can further steel us to commit to disciplinary narratives of exclusion and self-sufficiency.

This purist position also confers on the holders the mantle of specialness, in full flight from the “ordinary”, the bog-standard. We may believe that, if others have difficulty understanding our specialist language or the point of our therapeutic techniques, this only serves to establish the credentials of our model. It is often the case in the professional world that the wider the gap between the highly specialist ways of speaking and thinking associated with our disciplinary knowledge, the greater the perceived status of the professional.⁴

A modality’s angry defence of the self-sufficient integrity of its core ideas can mask another anxiety: that its members lack the capacity for innovation and in particular—in the current context—for developing bold, short-term profitable new treatments for the therapeutic marketplace. A passionate attachment to historically sanctioned

ideas may make it difficult for an individual or an institution to host the development of popular new interventions and may serve as a proud excuse for the failure to do so. New treatments typically bring elements from different models together in new ways, creating a different therapeutic style and idiom with only a faint nod towards its theoretical forebears. Significant innovation originates from outside, or between, disciplines at least as often as it originates from within them. To try to develop a new integrative model in a setting where pride in therapeutic "purity" is strong threatens to unsettle hegemonic claims.

Other anxieties emerge when collaborative therapy ventures seem to assume implicitly that the operation of "common factors" (e.g. Messer & Wampold, 2002) explains the success of our work, that the *shared* characteristics of our clinical practice are the effective elements. If a systems approach can be trusted to be as useful for a couple in conflict as a psychodynamic or cognitive approach, it might be because the specialist techniques are nothing other than a vehicle for mobilizing powerful, common change processes. If we entertain this possibility, we are implying that each modality's distinct knowledge base, evolved over time, may need to be re-evaluated. Similarities have also been highlighted through the process of manualization of therapeutic activity, itself a consequence of the shift to evidence-based practice. By stripping the professional language of descriptions of therapeutic activity and translating ideas into a more everyday shared vocabulary, similarities across approaches become more identifiable. We might begin to wonder whether the specialist techniques are only a means for keeping the therapist engaged and enthusiastic, harnessing the power of therapist conviction and hope. Perhaps a common sensibility is at work in all effective therapists. And perhaps there are processes in effective therapy that no modality theorizes adequately.

It is worth considering whether being a provider of core psychotherapy training has a particular role in locking clinicians into a more unanimous, un-conflicted, even heroic account of their tradition, under an obligation to pass on a corpus of certain and secure knowledge in an unambiguous and forthright way. Qualifying-level trainees often expect a grounding in the work of a pantheon of revered figures from the past, as if this were a marker of a mature discipline. Canguilhem (1968) describes the ways in which scientific disciplines tend to identify themselves partly through a certain conception of

their history: what he calls "a sanctioned" past. Rose shows the way this history is typically arranged

in a more or less continual sequence, as that which led to the present and anticipated it, that virtuous tradition of which the present is the inheritor. It is a past of genius, of precursors, of influences, of obstacles overcome, crucial experiments, discoveries and the like. [Rose, 1996, p. 3]

The danger for a training institution can be that it increasingly attracts trainees who desire this version of a clinical tradition, associated with a mono-disciplinary model of mental disorder and its remedies, and discourages trainees who might want to move more freely between different disciplinary cultures. Such a culture will be at odds with the recent development of competency frameworks (Roth & Pilling, 2007) for practitioners who are not trained in a single therapeutic model.

Alongside this defence of revered traditions may sit an anxiety that our personal attachment to our core models—the personal relevance and meaning of these models in our own lives—is no longer a defensible element in our preference for one mode of working over another. For many therapists it is a steadfast belief in a relatively unchanging model that bestows the confidence to hold fast in the face of confusing and unbearable distress. Campbell, who developed the work of systemic family therapy at the Tavistock for 30 years, wrote that

The nature of the work, calling on our own emotional reservoirs, or having unwanted feelings and behaviours projected into us, requires an unshakeable conviction that we possess an equally powerful force—our own belief system, which will enable us to survive. [Campbell, 1998]

The modern NHS, in its reverence for evidence-based treatments, can seem to ignore the crucial role played by passion and emotion in securing clinician allegiance to one model over another (Cooper, 2008). And, of course, there is also likely to be an unconscious element in our attachments to our preferred modality. Stokes (1994) suggests that psychiatrists operate with a need to deny dependency, responding to their own experience of prolonged institutionalized dependency in their own training; other therapists, he argues, idealize the therapist-client relationship, "remaining endlessly 'glued' together as if the generation of hope about the future were by itself a cure" (p. 26). Any call to surrender some of the certainties of one's therapeutic allegiance may be felt as a significant loss.

