Sabato 16 febbraio 2019, ore 10.00-13.30
Sala della Traslazione, *Convento di San Domenico*, Piazza San Domenico 13, 40124 Bologna

Incontro con Robert D. Hinshelwood
organizzato dalla Comunità Terapeutica *Il Porto* (Moncalieri, Torino) e dalla rivista *Psicoterapia e Scienze Umane*
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Introduzione di Robert D. Hinshelwood

Psychodynamic psychiatry: Where are we going?

Welfare has a long history – from WW1 and before. The communalism during WW2 however started something in earnest. Perhaps Britain was earliest, only because the countries on the continent were still devastated by the war. And the US was dominated by such suspicion of communism it could only idealise inequality – despite its declaration that all men are equal. Things have changed since then, and especially in the 1980s with a change in the views of economists, and the reversion to the 18th century, and Adam Smith's notion of the "invisible hand"[1]. Reaganomics (President Reagan's economics) came in with an emphasis on the responsibility of every person to manage their own life, with a degree of independence which has become illusory. At least it appears illusory to those not subscribing to the ideology of free enterprise and neoliberalism and the belief in the complete freedom for any enterprise. Such freedom is actually much more complicated

The period from the 1940s to the 1980s was the period of reconstruction and inevitably had a set of attitudes about the relation of the individual to the community which he was part of, and which he had some responsibility to rebuild. From the 1980s, reconstruction had been accomplished. The provisions of the community, whatever they were, could be taken for granted, and the individual in his own right became almost immediately the priority.

Perhaps it was the growth and creativity of the advertising industry which helped to accomplish this radical re-orientation of attitudes. The nature of the individual, as I conveyed, was to return to the individualism of the 18th century, when of course the individual really meant the inherited aristocracy and the new financial aristocracy – not the peasants. But the principles of Taylorism and Fordism moved this pseudo-equality of the individual into the middle of the marketplace and revised it to be the individuality of *anyone* making consumer choices. It was a move, termed democratic, which was strongly assisted by the concentrated use of the *media* – especially television. Since the 1980s we have harvested the benefits and miseries of late capitalist consumerism. This, as I have tried to indicate, involves the increasing priority of the individual as towering in importance over the community.

I have started with this brief history of our recent past – as I see it. And you may not agree, but if you do, then we can see there has been a changing background to the development of our welfare services and mental health in particular. I have given an account of the move from individual responsibility for the community and its recovery to the individual's responsibility for himself. As a result in our field, this has led to a relative neglect of our work in two specific ways.

Firstly, it has led to the development of individualistic treatments, especially along the lines of medicine and medication. And secondly, the pressure on the individual to be responsible for himself has led to a decline in importance of his social responsibility for the community. This amounts to a *denial of dependency*, and a collective denial of the importance of each person to the rest of us. We are, or should be, self-supporting individuals who need little from anyone else. Our actual relations with the wider community and the communal provisions for us are on the whole denied and remain hidden, or at least they have become shadowy. Our only connections that are given prominence are with the close and immediate family. This brings into prominence those people who have a particularly disordered relation to the wider society (and to their families).

[1] La "mano invisibile" è una metafora creata da Adam Smith (1723-1790) per rappresentare una sorta di Provvidenza grazie alla quale nel libero mercato la ricerca egoistica del proprio interesse gioverebbe anche all'interesse generale della società creando ricchezza, e quindi trasformando, per così dire, "vizi privati" in "pubbliche virtù".

We might call them "personality disordered", and we place them on the *borderline* with the truly mad.

We can also note that from the 1980s, as the attitudes to the community changed, psychiatrists, at least in Britain, explicitly moved from institutional care to what was called "community care". In 1978 there was a law in Italy, too (Law no. 180/1978), which required the same change. So, there is an irony that when the idea of a community receded into the shadows and the individual came into the limelight in a rather shallow way was exactly when *community care* was emphasised in psychiatry. This has been problematic for psychiatry when the idea of community has weakened and almost disappeared in the wider public sphere.

But now, perhaps we are moving back a little in the 21st century and the debates, in Britain at least, about our dependence we have on the European Community (EU), which is opposed by the traditionalists who assert we can simply cut all connections with Europe, without any loss. This is basically a debate about dependence *versus* independence; it is a debate that has not been seriously undertaken in Western society during all the period when individualistic consumerism has been dominant.

Interestingly, our society has developed a conflict that also exists in the shadows and is not commonly recognised. That is the fact that individuals are increasingly defined by their roles, by the demographics of the categories they are assigned to – social class, gender, age, etc. But at the same time, as we conform to the roles assigned by the categories we occupy, that social pressure is denied and we are required to be fully independent as individuals. There is a blindness here – social categories are used whilst denied. This is not less true of advertising than diagnostic psychiatry. Such a conflict however may not be able to exist out of sight indefinitely.

When I first went into psychiatry as a young doctor in the 1960s, my strongest impression was the shock of the *warehousing* method of caring for people in the mental hospitals. At the time there was a strong influence in psychiatry that came from social science, and the attempt to understand these institutions. Erving Goffman was well know and his idea of the dominating influence of the "total institution"[2]. And the importance of Kurt Lewin's social field theory was an undercurrent[3]. Field theory understood the individual as a roles within society. The way individuals are pushed into roles by social forces was implicit. This led to the interest in institutionalization.