The art of mis-meeting

We believe that together these represent some of the anxieties that may lead psychotherapists to develop a backward-looking narrative characterized by metaphors of pure/impure and strong/diluted applied to ideas and the notion of insider/outsider applied to fellow clinicians. Such exclusive disciplinary or institutional narratives tend to evolve in relation to stories told about rivals or adversaries. Disciplinary religiosity requires a clearly defined, clearly maligned other. Baumann writes about how the creation of a "we" involves a delimitation of a "them"—the determination of an "other" to play the role of the outsider:

Only by crystallizing and solidifying what they are not (and what they do not wish to be, or what they would not say they are) into the counter-image of the enemies, may the friends assert what they are, what they want to be and what they want to be thought of as being. [Baumann, 1991, p. 53]

To turn advocates of another modality into the "other" often involves resorting to ill-informed mutual criticism based on anecdotes of mis-understood or atypical episodes. Where an alliance *is* struck between advocates of different models of psychotherapeutic intervention, the friendship is often formed in opposition to a hostile other.

For psychological therapists in many mental health settings, the "other" has traditionally been conventional psychiatric practice (Lemma & Patrick, 2010), characterized as obsession with diagnosis, pharmacological interventions, and non-intentional explanations. For psychotherapists, such a clear and time-honoured enemy is comfortably recognized in an adversarial contest that can serve to bolster the identity of each adversary. But this conventional enemy in mental health has to some extent lost intellectual power. In sophisticated circles, traditional psychiatry is increasingly discredited (Bentall, 2009) or seen as being limited in the application of its knowledge and expertise (Bolton, 2008). For many psychotherapists, the newer enemy is the advocate of a cognitive approach, whose recent success has taken many by surprise and who has turned out to be a determined opponent. But if dialogue was limited in the settled adversarial world of known enemies, it has become even more limited in this new competitive world where, in the United Kingdom, the National Institute for Health and Clinical Excellence (NICE) rules. In the mental health

wars, cognitive therapies are, in Baumann's terms, the "strangers", the newcomers who arouse confusion and perturbation and who must be treated with disdain. Many psychotherapists struggle to take cognitive therapy seriously as a therapeutic approach, and myths abound about what cognitive therapists think and do: their work is held to be completely formulaic and rule-bound; they are said to take no account of the individuality of the client; therapist subjectivity is treated as a nuisance factor, and so on. Caricaturing of this kind perfects "the art of mis-meeting":

Intercourse with the stranger is always an incongruity. . . . It is best not to meet strangers at all. As one cannot really keep away from the space they occupy or share, the next best solution is a meeting that is not really a meeting, a meeting pretending not to be one. . . . The art of mis-meeting is first and foremost a set of techniques that serve to de-ethicalise the relationship with the stranger . . . denying the stranger moral significance. [Baumann, 1993, p. 153]

This art of mis-meeting—this denial of the humanity and comprehensibility of the "stranger"—works against the possibility for dialogue and, ultimately, for adaptation and innovation.

We believe that open processes of contest and rivalry between different traditions, embodying different values, are part of the constitutive nature of antagonism in social life, a condition about which the political theorist Mouffe has written vividly. For Mouffe, the moral and political significance of contest and struggle, conflict and passion cannot be overstated. Tensions can be negotiated, precarious solutions can be articulated, but elimination of the antagonism can never be a reasonable aim. Acceptance of "a plurality of just answers" (Mouffe, 2000a) is the necessary condition for a democratic society. According to this view, agonistic confrontation, far from jeopardizing valuable processes of decision-making, is the very condition of its existence. A well-functioning institution will therefore be characterized by vibrant clashes of passionately held positions. Only at times of extreme crisis is there a danger that the presence of the Other might be perceived as a negation of one's own identity (Mouffe, 1993).

Writing from a cultural theory perspective, Thompson (2006) also sees this kind of conflict in any policy process as "endemic, inevitable and desirable, rather than pathological, curable or deviant". He cites the influence of Schapiro (1988), who coined the term "clumsy institutions" as a way of escaping from the idea that, when we are faced

with contradictory definitions of a problem and solution, we must choose one and reject the rest.

Clumsiness emerges as preferable to elegance (optimising around just one of the definitions of the problem and, in the process, silencing the other voices) once we realise that what looks like irreconcilable contradiction is, in fact, essential contestation. [Thomson, 2006, p. 232]

Allowing different models to have a strong and legitimate voice in an institution means committing to the belief that the liveliness of its culture rests on the possibilities for dialogue, and that from such dialogue creative developments will emerge.

*Organizational change:
the rules of the democratic game*

Of the many modalities in the current NHS mental health economy, none can have the last word on the future of mental health treatment. In our mental health institutions we should welcome the frank argumentation that arises when clinicians shape a set of collective identities around clearly differentiated positions and are supported to articulate their argumentative positions. We need to hear from those who emphasize therapist knowledge and authority about the mind and its structures, from those who explore unconscious elements of emotional life, from those who pay special attention to the constraining effect of the actually existing conditions of clients' lives, from serious practitioners of brief evidence-based models, and from experts on the science of outcomes and effectiveness. And, in addition, we need people voicing the suspicion that it is power rather than reasoning that is at stake in debates between these diverse modalities. If one of these viewpoints is ignored or dismissed, it will eventually force its way back onto the agenda. At some point, one disciplinary discourse will appear to "win" the conversation and so get to dictate the terms of debate for a while. Then the power shifts again, new voices are heard or old ones listened to afresh, experiences are re-described, and explanations reconfigured, in new or revitalized vocabularies.

What is required at the organizational level for a range of different

modalities and cross-disciplinary attempts to be heard, taken seriously, and brought "compulsively" into connection?

1. The institutional leadership needs to believe that no theoretical approach is all-encompassing, no knowledge is exhaustive. At the top there needs to be an acknowledgement that there is a dimension of undecidability between the leading therapy models, a disavowal of the notion of "universal" systems of thought whose aim is to arrive at a single, stable account of mental life and relational processes. An institution that supports genuinely collaborative cross-disciplinary work must believe that no modality represents anything more than a partial, tentative, and fallible account of the world it purports to explain. This surrender of claims to certainty and necessity can be painful:

Crusading truths los[e] their power to humiliate but they also forfeit much of their past ability to offer the succour . . . that truths used to lavish on the converted. [Baumann, 1991, p. 251]

We can claim that the knowledge in our tradition is satisfying, useful, elegant, productive, even that it fits the fact as we see them. But there is no point external to all models from which we can offer a universal judgement, a stamp of authoritative confirmation. There can be no "solace of closure" (Hall, 1991).

2. An organization needs many occasions where disagreement—and hostility—can be shaped and its destructive potential diffused. For a start, there have to be adequate settings where different disciplines or modalities are present and available for dialogue and debate. This work needs to happen in small enough groups with sufficient regularity for real articulation of positions—not parodies—to take place. We need to be wary of simplifications and acknowledge that each member of staff has multiple affiliations or identities, which are important for his or her self-definition. And there must be agreement as to the rules of the democratic game. Mouffe (2000b) reminds us that rules are not neutral procedures: they assume substantial ethical commitments. Rules in plural or "clumsy" institutions must signify a determination to confront professional conceit and unhelpful group dynamics and to dismantle the structures that allow them to flourish.

3. Institutions must resolutely challenge any assumption that the world views of the different modalities are incommensurable. People must be encouraged to work to make their meanings plain, to unpack

the givens of their approach in language that can be readily understood by "outsiders", and to use specialized language only where a term or concept is genuinely unavailable in ordinary parlance. As specialists, we should all be under pressure to share the wisdom of our approaches, to lend our knowledge, to scaffold others' grasp of our best ideas through sustained dialogue. This means paying attention to the actual detail of our cross-modal transactions to reveal and understand the intricate and uncertain process of negotiation. Some staff may be better at taking on the hermeneutic work of "translating" across languages, turning the unfamiliar into the familiar and excising jargon, and they should be valued for this talent.

4. Each discipline or modality may make its own accommodation to meet the external demands for manualization, brief-treatment models, and the quantification of outcomes. But this process of accommodation should not back us into our disciplinary corners. Rather, we should be drawn to share what we feel is non-negotiable in our approaches. We should make opportunities to spell out which technical or theoretical commitments in our modalities must survive all pressure to reduce, to trim, to package, and to measure.