The really interesting thing is how the role-playing in terms of the force field of society could be seen as an influence for the good, or for the bad, on the individual and his identity and inner dynamics. The study of how those influences *on* the individual connected to, and interacted with, the forces and influences *within* the individuals seems crucial for psychiatry, and indeed for psychoanalysis. I found my way into a branch of psychiatry which was alert to and interested in that kind of issue – that is, the fit between the roles an individual plays, and his internal psychodynamics. I found myself reading Bion's *Experiences in Groups*[4] around 1968, and eventually, from 1969, I began working in therapeutic communities.

At that time, in the 1960s and 1970s, there was a second generation of therapeutic community workers, including Ronnie Laing and David Cooper. I was perhaps a third generation. I have therefore seen this branch of psychiatry develop through the crucial transition period from the 1960s to the 1980s up to today. It is, as I have indicated, a transition from attitudes that acknowledge the importance of a social community to the importance of the individual who consumes products (including his treatment). This means the individual person is a very different member of a community today, compared with 60-70 years ago. It means his contribution is seen very

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[2] Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. New York: Anchor Books, 1961 (trad. it.: *Asylums. Le istituzioni totali: i meccanismi dell'esclusione e della violenza*. Torino: Einaudi, 1968).

[3] Alcuni libri di Kurt Lewin (1890-1947) tradotti in italiano: *Principi di psicologia topologica* (1936), Firenze: OS, 1961; *Teoria dinamica della personalità* (1935), Firenze: Giunti, 1965; *Il bambino nell'ambiente sociale* (1948), Firenze: La Nuova Italia, 1967; *Antologia di scritti*, a cura di G. Galli, Bologna: Il Mulino, 1977; *I conflitti sociali. Saggi di dinamica di gruppo* (1948), Milano: FrancoAngeli, 1972; *Teoria e sperimentazione in psicologia sociale* (1951), Bologna: Il Mulino, 1972.

[4] Wilfred R. Bion, *Experiences in Groups*. London: Tavistock, 1961 (trad. it.: *Esperienze nei gruppi e altri saggi*. Roma: Armando, 1970).

differently. We now picture the individual in a very different way; he is a different kind of persons who is as independent of the community as possible.

As we might expect there have been serious effects on the therapeutic community over this transition. The loss of interest in, indeed antagonistic rejection of, the importance of community has made the emphasis in a therapeutic *community* an anomaly. As I have said this coincides with a tendency to reject public and social provision of care. This has been balanced in Britain at least by the adaptation of therapeutic communities to claim a special ability to cope with borderline disorders – the very personality problem that seems to be created by these changes in social attitudes.

A somewhat similar set of problems and conflicts occur in the more general field of psychodynamic psychiatry. When I trained in the 1960s, the influence of Adolph Meyer was still strong, and the integration of psychodynamics and diagnostic psychiatric was still hopeful. The history, as I have described it, together with the power of the advertising industry (and especially of the drug companies in psychiatry) has made this integrative project more and more unlikely.

The time may be approaching when new attempts at integration may come about. I am aware that this kind of integration has been especially pioneered in Italy, and Metello Corulli has been an important figure in that. I might also mention that the *International Psychoanalytic Association* (IPA) has recently formed a committee to investigate the relations between psychoanalysis and psychiatry. And one of their first achievements has been to produce a book, edited in part by Giovanni Foresti in Milan[5].

I am not myself sure about the prospects of a new meeting of psychodynamics and psychiatry. Though I am of course hopeful. And it is a good thing that the traditions from the 1940s are still alive and remembered with inspiration, even though they have been increasingly difficult to practice in the last few decades.

My final point is to indicate a more fundamental issue about this analysis of the plight of psychodynamic thinking in general psychiatry. I do not have a lot of faith in the strategies that promote projects and ideas in the ordinary way. Important though that is, we are fighting against a wide social movement from the 1980s of neoliberalism which is still powerful asserting the responsibility of the individual for his own choices, the insistence that the individual *is* the role he is playing without the need to explore further. On both sides – the neoliberal assumptions and the campaigns for more enlightened methods – are I think attempts to address and correct the "symptoms", without turning to the underlying pressures and forces from which the symptoms come. I think we need to consider the causation of the current sets of attitudes, and what sustains them. This is a medical approach, I know – Do not treat the symptoms, treat the *causes* of symptoms. But, to be fair, refocusing on causes rather than symptoms has had a lot of success in physical medicine since the mid-19th century. Our problem is that the underlying causation is composed of the sets of social attitudes which blind us to the nature of people, and have reduced them to the roles they play in a group or community.

I do not know how we can address that underlying cause of the difficulties we have in regenerating psychodynamic psychiatry. But I do think that there are small islands of resistance – that is, there are islands of different attitudes, where individuals are not just roles, and communities are not insignificant shadows. Most of all, there is the inherent conflict that despite the diminished interest in society and community, it is precisely there – in the social attitudes – that the role-identities of individuals are formed.

I have tried to take a historical perspective on our predicament today. And also to argue that to change the direction we are going, we need to identify the underlying causes and conflicts. What we do about those underlying influences, is then a problematic question, as it requires a wide social change of attitudes, as occurred in the 1980s – and in fact opposite to the changes occurring in the 1980s.

In other words – how do we change society in this respect?

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[5] Claudio Laks Eizirik & Giovanni Foresti (editors), *Psychoanalysis and Psychiatry: Partners and Competitors in the Mental Health Field*. London: Routledge, 2018.