5. Taking these considerations seriously, accredited disciplinary training courses should be obliged to introduce students to a sympathetic explication of at least one other model, to inculcate a critical understanding of the science of "common factors" alongside the science of "evidence-supported treatments", and to promote an authentic and energetic discussion of cross-disciplinarity in its many forms.

6. We need to make serious—and creatively playful—attempts to combine or integrate modalities. This may be in the context of working together in a service or on a case, or it might mean conceiving multilayered, pioneering clinical interventions or professional trainings. The complex difficulties that arise across the age range—such as couples engaged in intimate violence and their children, families where chronic disability or illness affect individuals across time, the impact of abuse and trauma—are examples of work where debate could be creative. Debate will focus on such questions as: where are the points of tension and the points of outright disagreement, and how can they best be talked about? What is at stake for the different professionals in deciding how to proceed? What is being emphasized or privileged in each of the modalities, and what is felt to be missing? Psychotherapy process research can help us

here with its curiosity about change processes in the talking therapies and how these may be better understood through close inspection of everyday client-therapist interchanges (e.g. Castonguay & Beutler, 2006). It may be, as social researcher Pawson complains, that "social science is a science like no other, deliver[ing] a curious knowledge base beset with inconsistency and rivalry" (Pawson, 2006, p. 1), but we might find ourselves united across the modality divide in our surprise and occasional delight at the elegant findings of high-quality, clinically meaningful research.

We do not underestimate the dangers. The emphasis on newly minted brief interventions, the paring back of concepts and ideas, the oversimplification of accepted knowledges for training purposes, can underestimate the "indescribable"—the art of therapy and human dialogue that is kept vibrant through intradiscipline conversations and scholarship and that needs to be valued and preserved. The very structure of disciplines that still exists within the NHS can provide a check to threats to quality in service delivery and workforce development. We are far from advocating the abolition of disciplinary difference, but we are trying to develop its generative rather than its ossifying potential.

Mental health institutions like the Tavistock and Portman have a public service commitment to strive for a better understanding of how the different psychotherapeutic modalities are connected, to explore what shared principles or processes link us in our diverse practices, to look at how we most creatively combine ways of working, and to engage in the critical debates that emerge when we consider our differences. We can usefully and resourcefully argue for why one approach is superior to another, not that it is superior for all time. The challenge is to feel enough confidence in one's preferred model that these ideas serve as a basis for action, while not needing these ideas to be dominant, and to recognize the way that alternative models do the same work for others. We have to manage the pull towards arguments and dissension, splits and divisions, without breaking off into destructive rivalry. This means that claims to epistemological privilege need to be disabled and disciplinary priority brought to an end. In all contexts where mental distress is evidenced and mental well-being sought, we need new alliances where people step away from complacency and dogma and start to evolve new connections, new solutions, more "just answers".

Notes

1. Systemic psychotherapy was only officially accepted as a separate discipline, and the second key modality in the Trust, in 2002.
2. Bolton and Hill write: "Threats [e.g. to expectations of safety] can be denied representation, or they can be attacked and destroyed in thought. Satisfaction of needs can likewise be thought, even if not really achieved. Such strategies operate within the mind as opposed to reality: they are acts of the imagination, and they involve departure from or distortion of reality" (Bolton & Hill, 2003, p. 293). They then draw a parallel between this insight of Freud's and "the post-empiricist recognition that some intentional states constitute the core of belief, to be protected from counter-evidence, and the inevitable conclusion then that while such protection averts perceived catastrophe, it involves at least distortion of reality, and perhaps manifest disorder" (p. 292).
3. A free adaptation of the classicist and philosopher Allan Bloom's notion of what the "strong poet" fears (Bloom, 1973).
4. On these issues, see Till (2009) for the profession of architecture.

References

- Baumann, Z. (1991). *Modernity and Ambivalence*. Cambridge: Polity Press.
- Baumann, Z. (1993). *Postmodern Ethics*. Oxford: Blackwell.
- Bentall, R. P. (2009). *Doctoring the Mind: Why Psychiatric Treatments Fail*. London: Allen Lane.
- Bloom, A. (1973). *The Anxiety of Influence: A Theory of Poetry*. Oxford: Oxford University Press.
- Bolton, D. (2008). *What Is Mental Disorder? An Essay In Philosophy, Science and Values*. Oxford: Oxford University Press.
- Bolton, D., & Hill, J. (2003). *Mind, Meaning and Mental Disorder: The Nature of Causal Explanation in psychology and Psychiatry* (2nd edition). Oxford: Oxford University Press.
- Campbell, D. (1998) (with Bell, D., Klauber, T., & Clulow, C.). *Ideas Which Divide the Tavistock: What Are They Really About?* [soundrecording]. Tavistock Centre Scientific Meeting, Tavistock Clinic, London (12 January).
- Canguilhem, G. (1968). *Etudes d'histoire et de philosophie des sciences*. Paris: Vrin.
- Castonguay, L. G., & Beutler, L. E. (2006). Principles of therapeutic change: A task force on participants, relationships, and techniques factors. *Journal of Clinical Psychology, 62* (6), 691-698.
- Cooper, A. (2008). Interprofessional working: Choice or destiny? *Clinical Child Psychology and Psychiatry, 14* (4): 531-536.
- Dicks, H. V. (1970). *Fifty Years of the Tavistock Clinic*. London: Routledge & Kegan Paul.
- Fairfield, S., Layton, L., & Stack, C. (2002). *Bringing the Plague: Towards a Postmodern Psychoanalysis*. New York: Other Press.
- Hall, S. (1991). On postmodernism and articulation: An interview with Stuart Hall. In: D. Morley & C. Kuan-Hsing (Eds.), *Stuart Hall: Critical Dialogues in Cultural Studies*. New York: Routledge.
- Harris, A. (2005). Gender in linear and nonlinear history. *Journal of the American Psychoanalytic Association, 53*: 1079-1095.
- Harriss, J. (2002). *The Case for Cross-Disciplinary Approaches in International Development*. Working Paper Series No. 02-23. London: London School of Economics.
- Hulme, D., & Toye, J. (2005). *The Case for Cross-Disciplinary Social Science Research on Poverty, Inequality and Well-Being*. ESRC Global Poverty Research Group paper. Available at: <http://economics.ouls.ox.ac.uk/14081/1/gprg-wps-001.pdf>
- Lemma, A., & Patrick, M. (2010). *Off the Couch: Contemporary Psychoanalytic Application*. Hove: Routledge.
- Messer, S. B., & Wampold, B. E. (2002). Let's face facts: Common factors are more potent than specific therapy ingredients. *Clinical Psychology: Science and Practice, 9* (1): 21-25.
- Mitchell, S. (1993). *Hope and Dread in Psychoanalysis*. New York: Basic Books.
- Mouffe, C. (1993). Pluralism and modern democracy. In: *The Return of the Political*. London: Verso.
- Mouffe, C. (2000a). Wittgenstein, political theory and democracy. In: *The Democratic Paradox*. London: Verso.
- Mouffe, C. (2000b). *Deliberative Democracy or Agonistic Pluralism*. Political Science Series papers. Vienna: Institute for Advanced Studies.
- Music, G. (2010). *Nurturing Natures: Attachment and Children's Emotional, Sociocultural and Brain Development*. Hove: Psychology Press.
- Patrick, M. (2010). Psychoanalytic psychotherapy now. *Psychoanalytic Psychotherapy, 24* (1): 8-13.
- Pawson, R. (2006). *Evidence-Based Policy: A Realist Perspective*. London: Sage.
- Rose, N. (1996). Power and subjectivity: Critical history and psychology. In C. F. Grautmann & K. J. Gergen (Eds.), *Historical Dimensions of Psychological Discourse*. Cambridge: Cambridge University Press.

- Roth, A., & Pilling, S. (2007). *The Competencies Required to Deliver Effective Cognitive Behavioural Therapy for People with Depression and with Anxiety Disorders*. Available at: www.ucl.ac.uk/CORE.
- Schapiro, M. (1988). Judicial selection and the design of clumsy institutions. *Southern California Law Review*, 61: 1555–1569.
- Stokes, J. (1994). The unconscious at work in groups and teams: Contributions from the work of Wilfred Bion. In: A. Obholzer & V. Z. Roberts (Eds.), *The Unconscious at Work*. London: Routledge.
- Thompson, M. (2006). Cultural theory, cultural change and clumsiness. In: M. Verweij & M. Thompson (Eds.), *Clumsy Solutions for a Complex World*. Basingstoke: Palgrave Macmillan.
- Till, J. (2009). *Architecture Depends*. Cambridge, MA: MIT Press.

PART II

PSYCHOANALYTIC INTERVENTIONS
WITH YOUNG ADULTS AND ADULTS